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FINAL EVALUATION OF USAID/SENEGAL'S FAMILY HEALTH AND POPULATION PROJECT

(Project No. 685-0248)

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PREFACE

The original Grant Agreement for The Family Health and Population Project, executed on July 31, 1985, required a number of evaluations to be carried out over the life of the Project. These were to include evaluations to determine progress toward attainment of Project objectives, to identify problems inhibiting attainment of objectives, to assess information needed to overcome problems identified, and to judge, to the degree possible, the overall development impact of the Project.

The Project's evaluation plan called for three evaluations. The first evaluation was to be carried out at the end of year two to review whether procedures and institutional arrangements were in place for the proper administration and implementation of the Project and to determine if arrangements had been worked out to secure technical assistance, procure commodities, and assure effective financial management. The first evaluation was to review the nature of the coordination mechanisms that had been established and to inquire into performance of service delivery, training, education and communication activities, and demographic data collection.

The second evaluation was to have been carried out in the fourth year of the Project, building on the first, and moving beyond detailed management and administrative considerations to focus on overall program management and performance, policy and strategy development, and results of demographic data analysis.

The final evaluation--the present one--was to have been carried out during the sixth year of the Project, building on the first two evaluations. It was to study how the Project resolved implementation problems identified earlier and focus on anticipated accomplishments such as the impact of the Project on child spacing and the number of mothers having undesired or high risk pregnancies.

A major constraint on the present evaluation is that the first two evaluations were never carried out. The Project has gone on for five and a half years without an overall independent program review. Minor issues that could have been spotted and corrected earlier in the project have now become built in. The present evaluation team quickly became enmeshed in hundreds of small, detailed problems which should have been resolved earlier, but each of which now had to be followed up and analyzed.

In view of the large number of Project components and the large number of minute problems that the evaluation team found on the ground, including limited access to accurate data, the team had to be selective in what it could evaluate. USAID staff agreed that it

it might have been more effective for separate evaluations of the major Project components to have been completed before the present team came to Senegal to synthesize results and reach more fundamental conclusions.

The Project "crises" of 1989/90, a recent Government of Senegal (GOS) reorganization, and turnover of Project, USAID and Contractor personnel placed burdens on the team not anticipated in the Scope of Work for this third evaluation and made it difficult to fully understand the Project background and to secure data and views. In 1989, because of suspicions of mismanagement, the A.I.D. Regional Inspector General and the GOS Inspector General de l'Etat audited and inspected the Project. Both found considerable evidence of malfeasance, which led to the change of the Project Director and replacing the Project Accountant and Logistician. These were three central figures who had been controlling Project planning and management, all of whom had major implementation roles from the beginning of the Project, and who had received training from the beginning of the Project.

At about the same time, the Ministry of Social Development, under which the Project was originally designed, which had negotiated the Project Agreement and first two amendments, and which had supervised the Project for the first five years, and the Ministry of Health which provided the technical support and family planning personnel, were both abolished. A new Ministry of Public Health and Social Action was created which assumed the responsibilities of both abolished ministries, for management of this Project. While in the long run this reorganization should have a positive impact on the Project, in the short run, new GOS structures must learn how to carry out their new responsibilities, and former and new employees must learn how to fit into the new structure.

In 1989, at USAID/Senegal there was a turnover in the Chief of the Health, Population and Nutrition Division, and the Chief of Party of the technical assistance contractor completed his tour. One result of these changes has been a major loss of experience, operational knowledge and institutional memory. The evaluation team, therefore, found it difficult to locate primary data, to speak with people who could help us understands record and reports, or to get first hand views of what "really" occurred in specific cases. In many respects, therefore, the present evaluation is a snapshot of the Project as of March-May 1991, when the team was in Senegal.

At the time of the evaluation, USAID/Senegal had made a number of decisions which affected the approach of the evaluation team. The Mission had already decided to add money to the present Project and extend the Project's activity completion date; the Mission had submitted to A.I.D./Washington a Country Program Strategy Plan (CPSP) for 1992 to 1997 which proposed continuation of family planning activities; and the Mission decided to fund a health and a population sector analysis with proposed strategies. Since USAID/Senegal has already indicated its continued interest in family planning, and since A.I.D./W has already indicated approval of the CPSP, the evaluation team concentrated on findings and

recommendations which would help USAID/Senegal to design a better managed and more implementable project in the future. Since the sector analysis already provided guidance on policy and strategy, the evaluation team focused on management, budget, coordination, and the technical details of service delivery.

The methodology for the conduct of this evaluation and substantive background is presented in Chapter I. Chapter II covers Project administration and management. The substantive portions of the report are organized in accordance with the three main Project components. One chapter not specifically called for in the Scope of Work, but deemed essential by the evaluation team, is on the development of an effort to generate family planning service statistics and to carry out research and evaluations. This is included as Chapter X under the Family Planning Program component.

Because the report is long, it includes two summaries. The first is an extensive Executive Summary which contains a cross-cutting synthesis of the substantive chapters; the second is a Summary of Findings and Recommendations contained in the substantive chapters. This pulls together in one chapter the detailed findings and recommendations for the reader who does not want to go through the full description and analysis in the evaluation's ten chapters.

The overall organization of the substantive chapters of the report is:

The National Family Planning Program Component

Chapter III.	Information, Education and Communication
Chapter IV.	Family Planning Clinical Services
Chapter V.	Diagnosis and Treatment of Sexually Transmitted Diseases
Chapter VI.	Conduct of Bio-Medical and Psycho-Social Research
Chapter VII.	Construction and Renovation of Facilities and Equipment
Chapter VIII.	Contraceptives Logistics Management
Chapter IX.	Women in Development
Chapter X.	Family Planning Service Statistics, Research and Evaluation

The Private and Para-Public Sector Component

Chapter XI.	The Private and Para-Public Sector and Contraceptive Social Marketing

The National Census Bureau Component

Chapter XII.	Enhancing the Demographic Data Base to Improve Development Planning

The team left an English draft and a partially completed French translation in Senegal before departing from Senegal on May 11, 1991. Additional material was submitted to USAID/Senegal by the end of May. The drafts were reviewed between May and August by USAID/Senegal, the Project staff, the technical assistance contractor, the U.S. Bureau of the Census and the Government of Senegal. Ten sets of separate comments on the draft report were received. As was to be expected, comments did not always agree with one another. The evaluation team leader attempted to incorporate comments, as appropriate. He was particularly responsive to USAID's concern that the draft did not describe more of the Project's accomplishments and that there was insufficient synthesis of detail. All of the comments are included in Annex O of the report.

ACKNOWLEDGEMENTS

Devres is grateful to A.I.D. for the opportunity to evaluate this important Project in Senegal and is grateful to the many persons who gave of their time, experience, and knowledge to help the team. During the evaluation, the team had the opportunity to meet and interview over 100 Senegalese in Dakar, Kaolak, Fatick, Thies, Kolda and Zinguinchor. The team spoke with Senegalese public health officers, government administrators, public and private sector doctors, midwives, nurses, and, most importantly, to family planning clients and their families. The team was received by high government officials in Dakar, Governors and their staff in the regions, private business people, and representatives of non-governmental organizations throughout the country. Wherever the team went, they were received with courtesy. It is principally to the Senegalese people that Devres owes the success of this report.

We wish particularly to thank the Minister of Ministry Public Health and Social Affairs (MPHSA), Mr. Assane Diop, for opening all doors to the evaluation team, Mr. Sylla, the Director of the Minister's Cabinet, and Dr. Lamine Cisse Sarr, Director of Public Health, who met a number of times with the team and individual members to discuss issues of policy and procedure.

Within the Project, three persons spent hours helping the team to understand the Project. Mrs. Marieme Diop, the present Project Director, worked with the team from the very first day to help refine the evaluation scope of work. She called ahead to make sure her staff would be available to the team, and met with the team whenever she was needed. Mrs. Diop reviewed the final draft. Devres wishes her the best of luck in making use of the evaluation effort to improve the Project. The team wishes to acknowledge Dr. Ibrahima Sarr, Director of the National Bureau of the Census, who is head of the Data Base Improvement Project component. To the extent that demographic data are available, it was through his intercession. He put considerable effort into review of the draft final report. We wish to acknowledge the contribution of Mr. Alpha Dieng who has been with the Project from the time it was first designed. Mr. Dieng was Director of the Private and Para-Public Sector Project component which, in the future, could well become the Project's most important effort. He was open with views and material, reviewed the draft report, and encouraged the team in its efforts.

Important discussions were held with other bilateral and multilateral donors which also had projects in the health and population sector. We particularly note Ms. Wilma Goppel, Director of the UNFPA office, who shared views and documents to help the team supplement its available information.

The team is aware of different points of view on this Project held by members of the A.I.D. Mission to Dakar. Devres wishes to acknowledge the support of Julius Coles, the Mission Director and Gary Nelson, the Deputy Mission Director. We acknowledge the time and effort given to the team by Dr. Mary Ann Micka, Chief of the Mission's Health, Population, and Nutrition Division which is responsible for supervising this Project, by Linda Lankenau, the Project Director; and by Massaer Gaeye, the Senegalese Project Manager. The latter two USAID staff were with the evaluation team every step of the way. They provided data, material, contacts, logistical support, transportation, arranged for bills to be paid, and soothed those on whom the evaluation team may have stepped. Linda Lankenau advised the team on sites to visit, made important contributions to the development of the questionnaires which were the basis of the evaluation, and read every page. Devres acknowledges her criticism and support.

Devres acknowledges the efforts of the evaluation team members. The team represents not only different skills, but many points of view. The evaluation report reflects this diversity of view. In addition to the four Americans and one Malian under contract to Devres, two Senegalese officials were assigned to the team by the Government of Senegal to assist with contacts and information. This evaluation, therefore, was a major effort completed with the full professional involvement of seven members.

Devres wishes to note, in particular, the participation of Dr. Aboubakry Thiem, the Senegalese co-leader of the evaluation team. Dr. Thiem is the Technical Advisor to the Minister of Public Health and Social Action, who is responsible for the FHPP Project. He wrote sections of the report, and acted as interlocutor with the Government, a guide in the villages, and as a translator, when necessary. We know the Minister made requests of Dr. Thiem that often conflicted with his work on the evaluation team. Nevertheless, Dr. Thiem supported the team's efforts throughout the course of the evaluation. This evaluation, therefore, is a joint endeavor with the Government of Senegal. The facts, information, opinions, findings, and conclusions are deeper than what could have been obtained if the team had been made up only of Americans, and the recommendations are more realistic in terms of what is possible to implement given the local political and economic situation.

LIST OF ACRONYMS AND ABBREVIATIONS

ACNM	American College of Nurse-Midwives
AFO	Administrative and Financial Office
A.I.D.	U.S. Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
ANSFS	Senegal National Association of Nurse-Midwives (F)
ASC	Community Health Agent (F)
BAF	Administrative and Financial Office (F)
BI	Computer Office
BNI	National Investment Budget (F)
BNR	National Bureau of Statistics (F)
BUCEN	U.S. Bureau of the Census
CBA	Cost Benefit Analysis
CBR	Crude Birth Rate
CDC	Center for Disease Control, Atlanta, Georgia
CFR	Rural Economic Development Center (F)
CONAPAP	National Population Committee
CNM	Certified Nurse-Midwife
CPR	Contraceptive Prevalence Rate
CPSD	AID/Washington, Office of Population, Commodity Procurement Support Division
CPSP	Country Program Strategy Plan (for Senegal)
CPT	Contraceptive Procurement Table
CSS	GOS Social Security Office
CYP	Couple-Year of Birth Control Protection
DPS	Statistics Office in the Ministry of Economy, Finance and Planning (F)
DSD	Division of Surveys and Demography, BNR
EDF	Demographic and Health Study of 1986
ENSFE	Senegal National School of Nurse-Midwives (F)
ESF	Senegal Fertility Study of 1978 (F)
(F)	French, or English Translation, from the French Acronym
FCFA	West African Currency

FHPP	Family Health and Population Project
FP	Family Planning
FPIA	Family Planning International Association
FPLM	Family Planning Logistic Management
FUNAP	United Nations Family Planning Agency (F)
FWRA	Fertile Woman of Reproductive Age
GOS	Government of Senegal
HPN	USAID/Senegal, Health Population and Nutrition Division (or officer)
ICP	Health Chief of Post (F)
IEC	Information, Education and Communication Program
IFAN-CAD	Fertility Study of Adolescents of 1988
IPM	Institution Prevoyance des Maladies (F)
ISTI	International Science and Technology Institute, Inc.
IUD	Inter-Uterine Device
JHPIEGO	Johns Hopkins Program on International Education in Gynecology and Obstetrics
KAP	Knowledge, Aptitude and Practical
LMIS	Logistics Management Information System
LOP	Life of (A.I.D.) Project
LTTA	Long Term Technical Assistance
MATRIX	A US freight forwarder for contraceptives
MCH	Maternal and Child Health
MDP	Ministry of Development Budget
MEF	Ministry of Economics and Finance
MIS	(Contraceptive) Management Information Systems
MOH	Ministry of Health (no longer exists)
MPHSA	Ministry of Public Health and Social Affairs
MSD	Ministry of Social Development (no longer exists)
MSH	Management Services for Health (A commercial contractor)
MST	Sexually Transmitted Diseases (F)
NFPP	Natural Family Planning Program
NGO	Non Governmental Organization
OR	Operations Research Study
ORT	Senegal Office of Radio and Television
OYB	Annual Operating Year Budget
PEV	Expanded Program of Vaccination (F)

PF	Family Planning (F)
PNA	National Pharmaceutical Supply Agency (F)
PLM	Planning Logistics Management (a private contractor)
PPPS	Private and Para-Public Sector
PSPF	Health and Family Planning Project (F)
PVO	Private Voluntary Organization
SIDA	Acquired Immune Deficiency Syndrome (F)
SMI	Maternal and Child Health (F)
SMO	USAID/Senegal Supply Management Office
SN	Senegal National Health Service (F)
SOCOPAO	A freight forwarding and customs clearance agent in Senegal
STD	Sexually Transmitted Diseases
STTA	Short Term Technical Assistance
UNFPA	United Nations Family Planning Agency
USAID	A.I.D. Field Mission to Senegal (Dakar)
VSPP	Private and Para-Public Project Component (F)

In the body of the report, we use the following key terms:

- The Project refers to the overall USAID-funded Family Health and Population Project;
- FHPP refers to the Senegalese organization, the Family Health & Population Project created to implement the effort;
- Activity refers to the inputs and outputs covered in each of the chapters of the report.

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EXECUTIVE SUMMARY

A. Goals, Objectives and Scope of the Project

The Family Health and Population Project (FHPP) is a seven year $28 million project, $20.6 million of which is to be provided by USAID, to improve the health of Senegalese women and their children and to help the Government of Senegal make available the data which will enable better planning to meet basic health and social needs of the people. The Project is to provide comprehensive support to integrated maternal and child health services and family planning, improve the existing capacity of the country to provide safe and effective contraception to 15 percent of married women of reproductive age, improve the demographic data base so that more effective planning can take place and increase the awareness of policy makers and planners of the impact of rapid population growth on the economic development of the country.

The original Project Agreement was signed July 31, 1985, and amended on August 22, 1986 and June 10, 1987. The Project activity completion date (PACD) is presently June 30, 1992. A third amendment is in process to increase the USAID contribution by $1.4 million to a total of $22.0 million and to extend the PACD by three months to September 1992.

B. The Evaluation

Although the Project has undergone a number of financial audits, and while separate studies and research has been funded by the Project on specific topics, this is the first, overall program evaluation. The evaluation was carried out by a seven-person team of four Americans--a team leader, who is also a management specialist, a demographer, a logistician and an information, education and communication specialist, one Malian--a medical doctor, and two Senegalese government representatives--a medical doctor and a human resources specialist. The evaluation was conducted in Senegal from March 28 to May 10, 1991 for the USAID/Senegal Office of Health, Population and Nutrition and for the Senegalese Ministry of Public Health and Social Action.

The Project has a large number of components and activities. The evaluation team was able to review most of the components. One gap was the inability, because of limited time, to respond to a request of the Government of Senegal (GOS) to conduct cost-benefit analysis of Project activities. Additional investigation and follow up should be conducted by the teams which will design the next phase of the Project.

C. Synthesis and General Findings and Conclusions

1. Increased awareness of demographic factors

USAID, the Government of Senegal, the technical assistance contractor and several organizations and individuals that have provided technical assistance have put a great deal of serious effort into the Project. Despite the constraints and problems in implementation, the family planning environment in Senegal has changed dramatically since the beginning of the Project. This is in large part attributable to the important contribution made by the Project. The knowledge and practice of family planning has grown significantly; many family planning services have been introduced into clinics in many parts of the country; many health workers and managers have been trained in clinical services, communications and family planning management, effective information, education and communication activities; and an important program was begun in the non-government sector. The Project helped to increase the awareness of GOS planners and policy makers to the importance of demographic factors in development planning. As a result, a National Population Policy was adopted in April 1988 and the President of Senegal signed a National Family Planning Policy into effect in March 1990.

2. Increased access to modern family planning methods

The Project has facilitated the access of couples to modern family planning methods. For example, data provided by ISTI indicate that:

- the number of active contraceptive acceptors increased from 7,500 in 1985 to 29,890 in 1990 at public sector clinics, an average annual increase of 28 percent;

- the number of active contraceptive acceptors in the private sector has increased from 1,000 in 1985 to 9,111 in 1990, an average annual increase of 44 percent;

- combined public and private sector clients increased from 8,500 to 39,000 between 1985 and 1990;

- there was a slowdown in the rate of increase of active clients from 1988 to 1990 so that the latest annual increase in the public sector was only 14 percent; and

- against the original project goal of 200,000 acceptors by 1992, there were, in 1990, 70,107 acceptors in all sectors (public, PPPS, commercial and UNFPA) using modern contraceptive methods.

3. Overdesign and underfunding of the Project

The Project was overdesigned and underfunded in terms of having:

- Too optimistic and unrealistic a Project purpose to be accomplished within the proposed time frame and given the cultural and policy position of Senegal at the time the Project was first designed;

- Too large a number of Project components to be successfully managed by USAID, the GOS, the Project, or the technical assistance contractor, during the anticipated life of the Project;

- Too large a number, and too wide a focus, of activities to be carried out under each component;

- An insufficient level of financial resources provided by USAID and/or available from the GOS, to support the large number of components and activities; and

- An insufficient amount and types of training and technical assistance provided to develop an adequate number and quality of local management and technical staff capacity to sustain all Project components and activities.

4. Change in the project environment

There have been a number of important changes in Senegal that have aggravated Project design problems. These include:

- Economic deterioration in the country and an IMF directed structural adjustment program which reduced the Government's ability to meet its financial obligations to the Project, and which will reduce the Government's ability to support a follow-on Project under standard A.I.D. arrangements;

- Personnel changes in the Project, USAID, and the technical assistance contractor, which reduced the number of key people with long term knowledge of the Project; and

- A government reorganization which changed, and in the short run weakened, GOS authority and structure to coordinate the Project.

5. Weak project management and supervision

Project management and supervision have been weak as reflected by:

- An audit by the A.I.D. Regional Inspector General which indicated inefficiencies in Project financial control and a USAID determination that the GOS accounting system was insufficient to control advances of U.S. funds;

- Approximately 80 findings and 100 recommendations in this evaluation's substantive chapters relating to Project improvement, highlighting issues to which GOS, USAID and contractor personnel have not given sufficient attention;

- A diffusion of authority within the Project among many Project components so that it is difficult to determine who is ultimately responsible for many decisions;

- Internal management and supervision of the family planning network by the GOS having just as weak as external management and supervision of the Project by USAID; and

The GOS, sensing, these management difficulties, is moving to correct them in the soon to be implemented integrated National Family Planning Program.

6. Insufficient and inaccurate population service statistics

Population service statistics were found to be insufficient and inaccurate.

- Improving the collection, analysis, and use of micro level family planning data was not an objective of the Project.

- Lack of consistent, and supportable clinical data, makes it difficult to use the data that are available as a basis for evaluating the quantitative or qualitative accomplishments of the Project.

- Lack of timely and accurate operational information and data is a major constraint to improved Project management.

D. General Summary and Synthesis of Recommendations

1. Improvement of the institutional capacity of the GOS to plan, implement and manage the National Family Planning Program

o Restructure present technical assistance so that it:

-- Supports, but does not substitute for, GOS decision making and responsibility to manage the project;

-- Results from joint planning among USAID, GOS, Project and contractor personnel, based on ideas provided by the Project itself, and its own perceived needs; and

-- Assists the Project prepare work plans and budgets, manuals and procedures for internal processing and decision making.

o Direct technical assistance under the new Project toward improving the management capability of the GOS to assume full responsibility for Project implementation.

o Provide training to improve management skills such as policy planning, budget and accounting, and staff management.

o Improve management procedures and financial controls so that they become part of the effort to improve GOS project management capability, as well as to achieve accounting control.

o Develop management information systems, data collection, reporting and internal evaluation techniques and systems that will enable the Project to act upon the information gathered.

o Assist GOS to make immediate improvements in its system for assessing the need for, ordering, and distributing contraceptives.

o Increase support for non-governmental organizations such as ASBETH and SANFAM to participate in and expand family planning activities and serve as model family planning clinics for innovative services.

2. Support of implementation of the GOS April 1988 Declaration of Population Policy and its December 1990 Integrated National Family Planning Program

The Government of Senegal should:

- Assure that, at the policy level, all Government Ministries take initiatives to support the new family planning Policy and Program;

- Rationalize the many separate GOS responsibilities in the family planning sector such as for family planning policy development, IEC, research, data collection and information, and certainly for the delivery of approved family planning services;

- Integrate family planning with other health service delivery activities in a way that will maintain the integrity of the family planning effort;

- Strive for a balance between integration and separate identity is necessary until family planning is accepted--culturally and technical--as a regular part of the regular health delivery system;

- Make important distinctions between different needs for integration as well as the separate identity of family planning at the national, regional and clinical levels;

- Ensure the close harmonious relationship among all family planning, Maternal and Child Health (MCH), Expanded Program of Vaccination (PEV) and other family health activities, at the regional level, under the direction of the Regional Medical Director;

- Achieve functional integration at the clinic and health post level, wherein all health workers, particularly midwives and nurses would be trained in family planning subjects as much as in other aspects of MCH such as Senegal Office of Radio and Television (ORT) and PEV; and

- Support current efforts of the Ministry of Planning to engage the participation in family planning of other government Ministries such as Youth and Sports, Education, Justice, the Military and Women.

USAID/Senegal should:

- Encourage cooperation among the development assistance donor's efforts in family planning such as in geographic coverage of family planning services, the mix, delivery and distribution of contraceptives; and

- Support the GOS program integration plan by providing specialized technical assistance to help improve the management and institutional capacity of the new program.

3. Ensuring the financial integrity of the Project so that it can be implemented as it was designed

The implication of the GOS new family planning policy intent must be matched by the application of scarce financial resources to implement the policy. The Government of Senegal should take actions to guarantee its full financial participation in the Project. The GOS should:

- Consider ways and means to provide an appropriate level of continuing public financial support to the Project;

- Seek ways to increase support from users and the private sector in order to keep the public sector financial burden to the minimum necessary; the Government might consider establishing fee-for-services based on an ability to pay;

- Encourage Community Health Committees to do the same as the above to assure financial support at the local level;

- Encourage private sector purchase and sale of contraceptives as a way to reduce some of the Government's financial burden to purchase and supply commodities on a subsidized basis. This would give the GOS the option to apply its limited resources to other important activities such as Project supervision and delivery of quality clinical service; and

- Ensure that internal procedures for mobilizing and securing counterpart funds are adequate for the GOS to meet its financial obligations.

USAID/Senegal's design for the future Project should take into account GOS ability to financially support the Project. USAID/Senegal should:

- Make realistic counterpart fund projections, maintain sufficient records to determine if the GOS commitment is being met, and hold the GOS to its commitment;

- Make innovative grant arrangements, such as where budget contributions by USAID are tied to Project performance by the GOS;

- Study the possibility of a health/family planning sector grant as a quid-pro-quo for additional policy changes or administrative actions to improve implementation of family planning activities; and

- Support the upcoming study on financing of health services and ensure that family planning activities are included in the study.

4. Investment priorities

Investment priority should be given to increasing the quality of family planning service delivery and focusing on those Project activities which will more rapidly achieve project goals. To do this the Project should:

- Develop a time phased priority plan of action to enable the Government, the Natural Family Planning Program (NFPP), and the USAID funded Project to become more focused in terms of number and type of components and activities, and more realistic in terms of what can be accomplished within available financial resources, local staff capability, and different time frames.

- Consolidate and give priority to efforts to improve clinical services in existing family planning facilities over plans to make expansions in the system; the rate of construction or renovation of new family planning centers, should be slowed, using those funds instead to improve patient care, upgrade counseling, and improve the contraceptive mix to provide greater options and flexibility for clients;

- Allocate resources to collecting and analyzing family planning service data to improve the management of project operations; and

- Provide USAID funds directly to the National Program; USAID should not devote technical assistance or project management attention to STD/Infertility activities.

E. Summary of Findings, Conclusions and Recommendations for Substantive Project Components

1. Administration, management and budgetary issues

Positive results of the Project should be consolidated and reinforced to improve Project management capacity and to improve organizational structures and coordination, particularly through training of key personnel and definition of their roles in the implementation of the Project. Project management improvement should balance USAID's need to control of Project funds and to assure that Project goals and purposes are being achieved. At the same time improving Project management should meet the need for the GOS and Senegalese to learn how to take over, manage, and financially support a sustainable

family planning program. The technical assistance contractor should reduce its role in direct management of the Project, and concern itself more with monitoring, advising, and arranging for technical assistance and training required by Senegalese Project personnel.

2. Information, education and communication (IEC)

Efforts to improve IEC concepts and approaches should be continued. Considerable progress has been made in the production and broadcasting of family planning information, particularly during 1988, the year of an intensive mass media campaign. The Project has trained approximately 1,000 social action personnel. Better identification of specific target groups, more directly IEC-related research, a more targeted materials production and distribution plan, a more incentive-based interpersonal education program, more direct involvement of health personnel in education, and a closer coordination between the many government agencies active in IEC would all help program performance.

3. Clinical services

The greatest need is for an increased level of technical supervision and direction of family planning clinical activities at all level. Improving staff capacity to deliver quality services can be achieved by training and technical assistance programs that respond to specific clinical problems. For this purpose, supervisors should include medical doctors, nurses, midwives, leaders of local health committees, as well as administrative personnel. Attention should be given to more effective use of existing facilities and staff resources through reorganization of responsibilities, feedback on work performance, and insuring that the contraceptive mix supports the national family planning service policy. Clinical workers should also receive training in IEC, psycho-social, gender, cultural and religious matters associated with the delivery of family planning services. Efforts to improve clinical services should focus on the quality of existing family planning facilities rather than making substantial expansion to the system.

4. Sexually transmitted diseases (STDs) and infertility

The advent of Acquired Immune Deficiency Syndrome (AIDS) and other sexually transmitted diseases has caused a disquieting and increasing public health problem in Senegal. Before the financial and management crisis of 1989/90, drugs for the treatment of the most frequent types of STDs were available and the Project renovated and equipped nine regional laboratories to assist STD centers in the diagnosis, detection and follow-up of STD patients. Since 1989, STD drugs have been unavailable at most of the Project family planning centers visited. Lack of a defined role for the Project to play in the National STD/AIDS Program has plagued the relationship between the two programs. The Project should no longer be responsible for STD/AIDS activities. Instead, USAID/Senegal funds should be made available for direct management by the National STD/AIDS program.

5. Research

Although a considerable number of research studies have been carried out, the Project has not developed an overall, long-range, research plan with priorities, schedules and suggested uses of limited research funds, nor is there anyone at the Project assigned the overall responsibility for managing the research program. At the present time, research activities are not a separately identified component, but are diffused throughout the Project. While operational research is important, new research should not be approved until the Project determines what has already been done, the uses made of existing research results, and who in the Project the should be responsibility for research funded by the Project. The issue of research should be considered together with the question of the collection, analysis and availability of population service statistics. Putting the two activities together could achieve Project-wide benefits.

6. Construction and renovation of facilities and maintenance of equipment

The Project has been relatively successful in meeting planned output targets for construction and renovation of facilities. Indeed, the provision of facilities has outpaced the ability of the system to effectively use the new and expanded family planning centers. The new Project should focus on improving service delivery at already existing facilities, rather than increasing the number of facilities. With regard to equipment, the Project should implement the recommendations of recent equipment specialists and focus on repair and maintenance of existing equipment, before additional equipment is purchased.

7. Contraceptive logistics

While there are currently sufficient contraceptive stocks in the Project's central and regional warehouses or in the pipeline to meet near term requirements, the distribution system would work more efficiently if the Project replaced its non-functional reporting/ordering system with improved forecasting techniques and the introduced an improved Logistics Management Information System. The computerization of delivery statistics and contraceptive inventory data at the Dakar central level could be accomplished by re-introducing the computer program developed earlier by Management Systems for Health, and by training Ministry and Project logisticians in its use. The lack of fuel and vehicles at the regional levels is handicapping the transport of contraceptives to the clinics and is the reason given for the disruption of supervisory visits of the contraceptives logistics system. USAID, the GOS, the Project and the technical assistant contractor must assume active responsibility for overcoming these management limitations.

8. Small-scale economic activities for rural women

Attempts to develop small projects to generate women's income and to increase women's exposure to family planning information have not been successful. Any future projects for rural women should be selected according to rigorous criteria and should be based on credit rather than grants. Small enterprise development projects require specialized

technical skills not ordinarily associated with health and family planning and, therefore, should be part of productive projects in such areas as agriculture, rural development, or forestry, rather than part of a health and family planning activity.

9. Collection of family planning service statistics

During the course of the evaluation, a number of problems were identified in the system for collecting, analyzing, and using family planning service statistics at the clinical and operational level, and in the availability of accurate, reliable, and timely data and information to fully understand, manage, and evaluate the Project. Indicators such as the number of new acceptors, levels of STDs, infertility, or women who have abandoned contraception, could not be used to judge the quantitative impact of the Project or the quality of Project success. While improvement of family planning service statistics was not an activity under the present Project, it is strongly recommended for consideration under the new Project. See Annex L for a list of service statistics which would be useful as the basis for managing and evaluating the Project.

10. Private and para-public sector (PPPS) activities

While the team did not spend much time on the PPPS component, visits to five PPPS supported clinics indicated a high level of motivation on the part of the PPPS workers. Facilities and equipment at these clinics seemed well cared for. While salaries paid to PPPS clinic staff are often higher than those paid to public sector personnel, the extra cost seemed to be more than justified by a higher level of effort. Many of the recommendations for technical training of public sector clinical workers would also be helpful for PPPS personnel. Continuing with a PPPS experiment in the new Project is one way to increase support from users and the private sector and to reduce the public sector's financial and administrative burden for management and delivery of family planning services. Private sector purchase and sale of contraceptives through a social marketing mechanism or efforts with PPPS organizations should be encouraged as a means of reducing some of the Government's burden for commodities, freeing up resources that could be better applied to supervision and delivery of quality clinical services.

11. Contraceptive social marketing

Considerable planning has taken place to develop a family planning contraceptive social marketing program. Political support has been secured from key sectors, such as the Caisse de Securite Nationale, the Institution de Prevoyance des Maladies, and various pharmacists' associations. Considerable effort, however, is still required to secure the support of the Government of Senegal and the medical profession.

12. Data base improvement

One important activity of the FHPP has been to improve Senegal's demographic data base. This activity has increased awareness of the relationship between rapid population growth and overall economic and social development, so that more effective development planning could take place. Two important demographic and family planning surveys and a national census of population were carried out during the project period. While data from the surveys and the census have not yet been fully exploited and disseminated, to a large extent, the objectives of this component of the Project were achieved.

The Project has provided useful technical assistance and training to the National Bureau of Statistics (BNR) staff in demography and census methodology. Training and seminars in population policy and the impact of population growth on development helped to increase GOS awareness of population issues and contributed to the development of a national population policy. Some internal management and resource problems at BNR were identified and solutions were recommended. The Project should continue to improve the demographic data base, but at a rate more commensurate with overall need and staff capability.

A Family Planning Statistical, Research and Evaluation Unit should be established within the Ministry of Public Health and Social Action. The BNR should consider the new unit as a complementary statistical service, and should provide it with professional assistance in analyzing and using macro-level population data.

Addendum to Summary Synthesis

USAID asked the team not only to evaluate the separate Project components and activities, but to propose priorities among the components in order to help the Mission design the new Project. The team devoted considerable skill to the former question. The substantive Chapters that follow represent the results of that evaluation. The team was more reserved on the latter question since prioritizing Project components is as much a political and budgetary matter as it is a technical question.

Within an effort such as family planning, certain activities are subject to other political agendas--sexually transmitted diseases and women-in-development, to name two. Some, for example, do not want to recognize that AIDS exists in Senegal, while others consider it an ongoing catastrophe. Some refuse to recognize the role of women as an economic factor, while others consider the position of women an issue that should be attacked on all fronts. The evaluation team was not in a position to make these political judgements for USAID or the GOS.

The strategy for the new Project must be planned in a collaborative way among USAID, the GOS, NGO, private sector, political, technical, administrative, and other stakeholders in the activity. Rather than tell the GOS what to do, USAID should set out program parameters, including financial and political limitations, technical guidance, and lessons learned from this evaluation. USAID should organize workshops or other forms of interactive dialogue with the GOS to come up with a program that both governments are willing to support. The substantive Chapters of this report provide input for the content and structure of such seminars. Such seminars have already begun to take place on the basis of material in the first draft of this report.

The evaluation team ranked thirteen Project components and activities as to their importance for the new Project. The Chief of HPNO and the senior American contractor also ranked these activities. The results, without attribution, are in Table 1.

According to these figures, "Improvement of the Quality of Clinical Services," deserves the highest ranking. "A Logistic System for Public Sector Provision of Contraceptives" and "Programs of Information, Education, and Communication," were also very important. On the low end were "Women's Small Enterprise Projects" and "Clinical Correction of Infertility." On the other hand, "Improvement to Management and Institutionalization of the National Family Planning Program" received the highest ranking from one evaluator and the lowest from another.

Table 1: Prioritization of Project Components for New Project: Independent Rankings by Evaluation Team Members, Chief of USAID/Senegal/HPNO and Contractor Administrative Officer

PROJECT COMPONENT	EVALUATOR AND RANKING								
	A	B	C	D	E	F	G	H	I
Improve Management and Institutionalization of National FP Program	1	3	5	12	6	13	3	6	6
A Logistic System for Public Sector Provision of Contraceptives	2	1	2	2	4	3	5	2	2
Improve Quality of Clinical Services	3	2	1	1	1	1	2	1	1
Collection, Analysis and Evaluation of FP Service Information	4	4	10	3	3	5	6	8	3
Programs of Information, Education and Communication	5	8	3	4	5	2	1	3	4
Support to VSPP, CSM and Other Private Sector FP Programs	6	5	8	5	2	4	11	10	5
Macro-Demographic Data Collection and Analysis	7	6	11	9	7	7	9	7	8
Long Term Studies and Research	8	9	7	10	8	6	12	13	9
Construction or Improvement of New Clinics	9	7	9	6	12	8	10	11	11
Construction and Support to Laboratories	10	10	6	8	13	9	7	9	10
Women's Small Enterprise Projects	11	13	13	11	11	12	13	12	13
Prevention of Sexually Transmitted Disease	12	11	4	7	9	10	4	5	7
Clinical Correction of Infertility	13	12	12	13	10	11	8	4	12

The evaluation report was not silent on the issue of priorities. It clearly indicates that:

- Actions to improve the quality of the delivery of family planning services should have higher priority than actions designed to expand the quantity of services into new geographic areas;

- Improvement of contraceptive logistics management requires immediate attention, whether or not a new Project is funded;

- While sexually transmitted diseases constitute a critical public health issue, they are not directly related to family planning and should not receive additional management attention from the Project;

- Since women's small enterprise projects require skills not ordinarily found in a family planning project, this activity should not continue to burden this Project's limited management capacity;

- While infertility is also an important social and health problem, it is only indirectly related to family planning, and should continue to receive only minimal Project attention;

- Assistance to BNR and the collection of basic demographic data has already achieved a measure of success so that assistance to this component can be reduced;

- Insufficient attention has been given in the present Project to the collection of population service statistics; it should receive greater attention in the new Project; and

- While assistance to the Private and Para-Public Sector was successful but underfunded in the present Project, it should receive higher priority in the new Project.

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS FROM SUBSTANTIVE CHAPTERS

A. Summary of Findings and Conclusions

1. Project Administration and Management (Chapter II)

a. On budget matters

- The Project Agreement required the GOS to make a contribution to the Project, in cash and kind, of the FCFA equivalent of $7.4 million for local costs. Except for a covenant on total gasoline costs and a covenant on total local operating costs, the Agreement did not specify the distribution of the GOS contribution. Not USAID, ISTI, the GOS or the Project is presently aware of the status of more than $220,000 in cash that the GOS's allocated toward its $7.4 million commitment.

- There are presently insufficient financial resources for local operating costs for vehicles, gas, per diem, local training, utilities, and other operating supplies and equipment. Many GOS and Project personnel believe this is a result of USAID's freezing the US local currency contribution. Actually, USAID has made its full contribution. The shortage is from amounts that should be provided in cash or in kind as the contribution of the GOS.

- USAID has not insisted that the GOS meet its financial commitment to the Project nor has USAID substituted U.S. funds for the local contribution which should be made available to the Project by the GOS.

- Before the financial audit and management crises of 1989/90, a collaborative process existed for development of the local currency work plan and budget wherein the Project prepared the budget, which was accounted for by ISTI. Since the crises, because of the concerns raised in the audit, and because of the transition in Project direction, USAID and ISTI have taken stronger roles in development and accounting of the local currency budget.

- The annual dollar budget is prepared by ISTI, after some discussion with the Project, and approved by USAID. The arrangement of ISTI as an intermediate financial, work planning, budgeting and administration unit offers little opportunity for MPHSA and Project personnel to develop the capability to manage and financially control, the Project.

- Project and GOS personnel have indicated that ISTI does not provide sufficient reporting and feedback on financial and budgetary activities making it difficult for the GOS and the Project to control expenditure of funds. ISTI, for example, has the authority to make adjustments in dollar budget line items of up to 15 percent without consulting with the Project, USAID or the Government, which further contributes to lack of control of financial management by the Project.

- ISTI presently deals directly with Directors of BNR and PPPS Project components on advances of funds which further reduces the ability of the GOS and the Project Director to properly coordinate Project activities. To ISTI, the fact that the GOS signs off on advances means the GOS knows what is in these advances. To the GOS, which does not fully understand U.S. accounting and management practices, clearing of document such as the DAP (as well as PIOs) is just something USAID requires them to do, with little understanding of the implication of the GOS approval.

b. <u>On management and coordination</u>

- Partly because an official MPHSA/Project component organigramme has not yet been approved, there is an overlapping of authorities so that it is difficult to coordinate the Project and to determine the interrelationships among the different components.

- There were few coordination meetings in the past among Directors of different Project components, and there are none now, to help overcome overlapping management lines of authority. Some of this confusion was built into the basic Project design and continued in ongoing Project implementation.

- The procedure used by ISTI for bidding on local contracts, particularly for construction, sometimes did not insure full and open competition and insufficiently involve GOS personnel in decisions.

- No procedure exists in the present Project Agreement to permit USAID to review the selection by the GOS of key Senegalese Project personnel. USAID has no "right of refusal" on people who are responsible for managing significant amounts of U.S. funds.

2. Information, Education, and Communication (Chapter III)

- The IEC program was, in general, well planned and well executed, with a complement of mass media, interpersonal, and material support activities. Its major focus was on family planning/child spacing, with a secondary goal of providing information on STDs and infertility. The subject of STDs and AIDS because of its complexity and uniqueness, was not given the special attention it deserved and needed. Conflict of organizational responsibilities (FHPP and EPS) may have played a role as well. As the recognition of the AIDS problem grows in Senegal, the need for an even more concerted, specific, and intensive effort will be required.

- The mass media campaign was particularly noteworthy, combining message research, collaborative planning, creative production, and close working relationships with ORTS. Access to radio was particularly successful. Access to television was limited because of increasing demands on the network for a variety of informational, entertainment, and development broadcasting.

- A large number of IEC agents and community volunteers were trained in family planning communication, close to the overall target figure required. These volunteer workers, however, were disproportionately distributed in the six Regions of the Project.

- The recruitment and performance of volunteer workers in certain areas, most notably Dakar, was less than hoped for. Many observers have cited the lack of any remuneration or incentive as a reason for this difficulty, and some have questioned the almost exclusive Project reliance on such volunteers for interpersonal education.

- The involvement of health workers in family planning IEC, particularly of midwives working at health centers and health posts, a major goal of the Project, was not met. This was largely due to administrative difficulties caused in part by the separation of family planning service delivery and IEC activities into two ministries. A potentially important interlocutor between the two agencies, the EPS Regional Coordinator, was involved only marginally, in most cases, in Project activities.

- Inefficient use was made of audiovisual and print materials. Too liberal public access was given to brochures, leaflets, and calendars; too little programmatic

focus was given to posters (i.e. to design them for use rather than for observation); and too little utilization made of audiovisual equipment such as film and slide projectors.

- Important IEC-related research was undertaken by the project. Information on women, men, and overall socio-cultural characteristics of the population was made available to IEC planners. Much of the data, however, was of too general a demographic nature to be of specific use to IEC planners, and was not translated into a form useful for them. As importantly, no significant research was undertaken into the knowledge, attitudes, and practices of Senegalese concerning STDs and AIDS. No operations research, important for determining media mixes, interpersonal strategies, etc., was carried out.

- Family Life Education, an important element in the Project Document, was not treated sufficiently in the Project. The Ministry of Education's reluctance to approve the introduction of population issues in the primary and secondary school curricula until 1989 was a significant barrier to Project efforts.

- IEC consultants, with few exceptions, were appreciated and used well by the IEC staff. However, according to FHPP staff, too little consultation between ISTI and the Project was held to more carefully and accurately assess Project needs and preferences.

- Supervision was less than considered necessary by the evaluation team, Project staff, and collaborators, due to the lack of resources fuel and per diem after 1989, but also due to the Project-mandated sharing of the supervisory vehicle between MSD for IEC activities and MOH for clinical work, and to unrealistic supervision programs and schedules in which one extension worker is to supervise 25 community volunteers.

- Although overall educational planning was done well, and involved a wide range of professionals and technicians, more detailed planning; i.e., the identification of specific, sub-groups of the population (e.g., urban men, older women, etc.) and the development of specific strategies to reach them, was not done as fully as had been hoped. This holds true equally for family planning and STDs/Infertility.

- Although community leaders were reached indirectly through the Project's choice of media (press and television), no specifically-designed, concerted campaign was developed to reach national, regional, and local religious, political, and traditional leaders.

- No pre- or periodic post-campaign audience evaluations were carried out under the Project. Such evaluations would have permitted an analysis of the appropriateness, acceptability, and memorableness of mass and other educational media. Similarly, no performance evaluations were carried out on personnel trained by the Project. As a result Project staff were unable to accurately assess the success of their efforts and take appropriate remedial efforts.

- No archive of Project-produced materials was kept. The lack of such an archive deprives future planners of a basis on which to develop new programs, and limits the thoroughness of evaluation efforts.

3. Family Planning Clinical Services (Chapter IV)

a. Clinical services

- The project has increased the availability of family planning services for the general population.

  -- The number of family planning clinics has increased from 17 in 1985 to 123 in 1990; (Note: There is disagreement on the exact 1990 number)

  -- The number of active clients in the public, private, and para-public sectors has increased from 8,543 to 39,000, over the same period.

- While health clinics have been improved and an increasing level of family planning services has been made available, effective management of the system is lacking. While some clinics and family planning workers are over-burdened with clients, others may be under-utilized. Hours of operation of the clinics and numbers of family planning workers assigned to clinics, for example, are not adjusted to workload requirements. Allocation of financial resources for operations of the clinics is insufficiently related to need.

- Deficiencies noted at the clinics include:

  -- Working hours limited to 8:00 a.m. to 12:00 a.m. in 62 percent of the public sector centers visited;

  -- A limited range of contraceptive methods and services provided by family planning centers (of the oral contraceptives that are provided, only low dose pills are included in the mix);

- -- Laboratory examinations are required in some public sector centers and in all Private and Para-Public centers, although not always necessary;

- -- Communication of technical information does not flow easily through the system; none of the centers visited, for example, had received a recent MPHSA circular letter concerning physical examinations.

o The quality of clinical services observed during visits to selected family planning centers was considered insufficient.

- -- The taking of clinical histories is often incomplete;

- -- Women are not well-counseled on the advantages and disadvantages of different contraceptive methods;

- -- Clients are generally given whatever contraceptive method they ask for, if it is available, whether or not it is clinically appropriate for them;

- -- Instructions provided to women on the proper use of contraceptive methods are not complete;

- -- Clinical follow-up and management of possible side effects to the use of contraceptives are not systematic; and

- -- Little effort is made to track and determine why women who have received contraceptives do not return.

o There is a growing community participation in the delivery of family planning services which should begin to impact positively on the quality of the service. Local family planning committees have been established to look over the activities of the clinics and to provide some additional resources from community funds and user fees.

b. <u>Training</u>

o Training has been insufficient to meet its potential for improving delivery of clinical services.

- -- While the absolute goal in the Project Logframe for training of midwives has been exceeded--over 300 have been trained--over one-third of the midwives at clinics have not received any family planning or IEC training.

- -- 60 physicians have received clinical family planning training courses. However, while the latter figure indicates that the number of physicians who have received training has exceeded project objectives, it also indicates that 60 per cent of medical doctors have received no family planning training.

- -- Study tours have been provided to 16 family planning workers.

- -- Few nurses--32--have received family planning training. The number trained is clearly below Project objectives, although now that legislation permitting such training has been passed, the situation may change.

- -- Since the audit and financial crises of 1989, with the reduced availability of local currency, local training has been at least temporarily suspended.

- -- The project has not developed a retraining program for trained workers.

- o The development of a core of national trainers capable of conducting training sessions in the regions has been a notable success of the Project. However, since the audit/financial/ management crisis of 1989 and the reduced availability of local currency, local training has been delayed.

- o Although responsibility for training was decentralized to the regional levels, the content and quality of training programs have not fully responded to specific local clinical needs and to problems noted in this evaluation, such as what action to take when facing medical side-effects and complications.

- o The GOS is considering an effort to more closely relate assignments of public health workers to their levels of skills. Rationalization of training needs and programs should begin to have a positive effect on family planning personnel resources.

- o Family planning has been integrated into the curriculum of the Midwives Training School.

c. <u>Data collection</u>

- o Family planning data collected at the clinical level is inaccurate and unreliable. Indicators such as the number of new acceptors, levels of

STD, infertility, or women who have abandoned contraception, can not be used to judge the quality of impact of the Project.

- Collection of reliable clinical data is subject to some of the following technical limitations:

  - Definitions of data categories are not clear or well understood by health workers who collect and record data; e.g., new or active acceptors, drop-outs;

  - There is often a shortage of forms and client records are not always available, filled out, well-stored, or filed;

  - The system for transmission of data from district to regional to national offices does not function adequately;

  - Guides or protocols on the collection of data do not exist.

- Collection of reliable data is subject to some of the following management limitations:

  - Midwives and other family planning workers who collect data do not understand why the data are being collected; they receive no feedback on the use of the data, and they see no benefit to themselves or to their clients to collect the data;

  - Hours of work at the clinics are often too short and workload too heavy for family planning workers to both carry out clinical duties and also collect family planning data; and

  - Family planning workers receive insufficient training and supervision on their data collection responsibilities.

d. <u>Supervision</u>

- Family planning clinics have not received adequate supervision from either national level staff or regional supervisors. Reasons given include insufficiency of funds for travel, per diem, and gas, confusion over organizational roles, uncertain responsibility for people and programs, and lack of supervisory protocols, guides, and management planning techniques.

- Inadequate supervision from the national or regional levels has reduced operational control of the clinics. A recent written instruction to family

planning clinics, for example, indicating that clinics no longer need carry out routine laboratory tests on clients before prescribing oral contraceptives was not received by the family planning centers visited by the team. Because family planning workers do not understand the purpose of the tests, clinics continue to carry them out.

- Private and Para-Public Sector clinics receive significant supervision. All such centers funded by the Project have been visited by ISTI staff who are primarily responsible for this component.

4. Treatment of Sexually Transmitted Diseases and Infertility (Chapter V)

- There has been insufficient attention to treatment of STD and infertility patients in the implementation of the Project. Attention, instead, has been given to provision of contraceptive and regular family planning activities.

- Services that were provided to patients were poorly handling and of low quality.

- There was inadequate use of STD laboratories in the diagnosis of STD cases.

- Few reliable figures exist on the incidence of STD cases and treatment over the Project period. Statistics are unreliable because of poor collection and analysis methods. This makes it difficult to analyze the impact of Project activities on STD clinical conditions.

- There is little coordination between the Project STD component and the National STD and AIDS programs.

- There is a lack of training given to family planning workers such as nurses and midwives, in special counseling, screening, clinical problems, and interpretation of laboratory tests to treat patients with STD and infertility problems.

- There is insufficient collaboration between clinical and laboratory personnel to assure full understanding of testing programs and implications of test results.

- Equipment or supplies for STD laboratories were warehoused for 18 months before they were released for use. Appropriate drugs are not available at family planning clinics to treat STD cases.

- The recommendations of an STD consultant for the Project concerned with improving laboratory methods have not been implemented.

- Insufficient research has been carried out on local knowledge, attitudes and practices regarding STD, AIDS, sexual behavior, and use of condoms.

5. Conduct of Bio-Medical and Psycho-social Research (Chapter VI)

- In regard to the initial goals of the research component:

  - The operational research on the feasibility of a community based program, was not carried out, neither in Pikine, nor in Kaolack and Fatick (one project for Pikine "Yevi Jaboot" was not approved for funding);

  - The survey on the feasibility of a national operational system for contraceptive distribution, was not carried out; and

  - Too much bio-medical, psycho-social, and academic research was carried out, in comparison to Project operational studies.

- The following areas have been identified as needing further attention to improve the research activity:

  - Planning and coordination of research activities encountered during the execution of the Project;

  - Involvement of Project actors in planning research; and

  - Dissemination and use of research results.

- Although a considerable number of research studies have been carried out, the Project has not yet developed an overall long-range research plan with priorities, schedules, and suggested uses of limited research funds. There is no one at the Project who is assigned this overall research management responsibility.

- The Project's Technical Director in the Ministry of Public Health and Social Action has not been sufficiently involved in the identification of many research topics, particularly those on psycho-social issues.

- Many Project research reports can be found at ISTI and the Project, but very few have been disseminated to government ministries or other potential users.

6. Construction and Renovation of Infrastructure and Maintenance of Equipment (Chapter VII)

a. On the physical premises

- 64 percent of the waiting rooms in the public sector clinics may be considered to be inadequate because of:

  -- inadequate space for clients and health workers and insufficient seating for patients;

  -- limited space in waiting rooms or waiting areas; and

  -- no seats at all in one center (Dominique).

- 36 percent of the consultation and examination rooms may be considered inadequate because:

  -- patients' privacy is not respected (other patients and clinical staff walk freely into and out of the consultation rooms) and

  -- rooms are small, cramped and often used as storage.

- Small renovations to provide increased space and improved visiting conditions are required at most facilities.

- Among Private and Para-Public Sector centers, the physical facilities are in better condition and well maintained. This may be because they are part of private or para-public organizations such as SOTRAC, PORT, etc. which make available more funding for improvement to physical facilities.

b. On equipment

- The equipment provided by the Project was technical equipment used for gynecological examination and IUD insertion, and some office furniture.

- While the number of consultations is increasing, insufficient equipment (speculums, scissors, forceps, gloves) is available in 67 percent of the centers.

- Equipment that is available in some centers is poorly maintained, i.e., broken with no facilities for making repairs, sterilization with flame.

- Basic sterilization procedures are not known or followed. Few of the staff in the centers visited (except for DANTEC and ASBEF) knew how to operate *autoclaves*.

7. Contraceptive Logistic Management (Chapter VIII)

- In April 1991, there were generally sufficient contraceptive stocks at the central and regional levels. Periodic "stock outs" of selected contraceptives, however, were reported at all the family planning clinics visited by the team. In addition, there were reports of over or under supply of particular contraceptives. In the early years of the Project, "stock outs" were a result of overall stock shortages. More recently, supply problems result from weaknesses in the distribution system.

- Following the GOS and donor effort to coordinate contraceptive inputs, the Project has recognized the need for increased coordination in the preparation of the annual contraceptive procurement tables by forming a "Contraceptives Products Requirements Committee" among the donors. The system of coordination among donors, principally USAID and UNFPA, however, does not yet work.

- Poor control of inventories exists at both the central (Dakar) and clinical levels. No clear control exists over the Project's central warehouse. No inventory cards or stock register books exist at the PNA warehouse or clinical sites. Regional and clinical methods for inventory controls vary considerably.

- The present logistic management information system does not produce the data and reports necessary to manage the logistic system. The established MPHSA and Project data collection system does not function as it should. ISTI has had to make special annual visits to the regions to collect contraceptive inventory data in order to plan and prepare annual contraceptive purchase orders.

- Data inconsistencies exist throughout the contraceptive logistic management information system. There is often a conflict on numbers of acceptors between logistics-based data and clinic-based reports. The Project, for example, has reported receiving 24,420 IUDs, but ISTI reports indicate 41,333 as being distributed.

- The system for tracking the purchase, shipment, delivery, and storage of contraceptives is weak. Since commodities are purchased under USAID's worldwide contraceptive procurement system, it is difficult to obtain firm financial data on disbursements for Project contraceptives.

- Lack of Project vehicles and fuel at the regional levels are often cited as the reasons for delay in the delivery of contraceptives to the clinic sites.

- Logistics staff have not been sufficiently trained in many basic concepts of logistics management such as first-in first-out, secure verses working stocks, push verses pull, as the guidelines to provision of stock.

8. Women in Development Projects (Chapter IX)

- Credit should not be a gift to women entrepreneurs, but an incentive to help generate additional revenues for community volunteers. Few of the 62 WID projects envisioned under the original Grant Agreement would meet minimum credit criteria.

- The Government agency responsible for management of village-level development projects does not seem to be prepared to provide the management and staff resources to administer the WID sub-projects.

- FHPP is not equipped to deal with the institutional requisites necessary to manage the women's sub-projects if they were as complicated as a full-scale, small enterprise, credit programs.

- These women's activities seem to be marginal to the central clinical thrust of the present family planning Project.

9. Family Planning Service Statistics (Chapter XI)

- The Project Agreement and Logframe do not contain a separate component or activity for improvement of the system for collection of population service statistics, and the scope of work for this evaluation does not request the team to look into the matter.

- During the course of the evaluation a number of problems were identified in the system for collecting, analyzing and using, family planning service statistics at the clinical and operational levels of the Project, and in the availability of accurate, reliable, and timely data and information to fully understand and manage the Project. The team added a Chapter on the subject.

10. The Private and Para-Public Sector Component (Chapter XI)

    a. PPPS

    - Visits to five PPPS supported clinics indicated a high level of motivation on the part of the PPPS workers and facilities and equipment

at these well cared for clinics. While salaries paid to PPPS clinic staff are often higher than amounts paid to public sector personnel, they seemed more than justified by a higher level of effort.

- The family health and population activities of private and para-public organizations generally conform with the health policies of Senegal and further the objectives of FHPP.

- Client satisfaction at PPPS FP clinics compared very favorable to client opinions at public sector facilities.

- There are no apparent funds that could substitute in any significant way to support PPPS clinics if USAID funding were terminated.

- Present estimates are that 10,000 new acceptors have resulted from PPPS component activities.

b. CSM

- Considerable effort has been made in the planning and design of a CSM program for Senegal, and the basic structure of the program has been outlined.

- Political support for a CSM program has been secured from key sectors such as the CSS, the IPM, and pharmacists' associations, but similar support must now come from the GOS and the medical establishment.

- Unspent component funds exist to permit considerable additional work in finalizing the CSM program and developing a suitable advertising and promotional program.

11. The Demographic Data Base Component (Chapter XII)

- The 1986 Demographic and Health Survey was a well-executed representative sample survey which provided useful information on maternal and child health conditions, vaccination coverage, fertility, family planning and nutrition information that was previously not available. A second Demographic and Health Survey which will document changes, in contraceptive knowledge and use, and its impact on fertility during the Project period is planned for 1992.

- Basic census reports were published within three years of the census as specified in the Project logframe. The census was almost two years behind schedule and the data have not yet been fully exploited or analyzed in terms of fertility and mortality. Important demographic analyses are underway which

should provide important information on demographic trends between 1976 and 1988. Important demographic questions were not included in the 1988 census questionnaire which limits the demographic parameters that can be estimated from census data.

- Data are not exchanged among Project components. Information, for example, such as the DHS prepared by the BNR Project component has not been adequately diffused to, or used by, the clinical sub-components and other data users. Existing surveys and census data have not been fully exploited to assist the family planning program in planning and evaluation of impact.

- The regional demographic surveys have not been carried out as planned. It is now unlikely that the BNR will be able to carry out these surveys (five regional surveys covering two regions in each survey).

- In-country, long-term overseas and short-term overseas training provided by the Project was achieved as planned and appears to have provided needed skills to census staff in the areas of demography, statistics, census cartography, census and survey data processing software, maintenance of computer hardware, software for presentation of census and survey results, and the development of a sound system of documentation and data base management. The training objectives were achieved during the Project. However, new training needs have been identified, and the BNR missed opportunities to participate in two regional seminars on census analysis and population models because of its delay in initiating necessary paperwork.

- BNR planning and preparation for some of the visits of U.S. BUCEN consultants to BNR were insufficient, often leading to inefficient use of their time during BNR visits.

- During the Project period the BNR had four (4) different Directors and undergone a number of reorganizations which has disrupted the continuity and coherence of the BNR component of the Project.

- More technical assistance should have been provided to the FHPP to improve the reporting, data processing, analysis, and evaluation of the family planning data collected at the family planning clinics.

B. Summary of Major Recommendations

1. Project Administration and Management (Chapter II)

a. On financial and budget matters

- The GOS should take appropriate measures to assure that it is able to meet its financial commitment to the Project. For example:

  - Propose ways and means necessary to assure a level of Government support for family planning that is adequate and lasting;

  - Set service fees to acceptors based on ability to pay for the services;

  - Improve internal procedures which mobilize and secure local funds to assure that the GOS is administratively capable to meet its financial contributions;

  - Specify budget preparation procedures and assignment of financial responsibilities;

  - Assure that GOS counterpart part funds are provided on time; and

  - Seek ways to increase support from other donors, as well as users, and the private sector to keep the public sector burden to the minimum.

- Encourage local Community Health Committees to carry out many of the actions cited above at the local level.

- Encourage private sector purchase and sale of contraceptives as a way to reduce some of the Government's burden for commodities that the GOS might better apply to supervision and delivery of quality clinical services.

- USAID, in its design of the future Project, should take into account the GOS ability to financially support the Project and,

  - Make realistic counterpart fund projections that anticipate the amount of local currencies that will come available to the GOS, taking into account the limits imposed by the IMF structural adjustment program;

-- Maintain sufficient records to determine if the GOS financial commitment is being met, hold the GOS to its commitment, and establish Project revisions and reductions that will be made if sufficient funds are not available;

-- Make flexible grant agreements, such as where USAID financial contributions are tied to pre-determined Project performance or other criteria;

-- Study the possibility of a health/family planning sector grant to encourage policy changes or administrative actions to improve implementation of family planning activities; and

-- Support the upcoming study on financing of health services and ensure that FP activities are included in the study.

b. On management and coordination matters

o Make every effort in the new Project to shift decision-making for operational and budgetary matters from USAID and any future technical assistance contractor, to GOS agencies and personnel so that family planning can be institutionalized as a GOS effort.

o Clarify and strengthen the planning function either by hiring a health and family planning planner or improving the planning skills of Project personnel.

o Involve key Project personnel in more financial decisions such as for purchases of contraceptives and selecting contractors.

2. Information, Education, and Communication (Chapter III)

o Address the issue of Project sustainability, considering the following three alternatives:

-- Contraceptive Social Marketing, whereby contraceptives are imported free of charge from a donor like USAID, then sold on the market at a price which reflects consumer purchasing power but also the need for operating revenues (including revenues for IEC);

-- The Bamako Initiative, whereby generic contraceptives are purchased on the international market according to competitive bidding; the difference between the low purchase price and a fair sales price will provide operating revenues, as in (a), above;

-- Community-Based Distribution, whereby local communities manage contraceptive distribution and sale programs. Contraceptives are purchased through either (a) or (b), above, then sold at a modest margin, providing local operating revenues and incentives for local sales agents.

- Assure the best possible coordination of IEC activities both at the national and regional levels of the proposed NFPP, integrating different services from different ministries. The roles and interrelationships among the Health Education Service of the Ministry of Health, the UNFPA Project staff, and to UNICOM (Ministry of Planning) must be clarified.

- Develop specific messages for target groups of the population. Regional, religious, and ethnic differences as well as differences in age, sex, education, and place of residence must be taken into consideration when developing messages and thematic strategies. A close working relationship with UNICOM should be established of particularly importance would be of help to determine the best way to reach national, religious, and traditional leaders.

- Establish a fee-based agreement with ORT to guarantee the correct, timely, and error-free broadcasting of family planning and STD/infertility messages.

- Monitor the IEC program's impact more closely. Both sample survey and focus-group data collection methods should be employed to see to what degree people receive, understand, favor, accept, and use information provided.

- Encourage collaboration between IEC specialists and researchers before research designs are completed to ensure the inclusion of specific, message-related inquiries in all research; and to ensure that research data are analyzed, interpreted, and presented with the IEC planner in mind.

- Strengthen supervisory programs. The allocation of budget resources, to enable community volunteer and/or extension worker to participate in regional or national group supervision/training, instead of using these resources for gas and vehicles, may achieve improved supervisory goals as well as providing an opportunity for additional training.

- Increase the role of clinical personnel--particularly midwives and family planning nurses--in family planning education. A review of the curricula in professional schools should be conducted to ensure that they include an IEC/counselling component. Clinic operations should be reviewed to assure that adequate time is allowed for quality provider-client counselling. Regional

EPS Coordinators should play a more active role in the in-service education of midwives in family planning IEC. All supervision of midwives should include a review of education and counselling activities.

- Limit the production of print materials to those targeted for a specific, literate, and reasonably educated audience (doctors, media professionals, health workers, etc.). Few additional funds should be spent on audiovisual equipment (VCRs and 16mm projectors in particular) since this equipment has a discouraging history not only in Senegal but in other countries as well.

- Renew dialogue between the MPHSA and the Ministry of Education to revitalize interest in Family Life Education and to design a program acceptable to both parties. In view of the Ministry of Education's current program to integrate population issues into the curriculum, the Project's efforts might focus on out-of-school education, such as young women's associations.

- Explore the Community-Based Distribution scheme as a means to increase contraceptive availability, to accelerate the rate of family planning acceptance, and to provide motivation to individual volunteer workers. Attention should also be given to motivate retailers to whom a fee subsidy has been passed to provide greater access to contraceptives.

- Provide additional resources to the Project specifically for STD/AIDS education; or transfer the MST/SIDA education program of the Project to another agency, such as EPS, which may be better staffed and equipped to direct and manage it. In either case a closer working link with the Ministry of Public Health and Social Affairs' STD program and the National AIDS committee work should be forged.

3. Family Planning Clinical Services (Chapter IV)

   a. Clinical operations

   - Reorganize responsibilities, personnel assignments, and hours of operation, at family planning clinics to permit more effective use of available staff time, facilities, and equipment.

   - Insure that a regular supply of an appropriate contraceptive mix is being supplied to, and available at, the central, regional and clinic level, including injectibles and standard dose pills, in accordance with the national service policy.

   - Supervision and training should stress prescription of approved clinical methods such as careful attention to client counseling, considered choice of contraceptive methods, and client follow-up.

- Reference documents should be made available to clients and family planning service providers.

- Develop and strengthen clinical programs to attract men to clinics and facilitate their use of family planning methods.

- Integrate family planning programs with other health activities such as health education, nutrition, mother and child and pre- and post-natal care, immunization and oral rehydration.

b. Training programs

- Improve the GOS management capacity for delivering improved family planning services by creating training and retraining programs designed for family planning supervisory personnel at all levels--central, district, regional and clinical personnel. For this purpose, supervisors may be medical doctors, nurses, midwives or leaders of local family planning committees, as well as administrative personnel.

- Provide clinical workers with training in IEC, psycho-social, gender, cultural and religious matters, counselling and associated social issues, along with the technical issues of the delivery of family planning services.

- Confirm the responsibility of the National Clinical Coordinator to make training more relevant by reviewing the curricula of the various local training programs to assure that it is updated according to human resource needs actually assessed and clinical problems discovered during supervision.

- For an extension of family planning services especially in rural areas, the training of physicians and nurses, in particular, is essential.

- Continue integrating family planning subjects into other nurses and midwives training schools curriculum as initiated already at the Midwives Training School.

c. Data collection

- Improve the system for collection, processing, and analysis of health service data by developing written guides and training programs for data collectors and assuring the availability of basic documents, forms, and supplies to carry out the data collection.

- Assure the publication and dissemination of the results of the analysis.

d. Management and supervision of the family planning center

- Increase supervision at all levels of the family planning system, especially for quality of service delivery, improved recordkeeping, and technical clinical activities. Develop written protocols along the line of Annex C-1, for carrying out supervisory visits. Develop a system of evaluations on a time-phased basis, with reports and feedback to units supervised, as well as to the next higher level and to the Project itself. Supervisory visits should stress the early discovery of problems which need management attention, rather than audit and control to "catch" someone.

- Confirm the responsibility of the central MCH level for coordination, monitoring, and supervision of MCH and family planning activities.

- Conduct studies on other aspects of family planning activities such as causes of dropout rates, profile of users, services, provider role in the choice of the contraceptive method.

- Give more attention to supervision and evaluation of training programs receive more attention. Supervision should cover content and methodology of training, as well as follow-up to determine the impact and effectiveness of training provided.

- Have the team designing the new Project review the results of the supervisory seminar and the supervisory manual that has already been published to determine why it was never introduced. A detailed supervisory protocol should be included in the new Project.

4. Treatment of Sexually Transmitted Diseases and Infertility (Chapter V)

a. In the short term

- Improve the capability of family planning workers to handle the clinical problems of STD and Infertility.

- Improve the understanding by family planning workers on the uses and implications of specialized laboratory test so that workers can make better clinical decisions and provide more relevant counseling to clients.

- Improve the coordination between the Project STD program and the National Programs on AIDS and other sexually transmitted diseases.

- o Complete activities initiated under the Project, such as the provision of laboratory equipment and training in its use for testing.

b. In the long term

- o Shift management of the STD activity out of the Project, directly into the National STD/AIDS Program--in essence, lowering the priority of this activity within FHPP.

5. Conduct of Bio-Medical and Psycho-Social Research (Chapter VI)

a. Short term

- o Locate copies of prior research funded by the Project and establish a library for the reports. Develop a bibliography of studies and research that have been completed. Determine who should receive copies of the research reports and undertake a purposeful program of dissemination.

- o Begin new operational research only after the Project determines the usefulness of what has already been accomplished by the research component.

b. Long term

Under the new Project, the design team should:

- o Determine who and where in the Project or MPHSA the assignment should be made for long-term management responsibility for a continued operational research program. The design team should consider assigning this responsibility as one of the principal duties of the new family planning statistics, research, and evaluation unit recommended in Chapter X.

- o Develop a priority plan for the long-term use of operational research funds.

- o Seek out local resources whenever possible to carry out studies and research. Develop a local capacity to carry out KAP studies, probably associated with those responsible for IEC activities.

- o Develop a research study to create protocols to evaluate various family planning processes; for example, quality of clinical service, performance of family planning workers, client attitudes toward service received, and client understanding of family planningconcepts and methods.

- Develop studies to evaluate the impact of family planning services within the Ministry, capacity of family planning staff to deal with clients, staff comprehension of family planning concepts and methodology, and challenges to integrate family planning with other health delivery activities.

6. Construction and Renovation of Infrastructure and Maintenance of Equipment (Chapter VII)

- Include the condition of the physical facilities of the family planning service, including the buildings and equipment, under the increased level of supervision and inspection proposed to improve the overall delivery of family planning services.

- Give priority to consolidating efforts to improve clinical services in existing family planning facilities over making expansions to the system. Sufficient budgetary resources should be provided to assure the success of the consolidation plan that is approved.

- Slow the rate of construction or renovation of new FP centers and, instead, use those funds to improve patient care, counseling, and to improve the contraceptive mix.

- Conduct a complete physical inventory of available equipment and need; then, provide centers with adequate equipment, and train staff in operation and maintenance of the new equipment.

- Increase attention to the availability, quality and use of family planning equipment. Develop a program that includes the carrying out of periodic equipment needs assessments, the preparation of standards and criteria on the number and type of equipment to be used, and develop protocols for the continued management and supervision of equipment use.

7. Contraceptive Logistic Management (Chapter VIII)

- Reduce periodic stock ruptures by introducing a logistics management information system and by increasing contraceptive stocks at the regional warehouses and clinics to a level that better approximates working needs and reasonable security stock.

- Commission FPLM to develop and introduce a logistics management informationsystem for the Project.

- Stock contraceptive supplies at the following levels: central level, 12 months; regional level, 6 months; clinic level, 3 months.

- Implement the contraceptive commodity exchange agreement between USAID and UNFPA to allow a more complete mix of contraceptives, including injectibles and standard-dose oral pills to be used by the NFPP.

- Devise and implement a more efficient shipment tracking system for contraceptives; disseminate information more widely to MCH and FHPP staff.

- Designate the FHPP logistician as the person responsible for managing the Project central warehouse.

- Assure that central and regional financial, logistic, and staff capacity exists for USAID to conduct supervisory visits and to transport contraceptives.

- Develop an internal order form, perhaps as part of the new Procedures Manual, whereby clinics, regional headquarters and warehouses, and central offices and warehouses would use the same procedures and documentation to order and account for commodities and contraceptives.

- Devise a logistic supervisory protocol as a checklist for central and regional supervisors. See Annex C as a guide for the preparation of such a protocol.

- Reduce the quantities of condoms scheduled for 1991/1992 delivery and consider airfreighting a part of the IUDs scheduled for 1991 delivery.

- Make operational the computerized contraceptive and inventory program installed at PDFP by MSH and train the MCH and FHPP logisticians to use the program.

- Organize, along with MPHSA, Project management, USAID and ISTI, a professional formal assessment of the needs for trained staff in management of the contraceptive procurement system; develop an organized, long-term, training program to help implement the above recommendations. Training should be provided in at least the following:

  -- How to prepare CPTs and procure contraceptives;

  -- Contraceptive forecasting techniques;

  -- Collection, analysis and use of contraceptive supply data;

  -- Correct logistics management procedures, including warehousing, storage, and transportation; and

  -- Use of the computerized contraceptive and inventory information program.

8. Women in Development Projects (Chapter IX)

- Require rigorous technical and economic appraisal before funding projects. Credit projects, for example, should be ranked according to potential profitability before selection and inclusion in the program.

- Install rigorous financial and management procedures before the disbursement of funds begins. Such procedures include the establishment Capital Replacement Accounts and Maintenance and Repair Accounts, establishment of clear disbursement procedures, etc.

- Organize a conference on small-scale and rural credit should be organized for organizations currently working with small-scale projects in Senegal in order to share with the Government of Senegal and Project officials prior local development experience.

- Hire specialized technical staff to run the component, or shift funds to another GOS agency or a PVO specially staffed to carry out such activities.

9. Family Planning Service Statistics, Research and Evaluation (Chapter X)

a. General recommendation

- Establish a Family Planning Statistics, Research and Evaluation Unit (FRSRE) in the new GOS NFPP and give it a high priority in the future family planning project.

b. Detailed recommendations

- Improve the collection of management oriented family planning data and information.

- Collect and process data and carry out analysis of family planning program activities, and assure feedback to service monitors.

- Organize periodic training of clinic and other family planning systems staff in data collection and analysis.

- Improve supervision of data collection in family planning clinics.

- Consider incorporating the Project's operational research activities into the newly created FPSRE unit.

- Charge the new FPSRE unit with conducting program evaluation studies suggested in the logframe, such as studies of quality of care and health issues related to contraceptive use.

- Place future family planning technical assistance consultants directly under the responsibility of the FPRSE to meet the needs of the research program and to assist in training and institution building of this specialized activity.

- Publish and disseminate existing demographic survey data and family planning clinic data.

- Coordinate with BNR and other statistical units in the GOS on the collection and analysis of selected data.

- Develop ways to motivate midwives to collect complete and accurate data (e.g., show them results for their respective clinics and explain the purpose and uses of the data collected; offer annual awards to selected clinics for quality service statistics (according to pre-specified criteria for determining high quality, e.g., timeliness, completeness of forms, etc).

- Encourage the FPSRE unit to take advantage of the expertise available through USAID-supported organizations involved in family planning program research and evaluation. These organizations could provide technical assistance for research and training to the Unit, including the development of a long term research program and assistance in the execution of studies.

10. The Private and Para-Public Sector Component (Chapter XI)

a. PPPS

- Continue support for a PPPS component as one way to increase support from users and the private sector and to reduce the public sector financial and administrative burden. The considerable energy and physical infrastructure of the private, para-public and non-governmental sectors should be enlisted more directly to support the objectives of the GOS to improve the health and quality of life of the people of Senegal.

- Apply the relevant recommendations for training of public sector clinical workers to the training of PPPS personnel. Subjects for training should include improvement in the quality of service delivery, application of the GOS new rules on use of physical examinations, and coordination among clinics that are part of the same PPPS organization.

- o Assure that the financial resources made available to the PPPS component in the Project Agreement are fully disbursed during the remaining life of the Project.

- o Encourage continuation and expansion of the PPPS component, at least as an experimental component for further study.

b. CSM

- o Begin formal negotiations with the GOS to permit the design and development of a small-scale contraceptive social marketing component under the new Project--either as part of an expanded PPPS component, through an NGO, or under public leadership worked out through MPHSA.

- o Develop a detailed CSM work plan as part of the new family planning Project covering activities in the following categories: political mobilization; definition of a distribution network; establishing a pricing system; establishing a local packaging system (if necessary); developing a detailed institutional and product advertising program.

- o Finalize institutional relationships and responsibilities with SANFAM, or another NGO, either under the family planning Project or under the new umbrellas PVO Support Project, to bring private, para-public, and other non-governmental organizations into the CSM program.

- o Support study tours for GOS, Project, NGO and PPPS personnel to neighboring countries such as Mali, Gambia, and Togo, which have already embarked on CSM programs.

- o Provide technical assistance, particularly in the areas of institutional organization (relationships among public, private, and NGO sectors), pricing, and advertising.

11. The Demographic Data Base Component (Chapter XII)

a. General recommendation

- o Continue selected support to macro-demographic data collection and analysis through BNR and improve GOS's institutional capacity to carry out such activities.

b. Data collection and analysis

- BNR should give high priority to conducting the Demographic and Health Survey II (DHS II) in 1992. Increase the sample size so that regional level estimates and analysis of fertility, mortality, and contraception can be obtained. Include male sub-sample for the 1992 DHS. Questions on maternal mortality should be included. Conduct a national DHS III again in 1997 (with large sample size). The additional costs of increasing the sample size and adding a male sub-sample to the DHS II will need to be allocated in the next five year Project. Install software such as REDATAM for improving BNR's data analysis capability at the district, village, and neighborhood level.

- Assure that adequate funds are allocated for the full exploitation, analysis, and dissemination of the fertility, mortality and family planning data from the 1986 DHS, 1988 Census, 1990 EPF, and the DHS II planned for 1992. Include a question on number of children ever born (CEB) in the 1998 census for estimation of fertility from census data. Family planning survey data collected by BNR should be more fully exploited with respect to IEC issues (e.g., obstacles to family planning acceptance), access to contraception, fertility desires and contraceptive method preferences, and problems associated with contraceptive use (e.g., side effects, method failure, discontinuation).

- Do not conduct Regional Demographic Surveys. The regional surveys are redundant to the DHS Survey Program and some would cover topics (e.g., migration) that are not a priority for the FHPP program. Furthermore, a national migration survey of 6000 household is already planned for 1991 funded by IDRC, and a national demographic and health survey is planned for 1992 (DHS II). Thus, the regional surveys would also place a strain on BNR infrastructure, would be of limited utility, and the timely analysis of the results would be unlikely.

- Encourage more collaboration/coordination between BNR, the FHPP and MCH in the future on data collection and analysis needs (e.g, joint effort on questionnaire design and BNR assistance on analysis of family planning program statistics. (Note: Chapter VIII recommends establishing a Statistical Research and Evaluation Unit in the FHPP/MCH for data processing and program-oriented analysis of family planning program statistics and for conducting program evaluation studies. BNR staff could provide valuable technical assistance in the establishment of this Research and Evaluation Unit, particularly in the areas of questionnaire design, sampling, interviewer training, field operations, data coding, editing, and analysis.)

c. Training

- Provide training in management procedures to the BNR Director and Division Heads at BNR and at BI (e.g., training in how to plan annual work programs for data collection, analysis, publication and seminars and training; planning for technical assistance visits; setting work priorities; delegation of responsibilities and division of labor; intra-office communication; conduct of staff meetings; and delegation of authority when director and/or division heads are travelling).

- Encourage BNR to participate in Regional Census Methodology and Analysis Seminars (e.g., seminars sponsored by CERPOD; UNFPA; U.S.BUCEN; RAPIDII) and improve planning for participation in these seminars and the availability of funds for participation.

- Provide training to selected BNR Staff in data use and dissemination, survey sampling techniques, multivariate statistical analysis techniques, and the use of survey statistical packages for micro-computers. This could be done in-country or as short-term training abroad (e.g., U.S. BUCEN; University of Chicago; University of Michigan summer program; IRD-DHS, or University of Montreal). Training in the statistical software REDATAM for improving data base management capabilities and analysis at BNR.

d. Technical assistance

- Provide technical assistance for the 1998 Census of Senegal during the 1992-1997 period. This includes costs for census planning and preparation, consultation with data users, questionnaire design and table outlines, the development of computer programs and, especially, mapping. Substantial funds are needed for training, staff, computers, etc. for the three years preceding the 1998 census. For the short term (i.e., the current Project), better planning is needed on the part of BNR for technical assistance missions of U.S. BUCEN staff to BNR (e.g., preparation of work agendas for visits; exchanging progress reports and analyses completed prior to the visits; and ensuring availability of BNR staff during the TA visits). In the future more BNR technical assistance should be provided directly to the FHPP/MCH for the collection, data processing, analysis, evaluation and dissemination of the family planning survey data and family planning clinical service statistics.

- Encourage BNR to continue to take advantage of technical assistance from selected USAID Cooperating Organizations (funded by USAID central funds), providing that collaboration with these organizations

would be for the purpose of achieving specific objectives of the FHPP Project and consistent with the work program defined by BNR under the Project.

- o Support the purchase for BNR of two new printers, and funds to pay for analysis, publication and dissemination of results from the 1988 Census and the 1990 urban family planning survey.

- o Encourage the BNR and the FHPP to identify specific technical assistance needs and to have the flexibility to chose the most appropriate organization(s) and/or consultant(s) to provide this assistance.

e. <u>BNR internal and external management</u>

- o BNR should adopt a one-year and a five-year work plan and carry out an annual evaluation of the execution of the annual plan.

- o BNR needs to pay more attention to the following issues:

  - -- Programming of time and keeping to work deadlines;
  - -- Over-committing in survey data collection;
  - -- Documentation of work accomplished;
  - -- Processing financial paperwork, timely requests for training to USAID;
  - -- Preparation for visiting consultants;
  - -- Documentation of data files;
  - -- Adequate arrangements with USAID or GOS for the maintenance of micro-computers, bernoulli disks, laser and other printers; and
  - -- BNR Director's attention to Management and Administrative issues.

I. PROJECT BACKGROUND AND EVALUATION METHODOLOGY

A. Demographic Summary of Senegal

Senegal is a West African country with a population of more than 7 million inhabitants in 1991. Although 60 percent of the population still lived in rural areas as of 1988, the country is rapidly urbanizing. Urban areas are growing at almost twice the rate as rural populations, due to heavy rural to urban migration combined with high rates of natural increase. The current rate of natural increase in Senegal is 2.7 percent annually, implying that the population will double in size in 26 years if the rate continues unchanged. About 85 percent of the population are Muslim and polygamy is widely practiced (47 percent of married women were in polygamous marriages in 1986). Women tend to marry at an early age which contributes to the high fertility in the country. In 1986, the median age at first marriage among Senegalese women was 16.6 years, although the average age at marriage is later among women with higher education and those living in urban areas. The minimum legal age at marriage is 16 years for women, but this law is not strictly enforced in rural areas.

The provisional estimate of the total fertility rate for 1988, based on births during the 12 months prior to the 1988 census, is 6.3 births per woman (Ndiaye, 1991). In 1986, the total fertility rate was estimated to be 6.6 births per woman, down from 7.1 per woman in 1978 (1986 EDS; 1978 ESF). Most of the decline in fertility has been among younger educated women and women living in urban areas. "Ideal family size" among married women declined from 8.8 children in 1978 to 7.2 in 1986, and one-fifth of married women in 1986 said they did not want any more children.

Contraceptive knowledge has been increasing over the past decade, with the proportion of women knowing of at least one contraceptive method increasing from 59 percent in 1978 to 90 percent in 1986. Among married couples, the percent practicing any method of contraception (modern or traditional) increased from 4 percent in 1978 to 11 percent in 1986. However, the percentage of married couples using any modern method was less than 1 percent in 1978 and only 2 percent in 1986.

Preliminary results from the 1990 Urban Family Planning Survey show that current contraceptive use among currently married urban women ages 15-49 was 21 percent (10 percent modern methods and 11 percent traditional methods). The 10.4 percent contraceptive prevalence rate for modern methods in urban areas estimated for 1990 represents an increase in modern contraceptive prevalence of over 50 percent from 1986 when urban contraceptive of modern methods was estimated to be 6.7 percent. "Ever use" of modern methods among currently married urban women 15-49 in 1990 was 20 percent and ever use of traditional methods was even higher at 38 percent (1978 ESF; 1986 EDS; 1990 Urban EPF). The large difference between current contraceptive use and ever-use estimates could be an indication of

a high level of discontinuation of contraceptive use or possible evidence of some contraceptive use for spacing purposes.

Life expectancy at birth was estimated to be 48 years in 1988 up from 42 years in 1968. During the period 1971-75 to 1981-85, the infant mortality rate was estimated to have declined from 120 infant deaths per 1000 live births during the 1971-75 period to 86 infant deaths per 1000 live births during the 1981-85 period. The proportion of children dying before age five was estimated to be 19 percent in 1986, down from 29 percent in the early 1970s.

The population of Senegal is projected to increase from 6.6 million in 1986 to 13.1 million in the year 2011, with the population doubling in only 25 years, even under conditions of declining fertility. The crude birth rate is estimated to have declined very little between the two censuses, from 48 births per 1000 population in 1976 to 46 in 1986.

In 1988 Senegal adopted an official declaration of population policy for the country and in 1990 the President signed into effect a National Family Planning Program. The government has stated that the current levels of fertility and population growth are unsatisfactory and too high.

B. Project's Goals, Purpose and Approach

1. Goals

On July 31, 1985, the Government of Senegal and the Government of the United States signed Grant Agreement No. 685-0248 to initiate a seven year, $28 million, Family Health and Population Project. This was Phase 2 of an earlier Senegal health and population project. The primary goal of the present Project is to improve the health of Senegalese women and their children through more effective birth spacing and to achieve population growth rates consistent with GOS ability to provide for basic health and social services. The long term goal of the project is to achieve a population growth rate which does not exceed projected increases in agricultural output and GOS costs for basic health and social services.

2. Purpose

The overall purposes of the Project are to:

- Provide comprehensive support to maternal and child health services including the detection and treatment of sexually transmitted diseases and infertility, and integrated family planning and malaria treatment at the community level;

- Improve the capacity of the country to provide safe and effective contraception to 15 percent of "married women of reproductive age" (MWRA)--approximately 200,000 couples; and

- Improve the demographic data base so that more effective development planning can take place, and increase the awareness of policy makers and planners of the impact of rapid population growth on economic development of the country.

3. End of project status

Expected end of project accomplishments include:

- Medical, paramedical, and auxiliary health personnel, as well as community agents and personnel from public and private institutions, will be trained to deliver family planning services and to assure that family planning becomes an integrated part of maternal and child care at the national, regional and departmental levels;

- Information, education and communication programs concerning the impact of rapid population growth on development, the importance of child spacing as a health measure, the importance of all aspects of family health such as nutrition, immunization, prevention of sexually transmitted diseases and infertility, and the use and availability of contraception will be developed, tested and modified; and

- The 1987 census will be fully processed and analyzed and accurate data will be available for planning purposes. A sufficient number of surveys will have been fielded and analyzed so that good quality and timely information on contraceptive knowledge, attitudes, practices and standards of MCH will be obtained.

4. Project components

The project has three components. These are support to:

- The GOS National Family Planning Program (NFPP);
- The Private and Para-Public sector which provide health or population related services (PPPS); and
- The Senegal National Census Bureau (BNR).

5. Project activities

Each of the three components incorporates one or more of the following activities:

- Information, education and communication;
- Clinical family planning and health service delivery;
- Training;
- Data base improvement;
- Population policy development; and
- Health systems and psycho-social research.

6. Project outputs

The logframe issued at the time the Agreement was signed included the following outputs:

- Renovation, construction and equipping of 106 health and population facilities;
- Refurbishing the STD and infertility facility at Le Dentec Hospital;
- Equipping and renovating two regional STD centers;
- Providing STD treatment to at least 30,000 patients;
- Making available family planning services to all of Senegal's health centers;
- Training faculty of local health and population schools and centers;
- Overseas training in family planning service delivery for at least 50 physicians, 100 midwives and 50 IEC specialists;
- In country training of at least 50 physicians, 200 midwives and 70 nurses;
- Family planning training for 350 outreach personnel;
- Implementing small scale WID activities;
- Training in demographic data modeling, analysis and interpretation for at least 35 development planners and 35 statisticians and demographers;
- Publishing by the end of 1990 major findings of the GOS census;
- Fielding at least 5 surveys on family planning subjects;
- Sending policy makers on overseas study tours; and
- Training for at least 100 persons in supply management and logistics.

7. Project budget

Of the $28 million budgeted for the Project, USAID was to provide $20.6 million in cash and the GOS was to provide the equivalent of $7.4 million in FCFA and kind. USAID's contribution was distributed among the three major Project components, as follows:

Family Health and Population Services	$ 16,057,000
Data Base Improvement	3,076,000
Private and Para-Public Sector	1,467,000
Total	$ 20,600,000

8. Special local currency counterpart covenants

Two special covenants with regard to local costs are important to highlight. Section 5.3 (g) of the original Grant Agreement states that the Project will finance all gasoline for project vehicles for the first three years, after which time the proportion of gasoline expenses will shift to the Government of Senegal as follows (in FCFA):

Year	Total	USAID	GOS
1	5,200,000	5,200,000	0
2	5,720,000	5,720,000	0
3	5,773,200	5,773,200	0
4	6,350,400	4,445,200	1,905,200 (30%)
5	6,985,600	4,191,200	2,794,400 (40%)
6	7,684,000	1,536,800	6,147,200 (80%)
7	8,452,400	0	8,452,400 (100%)

Section 5.3 (h) of the Grant Agreement states that USAID, will finance 100 percent of the operating costs (utilities, telephone, stationery, etc.) of the headquarters for the national project for the first three years of activities, after which time the proportion of these operating expenses supported by the Project will shift to the GOS as follows (in FCFA):

Year	Total	USAID	GOS
1	37,200,000	37,200,000	0
2	39,060,000	37,060,000	0
3	41,012,800	41,012,800	0
4	43,063,600	30,144,400	12,919,200 (30%)
5	45,216,400	18,086,800	27,129,600 (60%)
6	47,477,200	9,495,200	37,982,000 (80%)
7	49,850,800	0	49,850,800 (100%)

The purpose of the above covenants was to have the Government of Senegal assume greater financial and managerial responsibility for the Project so that it would be fully responsible by the PACD date. What appears to have happened, however, was that while USAID reduced its support for local expenses according to the Agreement, the GOS did not meet its increased financial obligation. As a consequence, beginning in the fourth and fifth years, Project activities requiring local costs began to grind down and accomplishments achieved in the first three years were not sustained.

9. Project extension

The original PACD was June 30, 1992. At the time of the evaluation, USAID was negotiating with the GOS to add $1.4 million to the Project and to extend the PACD to September 30, 1992 when a new Project could be designed and additional funds provided.

C. USAID/Senegal's Proposed 1992-1997 Strategy

In its February 1991 Country Program Strategy Plan (CPSP) for Senegal for 1992 to 1997, USAID/Senegal indicated it wished to focus on the linkages among reduced fertility, improved health, improved education, increased labor productivity, and improved conservation of Senegal's natural resource base. USAID proposed to exploit its experience by assisting Senegal to moderate its relatively rapid rate of population growth through the design and implementation of policies and programs to decrease family size. USAID/Senegal proposed, through a well focused program to increase both demand and supply of family services in the public and private sectors, to decrease the fertility rate from an average rate in 1986 of 6.6 children per woman at age 49 to a rate of 6.0 in 1996.

The new USAID/Senegal strategy for decreasing family size in Senegal includes two targets:

- Target No. 1: Increased use of modern contraceptive methods in urban areas (Benchmark Indicator--Urban contraceptive prevalence using modern methods to be increased from 6.7 percent of married women of reproductive age (MWRA) in 1986 to 20.0 percent in 1996)

- Target No. 2: Increased awareness of modern contraceptive methods in rural areas (Benchmark Indicator--Knowledge of modern contraceptive methods increased from 58 percent of MWRA in 1976 to 75 percent in 1996)

By the end of the strategy period, USAID expects that every population center in Senegal of more than 10,000 inhabitants will be covered by maternal and child health/family planning (MCH/FP) service delivery points, and that the quality of services will have improved, as indicated by increases in contraceptive continuation rates.

In rural areas, the USAID strategy will concentrate on assisting the GOS to increase awareness of the benefits of modern contraceptive practices. USAID/Senegal will employ information, education, and communication (IEC) techniques to increase knowledge among mothers of the benefits to themselves and their infants of increased child spacing. USAID will also attempt to reach half of the traditional healers and local leaders with family planning messages.

The evaluation team is aware of USAID's future strategy which was approved in principal by A.I.D./Washington while the team was in Senegal and has taken it into account in this evaluation's detailed recommendations.

D. Methodology for the Present Evaluation

1. The evaluation team

The composition of the evaluation team, determined by USAID in consultation with the GOS, influenced the choice of substantive subjects to receive attention by the team. USAID requested that the evaluation team include a:

- Team leader/management specialist with experience in project design, management and/or evaluation;
- Clinical specialist who would be a physician, midwife, or family planning nurse practitioner with practical clinical experience;
- IEC (Information, Education and Communication) specialist with practical experience in developing and managing IEC work in family planning;
- Demographer with advance training in demography and statistics, experience with development and implementation of census activities, and knowledge of research and special study methodology, particularly in family planning; and
- Logistics expert with experience in procurement, distribution, storage and inventory control of contraceptives.

In addition to the five person team called for in the contract, a Senegalese Public Health and MCH/Family Planning Specialist from the Cabinet of MPHSA was assigned by the GOS to assist the team. While this member was not paid for by, or responsible to, the contractor, he acted as a substantive team member in his field of expertise. The GOS also assigned a second national government employee to travel with, and assist, the evaluation team. His specialty was in human resources development.

Additional technical skills would have been helpful in conducting this evaluation. The following specialists could have made insightful contributions:

- An anthropologist to study and help determine if Project personnel fully understood the attitudes, views and cultural patterns of the population with regard to family planning, the economic role and social position of children and women, and the potential winners and losers in a successful family planning program;

- An engineer to determine if the project properly repaired, renovated and reconstructed, at a reasonable cost, family planning clinics and laboratories and properly used and maintained special family planning equipment;

- An economist to assist the team in determining the cost effectiveness of different project components and the cost/benefit of the overall project; an economist might also have helped determine why the government did not meet its financial commitments to the project and what alternative financial/budgetary arrangements might be suggested for the new project;

- A private sector/business specialist to review the Private and Para-Public component of this Project and to look into the issues of social marketing for contraceptives;

- A training specialist to determine if the scope, content and method of delivering local training as well as the provision of training in the U.S. was meeting the needs of the Project; and

- A public administration and management specialist to review government organization, procedures, processes, policy and decision making and budget and accounting techniques, necessary to support the project.

2. Level of effort

The evaluation scope of work provided five weeks for the team to complete its work in the field; the demographer was given only four weeks. A five week period to evaluate a $28 million project that had not been evaluated in six years insured that not all Project components would receive the necessary attention they required.

The design team was aware that the present Project has 16 months before the PACD and that USAID/Senegal is planning a next phase of this Project. While most of the recommendations are proposed for implementation within the time remaining in the present Project, they also lay the basis for, and take into account, the longer term Project needs.

3. Steps in the evaluation process

a. Consultation in Washington with A.I.D./W and ISTI backstop staff

Because of the long history of this project (6 years) without an evaluation, it was necessary to develop background from A.I.D./W and ISTI staff formerly assigned to Dakar. Because population and family planning is so sensitive, it was necessary to understand A.I.D./W's latest thinking on the sector.

b. Consultation in Dakar with USAID Mission management and Project management

While this was an "independent evaluation," the team worked very closely with the Mission to determine the detailed scope, decide on sites to visit, prepare evaluation questionnaires, etc. Consultations were intense during the early days and continued throughout the evaluation.

c. A series of interactive workshops with GOS personnel, project staff and Ministry personnel

Workshops with GOS personnel, Project staff and Ministry personnel were necessary to determine which of the Project's many components and activities the Government wished to receive priority attention in the evaluation. These workshops took up the first two weeks of the evaluation.

d. Evaluation team meetings

A series of team meetings was held to:

- Determine the important project components to evaluate;
- Make team assignments;
- Develop a time schedule for completion of drafts and presentations to USAID and GOS;
- Agree on criteria indicators of output;
- Decide on evaluation criteria for each of the components to be reviewed; and
- Reach team agreement on the content of the final evaluation report, i.e., the nature of the "deliverable."

e. Detailed evaluation questionnaire

During the third week, detailed evaluation questionnaires were developed for each of the Project components and activities to be reviewed. These questionnaires were reviewed by USAID to assure that issues of importance to USAID would be studied by the team. The questionnaires were also reviewed by the full team to assure a measure of commonality among different parts of the evaluation. Since team members did not travel as a group, it was important for each member to know what information others were seeking so that team members could bring back information from sites not visited by other members, and so that the evaluation report could be reviewed by, and considered a team report. The detailed questionnaires are attached as Annex C to the evaluation report.

f. Selection of clinics, hospitals, laboratories, warehouses, villages and other project sites to be visited

The sites were proposed by MPHSA and reviewed by Project personnel, USAID and the evaluation team. Visits were planned so that at least one team member would visit each of the six regions being supported by the Project--to public as well as PPPS facilities, and to sites considered as good, average and bad. The team assumed the family planning centers selected were representative.

g. Findings and conclusions

Determination of findings and recommendations was a team effort. The full team met to review, consider, and agree upon the findings and recommendations contained in each chapter of the evaluation report. The team approach assured that all statements could be verified by the writer and supported by other team members.

h. Data consistency

Consistent, reliable and timely data was not available on various project activities. The team held a number of meetings to agree what data should be used in all chapters of the report. In a number of cases inconsistencies could not be resolved and will show up in the report.

i. Report writing

The last two weeks were devoted to writing the report to be left with the USAID and GOS, and to making presentations to the GOS and USAID officials. The final report was prepared in Washington.

j. Report clearance

While the original scope of work called for an English language report to be left with USAID, three of the seven team members wrote in French. Their work had to be translated into English for review by USAID, while the work of the English writers had to be translated into French for review by the GOS. This introduced some delays in clearing and preparing the final report.

4. Presentation of report material

Different evaluation team members wrote different chapters. To assure consistency of presentation each substantive chapter will follow the same outline.

- Goals and Objectives are presented as found in the amended Project Agreement and Logframe.

- Description of the Component or activity presents sufficient detail to permit the reader to understand what is being evaluated.

- Analysis and Evaluation of the component compares and analyzes component activities against component goals. Where data were not available, the team members specified assumptions and hypotheses.

- Summary of Major Findings and Conclusions contains the positive, as well as the negative, findings and conclusions isolated in the Analysis and Evaluation. It also presents neutral observations to help the reader better understand the component

- Summary of Major Recommendations for change and improvement of the project components to better achieve the stated goals and objectives details of the recommendations, and preliminary steps to achieve recommendations included in earlier sections.

5. Lessons learned on evaluation methodology

a. Joint GOS/USAID evaluations

USAID/Dakar should be commended for agreeing to have two Senegalese government officials serve as members of the evaluation team--one as the team's co-leader. This evaluation, therefore, is a joint endeavor. The facts, information, opinions, findings, and conclusions are deeper than what could have been obtained if the team had been made up only of Americans. The recommendations are more realistic and implementable in terms of what is economically and culturally possible, and acceptable, given the local political situation.

On the other hand, in moving in this direction, USAID must be prepared to pay the additional costs that result from a joint evaluation. Working in two languages--English and French--requires more time to work through points, and more funds to translate material into both languages. More funds are needed for support staff for local counterparts who do not use computers and word processors. In this case, USAID/Senegal was slow to provide the additional resources needed.

b. Timeliness of evaluations

USAID should not wait six years before carrying out the first project evaluation on such a large and complicated project. After six years, minor issues that could have been corrected earlier in a Project life become "built in", and accepted as normal. Organizations become comfortable with existing approaches. Unless pressed, few bureaucrats or technicians will take the initiative to make changes to project implementation.

c. Appropriate scope of the evaluation

In a large project such as this one, there is some advantage to having separate technical evaluations of independent Project components before conducting an integrated program and management evaluation. For this Project, there could have been prior evaluations of the BNR demographic component, the IEC component, the logistic component, and certainly the clinical component.

II. PROJECT ADMINISTRATION AND MANAGEMENT

A. Goals and Objectives

GOS representatives urged that the evaluation team give attention to project administration, especially the cost effectiveness of Project components. Improvement of Project administration and creation of an efficiently managed Project that maximizes the use of limited financial and human resources and assures project sustainability is not a specific goal of the Project. Criteria for evaluating management effectiveness are not included in the Project Agreement. The lack of relevant evaluation criteria, lack of a system for collecting operational data, and insufficient time of the evaluation team limited an evaluation of management issues in any depth. However, a brief description of selected management factors, focusing on aspects of decision making, coordination and budgeting is presented below.

B. Description of Project Administration and Management

1. Administrative organization

a. At Dakar headquarters

The USAID/GOS Grant Agreement was signed on July 31, 1985. GOS Decree No. 001543/MPHSA/DC of February 12, 1991 (See Annex F-2), formalized the existence of an FHPP Project Management Unit made up of the following Senegalese staff:

- A Project Director/Coordinator;
- A Deputy Director in charge of the Financial and Administrative Office (BAF);
- Two Administrative and Financial Office (BAF) officers, in charge of financial and inventory accounting (presently an accounting secretary and an administrative secretary);
- Five officers (all female) to manage the following technical activities:
  - IEC--a technical education teacher and a home economics instructor;
  - Clinical--a midwife;
  - Studies, research and evaluation--a social scientist and an administrative assistant; and
- Support staff of secretaries, drivers, messengers and janitors.

b. Field organization

Following Senegal's system of decentralized health care, the Project has extensions into six geographic regions. Each region is headed by a regional medical doctor whose staff includes a regional MCH coordinator and a regional IEC coordinator.

Before the March 1990 government reorganization, when the Project was under the direction of the Ministry of Social Development (MSD), the regional IEC coordinator was supervised by the MSD Regional Development Inspector. Coordination between the regional medical doctor, who was then under the Ministry of Health (MOH), and the IEC coordinator under MSD was not easy. Since March 1990, when MOH and MSD where combined as the MPHSA, coordination has improved.

At the district level, a number of different organizational arrangements exist:

- At health posts where there is an Health Chief of Post (ICP) and a midwife who coordinate well with one another, and the midwife exclusively handles family planning activities, there have been few conflicts.

- At some health posts (e.g., Dioffior) where the chief doctor made a decision to have health persons work independently, there were some conflicts.

- Some health post only have midwives who are concerned with family planning activities.

- At health posts where there are no midwives, but only a home economics teacher, she conducts IEC and family planning activities.

Thus, at the district level, one finds various combinations of multi-disciplinary personnel--an ICP, midwives, a home economics teacher, and representatives of other technical ministries. These technical personnel are supervised by the head of the local Rural Economic Development Center (CER) who represents the local Prefet or Sous-Prefet. The CER Head is appointed by, and is an agent of, the Ministry of Interior.

2. Project direction

FHPP has coordination and implementation requirements to:

- Develop the Project's annual work programs and budget;

- Plan, implement and evaluate Project activities as reflected in its various components, i.e., clinical, IEC, PPPS, and BNR;

- Organize training programs; and
- Ensure cohesiveness of Project implementation.

3. Project participants

Project implementation requires the participation and cooperation of several organizations: USAID, ISTI, MSD, MOH, MPHSA (since March 1990), PPPS, BNR, MEF, MOP, as well as the Project, FHPP. In principle, each organization has a well-defined role.

a. USAID/Senegal

USAID/Senegal has a diverse range of responsibilities. It:

- Is the donor;
- Supervises the implementation of the Project through its health office, HPNO;
- Sees to compliance with the terms of the Grant Agreement and the commitments made by both sides;
- Manages the dollar fund for purchases in the U.S. and for technical assistance from BUCEN;
- Purchases vehicles, computers and contraceptives; and
- Delegates the management of the local account to ISTI, the technical assistance contractor.

b. ISTI

At present the ISTI Liaison Officer spends a major portion of his time acting as a motivating force or catalyst to help the Project Director expeditiously program, coordinate and execute Project activities. ISTI:

- Is in charge of the financial management of the Project;
- Is responsible for managing the Private and Para-Public component (PPPS/VSPP);
- Takes care of administrative issues relating to external training, particularly in the United States, through its headquarters in Washington;

- Manages the Project local currency account;
- Arranges for long- and short-term technical assistance; and
- Is an intermediary between USAID and the Project components.

c. MSD and MOH (now, MPHSA)

Before the March 1990 GOS reorganization, the Project was under the direction of MSD, and cooperated with MOH. These responsibilities are now combined in the new MPHSA.

MSD:

- Is in charge of the design and definition of a family planning policy;
- Implements the family planning policy; and
- Is responsible for Project aspects dealing with information, education and communication.

MOH:

- Implements the family planning clinical and technical activities, e.g. prescribes pills, inserts IUDs, implants Norplants;
- Carries out family planning procedures under Letter # 967/PM/SP/ of 10/25/79 from the Prime Minister, as quoted in letter # 1989/MPC/DRH of 5/2/88;
- Contains the Direction de l'Hygiene et de la Protection Sanitaire (DHPS) which became the Direction de la Santé Publique (DSP) in MPHSA;
- Supervises Project technical implementation through its Service National de Sante Maternelle et Infantile (MCH) which reports to the DHPS;
- Provides the Project technical director; and
- Carries out clinical aspects of family planning through MCH.

d. BNR

BNR, the National Bureau of the Census, is a division in the Ministry of Economy and Finance. BNR:

- Is the locus of one of the Projects three substantive components;
- Is charge of improvement of Senegal's demographic data base; and
- Maintains the national data bases, and improves collection and analysis of data to help improve development planning.

e. PPPS (VSPP)

PPPS is one of the Project's three main components. It:

- Promotes family planning activities through the Private and Para-Public sector; and
- Is under the responsibility of USAID which has delegated supervisory authority to ISTI.

The Director of this component is supervised by ISTI.

f. Ministry of Development Budget (MDP)

MDP:

- Ensures that GOS meets its financial commitments by including budgetary resources in the national investment budget;
- Intervenes during the fund mobilization process to assure that ministries meet their contribution to development projects;
- Assures that national expenditures are in accordance with approved development plans; and
- Draws up the annual national balance sheet.

g. Ministry of Economics and Finance (MEF)

MEF:

- Prepares and manages the national operating budget (Budget National de Functionnement); and

- Mobilizes operating funds for GOS Ministries on the basis of budgets prepared by ministries for development projects.

h. Family Health and Population Project (FHPP)

FHPP:

- Ensures the coordination of all Project interventions with a view to maximizing efficiency by providing participants with the necessary information, means and direction to carry out their work;

- Manages and assures the technical coordination of the Project components, i.e., clinical, IEC, VSPP, and BNR;

- Is directly responsible for the clinical component;

Until August 1989, the Project was managed by a senior civil servant appointed by MSD. He was assisted by a doctor designated by MOH who also acted as the technical director. The Project's technical director was also Chief of MCH to facilitate the integration and coordination of GOS and Project family planning activities. Within the clinical component is an MST/CIDA (STD/AIDS) sub-component responsible for the prevention, detection and treatment of sexually transmissible diseases. This sub-component is headed by the Chief Doctor of the STD/AIDS Department in MPHSA.

i. Maternal and Child Health (MCH)

MCH is a unit in MPHSA under the Director of Public Health. It is:

- Responsible for all matters connected to maternal and child health and family planning;

- In charge of the implementation of the national family planning program; and

- Is responsible for child spacing, the fight against STD and treatment of infertility and sterility.

Prior to March 1990, the Chief of MCH carried out the technical and medical management of the Project.

4. Coordination

At least four types of coordination are necessary: coordination between the Project and the U.S. government, internal Project coordination, coordination between the Project and the GOS, and Project coordination with donors.

a. Coordination with the U.S. government

The Project is supervised for the United States by USAID/Senegal's Office of Health, Population and Nutrition which ensures overall Project coordination of U.S. Government activities in the health sector. USAID/HPNO manages:

- Direct dollar funding to purchase certain commodities and technical assistance in the United States;
- The Participating Agency Service Agreement with the United States Bureau of the Census; and
- The technical assistance contract with ISTI, which focuses on the Project's financial management. ISTI manages dollar fund to finance external technical assistance, and a local currency budget for local training and other local costs.

b. Internal Project coordination

(1) Coordination within the Project

Within the Project, each of the three components function, to a great extent, on its own. There have been few coordination meetings among component Directors--certainly not since the March 1990 GOS reorganization. Such meetings would allow for a better understanding of component interrelationships, provide opportunities for components to better support one another, and might help improve relationships with MCH.

(2) Coordination of components

When the Project was under the direction and supervision of the two Ministries, administrative meetings were held once each quarter. After the reorganization, during the period between Project Directors, coordination meetings have not been held. Organized Project coordination was replaced by direct contacts between component directors and ISTI or USAID to resolve administrative or budget issues. Because all budgets are not centralized at FHPP, the Project is insufficiently aware of component activities and is unable to participate in designing or supervising their activities. This situation is described in the newly written Project Procedures Manual, in which it is stipulated, at least with regards to the preparation of budgets and replenishment of advances, that ISTI must inform the Project and all components of administrative and budget actions taken.

(3) Coordination with the regions

The simpler structure at the regional level minimizes the impact of lack of coordination at the national level. In the past, orders to the field were assigned by MSD, without involving MOH and MCH. At other times, regional coordinators prepared statistical reports which were transmitted directly to the Project, no copy being sent to MCH. On occasion, MCH was obligated to ask the Project for certain family planning statistical data. This situation disturbed MCH which, at one point, asked regional doctors not to receive Project teams without the knowledge or participation of MCH. This resulted in blockage of Project activities, which in turn, led to a greater desire on the part of MCH for involvement in the planning of data needs and collection, training of regional personnel, preparation of budgets, etc.

MCH and other GOS officials have cited the lack of vehicles and local currency for gasoline and per diem for limited GOS coordination and supervision of daily Project activities. They claim they are dependent on FHPP for resources which recently were frozen by the Project, thereby halting MCH supervision and coordination. USAID, in fact, completed its financial commitment to the Project for local operating costs. Local resources for local expenses must now come from the GOS contribution to the Project. It is these contributions that are not being provided.

c. Coordination between the Project and the GOS central level

The central level is made up of the Minister's Cabinet, the Technical Advisors and the Departments within the Ministry of Public Health and Social Action (MPHSA). As already noted, when the Project was initiated, it was under the joint auspices of the Ministry of Social Development and the Ministry of Health. MSD was in charge of administration, budget and IEC; MOH had the technical role. After the GOS reorganization, the Project worked in conjunction with the new Ministry of Public Health and Social Action (MPHSA).

The principal Project contact in MPHSA is the Director of the unit responsible for mother and child health (MCH). MCH is responsible for child spacing, cure of sexually transmitted diseases, and treatment of sterility.

MCH is headed by a medical doctor and includes the national MCH coordinator, the national IEC coordinator and an STD/AIDS component under the authority of the Office of STD/AIDS responsible for prevention, detection and treatment of STD/AIDS.

The Senegalese Director of the USAID funded Project now attends weekly coordination meetings organized by the MPHSA in which participants are senior members of the Ministry. The weekly meetings provide a coordination framework. It has been reported, however, that the meetings tend to be ineffective because of the large amount of material to

be examined, and insufficient time devoted to each problem. This was the reason that a Technical Advisor was appointed, within MPHSA, to follow issues relating to the USAID funded family planning project (FHPP).

Two other MPHSA departments are involved in family planning activities: DAGE, which prepares the national investment budget for MPHSA and expresses in financial terms, the Government's commitment to the Project, and DSP, which ensures the coordination and technical supervision of the Project.

The principal actors, FHPP, MCH, and BNR are all branches of the same government and two (FNPP and MCH) are part of the same Ministry (MPHSA). If there is a lack of communication between FHPP and the other components, it is not the principle role of ISTI, an outside agency, to take direct responsibility for the communication among different sections of a host country entity. It is the responsibility of the government, itself. However, as the principal provider of technical assistance, ISTI's role is to provide guidance to the GOS on how to carry out coordination.

d. Project coordination with other donors

At the time of the signing of the Grant Agreement there was no GOS policy framework defining national objectives and strategies in the area of family planning. Individual donors who assisted the Government in this field determined Project objectives in negotiation with separate GOS ministries. It was in this context that the present USAID family health and population Project was initially developed. That situation has now changed with the issuance, in January 1991, of the new GOS policy on family planning.

5. The technical assistance contractor

USAID signed a technical assistance contract (No. 685-0248-C-00-6001-00) with ISTI on September 25, 1985 for $6,500.000. The contract budget, as of April 15, 1991 is detailed in Table 2. The contract called for five categories of effort by ISTI:

o Long-term resident technicians who:

-- Assist the GOS design, implement and monitor FHPP, by ensuring compliance to implementation plans and the achievement of Project objectives;

-- Assist Private and Para-Public Sector organizations organize and implement educational and other family planning activities;

-- Serve as liaison between GOS, private, and para-public institutions and USAID to assist in Project implementation procedures; and

Table 2: AID/ISTI Contract Budget of April 15, 1991

Line Item	Dollars
Salaries and Wages	2,150,088
Fringe Benefits	84,125
Overhead	901,017
Consultants	227,277
Travel	201,607
Allowances	1,024,985
Subcontracts	451,533
Other Direct Costs	1,085,287
Training	1,272,508
G & A	876,037
Fixed Fee	322,613
Commodity Fixed Fee	102,177
Disallowances	(41,477)
Total	8,657,777

-- Provide logistic support for short term consultants hired by the contractor;

- Inventory accounting and management services to all Project's activities;
- Purchase of equipment and material for small income generating Projects to be managed by women's organizations involved in the extension of family planning methods;
- Purchase of commodities for all Project components, with the exception of contraceptives, vehicles and computers; and
- Supply 18 months of short term technical assistance.

6. Planning within the project

a. The planning process

Because of the recent change of key personnel within the GOS, within the Project, and USAID, the evaluation team did not succeed in determining precisely who made final decisions on a number of project activities. Before the "crisis" of 1989/1990, each component used specialized planning tools to program its activities. These included annual action plans and annual budgets which were prepared by the components with the assistance of ISTI. Discussions were held between the Project and component managers to ensure overall coherence of the plan before USAID approval was requested. Since the "crisis" had such an important effect on the operation of the Project some comments are necessary.

Suspicions of mismanagement, long brewing, got to the point in 1989 where both USAID, through the office of the Regional Inspector General, and the GOS, through the Inspection Generale de l'Etat, found it necessary to investigate the project. Both found considerable evidence of malfeasance, which led not only to a change of Project Directors but also to replacing the Project accountant and logistician. These were the three central figures who had been controlling Project planning and management, all of whom had major implementing roles from the beginning of the Project and had received training , on-the-job and off-the-job, at the Project's expense. This was a major loss in terms of experience, operational knowledge and institutional memory.

From the time the Director was removed on July 1, 1990 until he was replaced in October, 1990, there was little Project direction. Moreover, during the final stages of the investigation, the Director's authority was so weakened, his credibility so diminished, and his energies so absorbed in self-defense that the lack of effective leadership started long before his actual removal. USAID's reaction was one of increased control, and ISTI, reacting to the need for increased vigilance, took a more active role to fill the vacuum.

Added burdens resulted from the investigations--the time and effort spent by USAID, ISTI and the GOS responding to the investigations and the increased necessity to document every action, combined with the lack of a local currency budget due to the fact that a new Procedures Manual had not been agreed upon. This caused a suspension of most project activities, in a dramatic reduction of productivity, and serious loss of Project momentum. Thus, the amount of money lost through mismanagement only represents part of the problems that "the crisis" left in its wake. It is not the place of this evaluation to go further into the investigations and determine who was guilty or not. The evaluation is concerned only with the impact of the changing direction on the Project.

During the time of the present evaluation, each component seemed to plan its own activities without much reference to the Project. This is where the Project's responsibility seemed to be weak, and where ISTI and USAID become more directly involved in certain aspects of Project planning and implementation, especially for accounting and financial control.

Since 1989, the planning process seems to have moved further out of the control of the Project, to ISTI and to USAID, whose decisions now start from the definition of Project plans. For the budget, ISTI's activities have increased to the point that the evaluation team could not determine who made final budget decisions. This shift of authority to ISTI for financial implementation, control of the local account budget, and arrangements for external training is not appreciated by Senegalese Project and GOS personnel.

But this may already be changing and the role of the project leadership may be improved as witnessed by the planning workshop (held July 2-4, 1991 after the evaluation team completed its work in Dakar) and the two weeks of programming and budgeting that followed--in which PSFP, Bien-etre Familial, MSPAS, USAID, the World Bank, UNFPA and ISTI all participated.

b. Planning and management tools

As noted above, component Directors use a number of planning and management tools such as annual programs, action plans and budgets. Actions plans, for example, cover all activities including training, technical assistance, construction, distribution of contraceptives, supervision, etc.

When these processes were more clearly under the supervision of the Project, overall Project coherence was managed and refined by the Project and confirmed in the annual budget. The implementation of plans was carried out through quarterly activity programs and 90 day budget advances. Since the crisis, it has been ISTI, rather than the Project which has worked with component managers, and with the MCH technical director on Project planning. Evaluation team interviews with component Directors could not clarify who was actually in charge of the preparation of these planning tools. The link between ISTI's annual work plan and the components' action plans was not obvious, nor was it clear who supervised the implementation of these plans.

7. Project financial resources

a. Summary

Under the Grant Agreement of July 31, 1985, the U.S. agreed to provide $ 9.45 million. Amendments dated April 22, 1986 and June 10, 1987 brought the Grant up to $ 20.0 million then to $ 20.6 million. The contribution by the Government of Senegal was to be the equivalent of $ 7.4 million in cash and kind. The total FHPP resources thus amount to $ 28.0 million.

b. USAID funds

Table 3 indicates the distribution of U.S. funds by budget line item and component. It is based on the original Project Agreement, as revised in Amendments One and Two.

Table 4 indicates the revised Project budget as of 3/14/91--the time the evaluation team was in Senegal. Disbursement and accrual data are current as of 3/31/91. At the time the team was in Senegal there were negotiations between USAID and the GOS for a third amendment. Planning figures for the third amendment are included in the right hand column. The evaluation team could not determine whether the distribution of additional funds was done jointly with the GOS, the MPHSA, and/or the Project.

c. Fund management

The evaluation team attempted neither a financial audit nor a detailed consideration of financial procedures. In view of some of the financial matters resulting from the 1989/90 crises, USAID contracted with a management accounting firm to write a new Procedures Manual which is now an important part of the Project's financial control system. Under the new system:

- USAID, pursuant to its own procedures and regulations, directly contracts for services of the technical assistance contractor; contraceptives, vehicles and computers;

- The technical assistance contractor, ISTI, is in charge of the purchase of other equipment and services;

- The contract with ISTI stipulates that a significant portion of the technical assistance will be to the Senegalese institutions which are responsible for the Project's activities. USAID indicated that the contractor should assure that the aided GOS institutions where to provide advice on the assistance to be provided to them.

Table 3: A.I.D. Bilateral Portion of Revised Budget By Major Component ($US)

Budget Category	Family Health Services	Improve Data Base	Private & Para Public	Total
Technical Assistance	5,656,000	554,000	0	6,210,000
Training	1,600,000	437,000	600,000	2,637,000
Commodities	1,800,000	340,000	567,000	2,707,000
Contraceptives	1,125,000	0	300,000	1,425,000
Construction	576,000	0	0	576,000
Local Costs	1,716,000	847,000	0	2,563,000
Research	400,000	0	0	400,000
WID and IEC	760,000	0	0	760,000
US BUCEN PASA	0	585,000	0	585,000
Evaluation	130,000	0	0	130,000
Contingency/ Inflation	2,194,000	313,000	0	2,507,000
Unallocated	0	0	0	0
Grand Total	16,057,000	3,076,000	1,467,000	20,600,000
%, by Component	78	15	7	100

Table 4: Summary Financial Status as of 3/31/91 ($US)

Budget Category	Authorized	Revised Budget	Disbursed & Accrued	Proposed Add-on
Technical Assistance	4,269,000	7,000,000	7,125,868	103,250
Training	3,154,000	2,637,000	2,089,971	77,600
Commodities	2,873,000	3,678,000	3,854,749	14,400
Contraceptives	1,667,000	1,425,000	878,993	12,000
Construction	750,000	850,000	862,217	134,000
Local Costs	3,572,000	3,135,000	3,197,924	360,600
Research	0	400,000	260,379	103,400
WID	760,000	350,000	23,609	154,391
IEC	**	410,000	52,200	91,200
Data Base Improve	600,000	585,000	194,943	264,000
Evaluation	100,000	130,000	191,928	35,000
Contingency/ Inflation	2,989,000	****	****	50,159
Grand Total	20,600,000	20,600,000	19,057,772	1,400,000

* Original Project Agreement, plus Amendments One and Two

** IEC included in the WID amount

*** IEC commodities earmarked in commodity line item because disbursements cannot be separately identified.

**** Contingency and inflation distributed to other line items.

***** Revised budget based on USAID/HPNO Report of 3/14/91. Disbursed and accrued data as of 3/31/91.

- Approved budgets are communicated by USAID to the GOS in the form of PIL or Project Implementation Letter. USAID corrects proposed budgets or suggested expenditures through new PILs or PIL amendments.

- USAID funds are divided into three accounts (See Table 5):

  -- A dollar account managed directly by USAID including the activities of the U.S. Census Bureau (BUCEN);

  -- A dollar account managed by ISTI for the funding of external training, especially in the USA, external technical assistance, and commodities purchased in the U.S.;

  -- A local currency account managed by ISTI for the local costs of technical assistance and other local cost items. The two accounts managed by ISTI for respectively, $10,672,000 for the dollar account and $6,190,000 for the local account.

- Financing activities are carried out, as follows:

  -- Budgets and programs of activities are established by component director, with assistance from ISTI;

  -- A request for advance of funds, distributed by budget item, and covering the requirements for three months, supported with a detailed program of activities, is transmitted by component directors to ISTI;

  -- ISTI centralizes requests for funds from components and forwards them, with an SF 1034, to USAID; and

  -- USAID issues an advance of funds check in the name of ISTI.

This description leaves the Senegalese Project Director out of the loop to reflect the situation that existed at the time of the evaluation. The situation may have been different before the crisis, but that has been hard to document. ISTI did work directly with component Directors to elaborate the 1990-91 Budget, which later became the 90-day Interim Budget, due to the lack of a Project Director at the time the budget was being prepared. However, by the time it was submitted to USAID for approval, the new Director was on board. Recommendations below support efforts to bring GOS personnel into the process.

Table 5: Analysis of Revised Budget/Program and Implementation Authority by Principal Organizational Unit (in $ 000)

Budget Category	ISTI $	ISTI FCFA	BUCEN	USAID	Total
Technical Assistance	6.407	14	835	74	7.331
Training	1.273	1.078	0	87	2.438
Commodities	1,852*	1.063	0	831	3.746
Contraceptives - Direct	0	0	0	885	885
Contraceptives - Transfer	0	0	0	?	?
Construction	0	900	0	44	944
Local Operating Costs	1.140	2,000	45**	260	3.445
Research	0	200	0	211	411
WID	0	175	0	0	175
IEC	0	410	0	0	410
Social Marketing	0	0	0	173	173
Data Base Improvement	0	350	0	0	350
Evaluation	0	0	0	223	223
Contingency	0	0	0	70	70
Grand Total	10,672	6.190	880	2.858	20.600

Data based on USAID/Dakar/HPNO Report of 3/13/91

* Funds included in a Letter of Commitment

** Handled by USAID before a local account was set up.

d. The Senegalese contribution

The GOS contribution in cash and kind equivalent of $7.4 million is approximately FCFA 2,960,000,000 ($1.00 = 400 FCFA) at the time of the signing of the Grant Agreement.

(1) The legal framework

The GOS contribution to the Project is prepared by National Investment Budget (BNI) or BNE and is included in the national investment budget. The legal framework is broad and includes all the legislative and regulatory texts organizing state finance. Of special importance is Decree 66458 on the Regulation of State Public Accounting which determines budget preparation procedures and the persons in charge of its implementation.

The annual financial law comprising the budget makes a distinction between the general operating budget and the investment or equipment budget. The contribution to the Project is posted in the National Investment or Equipment Budget (BNI/BNE).

Each ministry prepares its investment budget for the duration of the 5-year Economic and Social Development Plan. This budget includes the necessary contributions to Projects under its supervision. If the contribution is to be in cash, the amount is divided according to the programming of actions over the five years. Each portion of the financing bears the authorization name of the program. If the funds for any given year are not used, they are carried forward to the following year until the end of the fifth year. At the end of the fifth year they become free funds, or are deposited into a liquidation account if they had been the object of a commitment.

(2) Fund management

It is within the above context that MSD/DAGE prepares the funds necessary to cover the contribution to this Project. The corresponding budget line is Chapter 2857, Article 7011-1, and since 1989/1990, Article 7012-1.

Before the government reorganization, MPC was the institution which could authorize expenditures, now it is the MEFP. After the budget vote by the National Assembly, MPC notifies each Ministry of investment segments for which it is responsible. MSD (now MPHSA) draws up an Annual Technical and Financial Implementation Form at the beginning of the fiscal year. Together with the implementation program and the Voucher, this Form is submitted for the approval of MEF, MPC and Controller of Finance. When all approvals are secured, the funds are made available by the Public Treasury and put into a deposit account or a bank account. At that time, expenditures can be made. The amounts allocated since the beginning of the Project and made available by the Government are shown in Table 6. Of these amounts, FCFA 60,000,000 were allocated from 1985 to 1989. The 1989-1990 and

Table 6: Allocation by Fiscal Year of GOS Cash Contribution

Fiscal Year	FCFA Amount Allocated
1985 - 1986	10,000,000
1986 - 1987	20,000,000
1987 - 1988	10,000,000
1988 - 1989	20,000,000
1989 - 1990	80,000,000
1990 - 1991	50,000,000
TOTAL	190,000,000

1990-1991 amounts of FCFA 80 million and FCFA 50 millions were not allocated because the mobilization procedures established for the Project did not take place, despite correspondences between MPHSA and MEF.

The FCFA 60,000,000 was disbursed according to Table 7. Expenditures amount to FCFA 42,436,347, with an unexpended balance of FCFA 17,563,653. The financial restructuring imposed on Senegal by the IMF caused a freeze of funds of FCFA 9,500,000 at the Union Senegalaise de Banque (USB). A new balance of FCFA 8,063,653 is presently deposited at Credit Lyonnais.

A budget of FCFA 110 million has been earmarked as the GOS contribution to the Project for the GOS 1991 - 1992 fiscal year.

8. Commodity purchasing

a. Local purchases by ISTI

Local purchasing is carried out, as follows:

- Components prepare a DAP (Demande d'Achat et de Prestations) which they transmit to ISTI;
- ISTI determines fund availability and enters the request in its accounting register;
- ISTI initiates the purchase procedure--direct purchase for amounts below FCFA 50,000,--proforma invoice from three suppliers for amounts between FCFA 50,000-3,000,000.--competitive bids for amounts above FCFA 3,000,000;
- ISTI makes procurement decisions on its own, without Project personnel involvement. Deliveries are made to ISTI;
- ISTI establishes a stock account and issues a delivery order signed by the ISTI chief accountant and the liaison officer; and
- ISTI delivers the commodity to the beneficiary component and pays the supplier.

b. External purchasing by ISTI

When external purchases are needed, DAPs are approved by ISTI as well as by USAID prior to execution. Before the crisis, local purchases were carried out by the Project, with ISTI acting only to effect payments. The new procedures, negotiated

Table 7: Allocation and Disbursement of the GOS Cash Contributions to the Project

Items	Allocated Amounts	Disbursed Amounts	Balance
Fuel	9,976,200	9,915,275	60,925
Indemnities	8,568,000	8,120,000	448,000
IEC Material	-	-	-
Clinical Pedagogy	7,000,000	4,359,000	2,640,000
Staff Training	8,290,000	3,891,000	4,398,000
Clinical Materials and Maintenance	12,000,000	7,684,528	4,315,472
Misc. Services	565,800	399,654	166,144
Facilitators for Women's Organizations	-	-	-
Family Planning	13,600,000	8,065,800	5,534,200
Total	60,000,000	42,436,347	17,563,653
Frozen at Bank		9,500,000	8,063,653

Source: FHPP Accounting (April 91)

between USAID and GOS, set safeguards such as expenditure controls, to assure the use of funds only for approved purposes. Because of the "crisis" and audit, DAPs were strengthened to check the nature, costs and usefulness of expenditures. Budgets, DAPs, and activities program are also now submitted to MPHSA for approval.

The discussion here stems from the bitterness expressed by some GOS personnel that responsibility for procurement was taken away from the Project by USAID after the audit. From ISTI's perspective, ISTI has taken actions and made decisions to assure that procurement follows tightened procedures requested by USAID The Project has argued that ISTI is more concerned with price than quality. ISTI has argued that when decision of a technical nature need to be made, there is communication between ISTI and the Project and that the Project's views are taken into consideration.

c. Purchases made by USAID

Purchases made by USAID for heavy equipments and contraceptives comply with A.I.D. internal procedures. Intervention of the Project is limited to the expression of needs, the signing of the DAPs, and the reception of materials.

9. Human resources

The Grant Agreement requires the Government to provide the Project with a sufficient number of competent personnel. The Agreement does not give a description or profiles of personnel requirements and the designation of the Project's personnel is not submitted for USAID's approval.

The staff which is presently working on the Project represents various areas of expertise for the execution of the Project mission. The characteristics of the current staff are summarized in Annex H.

The team did not attempt an evaluation of the numbers, quality, or duties of Senegalese or expatriate personnel. This could be a very important assessment, particularly useful in determining training and technical assistance needs and accomplishments. It could be a useful activity for the upcoming project paper design team.

C. Analysis and Evaluation

1. Administrative aspects

FHPP was initiated before the National Family Planning Program (NFPP) was approved on March 15, 1991. Because of this, the Project was not carried out within a comprehensive GOS institutional framework which would have allowed for harmonization of strategies and better articulation of activities with other GOS programs. Better coordination

of the Project with MCH would have contributed to a better integration of ongoing activities and could have improved coordination and laid the basis for future institutionalization of Project activities.

Supervision of the Project by two ministries which existed at the beginning of the Project, established vertical processes and, sometimes, parallel development of programs. At the time of Project supervision by MSD and MOH, for example, until March 1990, MOH/SN/SMI's role was limited to clinical aspects of the Project and had no responsibility for IEC activities. IEC was the responsibility of MSD which provided agents to design, implement and evaluate IEC activities. This vertical and parallel development isolated family planning from other health activities, specialized health equipment and other means, even for accounting and reporting. In some regions, head doctors were not informed of the arrival of family planning materials destined to health centers located in his region.

This situation created frustrations among and between Project and other health personnel. For a period of time, the Project focused primarily on the training of midwives to the exclusion of other health personnel. The lack of interest in family planning activities demonstrated by some medical doctors may be partly explained by frustration, because they were not trained, and had not mastered the latest family planning techniques, which were well assimilated by the midwives under their authority. Some regional doctors therefore, considered family planning to be the midwife's job, and not their own.

During the period of Project supervision by the two ministries, there were rivalries between the ministries, one determining the means and the other the techniques for family planning activities. Field integration was not achieved and collaboration in some localities proved to be difficult. There was insufficient definition of duties and responsibilities of each ministry, and hence their agents in the field. Indeed, when the Project's technical director was appointed, there was no formal description of his role. His responsibilities were clarified only as activities unfolded.

GOS Decrees conferred upon the Project the role of coordinator as well as that of implementor of family planning activities. Since these activities can be carried out only within health centers, and more precisely within MCH units, MCH must be associated. In order to facilitate coordination and integration across GOS departmental lines, the head of MCH was designated as the Project's technical supervision.

Because MCH is responsible, at the national level for the coordination and implementation of all family planning activities, and because the Project has been outside of the regular GOS structure up to now, it does appear that roles were not clearly defined. All persons involved in family planning did not share an understanding of one another's mission and they did not have the same level of information on family planning issues. And, there was competition between those health workers funded directly by the GOS, and those funded by the Project.

The absence of common guidance hindered the harmonization of strategies between the Project and the two ministries. Competition between the two ministries exacerbated the situation. But even today, there are unresolved differences. MCH feels that the Project should limit itself to the planning and coordination of activities and not be involved in the implementation of family planning activities, leaving implementation to MCH. Actual roles do not seem well defined. The absence of an official organizational chart hinders the distribution of responsibilities.

In an attempt to overcome such difficulties, the GOS has published a decree which establishes the Project and clarifies the roles for coordination and implementation of activities. See Annex F-1. The recent appointment of a Technical Advisor in MPHSA, in charge of family planning, should facilitate better coordination within MPHSA and the other donors who play a part in family planning. It is desirable that periodic meetings be held between FHPP and MCH to define the type of support expected by MPHSA and the prospect of institutionalizing the Project's activities.

With regard to DAGE, the team is not certain that DAGE has brought all the necessary support to the Project by identification of a sufficient contribution or for the mobilization of such contribution.

2. Financial aspects

The authority given to ISTI by USAID for financial implementation of the Project removes much decision making from Project and GOS personnel. It is difficult for GOS and Project personnel to understand why the Government of Senegal, upon signing an agreement, must have the funds managed, controlled and utilized by an organization other than the Government or the Project. They do not understand why more than 35 percent of the grant for financing of technical assistance are spent by ISTI without serious discussions with the GOS. GOS and Project personnel do not understand why 36 percent of the funds deposited in the local account managed by ISTI must be used to cover foreign technical assistance costs rather than technical assistance which might be available locally. This percentage exceeds 50 percent if one adds the costs of training in the U.S. and equipment purchased in the U.S.

If the BUCEN technical assistance is included, GOS personnel complain that approximately 53 percent of the funding goes back to the U.S. Moreover, GOS and Project personnel complain that they do not always receive the reports, and conclusions of the work, of the technical assistance consultants. Senegalese have asked, therefore, how much actual value the GOS receives from these technical assistance services.

As a result of the management crisis and financial audit, USAID reinforced its direct control over Project financing by increasing ISTI's authorities and reducing those of the Project. At the present time, since it does not receive significant feed-back from ISTI, the

Project has stated that it is unaware of the precise status of Project funds. Under these circumstances, PHPP cannot monitor the Project, and the GOS cannot control the use of funds.

In the competitive bidding process, since GOS or Project representatives do not participate in the selection of companies, the GOS does not have a voice in selecting contractors to provide goods or services. It receives equipment, supplies, and services without being able to assess their quality or appropriateness.

It is the view of many Project and GOS personnel, that FHPP is deprived of an important management function--the control of financial resources. It is the view of Project personnel that they could and should carry out financial management without the intervention of ISTI, if more effort and resources had been provided to train Project staff in U.S. management practices and procedures.

Now that it has been agreed to physically, and institutionally, to locate the Project in MPHSA, the evaluation team considers the success of the ongoing and new Project will depend on a clarification and redefinition of roles that will shift greater authority and responsibility to GOS and Project personnel and will help improve coordination among the participants. Increased management training should be provided to Senegalese personnel to carry out these revised roles.

D. Summary of Major Findings and Conclusions

1. On budget matters

- The Project Agreement required the GOS to make a contribution to the Project, in cash and kind, of the FCFA equivalent of $7.4 million for local costs. Except for a covenant on total gasoline costs and a covenant on total local operating costs, the Agreement did not specify the distribution of the GOS contribution. Not USAID, ISTI, the GOS or the Project is presently aware of the status of more than $220,000 in cash that the GOS's allocated toward its $7.4 million commitment.

- There is presently insufficient financial resources for local operating costs for vehicles, gas, per diem, local training, utilities, and other operating supplies and equipment. Many GOS and Project personnel believe this is a result of USAID's freezing the US local currency contribution. Actually, USAID has made its full contribution. The shortage is from amounts that should be provided in cash or in kind as the contribution of the GOS.

- USAID has not insisted that the GOS meet its financial commitment to the Project nor has USAID substituted U.S. funds for the local contribution which should be made available to the Project by the GOS.

- Before the financial audit and management crises of 1989/90, a collaborative process existed for development of the local currency work plan and budget wherein the Project prepared the budget, which was accounted for by ISTI. Since the crises, because of the concerns raised in the audit, and because of the transition in Project direction, USAID and ISTI have taken stronger roles in development and accounting of the local currency budget.

- The annual dollar budget is prepared by ISTI, after some discussion with the Project, and approved by USAID. The arrangement of ISTI as an intermediate financial, work planning, budgeting and administration unit offers little opportunity for MPHSA and Project personnel to develop the capability to manage and financially control, the Project.

- Project and GOS personnel state that ISTI does not provide sufficient reporting and feedback on financial and budgetary activities. It is difficult, therefore, for the GOS and the Project to control expenditure of funds. ISTI, for example, has the authority to make adjustments in dollar budget line items of up to 15 percent without consulting with the Project, USAID or the Government, which further contributes to lack of control of financial management by the Project.

- ISTI presently deals directly with Directors of BNR and PPPS Project components on advances of funds which further reduces the ability of the GOS and the Project Director to properly coordinate and manage Project activities. To ISTI, the fact that the GOS signs off on advances means the GOS knows what is in these advances. To the GOS, which does not fully understand U.S. accounting and management practices, clearing of document such as the DAP (as well as PIO) is just something USAID requires them to do, with little understanding of the implication of their approval.

2. <u>On management and coordination</u>

- Partly because an official MPHSA/MCH/Project component organigramme has not yet been approved, there is an overlapping of authorities so that it is difficult to coordinate the Project and to determine the interrelationships among the different components.

- There were few coordination meetings in the past among Directors of different Project components. There are none now to help overcome overlapping management lines of authority. Some of this confusion was built into the basic Project design and continued in ongoing Project implementation.

- The procedure used by ISTI for bidding on local contracts, particularly for construction, sometimes did not always insure full and open competition and insufficiently involve GOS personnel in decisions.

- No procedure exists in the present Project Agreement to permit USAID to review the selection by the GOS of key Senegalese Project personnel. USAID has no "right of refusal" on people who are responsible for managing significant amounts of U.S. funds.

E. Summary of Major Recommendations

1. On financial and budget matters

- The GOS should take appropriate measures to assure that it is able to meet its financial commitment to the Project. For example:
  - Devise ways and means to assure a level of Government support for family planning that is adequate and lasting;
  - Set service fees to acceptors based on ability to pay for the services;
  - Improve internal procedures which mobilize and secure local funds to assure that the GOS is administratively capable to meet its financial contributions;
  - Make budget preparation procedures and assignment of financial responsibilities more specific;
  - Make arrangements to assure that GOS counterpart part funds are provided on time; and
  - Seek ways to increase support from other donors, as well as users, and the private sector to keep the public sector burden to the minimum.
- Encourage local Community Health Committees to carry out many of the same actions, as above, at the local level.
- Encourage private sector purchase and sale of contraceptives as a way to reduce some of the Government's burden for commodities that the GOS might better apply to supervision and delivery of quality clinical services.
- USAID, in its design of the future Project, should take into account the GOS ability to financially support the Project and,
  - Make realistic counterpart fund projections that anticipate the amount of local currencies that will come available to the GOS, taking into account the limits imposed by the IMF structural adjustment program;

-- Maintain sufficient records to determine if the GOS financial commitment is being met, hold the GOS to its commitment, and establish Project revisions and reductions that will be made if sufficient funds are not available;

-- Make flexible grant agreements, such as where USAID financial contributions are tied to pre-determined Project performance or other criteria;

-- Study the possibility of a health/family planning sector grant to encourage policy changes or administrative actions to improve implementation of family planning activities; and

-- Support the upcoming study on financing of health services and ensure that FP activities are included in the study.

2. <u>On management and coordination matters</u>

o Shift decision-making for operational and budgetary matters from USAID and any future technical assistance contractor to GOS agencies and personnel so that family planning can be institutionalized as a GOS effort.

o Clarify and strengthen the planning function either by hiring a health and family planning planner or improving the planning skills of Project personnel.

o Involve key Project personnel in more financial decisions such as for purchases of contraceptives and selecting contractors.

III. INFORMATION, EDUCATION, AND COMMUNICATION (IEC)

A. Goals, Objectives and Output

1. Goals

The overall goals of the IEC activity are to:

- Promote the adoption of family planning services in Senegal;
- Promote continued contraceptive use among those who have adopted it;
- Decrease the number of dropouts from the program; and
- Provide information on reproduction related topics, such as infertility and sexually-transmitted diseases.

2. Objectives

The specific objectives of the IEC program are to:

- Promote the concept of child spacing as a way to better family health and well-being;
- Inform about the risks and dangers of sexually-transmitted diseases, particularly in regard to fertility, but also in regard to personal health;
- Discuss the issue of adolescent sexuality as a way of preparing future adults for responsible parenthood;
- Discuss contraceptive methods, their advantages, disadvantages, and possible side effects; and
- Discuss the delivery of family planning services, i.e., where, when, and how to get them.

B. Description

1. Summary of IEC activities

The Family Health and Population Project (FHPP) has an important IEC activity. It consists of interpersonal education using a network of IEC agents and community volunteers; mass media including radio, television, and the press; and audiovisual materials including posters, brochures, flyers, and simple promotional material (T-shirts, key chains).

The IEC activity is directed and supervised by two FHPP IEC Coordinators in Dakar. Six Regional Coordinators of the Ministry of Social Development (now the Ministry of the Interior, Directorate of Rural Development [Direction du Developpement a la Base]) supervise approximately 54 Monitrices d'Economie Familiale (Family Life Extension Workers) each [1]. Each extension worker in turn supervises an average of 25 village volunteers, chosen according to selected criteria and in collaboration with village leaders and trained by the Regional IEC Coordinator, a team of regional trainers. These volunteers are the key elements in an educational program designed to attract new family planning acceptors.

A mass media campaign carried out by Project staff, assisted by external and national consultants, and executed in collaboration with ORTS (Office de la Radio et de la Television Senegalaise) was developed to support this effort. Through radio, and to a lesser degree television and the press, the Project conveyed information on child spacing, infertility, and sexually transmitted diseases. Audiovisual materials were produced to support training and educational activities.

Women who were motivated to adopt family planning by Project IEC personnel then went to Ministry of Health clinics (Health Centers and Health Posts supported by the Project) to make their choice of family planning contraceptives, and to be counseled about their use.

Despite certain financial and administrative difficulties that seriously affected the Project from mid-1989 onwards, the IEC component achieved considerable success in executing the activities set out for it in the Project Document. Although there has been no systematic attempt to measure the changes in knowledge, attitudes, and practices due to Project interventions, there are certain positive indicators that suggest that educational activities have contributed to increased family planning awareness and acceptance in the country as a whole. Since the FHPP is responsible for the large majority of family planning activities in the country (90 percent of all public sector programs; and almost 50 percent of all family planning activity [2]), changes in national trends in acceptance can be at least partially be attributed to the Project.

USAID data prepared by the HPN office and based on ISTI records indicates that the number of total contraceptive users in the country (public, private, and commercial) has grown progressively since 1986 (from approximately 20,000 to 61,000 in 1990). Similar USAID data for the six regions of the Project show parallel trends, although the growth between 1989-90 was not as accelerated. Of the six regions of the FHPP project, only Thies showed a decline in active users, and this only between the period of 1989-90.

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[1] There are 6 Regions in the Project; 3 Departments per Region; and 3 Arrondissements per Department. In principle, there is one extension worker per Arrondissement for a total of 54.

[2] USAID data based on ISTI statistics indicate 29,890 total FHPP acceptors of the total 32,996 public acceptors and of the total 61,376 total public and private acceptors, as of 1990.

A less sensitive but valid indicator of the success of IEC campaigns--the percentage of people who say that they are aware of family planning--has gone up dramatically. In 1978 the level of awareness of at least one method of contraception was only 60 percent; while in 1990 it has been estimated at 95 percent in urban areas. During the period of the Project 1986-90, the percentage of people aware of family planning grew from 85 percent (EDS) to the currently estimated 95 percent.

As important, the number of people reporting that they were aware of at least one modern method of contraception in 1990 was an estimated 89 percent (urban areas), considerably up from 1978. The one statistic that would be a reliable indicator of IEC impact, the number of new family planning acceptors, was not available due to problems of record-keeping and reporting.

Small-scale, regional studies done in 1989 [3] give some indication of IEC impact. In Ziguinchor City, for example, 43 percent of women interviewed had attended family planning talks; 65 percent had seen family planning posters; 61 percent were aware of the pill; and 60 percent knew of the proper administration and/or use of the contraceptive method of which they were aware. In Dioffior, 42 percent of women and 40 percent of men interviewed had heard of family planning on the radio.

In terms of total numbers of Project outputs, the Project has also had a certain degree of operational success. The number of people trained by the Project--approximately 1000 (including government IEC agents, community volunteers, and radio production people)--is double that envisaged in the Project Document. The Project trained approximately 20 people overseas (largely at Santa Cruz), including MSD and MOH staff (Health Education Service). Four out of a projected 20 study tours were undertaken.

A number of research activities were undertaken to help in the development of IEC messages. Three studies are of particular note: The Practical Guide to the Development of Messages [4]; the Posner study on the attitudes of men towards family planning [5]; and the study by ISTI's demographic consultant and others on knowledge, attitudes, and practices concerning family planning in the Region of Thies [6].

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[3] Evaluation de l'Impact du Project Sante Familiale et Population dans la Commune de Ziguinchor, Sonko, B. and Diop, M., December 22, 1989, Dakar; and Evaluation de l'Impact du Project Sante Familiale et Population: le Cas de Dioffor (Fatick), Samb, F., December 1989.

[4] Guide Pratique d'Elaboration de Messages, Makane Kane, Projet de Sante Familiale et Population, Dakar, July 1987.

[5] Posner, J., Men's Attitudes About Family Planning in Senegal, January 1987, USAID.

[6] Etude sur l'Information, l'Education, et l'Information (IEC) en matiere de Planification Familiale dans la Region de Thies, Charbit, et al, Dakar, USAID 1990.

Its performance in the mass media sector was equally noteworthy: an estimated 150 radio and television events (spots, sketches, dramas, magazines, etc.) were aired in 1987 compared to a projected 48, over 400 in 1988 compared to a projected 72, and 20 out of a projected 72 in 1989, a year in which Project funds were severely curtailed. Its performance in the production of educational materials was also significant. In 1987 the Project produced 20 out of 23 projected educational materials (including slide shows, a brochure, and promotional materials); in 1988 it produced 16 out of 23 projected (posters, flyers, calendars, diaries). Even in 1989 the Project (PPPS component) produced 2 materials (bus advertisements)[7].

The financial difficulties caused by the failure of the GOS to mobilize counterpart funds, an administrative crisis caused by a USAID financial audit and a subsequent change in Project direction, and the removal of the Project from the Social Development Ministry to the Ministry of Health (thus isolating IEC Coordinators and extension workers from the central management authority) negatively affected activities since early 1989. Most mass media activities were curtailed, as were most training supervision and interpersonal education activities. Had these continued as planned, it is likely that levels of understanding and family planning acceptance would have increased. The 1988 Project Action Plan, as reflected in the Journees d'Etudes relatives a l'elaboration des projets d'accompagnement et aux activites sur l'IEC, PFSP, Saly Portudal, January 1988, is a detailed, comprehensive plan whose objectives were largely met (see above-referenced Project Annual Report 1988). There are no reasons suggested why the Project should not have established, set, and met similar objectives set for 1989.

Nevertheless, a recent evaluation of the IEC component of the Project [8] indicated that while studies like those at Dioffior, undertaken just after the Project's large-scale mass media campaign and before administrative and financial difficulties began to have an impact, showed a relatively high degree of awareness of family planning messages, understanding was superficial.

Similarly, while overall awareness statistics (95 percent urban areas 1990) are in themselves impressive, and while the number of acceptors has also grown progressively, the modern contraceptive prevalence rate remains low at 2.4 percent (1986) and has grown relatively little from its 1978 level of 0.6. However, this relatively poor performance must be seen in the context of similar programs in other countries where a period of relatively slow

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[7] Data compiled from Project Annual Reports for the years 1987, 1988, 1989, 1990 (draft); and from independent estimates from FHPP IEC staff and from former mass media consultants.

[8] Delanoe, et al, Evaluation of the IEC Component of the Family Health and Population Project, USAID, Dakar, 1989

growth in contraceptive prevalence was followed by a period of much more significant increase. This phenomenon, noted in India and Korea, was a result of a "period of consolidation" where information received through IEC programs was being talked about, verified, and finally acted upon.

Data on the rate of new acceptors--as mentioned above, the most direct indicator of IEC impact--would have been useful in qualifying the rate. That is, if the rate of new acceptors had gone up, it might have indicated that a move from the consolidation phase to a more active one was beginning.

There are a number of factors--in addition to the major financial, administrative, and organizational ones mentioned above--which may have limited the impact of IEC campaigns and programs. These factors are described in detail in the Analysis section of this IEC chapter.

a. Volunteer-based support

A volunteer-based promotional system--particularly one which involves no rewards, incentives, or emoluments--may be able to achieve only a modest success. This may be particularly true in Dakar where it is said that the demand for remuneration, even for volunteer work, is high and persistent. The performance of the volunteer program has been limited and a relatively small number of volunteers have been recruited and trained. Community-based distribution schemes, in which contraceptive distribution is managed by the community, but carried out by local volunteers who receive a commission on sales, has been proposed in neighboring African countries, such as Mali, Togo, and the Gambia, and may be an appropriate way of generating the interest needed to secure volunteer support.

b. Health clinic education

Health clinic educational activities are insufficient. Given midwives clinical workloads, short hours of clinic operation, and often difficult physical work conditions, individual and group counseling which could increase understanding may not have occurred with the frequency and quality that is required to promote understanding and acceptance. Improved health center management, longer hours of service, increased facility-based family planning education and counseling may be the keys to better family planning performance. Even given the best possible motivational work done by IEC agents and volunteers, if the close, interpersonal counseling given by health workers is not available and of high quality, family planning acceptance is not likely to rapidly increase. Increased counseling in maternities is also important, since 38 percent of births take place in health facilities [9].

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[9] Pillsbury, B., Socio-Cultural Factors Influencing Delivery and Use of Health and Family Planning Services in Senegal, USAID, Dakar, August 1990

c. Integration of services

The administrative moves, placing the responsibility for family planning in the Ministry of Public Health and Social Affairs (from the former Ministry of Social Development), offers a significant opportunity for midwives to be brought more fully within the program. The continued separation of motivational workers (extension workers and community volunteers) from the health system (these IEC agents will be a part of either the Ministry of the Interior or the Ministry of Women) poses potential problems, given the need for close relationships between motivational workers and health care providers.

The proposed integration of all services--both health provision and motivation into one administrative structure, managed by the MPHSA/MCH is a positive step towards full functional coordination of disparate services. The final disposition of this new structure and its performance remain to be seen.

The degree to which the Health Education Service of the Ministry of Health is integrated within this structure is an important element. Up till now, the Health Education Service has played but a desultory role in the family planning education process. It has now been given the mandate by Government decree to manage all such activities, and the degree to which it forges an appropriate and strong link with either the Ministry of the Interior or Ministry of Women, will indicate the likelihood of even faster family planning acceptance. The EPS Regional Coordinator can play an important intermediary role between health clinic and social development personnel.

d. Costs of mass media programming

The success of the mass media component of the Project (in terms of numbers of programs produced and aired) was in large part due to the willingness of the radio, and to a lesser degree television, to air family planning broadcasts free of charge. As the economic and financial situation of nationally sponsored radio and television broadcasting in many African countries has become more precarious, they have increasingly begun to charge for even those programs in the public interest. This may likely be the case in Senegal. Even if this eventuality is still years away, such financial pressures are already beginning to be felt: the insertion and airing of family planning television programs, sketches, and spots--according to Project staff--was extremely difficult. While radio was a far more accessible medium (commercial demand for radio time is less), the situation may change. Thus, the real costs of mass media programming will have to be considered.

e. Targetting the message

Current IEC efforts, while specific in terms of message (i.e. child spacing, MST, and infertility) and theme (family harmony, child education, mother and child health), may not be directed enough to particular audiences. A more focussed IEC campaign directed at men and specific groups of women may be required to complement the more general media and educational approach. This targeting and focussing can only be done as a

result of in-depth research. While the Project was ambitious in its attempts to carry out research, the Evaluation Team felt that the data provided from these studies were not always presented in a useful form - or not adapted to the needs of communications professionals; and it was not always carried out with specific IEC objectives in mind. The Village Monographs, for example, provided certain demographic data, such as age of marriage, but did not attempt to correlate these data with other information, such as age of mother at birth of first child, sixth child, etc. Knowing the age of a mother at the time she reaches the total fertility rate (6.6 children 1986 EDS) would help communicators to better tailor their messages. The Makane Kane study on developing IEC messages was positive in identifying the many resistances men and women have to family planning, such as economics and religion, but did not go beyond these well-known factors to probe questions relating to what specific religious objections are behind the general resistance; what factors contribute to a conviction that more children equal more wealth? The Kane study also did not break down as fully as would have been hoped the differences between urban and rural men, for example, who have been shown to differ significantly in their attitudes (particularly by Region of the country).

f. Informational campaigns to reach decision makers

Informational campaigns specifically designed to reach national, religious, and traditional leaders were not carried out with as much vigor as intended in the Project document. Such campaigns are important to alert decision-makers to potential problems related to demographic growth, mortality and morbidity, the availability of natural resources, levels of education and literacy, etc., and to make them more disposed to considering family planning programs. These campaigns require special research and planning.

2. Details of IEC activities

This section will provide more detailed information activities by year and by major project category: research, training, materials production, study tours, technical assistance, mass media, and interpersonal education. In many instances an approximate number is given. While different project documents were in the main consistent, in others a reconstruction of events and materials produced was necessary. Mass media programs, such as sketches on the radio or television, were not considered to be "Materials produced"--an item in the Project Document--but "Mass Media"--programs that were produced by ORTS performers under the guidance of the Project.

a. 1986 [10]

The first year of the Project was devoted to completion of activities begun during the first project (i.e. final training of Social Development personnel; distribution of posters printed during the first project), but more importantly the planning for the 1986-87 period. In April-May 1986 JHU/PCS and PIACT/PATH consultants came to Senegal to help prepare a communications strategy. In August 1986, a three-day workshop was held to set forth a detailed IEC program [11]. The Posner study on men's attitudes towards family planing was also carried out during 1986. A reported 31 higher-level MDS IEC extension workers were trained compared to the 50 specified in the Project Document. Production targets for educational materials and media production were not met.

b. 1987

The Posner study was published, the preliminary design for a study on inactive family planning clients begun a profile of the typical FHPP client undertaken by Columbia University in Diourbel, based on computerized records; and the publication of a Government of Senegal National Policy Paper on Family Planning (published January 1990) of which IEC was a major component and for which ISTI provided 3 experts.

Foreign training for IEC Regional Coordinators and other IEC personnel began in 1987 [12]. The training of trainers began in the regions, with IEC Coordinators and selected extension workers trained as trainers of other extension workers and community volunteer workers. A three-week course to train 14 such trainers (along with 10 clinical personnel) was organized.

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[10] The information presented here on number of materials produced has been reconstructed from a number of sources - primarily from the Project Annual Reports and from detailed interviews with the IEC staff of the Project and their records. In some cases there may be a discrepancy between years, because material development begun in one year may have only been completed and reported in the next. As of the writing of this report, no detailed budget figures were available to permit a financial corroboration of materials produced, personnel trained, etc. There was also no objective way to corroborate the number of times a particular mass media program was aired. Neither ISTI nor the Project has kept a materials archive in which are kept copies or transcriptions of all media produced, media schedules, etc.

[11] See Compte-Rendu des Journees de Reflexion sur l'Information, l'Education, et la Communication 21-23 August 1986, October 16, 1986, PSFP, Dakar

[12] According to an ISTI document (Liste des agents formes) dated 6/12/90 (print out) a total of 20 Senegalese were trained in IEC abroad. These included National Project IEC Coordinators, Regional IEC Coordinators, VSPP staff, others MSD staff ("animateurs"), MSPAS personnel ("Assistantes sociales"), and ORTS personnel. This number compares to 25 set forth in the Project Document for the years 1986-90.

After the training of trainers came the training for extension workers, community volunteer workers, and radio production personnel (orientation of national staff on family planning). Approximately 41 extension workers and 93 community workers were trained, along with 17 ORTS personnel. Study tours to Egypt, Gambia, Jamaica, Mexico, and Zaire were taken by senior staff to review family planning IEC efforts in those countries.

Planning for the mass media campaign began with the arrival of an Academy for Educational Development (AED) consultant in 1987 whose job was to assist in the development of program objectives, strategies, and activities. Two other JHU/PCS consultants were invited to Senegal to work on mass media programming issues. A second JHU/PCS expert on radio production provided assistance on the development of radio programs. A staff member of the programming department of ORTS radio provided technical assistance and liaison with ORTS radio officials (Sow worked as a consultant while on short-term leave from ORTS). A seminar for radio producers was held in Dakar, and a pilot 26-minute video was produced.

Pre-campaign media production and broadcasts were begun in 1987. Three radio spots and five radio sketches were produced as well as one 38 minute sketch for television (describing how a family in Kaolack learns of the program and adopts family planning). The radio spots and sketches were aired once or twice a day for 45 days of the pre-campaign for a total of 45-90 broadcasts. These broadcasts were then tested (no detail available on this testing), modified, and refined for airing in the actual campaign to begin in 1988.

An additional video on the FHPP was also produced for national leaders on the importance of family planning to reach national goals. An 18 minute slide show on MST was produced as well as 15-minute slide show on modern methods of contraception. A Project Newsletter was begun in which current information was provided to regional staff.

The course of the National Extension Workers Training School (Thies) was modified to include family planning and family planning IEC.

The private sector PPPS program began many of its programs, including the setting up of its clinics in SOTRAC, CNSS, SOS Village Kaolack, and ASBEF. IEC training of midwives and other health personnel at these establishments was undertaken.

Approximately 185 social development workers, including trainers of trainers (24), MDS extension workers (41), village volunteers (93), and ORTS personnel (17) were trained in 1987 compared to a projected 100 in the Project Document. For radio and television broadcasts 45-90 were aired compared to the 48 targeted in the Project Document; and approximately 20 educational materials including: three radio spots, two radio sketches, one video for television, one video for national leaders, three slide shows, as well as T-shirts (10,000 produced), key-chains and pens (10,000 each), one brochure (10,000 copies) were produced and distributed compared to the 23 set in the Project Document.

c. 1988

The year 1988 was the year of most intense IEC activity. Final radio and television programs were designed (with the participation of a locally-recruited consultant and the continued participation of ORTS' programming staff member); the setting up of an IEC working committee, comprised of ISTI, the Project IEC staff, ORTS, the Health Education Service of the Ministry of Health, ASBEF, Le Soleil (newspaper) and local consultants; a signing of a formal agreement between the Project and ORTS and the production of audiovisual and other educational material; the recruitment of a foreign consultant to work on slide presentations. The Project Annual Report for 1988 reports the following production and distribution of material:

- Three brochures (on condoms, the pill, and the IUD) printed in 10,000 copies each;
- One calendar in 20,000 copies;
- One diary in 1000 copies;
- Two flyers--one on the Project; one on contraceptive methods;
- One radio soap opera of 20 episodes;
- Provision of family planning themes and program ideas to local (regional) radio stations;
- One video for television on child spacing;
- Four new posters produced and distributed at 2500 each for a total of 10,000 copies;
- The running of six regional "Information Days" in which regional health and social development staff present family planning information at local fairs and regional events;
- The running of two (Ziguinchor, Kaolack) "Open Phone" radio programs on family planning (one-two hours each);
- Eighteen radio sketches of 15 minutes each;
- Seven radio spots in six regional languages;
- Two television sketches of five minutes each;
- Family planning "Information Days" for journalists; and

- Production for the Health Education Service of the Ministry of Health (EPS) of two posters on AIDS; one leaflet; and one slide show (based on a small-scale KAP study carried out by the Project.

The total number of radio and television broadcasts was 443 compared to the 72 specified in the Project Document [13]. The total number of audiovisual and print materials prepared was 15 compared to 23 projected in the Project Document.

Approximately 350 extension workers and community health workers and 170 private clinic workers and community extension agents were trained against a Project Document target number of 100.

A foreign consultant came to Senegal to work on the production of a slide-tape presentation.

d. 1989

In 1989 the PPPS Train du Bien-Etre carried out its journey. Also two large bus panel advertisements for family planning were reproduced and affixed on 300 busses in Dakar.

Because of the administrative and financial difficulties above-mentioned, no new production of materials took place, but distribution of materials already produced continued. A modified version of the brochure on condoms was distributed. All the slide presentations were delivered and distributed. Approximately 270 social development agents and community volunteer workers were trained in 1989, compared to the 100 specified in the Project Document. Audiovisual equipment was distributed to each Region: a 16mm projector; a TV monitor and VCR, screen, slide projector, overhead projector, and various training materials. Work was carried out with local radio stations to ensure some degree of programming. At Kaolack, for example, four hours worth of family planning debates and discussions were recorded and aired during 1989.

The Delanoe evaluation of the Project IEC program was carried out. A consultant carried out a study on interpersonal education (not yet published); the small-scale village studies undertaken with CERPA (France) were undertaken in Thies; and a small-scale KAP study in Dakar, Pikine, the Port of Dakar, and Sebikotane was undertaken.

e. 1990

Few new activities were undertaken. Radio broadcasts were at a virtual standstill.

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[13] Calculated as follows for television: 10 broadcasts of television sketches; 3 of a Project-purchased film; 6 broadcasts of a Project-produced video = 19; for radio: 20 episodes of a soap opera; 52 of sketches (1 per week for the year of the campaign); and 352 spots (1 per day) = 424; for a total of 443.

Training, however went on apace, and between 187 social development agents and community volunteer workers were trained (30 extension workers and 157 volunteers). This should be compared with the 150 specified in the Project Document.

A consultant came to advise on IEC training; and final work was done on the study on interpersonal communications.

C. Analysis and Evaluation

There are a number of major functional elements of the Project's IEC component which must be analyzed for appropriateness, quality, and sufficiency: research and planning; the interpersonal education program; the management and supervision of that program; the mass media program; the production of audiovisual and other materials; technical assistance; evaluation; inter-agency coordination; and interaction with collateral agencies (such as UNFPA).

1. Research and planning

The difference between family planning awareness (95 percent of the urban population 1990) and family planning coverage (2.4 percent 1986) is significant. While the Project has gone a long way towards determining why this gap occurs, considerable additional attention needs to be paid to determining even more carefully the factors influencing non-adoption for specific sub-groups of the population and the design of individualized communications strategies to reach them.

As one consultant has suggested, there is no such thing as a Senegalese woman. She is defined much more by her education, her place of residence, her literacy, and her religious, ethnic, and cultural ties than she is by her nationality.

Statistics presented by Pillsbury indicate that 52 percent of all married women have their first child by age 19 and 35 percent have their first child between 15 and 19. If these young women are in a polygamous marriage they are even less apt to consider child spacing, eager as they are to have a family quickly and establish their position firmly within the marriage structure. At an estimated two years between births if no family planning is used, these women will have their sixth child by the age of 27. Since the average total fertility rate in Senegal is 6.6, a significantly large group of women will be ready to listen attentively to family planning messages with at least 15 more reproductive years remaining in their lives. These women will be the easiest to reach and in fact are the group that already accounts for most family planning acceptance. Women with 3-4 children, having established their family position, understanding the realities of child-rearing, and old enough to clearly envisage the future of 3-4 more children, are likely to be the easiest audience of all to reach. These relatively older women can also be effective communicators to younger women on matters of contraceptive choice and use. Messages addressed to these women should be specifically designed with their age, family size, position in the family, and other socio-demographic characteristics in mind.

It is also important, of course, to attempt to reach the young women in the highly reproductive 15-19 year old age group. While it is correctly assumed that young married women of 15-19 are likely to be rural, poorly educated, and traditional and, therefore, least likely to adopt family planning, their cohorts still in school are ideal targets for in-school Family Life Education.

Therefore, while specific family planning campaigns directed to 15-19 married women may not be recommended due to their expected strong resistance, in-school programs, unsuccessful to a large degree within the Project, may have promise. Although the messages of family planning might not be appropriate in a school setting, messages of simple population dynamics--the relationships between family size and maternal and child health, for example--can form the basis for future planning decisions.

According to EDS (1986) statistics, 14-28 percent of women do not know where to get contraceptive devices; and 6-21 percent of them do not adopt because they are concerned about "problems" with family planning. Over 12 percent of women say they have not adopted family planning measures because they simply do not have any information about how to do so. After over 10 years of a Family Health and Population Project, it is surprising that this number is not approaching zero.

Who are these women who only need more information? Who are those who say that they do not know where to find family planning services? How deeply-rooted are concerns about "problems" with family planning methods, and to what degree are these stated concerns really excuses for other, more traditional reasons?

Approximately 38 percent of women give birth in health facilities. These women already have moved into the modern mainstream of health services, and one would assume their relative readiness to at least listen to family planning messages. Is this a correct assumption? Does, as would be expected, birth in a maternity say something about the readiness of a woman to adopt family planning?

A recent study by the Ministry of Health, for example [14] indicates that the highest approval rating of family planning is in the South (36 percent of men questioned) and in the West (25 percent), compared with 44.8 percent of all women in Senegal (EDS). The average positive attitude level for rural men is only between 11-15 percent. This surprising percentage of men in the South and West of the country should be explored further: Who are these men; why does residence in the South and West have an effect on attitudes; to what degree can a communications program be designed to identify those characteristics among men in areas with much lower average rates of approval?

As important, more needs to be known about the vast majority of rural men (88-89 percent) whose attitudes are unfavorable. Although many say that religion is a factor, current research has not shown on what specific basis this religious concern is based and to what

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[14] Programme National de Planning Familial, MSPAS, DSP, SN/SMI, December 1990

degree it could be mitigated. More research needs to be done on the perceived relationship between economic status and fertility. Although many men may continue to believe that a family must have large numbers of children to produce the income needed to live and live reasonably well, economic development and capital improvements in some areas may have outstripped the need for labor. While this is unlikely to be the case in poorer, more marginal rural areas, it may be the case in more productive areas where an increase in family size simply reduces the amount of wealth per capita. The development of such relevant economic messages may help to mitigate the concern of many traditional religious leaders who feel that Islam does not permit family planning for purely economic (i.e., selfish) reasons.

The Project has planned to recruit more men as volunteers, and the IEC Regional Coordinator in Thies has indicated that a list of interested candidates has been drawn up. However, it remains to be seen whether such men, without remuneration, will take up these positions. While a number of attempts have been made to reach men through mass media programs, these attempts have been more couched in general family responsibility. More directed and specific messages talking to men by men, have not yet been explored in any depth.

In short, more understanding is needed about the characteristics and peculiarities of specific sub-groups of the population and more individually-tailored educational programs developed. The Project has made a start in this area--research has been done and attempts have been made to diversify target groups. Family Life Education is clearly for adolescents; and the Ministry of Social Development has made a particular effort to reach their Youth Groups, sports groups, and men's groups as well as the long-recognized women's groups. However, identifying the groups is only the first step. The socio-cultural characteristics of the groups must be understood and messages appropriate for the groups designed.

While basic acceptable message groups have been determined, such as education-child spacing, maternal health-child spacing, child health-child spacing, the form in which these messages are to be presented still lacks definition. Although, for example, it has been made clear that one must not stress the relationship between economic well-being and child spacing (elements of religious interpretation are brought into play) in family planning messages, relationships between family size and available resources (such as land holdings, farm mechanization, return on units of labor invested, etc.) and their ultimate impact on the quality of life, may in fact strengthen family planning messages to men.

Similarly, while certain messages and themes have been developed and found to be acceptable (such as "A planned family = A harmonious family"), they may not have the impact and memorability of more specific and detailed messages (Delanoe found, for example, that in the Dioffior study, although a relatively high number of respondents remembered a particular message, their understanding of it was only superficial). Family harmony could mean enough to eat, proper education, proper sanitation, uncrowded living quarters--all themes which are not at all inconsistent with child spacing. More specificity and a deliberate attempt to explore in depth certain themes.

The Journees d'Etudes held in 1988 to plan for the IEC program for the next year is commendable in its attention to planning issues, and it focusses clearly on specific regional needs for training, supervision, and other functional elements of programming. What it does not explore it the fundamental core of the educational campaign: exactly what is said to whom. It is this element which should receive more attention in the future.

The Project will have to do the following to assure a more targeted campaign: (a) draw together all existing research and documentation from Senegal and neighboring countries on the social, religious, and demographic issues raised above; (b) develop a national educational strategy, targeting specific groups (this activity, done in successful collaboration with expatriate advisors in 1986 and 1987 [see above], should be repeated); (c) develop a detailed work/action plan to carry out the strategy.

The subject of STDs has been included in both the planning for and the production of educational materials, and reference is made to STDs in both the 1986 and 1989 Journees d'Etudes during which the IEC program was planned and in the FHPP Annual Reports. Nevertheless, STDs were not a subject of the Makane Kane study on message development, nor was it discussed in any substantive detail in any of the planning documents. It is likely that the subject of STDS did not get the attention that may have been warranted because (1) the subjects of STDs and AIDS differ significantly from that of family planning. While the method to control conception and to control STDs may be the same, the cultural milieu and the psycho-social environment in which knowledge, attitudes, and practices concerning STDs occur is dramatically different. To a large degree the training, orientation, and mandate of the IEC portion of the Project was family planning, and not STDs. Secondly, the major STD educational program and the AIDS education program which is growing in importance, is the responsibility of EPS. Although the FHPP helped to produce the AIDS poster commonly seen, this was an occasional involvement, and it is generally conceded that the major thrust of the STD/AIDS program is the responsibility of EPS.

The Project, as designed, was to make a special, concerted effort to reach opinion leaders, particularly religious leaders. Although some effort was made to do so, particularly through the use of Le Soleil and television programs on the project, no real progress was made by the project to develop a special, specific, and detailed "lobbying" program (to borrow the words from UNFPA -see discussion on Collateral relationships, below) for individual leadership groups. UNICOM (see below on discussion of inter-agency coordination), the family planning IEC support group of the Ministry of Finance, Economics,

and Planning has, as a major objective, reaching such leaders. Particular work needs to be done to identify the many distinct sub-groups of such leaders: the private medical community, who may back family planning in principle, but have particular medical reservations about certain methods; political leaders who are concerned about the sensitivity of family planning messages; religious leaders who may have a particular interpretation of Islam or Catholicism that they feel important to represent; traditional leaders whose view of rural society may differ significantly from urban inhabitants.

2. Interpersonal education

As has been suggested above, the interpersonal education program is based on voluntary service. It remains to be seen whether such voluntary service--to date unremunerated--can be effective in increasing the number of effective contacts with the population. Community-based distribution systems, in which contraceptive supplies are managed by community health committees and sold at a small profit by village volunteers has worked in other countries and is now being set up in Mali as part of the Bamako Initiative. Such village-level sale can guarantee the small financial incentive required to motivate village workers. The need for medical surveillance of women who take the pill is at issue, and there are differing points of view on the proportion of women experiencing side effects (and hence likely to spread negative information about family planning), and the need for medical follow-up. This issue is considerable, and will need to be resolved before any CBD program can be begun. It is discussed in more detail in the clinical sections of this report. The Project has also envisaged that the revenue generated from the women-in-development sub-project could act as an incentive, but these projects are too few and too concentrated to enable hundreds of volunteers to participate in a remunerative scheme.

In addition, even if the volunteer system works effectively, it still requires village women to travel considerable distances to reach a health center. A CBD scheme would permit women and men to have access to contraceptives more conveniently.

The number of community health volunteers needed to cover the target population has been determined as follows: The Project considers that one community volunteer is needed to work with one Women's Group, whose size varies, but is generally thought to be between 50-100 women. In general, there is one Women's Group per village or per urban neighborhood. Some larger neighborhoods and villages have two women's groups. Some have none at all. In principle, the proportion of one community worker per women's group seems reasonable. It is worthwhile mentioning that the UNFPA-sponsored Bien-Etre Familial (Family Welfare) Project's community volunteers (supervised and trained in ways similar to the FHPP) work within many community groups, not exclusively the women's groups. Regional IEC Coordinators defend this more selective choice, stating that women's groups, from which community volunteers come, are their most natural constituency group and have enough

members to make exclusive contact worthwhile. Family Welfare Project personnel, on the other hand, cite the need for diversity in order to reach adolescent girls and boys and other important sub-groups of the community.

Project IEC staff have determined that the target for these volunteers should be 10 new acceptors per month. To reach this target, the volunteer is expected to give at least one group talk per week. However, given an estimated 500-600 population of an average village or neighborhood and an estimated 125-150 women in the reproductive age group, at maximum efficiency, each volunteer would meet her target after 12-18 months. This seems to be an unrealistic target, depending to a large degree on volunteer motivation, quality of training and supervision.

It is a measure of Project impact that it trained an approximate 900 volunteers. Calculations based on estimated population size and numbers of women in reproductive ages indicates a target of 1296 community volunteers to be trained: There are six Regions in the Project; three Departments each; with three Arrondissements per Department; three Communautes Rurales per Arrondissement; and an average of eight villages (or neighborhoods) per Arrondissement for a total of 1296 villages/neighborhoods and 1296 community workers at the rate of one worker per village/neighborhood.

According to Project IEC staff, however, these volunteers are not distributed equally. Dakar has a total of only approximately 45 operational volunteers; Fatick and Kaolack are reported to have trained a disproportionate number. The data needed to make a more quantitative analysis of the actual number of volunteers, the number of women's groups, the number of residents per village, etc., and therefore to explain more carefully the discrepancy, were not available.

The number of extension workers needed to supervise these volunteers has been fixed at one extension worker for every 25 volunteers. This corresponds to the number of villages in an arrondissement, the administrative level at which an extension worker is found. However, the IEC Coordinator at Fatick--the Region visited with the most complete and well-documented records--indicated that a 1:5 ratio was ideal at a supervision rate of one visit to every volunteer at least every three months.

Even at a 1:5 ratio (20 field visits per year), the amount of direct family planning supervision seems high, although not unreasonable. However, a visit to the Professional School for Extension Workers at Thies indicated that only five extension workers graduate per year from the school. At that rate, it would take five years to meet the demand (instead of 1:25, the ratio is reduced to 1:5, thus adding four new extension workers per Region. At a graduation rate of five extension workers per year, it would take five years to produce the 24 new staff needed).

It is likely that some new kind of group supervision system will have to be devised in which scarce resources are allocated to periodic supervision-cum-training sessions for volunteers (and extension workers) held at regional level. Money which was to be spent for fuel could be spent on local per diems.

The form system of control and referral has not worked well. This system, designed to help monitor women who have been brought into the family planning system (when first contacted by a volunteer, they are given a form which they present to the health clinic for family planning services. Once seen by the midwife, the patient is referred back to the volunteer who can be sure she stays in the program. If this system were to work, the extension worker would have less field work to do, but few people, extension workers included, have interest in it. The success of such a tracking system like any other record-keeping system is dependent upon provider interest and motivation. If a family planning worker's job performance and pay were in part related to proper management of the form system; or if it were clear that volunteer contraceptive sales (in proposed community-based distribution and sales programs) were directly linked to tracking and follow-up, record-keeping would likely improve.

A persistent problem concerning extension workers has been their reassignment to other areas of the country. While this is lamentable, it may be unavoidable, due to the relatively few numbers of women graduating from professional schools the continuing accepted tradition of women following their husbands when they are transferred, and the normal attrition rate from child-bearing.

One of the biggest and most important links in the interpersonal education chain, the midwife, is the weakest. As suggested above, she has neither the time, space,the training to provide quality counseling to her patients. Part of the problem is the short clinic day, open only in the morning. Administrative reform needs to be effected in order to lengthen the clinic day without causing professional mutiny. A second problem is inefficient management and supervision. Better management--more efficient work flow, record-keeping, patient services organization--can free more quality time for individualized educational contacts.

Although the Project has made a special point of training the higher-level staff in the many social organizations operating at the regional level (CER [Centres d'Expansion Rurale], Youth groups, etc.), these core staff are unlikely to do any family planning promotional work themselves, nor take it upon themselves to train their lower-level workers. Some mechanism must be found for energizing these lower-level echelons, such as institutionalizing training for them in family planning, and perhaps bringing them more into an incentive program. These workers are particularly important for many of them are men and able to talk directly to men about men's particular family planning issues.

The practical problems of supervision of interpersonal communications staff have been considerable. Firstly, only a shared vehicle has been provided to each IEC Regional Coordinator. Secondly, the fact that the Government of Senegal was to take over much of the operational costs of the Project by 1989 and could not, has affected the ability of supervisors to carry out their work. Finally, the administrative difficulties of 1989 have instigated very scrupulous auditing measures, and the project staff has yet to fully accommodate themselves to the new measures.

While data on the number of supervisory visits made in each Region are not available, it is assumed from anecdotal evidence that very few such visits happened after 1989. It is assumed that supervisory visits took place regularly before 1989, but data concerning their number and frequency are not collected in a systematic enough way to permit analysis.

As noted above, considerable training activities have been carried out under the auspices of the Project. Some objective indicators should have been developed to measure the success and impact of this training. Examinations of trainees, for example, could indicate how well they learned. The establishment of objective job performance criteria is useful in measuring training program impact and the degree to which trainees improve after training.

Operations research, investigating many of the above points, particularly those concerning proportions of supervisors to field workers, number and type of supervisory visits, types of volunteer interventions, etc., will be useful to devise the most cost-effective way to run an interpersonal program.

More detailed data collection, such as the number of group discussions held and the number of participants in such discussions, could be helpful in measuring IEC impact, particularly when compared with acceptor data. In Fatick, for example, the IEC Coordinator had such figures and was able to arrive at a performance proportion of 2500 acceptors (1990) out of an estimated 20,000 contacts made in her Region--a rate of more than 10 percent. This rate, if verified, would be considered very significant when in the commercial sector, success is measured by fractions of percent change in market share.

3. Mass media

The mass media component of the campaign appears to be the strongest in terms of quality of planning, development, variety, use of consultants, etc. While the evaluation team did not have access to the actual written French texts of radio, television, and press programs and articles, there is procedural evidence to indicate that the mass media program was noteworthy. The fact that a comprehensive working committee was established, the services of a trained professional Senegalese radio producer/programmer secured, the recruitment of well-known expatriate consultants from a well-respected educational firm carried out, all point to a reasonable level of competence in this area. There are, however, a number of areas which presented some difficulties. Firstly, according to Delanoe, radio and television the performers responsible for turning basic family planning themes and messages into sketches and dramas have been left largely to themselves, and have not benefitted from more field data-based guidance. Delanoe states that although the Makane Kane study was of good quality and potentially useful, it was not translated into terms directly meaningful for these comedians. Delanoe also states that the many excellent media programs produced, such as Fagaru (television) and the 20 episode radio soap opera, were not aired often enough; nor reproduced and distributed for showing on the many video screens provided throughout the country (television only).

More frequent airing has been itself a problem, and there is a consensus that very detailed and specific agreements must be concluded between the Project and ORTS to guarantee air time. As has been suggested above, it is likely that as with many countries in the West African region, ORTS is sure to begin charging even for social programs, and new projects will have to consider this new item in the operational budget.

It is difficult to fairly assess the reasonableness of the number of spots and programs aired--that is, to answer the question: is the number of spots, sketches, etc. sufficient to achieve targets set? First, the question has not been entirely answered in the United States. Most spots are aired to the maximum saturation limit allowed by often generous advertising budgets, particularly those provided for the launching of new products. Few data exist on the marginal difference between ten spots per week per station per listener and nine spots, for example.

Second, as accomplished as Project staff and their ORTS collaborators were in the research, development and production of media, they were still in the process of improving and perfecting their family planning communications skills during the life of the Project. Since the number of broadcasts required depends to a large degree on the quality of programming, and since the family programming is still considered to be in a developmental stage, no clear and confident numbers can be determined.

There is an issue of apportionment of budget resources, however. Investment in audiovisual materials in other countries has been highly cost-ineffective. Although these materials have their place, the question should be asked as to whether more of the print and promotional materials budget should have been allocated to the mass media.

Unfortunately, there are few proven models on which to base this judgement. As stated above, commercial campaigns if anything are overfunded and overprogrammed. They give no indications as to what would happen if promotional T-shirts, for example, were eliminated from their campaigns. Only carefully-planned research can give answers: In a given project, did those people who heard only the radio, have levels of awareness and understanding equal to those who heard radio and received a T-shirt?

The number of mass media broadcasts reported aired was a reasonable one, compared with experiences in other countries. The number of airings on the radio was quite sufficient to promote awareness and understanding (the accepted limits of mass media in social development--attitudinal shifts and habit change require interpersonal contact over time). Radio sketches, for example, were aired once a week; spots at least once a day in heavy-listening time; soap opera episodes every week. According to reports both by ORTS and by the Project, family planning messages were incorporated into a number of different existing

radio programs (as differentiated from specially-produced programs). The total air-time for family planning, therefore, could be significantly higher than Project figures indicate.

The programming mix is considered to be good, with a blend of short spots, longer programs, serials, and "Open-phone" programs (Antenne du Journal Parle) on family planning. Television programming by all accounts was less successful because of limited access to the medium. It must be understood, however, that television stations, particularly in countries with only one channel, are under extreme pressure from all sides to air social programming.

A close collaborative relationship should have been maintained with URTNA, a respected and well-known association of African radio and television professionals. This collaboration was not achieved; no reasons were discovered as to this failure.

The lack of a complete library of mass media materials--tapes of radio and television spots and programs; written texts of these programs; lists of broadcast times, etc.--not only impedes the work of an Evaluation Team such as this one, but does not permit the continuity required for a well-planned media program. An ISTI consultant, requested to review the IEC program, cites this lack a number of times in his report, and an interview with him revealed his frustration in being unable to review actual records of material production [15].

4. Educational materials

Posters, widely used in most social development programs, are a relatively expensive medium which have had their most cost-effective use in generously-financed, multi-media commercial advertising campaigns where they serve as a reminder about a brand name. Despite their common usage throughout the world in health and family planning campaigns, their effectiveness has never been proven although, in comparison to videos, for example, they have the advantage of being light enough to transport. But posters are difficult to design, relying as they do on one central image and slogan, and even the best pre-tests are biased: respondents can only comment on the item shown. Although the Project reports that all tests indicated that people liked and understood the posters, there has been no indication that they provide crucial information that cannot be provided either by the mass media or, more importantly, interpersonal educators.

T-shirts, pens, key-rings, and other relatively inexpensive "give-away" items have all had a role to play in family planning programs of other countries. Condom key chains, produced in Thailand were in demand throughout the world. T-shirts, balloons, and other inexpensive items have been somewhat successful in rewarding children for participation in once- or twice-only vaccination days. Calendars and diaries, while more expensive, have been similarly used. These items, however, have been programmed in projects which are

[15] Memo from Philippe Langlois, JHU/PCS Consultant to Albert Baron, ISTI, dated February 19th, 1991. Paragraphs 11, 14, 15, and 17 underline the fact that no material archives nor detailed records of media activity were available. Interview held in Dakar, April 29, 1991.

extremely well financed (similar to the new product advertising found in the United States). Whether they are appropriate in Senegal, with limited financing, and many negative demographic indicators (low contraceptive prevalence, high total fertility, high number of desired children) requiring in-depth, detailed, and intensive education, is another question. Furthermore, although they might have been potentially useful at the very beginning of the mass media campaign, as an added measure of recall, they are likely to have very little usefulness now. Yet, distribution of T-shirts, for example, continues until the present and stocks of such shirts were seen in Fatick.

Although detailed budget figures were not available at the time of the writing of this report, a significant portion of the IEC budget may have been spent on items which were inappropriate for the program (T-shirts, key-rings, etc.), expensive given their useful media life and cost-per-effective-educational contact (posters).

The Delanoe IEC Evaluation further comments that some creative uses of posters were used in the Project. Large, billboard-sized posters were affixed to 300 SOTRAC busses and were seen by estimated tens of thousands of Dakar residents.

Other promotional events, such as the Family Planning Train of the PPPS (a specially-equipped train which stopped at 17 different towns in the Project area, carried 80 IEC professionals, journalists, comedians, etc.), were considered to be a highly successful way of reaching large numbers of people in an innovative (and hence memorable) way. Cost data on the train were not available.

The only negative comment of the Delanoe evaluation was that the train was a one-time only affair (a Family Planning Bus has been planned, but not yet put into service). Delanoe and the current Evaluation Team found that the audiovisual equipment distributed to all regions (16mm film projectors, video equipment, overhead projectors, slide projectors) were very poorly used. By their own admission Regional IEC coordinators said they had been seldom used. In some cases, coordinators reported taking them out into urban neighborhoods or using them during training sessions, but the overall impression was one of underutilization. Few reasons were posited for this underuse. The lack of specific instructions on how to use, the insufficiency of material (see above on the reproduction of TV programs), and frequent breakdown are likely contributing factors.

The question of family planning advertising in pharmacies was raised by the Evaluation Team. Advertising in both public and private establishments could be effective point-of-sale advertising. Brochures, flyers, newsletters and similar media produced by the Project and which have a particular target audience, can be produced in a long series and which can be distributed widely, have been shown to have an impact in other countries.

The Project was not as successful in recording and adapting of audiovisual materials specified in the Project Document. This lack has also been noted in the Delanoe evaluation. No particular reason was discovered for the failure to meet this Project objective.

The development of a project logo, reproduced as stickers, is questionable. There is no evidence to show that such a logo served a useful purpose (such as unifying diverse messages and media or guaranteeing quality), and no evaluation was done of its impact.

The lack of a materials archive neither permits a thorough evaluation of program performance nor enables future media planners to base decisions on past production and distribution efforts.

The Project suffered from the lack of a clear conception of a materials development program. Future planning should include a well-justified selection of particular materials for particular audiences, specific objectives established for these materials, and a distribution plan which takes into account these objectives and the cost of materials.

5. Technical assistance

Technical assistance appeared to be the most appropriate and the highest quality (judging from Project staff responses) for the mass media. The type and quality of research was also considered good (Delanoe evaluation), although it appears that there was not enough. More frequent KAP-type studies and more specific, message-based data collection such as the kind described above, would have been also useful. Consultants used for audiovisual materials were thought to be the least useful.

Project staff was not involved to the degree to which they felt they should be in the request for consultants, the search for consultants, and the final choice of consultants. Consultants were chosen from a variety of different professional sources. The identification of one firm which could provide long-term, continuous, but diversified technical assistance might have been useful.

6. Evaluation and monitoring

As suggested above in the discussion of Interpersonal Education, the form system of client control--one which enables both midwives and community volunteers to keep track of family planning users in an attempt to limit the rate of dropouts--has not worked. It is reported to be time-consuming and cumbersome, particularly for unpaid volunteers, and is now rarely used. No other system for tracking family planning acceptors has taken its place. As with all other record-keeping, successful completion of family planning patient tracking forms is related to: the simplicity of the form; an understanding on the part of those who fill out the form of its direct usefulness to them; and job recognition--in the form of salary increase, supervisor praise, or promotion. In short the form system may still work if the question of remuneration is resolved, if correct reporting is linked to some type of improved motivation; and if the form becomes an aid to volunteer/community sales agents in identifying those customers who have dropped out of the program (and who are not purchasing contraceptives).

The only statistics available to measure overall IEC impact are clinic figures on contraceptive coverage. A more direct indicator of IEC success is the rate of new acceptors. Data on active coverage reflects clinic counselling, availability of contraceptives, side effects, etc.; but the rate of new acceptors measures the degree to which community motivators and media support have convinced target populations. It is extremely important, therefore, to begin the accurate and continuous reporting of such data.

There was a significant lack of Operations Research in the Project. Although a study on interpersonal communications is nearing completion, more studies of this type should have been undertaken. What is particularly needed is a study of the volunteer system, the advisability of a remunerations system, and ideal proportions of supervisors: educators, etc.

7. Inter-agency coordination

There are a number of government agencies responsible for IEC and for family planning/population in particular. In addition to the project activities of the Family Health Project and the Family Welfare Project, the Health Education Service (EPS) of the Ministry of Health, referred to above, has the mandate, under the official population strategy of the GOS, to coordinate all family planning IEC activities within the Ministry of Health, if not to play a major active role. Also, there is a population IEC cell within the Human Resources Division of the Ministry of Finance, Economics, and Planning. This cell, provided technical support by UNICOM (financed by UNFPA), is responsible, according to the official population policy of the GOS, for coordinating all population/family planning IEC activities in the country. This coordination is designed to assure that there are consistent and harmonious messages that go out to the population; to assure that appropriate and realistic research goals and objectives are set and to avoid duplication of effort; and to be sure that the many efforts of many ministries follow overall national planning guidelines. The role of UNICOM is also to generate support for the national population policy among traditional, political, religious, and other leaders in the country.

While each of these agencies and units have their own particular identity and responsibilities reasonably well-defined, there is no guarantee that each of them will necessarily respect the boundaries and limitations set for them. Also, as in all bureaucratic structures, administrative relationships evolve, poles of power and influence shift, and boundaries become unclear.

The new organizational structure proposed by the Ministry of Health offers the chance for a real, functional integration of family planning within the MCH. Under this system, the two family planning projects mentioned above, would be merged under one organizational head, and IEC activities combined. However, in the current organigram in circulation, the role of EPS--nor that of UNICOM--is not specified. EPS has already named one of its staff as the head of Family Planning IEC, but without clarification of the role of EPS vis a vis the SMI, productive inter-relationships may not be possible. It is assumed that under this new structure, all project IEC staff would work under an IEC head, but it is not clear as to whether this would be the EPS Family Planning person, one of the current project IEC staff, or someone else.

Since UNICOM has the intention of developing media programs, special lobbying efforts, and seminars specially directed to national and regional leaders, close collaboration with this unit will be important for MCH, particularly because the FHPP was less than fully successful in achieving this stated Project objective.

8. Coordination with collateral agencies

UNFPA has had a major role in family planning and population in Senegal. As would be expected, it has also invested a considerable amount in IEC. Recently, UNFPA has enunciated its preliminary IEC strategy in an Aide-Memoire prepared by a recent review mission[16]. This strategy has been spelled out in even more considerable detail in Strategie IEC en matiere de Population[17]. Among the more salient points most relevant to this Evaluation are the following:

- A focus on more qualitative psycho-social research to provide more current information on knowledge, attitudes, and practices concerning family planning;
- More operations research to more objectively analyze the means of communication, comparing for their cost-effectiveness, various interpersonal, mass media, and other educational techniques;
- Continuing focus on the coordination of the many current and potential programs on population and family planning issues. UNFPA has made a considerable effort through its support of UNICOM and inter-ministerial

[16] Mission de revue du programme et de developpement de strategies en matiere de population au Senegal 25 February - 29 March 1991, UNFPA Dakar, March 29 1991

[17] Handwritten document, unsigned, undated, but provided by USAID to the Evaluation Team as a UNFPA document.

seminars to identify needs and potential programs in government ministries responsible for in- and out-of-school education programs, juvenile justice programs, military programs, sports programs, etc.;

- A particular focus on religious leaders, with the objective of engaging them more completely in a dialogue on the place of family planning and population programs in Islam;

- A continued emphasis on mass education campaigns, but those which have a specific focus for specific target groups;

- A continued focus on interpersonal education, but an attempt to improve this process through more direct contact between change agents and clients (e.g., through smaller, better-facilitated discussion groups); and

- A strengthening of the audiovisual capability of the EPS to allow it to function better as the central health education facility in the country.

These strategic objectives seem compatible with FHPP activities and principles. Assuming both UNFPA Family Welfare and USAID Family Health and Population Projects fall under the same, new MCH administrative umbrella, even further harmonization of goals, objectives, and activities should result.

9. Sustainability

The issue of sustainability applies directly to IEC activities: a way must be found to provide for the financing of both mass media and interpersonal activities. The issue of sustainability is perhaps particularly important when considering IEC in Senegal, for it is likely that ORTS charges for social development communications will increase. There are a number of possibilities.

a. Social marketing

If contraceptives are still imported free of charge (e.g., through USAID), social marketing programs can be developed by which through the revenues realized through contraceptive sales, many operational costs of the family planning program can be met--including funds for promotion and publicity.

b. Bamako Initiative

The importation of generic drugs and pharmaceutical products, including contraceptives, according to competitive bidding, can keep the import cost of contraceptives very low. Sales prices of these same contraceptives can be high enough to provide operating revenues, while, because of low import price, kept to reasonable levels for consumers.

c. Private and parastatal financing

The role of parastatals, such as the Caisse de Securite Sociale, is key in family planning IEC financing. The Caisse, interested in reducing its currently high family welfare entitlement programs (benefits paid per child), has shown considerable interest in financing family planning information campaign programs. The Institution de Prevoyance Medicale, a health insurer, has shown similar interest in reducing its maternity payments and sponsoring educational campaigns.

d. Community distribution schemes

CBDs, in which local communities manage their own contraceptive distribution programs, is another alternative. In these programs, contraceptives are purchased through either mechanism (a) or (b) above, then sold at modest margins to village residents. Because of these margins, some of which are paid as incentives to village sales agents, the incentive for community promotion exists.

10. Family life education

Despite a strong commitment in the Project Document, little progress was made on integrating Family Life Education within in-school and out-of-school education programs. While at the beginning of the Project there may have been some reluctance on the part of the Ministry of Education to undertake what were considered to be politically sensitive topics (according to Ministry of Education officials, UNESCO made a series of attempts to promote the integration of population issues into the curriculum between 1976 and 1988 with no success), this reticence has, in the view of these same ministry officials, disappeared. The existence of a Family Life Education Project (supported by UNFPA and executed by UNESCO) within the Ministry of Education, in which population topics are included in primary and secondary school curricula is evidence of the positive evolution of ministry thinking. The basic goal of the project is to integrate population and family planning issues into the various school disciplines, and a Groupe d'Etudes en matiere de Population (GEP) , comprised of professors at the Ecole de l'Enseignement Superieur, has been charged with the development of modules for this integration. The project has only recently begun (1990). In view of this evolution, it is all the more striking that the Project has not progressed further, or at least developed a more close working relationship with the Family Life Education Project.

11. Study tours

A number of study tours were taken by Project staff. From the trip reports available, visits to Mexico to see that country's ambitious family planning program and equally ambitious IEC program were among the most profitable.

D. Summary of Major Findings and Conclusions

- The IEC program was, in general, well-planned and -executed, with a complement of mass media, interpersonal, and material support activities. Its major focus was on family planning/child spacing, but with a secondary goal of providing information on STDs and infertility. The subject of STDs and AIDS because of its complexity and uniqueness, was not given the special attention it deserved and needed. Conflict of organizational responsibilities (FHPP and EPS) may have played a role as well. As the recognition of the AIDS problem grows in Senegal, the need for an even more concerted, specific, and intensive effort will be required.

- The mass media campaign was particularly noteworthy, combining message research, collaborative planning, creative production, and close working relationships with ORTS. Access to radio was particularly successful. Access to television was limited because of increasing demands on the network for a variety of informational, entertainment, and development broadcasting.

- A large number of IEC agents and community volunteers were trained in family planning communication, close to the overall target figure required. These volunteer workers, however, were disproportionately distributed in the six Regions of the Project.

- The recruitment and performance of volunteer workers in certain areas, most notably Dakar, was less than hoped for. Many observers have cited the lack of any remuneration or incentive as a reason for this difficulty, and some have questioned the almost exclusive Project reliance on such volunteers for interpersonal education.

- The involvement of health workers in family planning IEC, particularly of midwives working at health centers and health posts, a major goal of the Project, was not met. This was largely due to administrative difficulties caused in part by the separation of family planning service delivery and IEC activities into two ministries. A potentially important interlocutor between the two agencies, the EPS Regional Coordinator, was involved only marginally, in most cases, in Project activities.

- Inefficient use was made of audiovisual and print materials. Too liberal public access was given to brochures, leaflets, and calendars; too little programmatic focus was given to posters (i.e. to design them for use rather than for observation); and too little utilization made of audiovisual equipment such as film and slide projectors.

- Important IEC-related research was undertaken by the project. Information on women, men, and overall socio-cultural characteristics of the population was made available to IEC planners. Much of the data, however, was of too general a demographic nature to be of specific use to IEC planners, and was not translated into a form useful for them. As importantly, no significant research was undertaken into the knowledge, attitudes, and practices of Senegalese concerning STDs and AIDS. No operations research, important for determining media mixes, interpersonal strategies, etc., was carried out.

- Family Life Education, an important element in the Project Document, was not treated sufficiently in the Project. The Ministry of Education's reluctance to approve the introduction of population issues in the primary and secondary school curricula until 1989 was a significant barrier to Project efforts.

- IEC consultants, with few exceptions, were appreciated and used well by the IEC staff. However, according to FHPP staff, too little consultation between ISTI and the Project was held to more carefully and accurately assess Project needs and preferences.

- Supervision was less than considered necessary by the Evaluation Team, Project staff, and collaborators, due to the lack of resources fuel and per diem after 1989, but also due to the Project-mandated sharing of the supervisory vehicle between MSD for IEC activities and MOH for clinical work, and to unrealistic supervision programs and schedules in which one extension worker is to supervise 25 community volunteers.

- Although overall educational planning was done well, and involved a wide range of professionals and technicians, more detailed planning; i.e., the identification of specific, sub-groups of the population (e.g., urban men, older women, etc.) and the development of specific strategies to reach them, was not done as fully as would have been hoped. This holds true equally for family planning and STDs/Infertility.

- Although community leaders were reached indirectly through the Project's choice of media (press and television), no specifically-designed, concerted campaign was developed to reach national, regional, and local religious, political, and traditional leaders.

- No pre- and periodic post-campaign audience evaluations were carried out under the Project. Such evaluations would have permitted an analysis of the appropriateness, acceptability, and memorableness of mass and other educational media. Similarly, no performance evaluations were carried out on personnel trained by the Project. As a result Project staff were unable to accurately assess the success of their efforts and take appropriate remedial efforts.

- No archive of Project-produced materials was kept. The lack of such an archive deprives future planners of a basis on which to develop new programs, and limits the thoroughness of evaluation efforts.

E. Summary of Major Recommendations

- Study and address the issue of Project sustainability as related to the three following three options:

  -- Contraceptive Social Marketing, whereby contraceptives are imported free of charge from a donor like USAID, then sold on the market at a price which reflects consumer purchasing power but also the need for operating revenues (including revenues for IEC);

  -- The Bamako Initiative, whereby generic contraceptives are purchased on the international market according to competitive bidding. The difference between the low purchase price and a fair sales price will provide operating revenues, as in (a), above;

  -- Community-Based Distribution, whereby local communities manage contraceptive distribution and sale programs. Contraceptives are purchased through either (a) or (b), above, then sold at a modest margin, providing local operating revenues and incentives for local sales agents.

- Assure the best possible coordination of IEC activities both at the national and regional levels. The roles and interrelationships among the Health Education Service of the Ministry of Health, the UNFPA Project staff, and to UNICOM (Ministry of Planning) must be clarified.

- Develop specific messages for specific target groups of the population; regional, religious, and ethnic differences as well as differences in age, sex, education, and place of residence must be taken into consideration when developing messages and thematic strategies. A close working relationship with UNICOM should be established of particularly importance would be of help to determine the best way to reach national, religious, and traditional leaders.

- Establilsh a fee-based agreement with ORTS to guarantee the correct, timely, and error-free broadcasting of family planning and STD/infertility messages.

- Monitor more closely the IEC program impact. Both sample survey and focus-group data collection methods should be employed to see to what degree people receive, understand, favor, accept, and use information provided.

- Increase collaboration between IEC specialists and researchers before research designs are completed to ensure the inclusion of specific, message-related inquiries in all research; and to ensure that research data are analyzed, interpreted, and presented with the IEC planner in mind.

- Strengthen supervisory programs while keeping in mind current financial and logistical constraints. The allocation of budget resources for community volunteer and/or extension worker per diems, for example, to enable them to participate in regional or national group supervision/training, instead of using these resources for gas and vehicles, may achieve supervisory goals as well as providing an opportunity for additional training.

- Assign a more active role in family planning education to clinical personnel--particularly midwives, and nurses when they are trained and engaged in the family planning program. A review of the curricula in professional schools should be reviewed to be sure that they include an IEC/counselling component. Clinic operations should be reviewed to assure that adequate time is allowed for quality provider-client counselling. Regional EPS Coordinators should play a more active role in the in-service education of midwives in family planning IEC. All supervision of midwives should include a review of education and counselling activities.

- Limit the production of print materials to those with a specific, literate, and reasonably educated audience (doctors, media professionals, health workers, etc.). Few additional funds should be spent on audiovisual equipment (VCRs and 16mm projectors in particular) since this equipment has a discouraging history not only in Senegal but in other countries as well.

- Renew dialogue between the MPHSA and the Ministry of Education to revitalize interest in Family Life Education and to design a program acceptable to both parties. In view of the Ministry of Education's current program to integrate population issues into the curriculum, the Project's efforts might focus on out-of-school education, such as young women's associations.

- Explore the Community-Based Distribution scheme to increase contraceptive availability, to accelerate the rate of family planning acceptance, and to provide a motivation to individual volunteer workers. Attention should also be given to motivation retailers to whom a fee subsidy has been passed to provide greater access to contraceptives.

- Provide additional resources (particularly staff) to the Project specifically for STD/AIDS education, or transfer the MST/SIDA education program of the Project to another agency, such as EPS, which may be better staffed and equipped to direct and manage it. In either case a closer working link with the Ministry of Public Health and Social Affairs' STD program and the National AIDS committee work should be forged.

While all the above recommendations are applicable for the longer-term, and should be considered for the new Project, every effort should be made to incorporate as many of these as possible into the present Project.

IV. FAMILY PLANNING CLINICAL SERVICES

A. Goals and Objectives

This Chapter focuses on the following goals:

- Provision of family planning clinical services;
- Training of family planning workers;
- Collection of family planning service statistics; and
- Supervision of clinical activities.

1. Goal of family planning clinical activities

The overall goal of the family planning clinical component of the Project is to provide safe and effective clinical services resulting in:

- 15 percent of married women of childbearing age (200,000 couples) through public (170,000 couples) and Private and Para-Public sector services (30,000 couples) becoming acceptors of family planning methods;
- Detection and treatment of 30,000 STD patients; and
- Improvement of the referral system of STD and Infertility cases, from health centers and posts, to regional centers.

2. Goal of project training

The goal of project training is to provide family planning centers with qualified health workers who can provide efficient and reliable family planning services to the client population. Specific goals are to provide training in clinical family planning techniques, program management, teaching methods, and STD and infertility to:

- 140 midwives, including 20 who would receive trainer training;
- 140 male-nurses;
- 140 family planning aides;
- At least 20 physicians; and
- 50 family planning program managers.

A broader goal is to integrate family planning training into the curriculum at nurses and midwives training schools.

3. Collection of family planning service statistics

Improving the collection, analysis, and use of micro level family planning data was not an objective of the Project. Lack of timely and accurate operational information and data is a major constraint to improved Project management and was a weakness in the Project design. This Chapter uses the data that are available to come to some conclusions about the Project's clinical component. Chapter VIII suggests considerations for developing a family planning information system for the follow-on Project.

4. Supervision

A specific goal for supervision was not included in the Logframe. In the context of this Project, however, it is a subject that requires attention.

B. Description of Family Planning Clinical Services

1. Scope of data collection by the evaluation team

a. Sites visited

The clinical members of the evaluation team visited 15 sites in three regions of the country. Eleven of the sites were public sector clinics; four were in the Private and Para-Public sector. The clinical sites visited were:

- Dakar
  - ASBEF
  - DANTEC Maternity
  - PAD* (Port Authority Clinic)
  - PMI Medina (MCHC Center)
  - Thiaroye sur Mer
  - JOTRAC* (Transport Agency Clinic)
  - Dominique (Clinic)
  - Roi Bandoin (Clinic)
- Kaolack
  - Kaswack (Clinic)
  - S.O.S.*
  - Regional Center
  - Kaffrine HC
  - Regional Laboratory

- Thies

  - Randoulene
  - 10e RIAOM
  - Malicounda*
  - MBour MCHC Center
  - M'Bour Municipal Laboratory

  * Para-Public Family Planning Centers

b. Officials interviewed

At the national level, the members of the team reviewing clinical issues met with the following persons:

- The Chief Medical Officer responsible for the national MCH service.
- The STD/AIDS project coordinator and his deputy;
- The chief medical officer of Le Dantec Hospital, gyneco-obstetrical clinic;
- The Deputy Director of the National School of Midwives;
- The ASBEF Executive Director; and
- The head of the national bacteria-virology laboratory.

In the three regions visited, the team met with:

- The Chief regional medical officers and their staff;
- Departmental and health center medical officers in Pikine, M'Bour, Kaffrine, and Thies;
- Fifteen midwives and one MCH supervisor; and
- The Deputy Governor and the Director of the School of Rural Women extension agents in Thies.

2. The system for delivery of clinical services

Family planning clinical services are provided in hospitals, dispensaries, health centers, MCH centers, maternities, and in some health posts that are part of the public as well as the Private and Para-Public Sector. Public sector clinical services are managed at the

central government level by the national MCH Service. The MCH Service Chief is also the Project's Technical Director. He manages the family planning service with the help of National Family Planning Coordinators and coordinators at the regional level. The project coordinators at the national and regional levels are responsible for coordination, training, and supervision of family planning services in the six regions served by the Project.

When the Project was under the supervision of the former Ministry of Social Development, it was difficult to involve the national Ministry of Health MCH family planning service in the coordination and supervision of family planning activities. This resulted in "verticalization" in the management and coordination of family planning activities. Chapter XII includes a more detailed discussion of the problems that existed when the Project was managed by the Ministry of Social Development.

At the regional level, the coordinators who are members of the regional health team manage and supervise the various family planning centers. At the clinic levels, family planning services are provided in dispensaries and at infirmaries of private companies as well as at public health clinics.

In family planning centers, clinical activities are usually under the responsibility of a midwife or, in rare cases, of a nurse. Family planning clinical services are provided through a series of activities conducted by health and family planning workers and are organized as follows:

- Reception and registration of women clients by a nurse's aide or a female social worker;
- Initial questioning, analysis, and counselling, usually by a midwife;
- Physical examination, by a midwife;
- Prescription of an appropriate contraception method;
- Client follow-up;
- Maintenance of records (consultation cards, record-books);
- Preparation of progress reports under the leadership of the center chief; and
- Sterilization and maintenance of equipment which is carried out by nurses' aides.

3. The system for training

Family planning training is under the control of ISTI and the project coordinators. Initial training of national and regional coordinators was carried out in the United States. Local training was developed by ISTI which provided technical assistance. After 1989, much of the training was carried out by the National School of Maternal and Child Health (NSMCH). In addition to formal training abroad and in Senegal, the Project also arranges for the exchange of experience through study tours.

The development of a core of trainers, made up of a national and regional coordinators, has permitted the Project to decentralize its training activities. However, because of the shortage of local funds in 1988-1990, organizing and carrying out training programs has been delayed.

As of May 1989, according to a report prepared by the National Project Coordinator, a total of 398 workers received clinical training in family planning, of whom 342 were trained in Senegal and 56 were trained abroad. Among the workers who received training are 300 midwives, 32 state nurses, and 65 physicians.

In 1991, an additional 25 midwives and 20 nurses received clinical family planning training, and 16 others participated in study tours to Gambia, Kenya, Sudan, Egypt, Morocco, Mexico, United States and France.

C. Analyses and Evaluation

The evaluation of clinical services focused on:

- The number of users on contraceptive methods;
- The operation of family planning centers, including the availability of contraceptive methods;
- Collection of family planning data;
- The interactions between family planning service providers and clients, i.e. workers' performance; and
- Physical conditions of facilities and equipment. (Note: This subject is treated in Chapter X.)

1. Clinical activities

a. Family planning method users

Table 8, Evolution of Active Family Planning Users, reflects the following.

- The number of active clients in the public sector, in the six regions covered by the project, has increased from 7,543 in 1985 to 29,890 in 1990. These figures represent a four-fold increase in the number of active clients over the five years of the project--for an annual average rate of increase of 27.5 percent.

- For the private and para-public sector, the numbers indicate an even more rapid increase. The number of users increased from 1,000 in 1985 to 9,111 in 1990--an annual average rate of increase of 44 percent. This increase is mainly in the number of active ASBEF clients who account for 31 percent of the total Private and Para-Public sector active clients. The increase in this group can be explained by the fact that the majority of private and para-public centers are located in Dakar.

- The public, para-public, and private sector in the six regions covered by the project, recorded a total of 39,001 users as of December 1990--a 30 percent annual average rate of increase. These figures do not take into account the use of condoms by male clients.

- Since 1988, however, there has been a slowdown in the increase of active clients. This slowdown has been stated by USAID and Project personnel to have resulted from a slowdown of project activities resulting from the vacancy of the Senegalese Project Director during the crisis, and a shortage of local resources for supervision of the family planning system.

- There has been a noticeable reduction in the number of active clients in the Thies region between 1989 and 1990. This has been blamed on the absence of a chief medical officer in that region and on the shortage of local funds for vehicles, gas, and per diem for supervision.

- The figures for the commercial sector (19,300 active users in 1990) must be interpreted with some caution. Although the Project did not directly intervene in this sector, it created a favorable climate for family planning activities. USAID has also played a role in the abolition of import taxes on contraceptives which reduced their price in the commercial market.

Table 8: Evolution of Active Family Planning Acceptors, 1985-90
(Number of Active Users)

Region	Dec 85	Dec 86	Dec 87	Dec 88	Dec 89	Dec 90
Dakar	3,836	4,308	6,407	9,053	11,529	15,171
Thies	721	1,854	3,374	4,405	5,053	4,068
Kaolack	1,359	1,691	2,512	3,761	4,046	4,140
Fatick	82	236	214	523	928	1,040
Kolda	120	102	342	558	962	1,500
Ziquinchor	1,425	1,651	2,439	2,725	3,759	3,971
Tot Pub Sect	7,543	9,842	15,288	21,025	26,277	29,890
% Growth		30.5	55.3	37.5	25.0	13.7
PPPS	1,000	1,400	2,700	4,900	6,642	9,111
6 Rg+PPPS	8,543	11,242	17,988	25,925	32,919	39,001
% Growth		31.6	60.0	44.1	27.0	18.5
Commercial*	8,000	10,000	14,000	16,000	18,000	19,269
4 Regions (UNFPA)				500	2,850	3,106
TOTAL	16,543	21,242	31,988	42,425	53,769	61,376
% Growth		28.4%	50.6%	32.6%	26.7%	30.4%

* Couple Year Protection calculated from contraceptives sold.

- In the four UNFPA regions, 3,106 active clients were identified in December 1990. It should be noted, however, that UNFPA did not start its activities until 1988 and has no more than 29 operational centers in its 4 regions.

- As of December 1990, the total number of acceptors in all sectors was 61,376.

Despite management difficulties, including stock outs, insufficient equipment, lack of supervision, etc., the Project has reached a significant proportion of the population and has helped promote access to modern contraceptive methods. The lack of verifiable data on new acceptors and on dropout rates per method, however, makes it difficult to determine the exact number of acceptors.

b. Center operations

(1) Hours of operation

In the public sector, family planning activities are generally conducted only in the mornings from 8:00 to 12:00 a.m. These limited periods for family planning service delivery result in client concentration, and increased workload per service provider, in a short period of time, particularly in highly frequented centers. These limited service delivery hours affect the way services are organized and provided, making it difficult for service providers to carry out their tasks with maximum effectiveness or attention to client needs. The situation is somewhat different with the private and para-public clinics where services are offered most of the day.

(2) Availability of contraceptives

Contraceptive methods that are supposed to be available in the public sector centers include pills (Lo-Femenal and Ovrette), IUDs (380A), condoms (Mixed brands and logos), and spermicides (out of stock for almost a year in most centers). In hospitals, tubal ligation and Norplant are also provided (the latter only in Dantec Hospital).

The unavailability of a complete variety of pill limits the family planning services that can be offered and restricts the treatment of side effects such as spotting and bleeding. In all of the centers visited, service providers did not fully understand the technical difference of various types of pills. Health workers in the centers could not intelligently provide guidance when necessary to change from one pill to another, in the event of a stock out.

(3) Reference publications

Family planning technical and reference documents for service providers or for clients are almost nonexistent in the centers.

(4) Community participation

Clients contribute for family planning services they receive at local centers. The fee is established for each center by the local health committee which manages the money and decides on its use. In most cases, the funds are used for medicines and supplies which supplement those provided by MPHSA or the project.

Rates for consultations vary from one center to another--from FCFA 100 and FCFA 1,000. This is an important issue for further study to determine impact of payment on service provided and accepted, client satisfaction, comparisons among sectors and clinics--including comparison with the private sector, and comparisons between urban and rural areas, etc.

As GOS public funds become more limited, and after USAID Project funds are no longer available, local fees may become an important source of revenues. Some have suggested these fees be used for clinical purposes such as to purchase contraceptives and medicines; others suggest the fees be used to support increased supervision. The issue deserves further study when designing the new Project.

c. Performance of health and family planning workers

(1) Reception of clients

This step is poorly carried out or not done at all in many centers visited. Poor reception of clients results from poor organization of activities at the clinics which is compounded by the lack of space for health workers and clients, and even benches for clients in some heavily frequented centers.

(2) Analysis and counselling of clients

Anamnesis, or the taking of medical history, the questioning of clients, and recording of health information on the family planning cards, is poorly done. Complete sections on the family planning record cards are often empty. Counselling is weak and often nonexistent. This deficiency results from lack of time as well as from inadequate understanding, by family planning workers, of medical matters and family planning techniques.

(3) Physical examination

The need for and use of physical examinations, as part of the family planning clinical service, is not well understood. General and gynecological examinations, essential to the understanding of medical contraindications, are inconsistent and incomplete. Health workers do not understand the utility, importance, or limitations of physical examinations. In addition, MPHSA has recently issued an instruction that it is not always necessary to conduct a physical examination before prescribing a contraceptive device;

taking a medical history may suffice. However, none of the 11 public centers visited received the circular letter concerning physical checkups. At the present time, therefore, prior to prescribing contraceptives, some public sectors centers and most Private and Para-Public family planning centers carry out a physical examination. Sometimes a clinical checkup is ordered after prescribing the contraceptive. This clearly indicates a lack of understanding of the purpose and utility of physical examinations.

(4) Prescription of contraceptive methods

Decisions on contraceptive methods for each acceptor is mainly based on the client's choice and does not usually take into account the medical history of the client or the results of the physical examination. Instructions to new acceptors on proper use of the contraceptive selected are incomplete.

(5) User follow-up and monitoring

Some important parameters are not systematically followed-up on, e.g., blood pressure, date of latest menses, clients' complaints, or effects of treatment. Actions to be taken when faced with side-effects and complications from use of contraceptive methods and complications have not been mastered by family planning workers.

(6) Improved management of the family planning centers

Difficulties to overcome at centers include:

- Poor organization of clinic activities;
- Inadequate and poorly maintained technical equipment in some centers;
- Inadequate training program content;
- Lack of retraining for staff;
- Insufficient qualitative and quantitative supervision of family planning activities; and
- Service delivery sometimes by untrained workers.

d. Collection of family planning statistics

There are three consultation cards in each public sector family planning center (one each for Family Planning, STD, or infertility cases), one register, and one standard reporting form. These data collection materials are standard in all public sector

clinics. A seminar on family planning data collection and use of statistics was organized in October 1987 and brought together project national coordinators and regional supervisors. The data materials and procedures for their use were reviewed but the results of the seminar were never disseminated to the centers.

A series of problems makes collection of statistical data difficult, incomplete, and unreliable. For example, the definition of who is an active client is not understood by most providers and even by some coordinators. This results in overestimating or underestimating the number of active or inactive clients.

Other problems include:

- Poor filing of consulting cards, shortage of cards, canceled folders and report forms;
- Irregular submission of reports from the centers to the regions and from the regions to the central levels;
- Data not being analyzed at either the central or regional levels, and the centers not receiving feedback on the statistics provided;
- Data collectors' lack of understanding of the use to be made of the data they collect, how the data relates to their work, or how it will make their work easier or harder; and
- Lack of a data collection guide.

2. Clinical training

a. Status of personnel trained

Table 9 summarizes training received in four Project regions. Analysis of the status of training received by family planning personnel in the four project regions for the year 1990 highlights the following:

- O 303 midwives working in the MCH family planning services, 110, or 36 percent have not yet received clinical training. Although the number of midwives trained exceeds the project goal, training of midwives needs more attention because of their increasing importance and the frequent changes and reassignments of these personnel.
- Of 281 nurses, 278 or 99 percent, have not yet received any family planning training. None of the public sector nurses received training

Table 9: Training Received by Family Planning Workers in Four Selected Regions and PPPS

	P	MW	N	NA
DAKAR				
T	16	157	117	150
NT	7	63	117	150
%NT	44	40	100	100
THIES				
T	6	47	54	55
NT	4	15	54	55
%NT	67	32	100	100
KAOLACK				
T	6	28	41	43
NT	4	11	40	42
%NT	67	39	98	98
FATICK				
T	4	21	37	4
NT	2	10	37	4
%NT	50	48	100	100
TOTAL 4 REGIONS				
T	32	253	249	252
NT	17	99	248	251
%NT	53	39	100	100
PPPS				
T	20	50	32	118
NT	14	11	30	55
%NT	70	22	94	47
GRAND TOTAL				
T	52	303	281	370
NT	31	110	278	305
%NT	60	36	99	83

Legend:
T = Total
NT = Not Trained
%NT = % Not Trained

P = Physician
MW = Midwife
N = Nurse
NA = Nurse-aide

Source: December 1990 ISTI Report

and only 6 percent in the Private and Para-Public sector were trained. This is, no doubt, because of the national policy which does not favor nurses working in family planning. Lack of training of nurses represents one of the weakest points in the project. While most nurses are at the level of the clinics and health posts, extension of family planning activities to the rural areas would require the training and use of these workers.

- Out of 52 public sector physicians, 31 or 60 percent have not been trained. Among physicians in the Private and Para-Public sector, only two have received family planning clinical training under the project. On the other hand, the number of physicians receiving training exceeds the number in the original project plan.

- Among nurses aides, only 306 out of a total 7,370, or 4 percent, have received training.

- Thirty-seven percent of all trained workers are in the Dakar Region.

b. Observation of other training issues

- The teaching of family planning at the Midwives Training School began in 1987, after the development of training modules in 1986, and the delivery of teaching material and services by the project. One class of 30 midwives has already received this training.

- The development of a national core of trainers has been a strong point of the Project's training effort. Clinical training sessions have been implemented in all project regions.

- Substantive areas which need increased emphasis include:

  -- Instruction to acceptors who face contraceptive side effects or complications;

  -- Use of general and gynecological examinations;

  -- Counselling of clients;

  -- Sterilization and maintenance of equipment; and

  -- Registration and organization of the record keeping system and the preparation of reports.

3. Supervision

Supervision of family planning services has been one of the weakest and most critical aspects of the project. Supervision has been fragmentary, weak, and, at times, nonexistent at both the national and the regional level. At the national level, there has been an absence of collaboration between the project and the MCH Family Planning Coordinator. This may explain a large part of the coordination problem. The quality of supervision that has taken place has been weakened by the lack of independence of the National Coordinator from the Chief of MCH. The Coordinator has no funds for supervisory visits and has had to "hitch rides" to the field with the logistician or other MCH staff. A supervision protocol designed during a workshop conducted in November 1986 by expatriate consultants and representatives of DRPF/MSP and WHO/Dakar has never been introduced.

At the regional level, lack of supervision has been blamed on the lack of resources such as vehicles, gas and funds for per diem. Supervision that has taken place has focused on quantitative aspect of the project such as data collection and file maintenance, rather than on qualitative aspect such as detection and correction of clinical problems or training of health workers.

D. Summary of Major Findings and Conclusions

1. Clinical services

- The project has increased the availability of family planning services for the general population. For example:

  - The number of family planning clinics has increased from 17 in 1985 to 123 in 1990; (Note: There is still disagreement on the exact 1990 number.)

  - The number of active clients in the public, Private, and Para-Public sectors has increased from 8,543 to 39,000, over the same period.

- While health clinics have been improved and an increasing level of family planning services has been made available, effective management of the system is lacking. While some clinics and family planning workers are over-burdened with clients, others may be under-utilized. Hours of operation of the clinics and numbers of family planning workers assigned to clinics, for example, are not adjusted to workload requirements. Allocation of financial resources for operations of the clinics is insufficiently related to need.

- Deficiencies noted at the clinics include:

  - In 62 percent of the public sector centers visited, working hours were limited to 8:00 a.m. to 12:00 a.m.

- -- Family planning centers do not provide a full range of contraceptive methods and services. Of the oral contraceptives that are provided, included in the mix are only low dose pills.

- -- Although not always necessary, laboratory examinations are always required in some public sector centers and in all Private and Para-Public centers.

- -- Communication of technical information does not flow easily through the system. None of the centers visited, for example, had received a recent MPHSA circular letter concerning physical examinations.

- o The quality of clinical services observed during visits to selected family planning centers was considered insufficient. For example,

  - -- The taking of clinical histories is often incomplete;

  - -- Women are not well-counseled on the advantages and disadvantages of different contraceptive methods;

  - -- Clients are generally given whatever contraceptive method they ask for, if it is available, whether or not it is clinically appropriate for them;

  - -- Instructions provided to women on the proper use of contraceptive methods are not complete;

  - -- Clinical follow-up and management of possible side effects to the use of contraceptives are not systematic; and

  - -- Little effort is made to track and determine why women who have received contraceptives do not return.

- o There is a growing community participation in the delivery of family planning services which should begin to impact positively on the quality of the service. Local family planning committees have been established to look over the activities of the clinics and to provide some additional resources from community funds and user fees.

2. <u>Training</u>

- o Training has been insufficient to meet its potential for improving delivery of clinical services.

- While the absolute goals in the Project Logframe for training of midwives has been exceeded--over 300 have been trained--over one-third of the midwives at clinics have not received any family planning or IEC training;

- 60 physicians have received clinical family planning training courses; while that figure indicates that the number of physicians who have received training has exceeded project objectives, it also indicates that 60 percent of medical doctors have received no family planning training;

- Study tours have been provided to 16 family planning workers;

- Few nurses--32--have received family planning training; the number trained is clearly below project objectives, although now that legislation permitting such training has been passed, the situation may change;

- Since the audit and financial crises of 1989, with the reduced availability of local currency, local training has been at least temporarily suspended; and

- The project has not developed a retraining program for trained workers.

o The development of a core of national trainers capable of conducting training sessions in the regions has been a notable success of the Project. However, since the audit/financial/management crisis of 1989, with the reduced availability of local currency, local training has been delayed.

o Although responsibility for training was decentralized to the regional levels, the content and quality of training programs have not fully responded to specific local clinical needs and to problems noted in this evaluation, such as action to take when facing medical side-effects and complications.

o The GOS is considering an effort to more closely relate assignments of public health workers to their levels of skills. Rationalization of training needs and programs should begin to have a positive effect on family planning personnel resources.

o Family planning has been integrated into the curriculum of the Midwives Training School.

3. Data collection

- Family planning data collected at the clinical level is inaccurate and unreliable. Indicators such as the number of new acceptors, levels of STD, infertility, or women who have abandoned contraception, can not be used to judge the quality of impact of the Project.

- Collection of reliable clinical data is subject to some of the following technical limitations:

  -- Definitions of data categories are not clear or well understood by health workers who collect and record data; e.g., new or active acceptors, drop-outs;

  -- There is often a shortage of forms and client records are not always available, filled out, well-stored, or filed;

  -- The system for transmission of data from district to regional to national offices does not function adequately;

  -- Guides or protocols on the collection of data do not exist.

- Collection of reliable data is subject to some of the following management limitations:

  -- Midwives and other family planning workers who collect data do not understand why the data are being collected, they receive no feedback on the use of the data, and they see no benefit to themselves or to their clients to collect the data;

  -- Hours of work at the clinics are often too short and workload to heavy for family planning workers to both carry out clinical duties and also collect family planning data; and

  -- Family planning workers receive insufficient training or supervision on their data collection responsibilities.

4. Supervision

- Family planning clinics have not received adequate supervision from either national level staff or regional supervisors. Reasons given include insufficiency of funds for travel, per diem, and gas, confusion over organizational roles, uncertain responsibility for people and programs, and lack of supervisory protocols, guides, and management planning techniques.

- Inadequate supervision from the national or regional levels has reduced operational control of the clinics. A recent written instruction to family planning clinics, for example, that clinics no longer need carry out routine laboratory tests on clients before prescribing oral contraceptives, was not received by the family planning centers visited by the team. And, because family planning workers do not understand the purpose of the tests, clinics continue to carry them out.

- Private and Para-Public sector clinics receive significant supervision. All such centers funded by the project have been visited by ISTI staff which is primarily responsible for this component.

E. Summary of Major Recommendations

Future project activities should be directed to improving the quality rather than the expansion of services.

1. Clinical operations

- Reorganize responsibilities, personnel assignments, and hours of operation, at family planning clinics to permit more effective use of available staff time, facilities, and equipment.

- Insure that a regular supply of an appropriate contraceptive mix is being supplied to, and available at, the central, regional and clinic level, including injectable and standard dose pills, in accordance with the national service policy.

- Encourage supervision and training to stress prescription of approved clinical methods such as careful attention to client counseling, considered choice of contraceptive methods, and client follow-up.

- Make reference documents available to clients and family planning service providers.

- Develop and strengthen clinical programs to attract men to clinics and facilitate their use of family planning methods.

- Integrate family planning programs with other health activities such as health education, nutrition, mother and child and pre- and post-natal care, immunization and oral rehydration.

2. Training programs

- Improve the GOS management capacity for delivering improved family planning services by creating training and retraining programs designed for family planning supervisory personnel at all levels--central, district, regional and clinical personnel. For this purpose, supervisors may be medical doctors, nurses, midwives or leaders of local family planning committees, as well as administrative personnel.

- Train clinical workers in IEC, psycho-social, gender, cultural and religious matters, counselling and associated social issues, along with the technical issues on the delivery of family planning services.

- Confirm the responsibility of the National Clinical Coordinator to make training more relevant by reviewing the curricula of the various local training programs to assure that it is updated according to human resource needs actually assessed and clinical problems discovered during supervision.

- Emphasize the training of physicians and nurses in plans to extend family planning services in rural areas.

- Continue integrating family planning subjects into nurses' and midwives' training school curricula, as already initiated at the Midwives' Training School.

3. Data collection

- Improve the system for collection, processing, analyzing, of health service data by developing written guides and training programs for data collectors and assuring the availability of basic documents, forms, and supplies to carry out the data collection.

- Improve the processing and analysis of data and assure the publication and dissemination of the results of the analysis.

4. Management and supervision of the family planning center

- Increase supervision at all levels of the family planning system, especially for quality of service delivery, improved recordkeeping, and technical clinical activities. Develop written protocols along the line of Annex C-1, for carrying out supervisory visits. Develop a system of evaluations on a time-phased basis, with reports and feedback to units supervised, as well as to the next higher level and to the Project itself.

Supervisory visits should stress the early discovery of problems which need management attention, rather than audit and control to "catch" someone.

- Confirm the responsibility that the central MCH level has for coordination, monitoring, and supervision of MCH and family planning activities.

- Conduct studies on other aspects of family planning activities such as causes of dropout rates, profile of users, services, provider role in the choice of the contraceptive method.

- Give more attention to supervision and evaluation of training programs. Supervision should cover content and methodology of training, as well as follow-up to determine the impact and effectiveness of training provided.

- The team designing the new Project should review the results of the supervisory seminar and the supervisory manual that has already been published and determine why it was never introduced. Include a detailed supervisory protocol in the new Project.

V. TREATMENT OF SEXUALLY TRANSMITTED DISEASES (STD) AND INFERTILITY

A. Goals and Objectives

The Project Paper indicated that this Activity was to provide the institutional framework and trained people to help diagnose 25 percent to 30 percent of the annual incidence of the main sexually transmitted diseases in Senegal by the end of the Project. The Project Agreement established specific output goals and objectives for this activity:

- Treat 30,000 patients by the end of the Project;
- Train health workers on STD and infertility issues;
  - 5 doctors and/or members of the Faculty of Medicine
  - 140 midwives
  - 140 nurses and other health workers
- Provide specialized equipment and material for two regional STD centers, including Le Dantec Hospital;
- Provide diagnostic equipment for 27 family planning centers for diagnosis of STD; and
- Improve the system of referrals from health clinics to STD regional centers.

B. Description

1. General

The advent of AIDS and non-gonococcic urethritis (chlamydia and mycoplasmas), and the increase in the number of other STD cases, has caused a disquieting and increasing public health problem in Senegal in the 1980's. In 1982, the report titled "Health programming in Senegal" indicated that more than 16,000 cases of syphilis and 31,000 cases of gonoccitis were diagnosed by health personnel.

In 1984, Dakar, Kaolack and Saint-Louis registered 3,400 cases of STDs, two-thirds of which were men. Gonococcitis accounted for one-third of the diagnosed cases. In addition to the high morbidity caused by STDs, this group of diseases has had significant effects on maternal and child health in general, and family planning, in particular.

In Senegal and elsewhere in Sub-Saharan Africa, STDs, particularly gonorrhea, constitute the main cause of male and female infertility. For this reason, treatment of STDs is included as a key activity in the "clinical" component of this family planning Project.

Implementation of this STD/Infertility Activity required the development of several actions in coordination with the Senegal National STD/AIDS Program. With the support of the Project, for example, the National STD/AIDS Program published two excellent manuals on STD diagnosis and treatment. Other activities are discussed below.

2. Training

In support of the family planning policies of Senegal, the Project developed and incorporated STD and Infertility subjects into family planning training curricula. Three hundred midwives, 32 nurses and health agents, and 32 doctors received training in STD and Infertility subjects.

The training in STD and Infertility was provided to doctors and midwives at sessions organized in Senegal by John Hopkins Program on International Education in Gynecology and Obstetrics (JHPIEGO) and the Gynecology and Obstetrics Clinic of the Faculty of Medicine of Dakar. Two other doctors and one nurse received STD training at JHIEPGO in Baltimore, Maryland.

Since family planning has been included only recently in the curricula of training schools for midwives and nurses, and since the hours of training are minimal, the performance on STD/Infertility matters, of service providers, has been low in almost all of the centers visited.

3. Treatment of patients

Before the financial and management crisis of 1989, drugs for the treatment of the most frequent types of STDs were readily available at all Project centers. However, personnel at the visited centers declared that, since 1989, they no longer had the necessary drugs to treat these diseases. The inability to prescribe drugs such as antibiotics, anti-parasites, and antifungicides has become a problem in almost all the Project family planning centers. Considering the low purchasing power of the patients, this lack of drugs at the centers constitutes a fairly limiting factor for the correct handling of STD/Infertility cases.

4. Diagnosis support for laboratory service delivery

The Project renovated and equipped nine regional laboratories in order to assist STD centers in the diagnosis, detection and follow-up of STD patients. Eight of these laboratories are currently functional.

C. Analysis and Evaluation

1. At the regional level

a. Overall quality of services

Visits to public family planning clinics found neither the diagnostic processes nor the therapeutic procedures for STD and infertility patients were appropriate. There was no systematic counselling and the detection and treatment of STD/Infertility contacts was not carried out in any organized way. Even though traditional curricula included "venereal disease" training, it is clear, considering the quality of the services provided by health workers who did not receive any pre-employment training in family planning, that the Project has not achieved its goals of providing sufficiently trained family planning workers who can offer quality treatment of STD patients. A review of the clinical training program for midwives showed that, even for those midwives trained by the Project, out of a total of 70 hours of teaching provided, only 7.45 hours (or 11 percent) were on STD or Infertility subject matter.

b. Use of STD laboratories

Inspection of Project funded regional laboratories in Kaolack and Kolda showed that support by these laboratories for the family planning centers could be improved. Certain midwives and nurses, for example, have serious problems interpreting the results of basic laboratory tests such as vaginal and urethral samples. There is little collaboration or meetings between clinical and laboratory personnel to develop feed back to improve the performances of family planning service providers and laboratory personnel.

In M'Bour, at the community laboratory constructed and equipped by the Italians, the situation is somewhat different. The midwife there works on Saturday mornings with the technician in charge of the communal laboratory on the interpretation of the results of tests. At this center and laboratory, active community management and financial participation by the local health committee have been responsible for a higher level of cooperation. In view of the variety of tests and analysis which are proposed, and the self financing system put in place, M'Bour may be a model for other areas of the country.

An inventory of laboratories was carried out in 1989 by a consultant.[18] Eight laboratories were visited, including M'Bour and Kaolack. The purpose of the

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[18] End of Mission Report to FHPP, Joanne M. Hauler, 1989.

consultant's mission was to assess the functioning of STD laboratories, to identify their needs for consumables, to ensure the standardization of test and analysis protocols in order to help all regional laboratories work according to pre-determined standards.

The consultant determined that M'Bour was one of the best managed and functioning laboratories in the country. She found that the situation was quite different in Kaolack, where the person in charge of the laboratory was not terribly motivated. However, none of the recommendations formulated by the consultant in 1989 were ever implemented. For example, no retraining session was organized for M'Bour or training for Kaolack. The most recent training of laboratory technicians was in 1986, when 17 technicians were trained.

c. Selected laboratory tests

An analysis of results of the Kaolack regional laboratory tests gives an idea of the STD situation in Senegal.[19] (See Tables 10, 11 and 12.) Out of a total of 1771 vaginal samples carried out in 1990, for example, 1037 cases were positive. This is a 58.55 percent frequency rate. Among those 1771 samples, 117 or 6.6 percent were from the Kaolack family planning centers. This is a low reference of STD affected patients for diagnosis from the public clinics.

In 1990 the Kaolack laboratory carried out fewer tests than it carried out in 1989. The number of tests fell from 1771 in 1989 to 1020 in 1990, or a 42.40 percent reduction. The reduction results, in part, from the lack of laboratory supplies, from the lack of personnel motivation, and from the lack of management and supervision to correct the situation.

2. Situation at the national level

The laboratory of A. Le Dantec Hospital assisted the Project in the installation of regional laboratories. The five years collaboration were uncertain, however, because of lack of definition of duties, responsibilities and the role of Le Dantec Hospital in the implementation of the Project STD component.

Lack of role definition also existed between the USAID funded Project and the National STD/AIDS Program. Constraints resulted from lack of coordination between the Project and the National Program. There was lack of regular supervision of Project laboratories by the National program, as well as shortages of diagnostic supplies and drugs.

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[19] Statistical Analysis by Mrs. Deguene Marie Diouf, Chief of the Kaolack Regional Laboratory

Table 10: Results of Analysis of Vaginal Samples Carried Out in Kaolack Regional Laboratory, 1990

Pathogenic Germs Present	1989	1990
Trichomonas vaginalis	538	309
Gardenerella vaginalis	336	90
Candida albicans	163	110
Total positive tests	1037	509
Number of samples	1771	1020
Frequency of positive tests	58.55%	49.90%

Source: Statistical Analysis by Chief of Kaolack Regional Laboratory

Table 11: Results of Urethral Samples Carried Out in Kaolack Regional Laboratory (June 1989 to January 1990)

Pathogenic Germs Present	
Neisherria gonorrhea	16
Trichomonas vaginalis	30
Total positive tests	46
Number of samples	76
Frequency of positive tests	60.52%

Source: Statistical Analysis by Chief of Kaolack Regional Laboratory

Table 12: Results of Vaginal Samples Carried Out on Patients from Other Family Planning Centers

Pathogenic Germs Present	
Trichomonas vaginalis	28
Neisherria gonorrhea	4
Gardenerella vaginalis	12
Mobiluncus vibrio	8
Total positive tests	92
Number of samples carried out	117
Frequency of the positive tests	78.63%

Source: Statistical Analysis by Chief of Kaolack Regional Laboratory

There was also an ambiguous situation concerning the financial support to be provided by the Project to the bacteria-virologic laboratory of the hospital. There was a reported lack of interest by the Project Director in the budgetary situation at that laboratory. This may explain the lack of interest shown by the Project Technical Office in MCH and the National STD/AIDS program to the Project's STD component.

3. Epidemiologic data

There is a lack of statistics, data and other information on the STD/Infertility situation in Senegal. The 1990 ISTI Annual Report stated that there were about 33,000 STD cases in family planning centers in 1989, compared to 26,000 in 1988 or a 26.90 percent increase. The 1990 ISTI Annual Report provides some idea of the STD/Infertility frequency in 59 public family planning centers and 24 PPPS centers in four regions covered by the Project--Dakar, Thies, Kaolack, and Fatick. In a total of 8,804 new consultations in Dakar, there were 1405 STD cases or a 16.46 percent frequency. In Thies the frequency was 14.76 percent, in Fatick 17.9 percent, and in Kaolack 19.51 percent. For the same year, the frequency in PPPS center was 40.36 percent. The total of STD cases in family planning centers of the four regions amounts to 9797 in 1990. Assuming that as many cases were seen in each year of the Project, a total of 30,000 patients would have been seen in family planning centers since the beginning of the Project.

While the number of venereal syphilis cases, based on statistics from the National STD Program, seems to be regularly decreasing--62,033 cases in 1971 and 3,527 cases in 1988, the number of gonococcitis cases is increasing with a peak of 19,206 cases in 1987. Even though the prevalence may have decreased in 1988 to 12,360 cases, the situation is still quite alarming. Table 13 shows the prevalence[20] of STDs based on a survey on high risk groups carried out by the National STD/AIDS Program.

4. The monitoring program

In 1988, a review of STDs in Senegal provided a warning and justified taking STDs into account by the Project. The study concluded that, despite the complications and the human suffering caused, very few quantitative data are available on STDs in Africa. The review concluded that, in Senegal:

- The 30,000 patients goal of patients to be treated was largely exceeded after 6 years of Project implementation;

- Since 1988, drugs for STD treatment are no longer available in most Project centers;

[20] Statistics prepared by Dr. Ibra N'Doye, Chief of the National STD Bureau and Coordinator of the National STD/AIDS Program.

Table 13: Results of National STD/AIDS Survey: Percentage of High Risk Groups Testing Positive

	Pregnant Women	Soldiers	Prostitutes
N. Gonorrhoea	2.0%	0.6%	16.6%
C. Trachomatous	11.9%	1.8%	12.6%
T. Vaginalis	30.1%	0.5%	46.0%
Syphilis	7.5%	2.5%	29.5%

- Quantitative training objective was largely exceeded;

- The quality of trained family planning workers is insufficient, particularly among midwives and nurses; and

- Nine regional centers were renovated and provided with lab equipment.

D. Summary of Major Findings and Conclusions

- There has been insufficient attention to treatment of STD and infertility patients in the implementation of the Project. Attention, instead, has been given to provision of contraceptive and regular family planning activities.

- Services provided to patients were poorly handled and of low quality.

- There was inadequate use of STD laboratories in the diagnosis of STD cases.

- Few reliable figures exist on the incidence of STD cases and treatment over the Project period. Statistics are unreliable because of poor collection and analysis methods. This makes it difficult to analyze the impact of Project activities on STD clinical conditions.

- There is little coordination between the Project STD component and the National STD and AIDS programs.

- There is a lack of training given to family planning workers such as nurses and midwives, in special counseling, screening, clinical problems, and interpretation of laboratory tests to treat patients with STD and infertility problems.

- There is insufficient collaboration between clinical and laboratory personnel to assure full understanding of testing programs and implications of test results

- Equipment and supplies for STD laboratories were kept in warehouses for 18 months before they were released for use. Appropriate drugs are not available at family planning clinics to treat STD cases.

- The recommendations of an STD consultant concerned with improving laboratory methods have not been implemented.

- Insufficient research has been carried out on local knowledge, attitudes and practices regarding STD, AIDS, sexual behavior, and use of condoms.

E. Summary of Major Recommendations

1. In the short term

- Improve the capability of family planning workers to handle the clinical problems of STD and Infertility.

- Improve the understanding by family planning workers of the uses and implications of specialized laboratory test so that workers can make better clinical decisions and provide more relevant counseling to clients.

- Improve the coordination between the Project STD program and the National Programs on AIDS and other sexually transmitted diseases.

- Complete activities initiated under the Project such as the provision of laboratory equipment and training in its use for testing.

2. In the long term

- Shift management of the STD activity out of the Project, and directly into the National STD/AIDS Program--in essence, lowering the priority of this activity within FHPP.

VI. CONDUCT OF BIO-MEDICAL AND PSYCHO-SOCIAL RESEARCH

A. Goal, Objectives and Outputs

The goals of the bio-medical and psycho-social research activity are to conduct operational research to answer questions pertaining to bio-medical and psycho-social topics that are raised during Project implementation; to determine the efficiency of community-based programs in Pikine, Kaolack and Fatick; and to determine the feasibility of a contraceptive distribution network. (See also Chapters III, IV and XII on IEC, clinical and demographic research.)

B. Description

1. Overall research program

From a review of Project documents, the team established a partial list of studies and research carried out during the Project. The list is partial because neither the Project Paper, Project Agreement, nor Logframe are specific on what research was to be carried out with Project funds or which Project unit would manage this research. No central research plan was developed after Project implementation began; no organized process was introduced to review research proposals, evaluate, or disseminate research results; and no central library was established as a depository for research papers and reports. Our partial list includes the following research activities:

- A series of studies in bio-medical and psycho-social aspects of contraceptive practices;
- Two socio-demographic/anthropological monographs conducted in the rural areas of Thies and Fatick;
- A study of adolescent fertility by Statistics Office in the Ministry of Economy, Finance and Planning, DPS/CRDI;
- Pre-introductory clinical trials of NORPLANT by FHI;
- Study for a symposium on laboratory testing requirements for contraceptives by FHI;
- Surveillance of obstetrical services in Kaolack by FHI;
- Analyses of "Fiches de Consultation des Censtres de Planning Familiale" carried out by FHPP, BNR, and Columbia University in 1989;

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- "Socio-cultural Factors Influencing the Delivery and Use of Health and Family Planning Services in Senegal; With Special Attention to Women's Health," prepared by Barbara Pillsbury for Senegal Health Sector Assessment, USAID/Senegal, August 1990;

- "Men's Attitudes About Family Planning in Urban Senegal," by Jill Posner for USAID/Senegal, January 1987;

- "Study of Interpersonal Communication Between Nurse-Midwives and Clients in Family Planning Clinics," Study for ISTI. (Data collected but not analyzed at the time of the evaluation);

- 1978 WFS articles and papers;

- 1986 EDS articles and papers. Book planned based on 1986 EDS and 1988 census analyses by Yves Charbit and Salif Ndiaye, editors;

- 1988 Census (special analyses in progress on fertility and mortality study; employment study; migration and urbanization); and

- 1990 Urban Family Planning Study (reports planned).

- Diagnostic Study of the Effectiveness of Contraceptive Practice and Continuity of Family Planning Service/Contraceptive Method Use, (Diop, Francois and Viola Vaughn) The Population Council. In progress. (Project funded by the World Bank);

2. Availability of specific research

The team was unable to locate, nor did they have the staff time to review the entire research portfolio. Four research activities are reported on below as examples of the research activity.

a. Norplant clinical tests

(1) Objectives of the study

The objective of this study was to test the efficiency and accuracy of Norplant in a group of Senegalese women.

(2) Methodology

The Norplant study was conducted jointly by FHPP, FHI and the Gynecology and Obstetrics Clinic of the University of Dakar. The sample of women studied was selected on the basis of clearly defined analytic criteria and clinical research protocols. The Norplant devices were provided by UNFPA, because up to the time of the evaluation, this contraceptive device was not provided by USAID

(3) Results

By February 1990, 177 women were using the Norplant device. As of April 1991, 267 insertions had been carried out. Twenty-eight of these had been removed because of:

o	Infections	(3)
o	Desire to have a child	(9)
o	Disturbances in the menstrual cycle	(14)
o	Failures (pregnancy)	(2)

A national "Norplant" cell has been established in MDHSA and the use of the Norplant device will be extended to Dakar region family planning centers (PMI Medina, Abaso N'Dao Hospital Family Planning Center, Dominique Health Center and ASBEF-Dakar). Based on the preliminary results of the research, it was concluded that Norplant is an efficient method which is well tolerated by Senegalese women.[21] The Unites States Food and Drugs Administration (FDA) recently approved the use of Norplant in the United States. Thus, its adoption by Senegalese officials, with USAID financial support, could lead to its introduction in the National Family Planning Program.

b. Preliminary para-clinical check-up for hormonal contraception

(1) Goal

To carry out a survey to demonstrate that a rigorous clinical examination, with a complete anamnesis, could constitute an acceptable alternative to the preliminary para-clinical check-up.

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[21] Strategy for Introduction of Norplant in Senegal, FHI/JHPIEGO/Gynecology and Obstetrics Clinic of the Faculty of Medicine, Dakar, 1989.

(2) Objectives

The objective of this study was to determine the percentage of women who were authorized to use hormonal contraception following laboratory examinations presently recommended in Senegal. The study tried to measure the correlation between selection results obtained through laboratory tests and those obtained after an anamnesis and a clinical examination.

(3) Methodology

Five hundred women who wanted to use oral contraception for the first time were recruited at three family planning centers, PMI Medina, ASBEF - Dakar, and A. Le Dantec Maternity. Ninety were excluded from the survey for various reasons: unavailability, incomplete files, former users. A three-part computerized form was filled out for each participant:

- The first part dealt with the anamnesis data, including the patient's medical history, breast feeding, cigarette smoking;
- The second part related to the medical examination which was completed and rigorous; and
- The third part related to data provided by additional examinations;

These tests were carried out at the Pasteur Institute in Dakow in accordance with international standards for such research.

(4) Results

The analysis uncovered 17 contra-indications, or 3.9 percent, in 410 cases. Five of the contraindications were from regular clinics (1.219 percent), and 12 from para-clinics (2.96 percent). The analysis led to the conclusions that:

- Laboratory analysis need not be automatically required for the prescription of hormonal contraceptives, and
- A complete clinical history (anamnesis) constitutes an acceptable alternative to a clinical check-up.

The study recommended a cervico-vaginal smear once a year for hormonal contraception users.[22]

An international symposium on "The preliminary para-clinical check-up for contraception" was organized in Dakar, in February 1990, to present the results of the study. A memorandum from the Ministry of Public Health and Social Action was sent to all regional medical doctors for wide distribution of the revised instructions relating to this issue. Unfortunately, three months after the distribution of the memorandum, during the evaluation team's visit to the field, no mid-wife seemed to have heard of the instructions--except for those in the Medina PMI who had participated in the symposium.

c. STD frequency

(1) Goal and objectives

The goal of the research was to review STD epidemiology in Senegal.[23]

(2) Methodology

This research consisted of a review of existing documents and reports.

(3) Results

Despite the lack of reliable STD data, this study indicated increasing trends in the number of sexually transmitted diseases, non-existence of an STD monitoring strategy, and insufficient resources to develop such a strategy. This study included some data on genococcities, syphilis, hepatitis, AIDS, papillomavirus and chlmydior frachomatis.

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[22] Report on the Results of Research on Preliminary Clinical Check-ups for Oral Contraception, F. Diadiou and M. Sangare of HALD, J. Stanback and T. Patrick of FHI, and B. Gentile of the Pasteur Institute, Published by the Pasteur Institute, Dakar, 1988.

[23] Review of Data on Sexually Transmitted Diseases in Senegal, D. Diop, in collaboration with S. M'Boup, I. N'Doye, L. Evison, CNM, Dakar, 1989.

Recommendations that came out of this research included:

- Increase and improve training of competent and motivated health personnel;
- Establish additional STD centers and clinics;
- Promote the use of condoms;
- Develop health education programs focusing on the nature of STD contacts;
- Adopt national STD treatment protocol; and
- Institute procedures so doctors, clinicians, and other health workers coordinate their efforts to develop an improved STD monitoring system. (Note: This recommendation does not change much of the present epidemiologic environment.)

The project has already published two guidebooks on STD diagnosis and treatment. (See STD/infertility Chapter V.)

d. Survey on statistics of active family planning clients

(1) Goal and objectives[24]

The goal of this study was to use existing FHPP data to prepare recommendations for improvement of family health and population service delivery. The objective was to collect and computerize data from each family planning center, to ensure the training of managers in data processing procedures, and to show them the usefulness of a computer information system. The study was to design and implement a plan to analyze the data relating to FHPP needs. This effort was to give the Project the opportunity to use the existing information system for the design of successful information collection and analysis campaigns. The study was to help FHPP integrate the regular analysis of data into its activities so as to strengthen Project management.

[24] Analysis of Consultation Forms in FP Centers for Improved Program Management, P. Kelly, University of Columbia, July, 1989.

(2) Methodology

The basic information source is the client consultation form prepared at the family planning center at the time of the client's first visit and updated at subsequent visits. The study covered 20 family planning centers in the six regions covered by FHPP. The target population was all active women in the 20 family planning centers managed by the Project. 16,312 consultation forms were studied.

Women were followed in accordance with agreed upon standards. Women who regularly visit the clinic for a resupply of contraceptives are called "actives"; those who do not return are called "inactive."

(3) Results

The study developed a profile of "actives" according to the following criteria: age, ethnic group, religion, marital status, education, status of the husband, number of children, pathology, and contraceptive method used.

Although in many centers the clinical staff did not give enough attention to the files of the clients, this study concluded that analysis of the files may still provide useful information for management of family planning centers. A 100-page report was published in 1989. However, it was never distributed, and its results are still not being used for improvement of project management.

C. Analysis and Evaluation

This evaluation focuses on the research process. Unable to locate research proposals or basic data upon which the results were based, the evaluation team has accepted the accuracy of the research results described.

The operation research activity was not well-managed. There were major deficiencies in the coordination process. One problem was lack of dissemination and, therefore, lack of use of results to solve problems and improve the Project management. Some surveys were planned, but not executed; e.g., the survey on interpersonal communication among service providers.

Coordination of Project operational research was a problem. The Project Technical Director had an undefined and casual involvement in identification of research topics, execution of the activities, and dissemination and use of the results. The Technical Director did not often participate in the identification of research topics, except for clinical topics and issues related to the direct delivery of health services. The Project Technical Director was never informed of some KAP surveys, e.g., "Excision and Infibulation in Senegal" and "Abortion in Pikine." He never evaluated

results of the research or ensured that reports were distributed. Table 14 summarizes his involvement in a number of research activities.

The Norplant survey is an example where results of the research seem not to have been made generally available. The results were not disseminated at the national level, not even for the information of clinical people working on the field such as midwives, nurses, or IEC/EPS agents. Some midwives (Kaolack regional center and rural maternity of Malicounda) had never heard of the Norplant survey before our interview.

While the results of operational research carried out to support improvement of basic data were disseminated and used to some extent by BNR, the clinical component of the Project does not seem to have benefitted from results of demographic studies and surveys.

D. Summary of Major Findings and Conclusions

- In regard to the initial goals of the research component:
  - The operational research on the feasibility of a community base program, was not carried out, neither in Pikine, nor in Kaolack and Fatick (one project for Pikine "Yevi Jaboot" was not approved for funding);
  - The survey on the feasibility of a national operational system for contraceptive distribution, was not carried out; and
  - Too much bio-medical, psycho-social, and academic research was carried out, in comparison to needed Project operational studies.
- The following areas have been identified as needing further attention to improve the research activity:
  - Planning and coordination of research activities encountered during the execution of the Project;
  - Involvement of project actors in planning research; and
  - Dissemination and use of research results.

Table 14: Level of Participation of the FHPP Technical Director in Project Research Activities

Research Topics	Topics Identified	Execution of Research	Dissemination of Results	Use of Results
1. Men's Attitude to FP	-	-	-	-
2. Excision & Infibulation	-	-	-	-
3. Analysis of Farmers Attitudes	+	+	ND	ND
4. Abortion in Pikine	-	-	NAI	NAI
5. Para-clinic Exam. & Contrac	+	+	+	+
6. Norplant Survey	+	+	+/-	+
7. Village Monograph	-	+	+	-
8. Health Education	+	+	+	+
9. Social Marketing	-	-	NAI	NAI

+ = Involved ND = Not Done

- = Not involved NAI = Information Not Available

- Although a considerable number of research studies have been carried out, the Project has not yet developed an overall long-range research plan with priorities, schedules, and suggested uses of limited research funds. No one at the Project is assigned this overall research management responsibility.

- The Project's Technical Director in the Ministry of Public Health and Social Action has not been sufficiently involved in the identification of many research topics, particularly those on psycho-social issues.

- Many Project research reports can be found at the ISTI and Project offices, but very few have been disseminated to government ministries or other potential users.

E. Summary of Major Recommendations

1. Short term

- Locate copies of prior research funded by the Project and establish a library for the reports. Develop a bibliography of studies and research that have been completed. Determine who should receive copies of the research reports and undertake a purposeful program of dissemination.

- Do not begin new operational research until the usefulness of what has already been accomplished by the research component has been determined.

2. Long term

In developing the new Project, the design team should:

- Determine who and where in the Project or MPHSA the assignment should be made for long-term management responsibility for a continued operational research program. The design team should consider assigning this responsibility as one of the principal duties of the new family planning statistics, research, and evaluation unit recommended in Chapter X.

- Develop a priority plan for the long-term use of operational research funds.

- Assure that the Project seeks out local resources whenever possible to carry out studies and research. Develop a local capacity to carry out Knowledge, Aptitude and Practical (KAP) studies, probably associated with those responsible for IEC activities.

- Develop a research study to create protocols to evaluate various family planning processes; for example, quality of clinical service, performance of family planning workers, client attitudes toward service received, and client understanding of family planning concepts and methods.

- Develop studies to evaluate the impact of family planning services within the Ministry, capacity of family planning staff to deal with clients, staff comprehension of family planning concepts and methodology, and challenges to integrate family planning with other health delivery activities.

VII. CONSTRUCTION AND RENOVATION OF INFRASTRUCTURE AND MAINTENANCE OF EQUIPMENT

A. Goals and Objectives

The goal of this activity, in the original Logframe, is to consolidate and expand the family health and population system by:

- o strengthening and expanding family planning services in the 22 existing centers;
- o increasing the number of family centers in the six regions covered by the project, at the rate of 10 centers per year (changed to 15 per year in a revised Logframe) to a total of 128 by 1992;
- o constructing two additional family planning centers in each of the four regions covered by the UNFPA funded "Bien Être Familial" Project, during the 1989-92 period (changed to 5 per year, or a total of 20);
- o renovating and making minor improvements, as needed, to 92 centers (changed to 106 centers in a revised Logframe); and
- o providing the family planning centers with appropriate technical equipment that can be efficiently used and maintained.

B. Description

1. Facilities

In the Dakar region, 25 facilities (family planning centers or laboratories) were constructed and/or renovated. In the Thiès region, 11 clinics were constructed or renovated: three in Fatick, nine in Kaolack, 15 in Kolda and Ziguinchor, and one in Saint-Louis. While the latter region is not covered by the present Project, one center there was improved by the Private and Para-Public Project component.

Out of the 92 public centers planned, 64 were renovated or constructed. The Project renovated one para-public center in Saint-Louis (SAED). From 1986 to 1990, approximately FCFA 270,000,000 was spent on renovation and construction activities in the six regions of the project, bringing to 64 the number of centers or laboratories constructed or renovated. According to the 1989 ISTI Report, a total of 92 public sector centers and Private and Para-Public centers are operational in the six regions.

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According to one USAID report, a total of 123 centers are operational. According to an April 5, 1991 report by USAID/Senegal/HPNO a total of 119 centers are operational. (The team was unable to resolve the different numbers.) In addition to the centers shown in Table 15, 29 centers are operational in the four other regions covered by the "Bien Etre Familial" project funded by UNFPA.

2. Equipment

Standard equipment provided by the Project upon request to public and PPPS clinics is listed in Table 16.

C. Summary of Major Findings and Conclusions

(Note: The evaluation team gave only minor attention to construction and equipment activities. The team had neither the staff time nor the specialized skill to complete such an evaluation. This evaluation, therefore, does not answer some important questions such as whether the Project provided the correct equipment or maintenance, repair and replacement of equipment, or whether projected levels of construction were sufficient to reach the CYP acceptor goals. To address these issues construction and equipment specialists should be part of the team that designs the new family planning project.)

Tables 17-21 summarize the physical status of the FHPP sites visited by evaluation team members. In addition to the information in these tables, on the physical condition of selected clinical sites, it is also noted that regional warehouses are for the most part small and unventilated. The Project-built warehouse at Kaolack is still not officially functioning because the contractor has failed to effect modifications demanded for providing adequate ventilation. The 1990 audit report indicates problems encountered in Project procedures in the area of competitive bidding and invitations to bid on renovations.

1. Physical premises

- Sixty-four percent of the waiting rooms in the public sector clinics may be considered inadequate because of:
  - Inadequate space for clients and health workers and insufficient seating for patients;
  - Limited space in waiting rooms or waiting areas; and
  - No seats at all in one center (Dominique).

Table 15: Growth of Family Planning Clinics 1985-1990: Number of Operational Centers by Geographical Area and Year

Public Sector	1985	1986	1987	1988	1989	1990
Dept Dakar	4	4	7	12	15	17
D. Pikine	1	1	4	7	9	13
D. Rufisque	1	1	1	5	6	6
Dakar Region	6	6	12	24	30	36
Fatick	1	1	2	5	5	5
Kaolack	2	3	7	10	12	12
Kolda	1	2	3	3	9	9
Thies	3	5	7	10	14	14
Ziguinchor	3	3	6	7	12	12
Total	16	20	37	59	82	88
VSPP	1	3	11	18	28	31
Grand Total	17	23	48	77	110	119

Source: USAID/Senegal/HPNO

Table 16: Standard Equipment for a Family Planning Clinic

Quantity	Purchased in the US
1	Adult Scale
1	Blood Pressure Gauge
1	Stethoscope
1	Timer
1	Baby Scale
1	Waste Can
2	Instrument Plate
2	Stainless Steel Container
	Syringes
	Gloves
	Pregnancy Test Kits
	Local Purchases
1	Supply Cabinet
1	File Cabinet
1	Desk
1	Examination Table
1	Stool
2	Chairs
2	Benches
	Consultation Forms
	Equipment Cart
	Registration Books
	Shelves
	Hanging Files
1	Couch
	Forms
	Pads

Table 17: Status of Premises in the Centers Visited

DAKAR

	MEDINA MCH	THIAROYE/MER	DOMINIQUE	ROI BAUDOIN	DANTEC
WAITING ROOM	- Cramped - Not enough benches in counseling room - Privacy more or less respected	- Premises renovated in 1988 - Cramped - Not enough benches	- No waiting room - Waiting patients must stand - Not enough benches	- Veranda only - Not enough benches - Counseling room exists	- Cramped
CONSULTATION ROOM	- 4 cubicles without lighting - 3/5 cubicles without water - Cubicles with curtain partitions - Samples - Walls are dirty	- Natural lighting - Running water	- Women's privacy not respected. Several people at the same time in one room - No running water	- Privacy respected but limited space. Pre-natal and FP visits in the same room - No sample for maintenance - Defective lighting - Running Water	- Cubicles - (not evaluated; not enough time)
REFERENCE DOCUMENT-ATION AVAILABILITY	- No	- A few brochures	- Some	- No	Not noticed
BUSINESS HOURS	- Daily 8AM - 12 Noon	- Morning and Afternoon	- Daily 8AM - 12 Noon	8AM - 12 Noon	8AM - 12 Noon

Table 18: Status of Premises in the Centers Visited

KAOLACK

	REGIONAL CENTER	KASNACK	KAFFRINE	ASBEF
WAITING ROOM	- Veranda doubles as waiting room - Not enough benches - No posters - Very cramped - Exposed to inclement weather - Counseling and reception room	- Veranda - Enough space - A few posters and visual aids - 1 counseling room - 1 reception room	- Veranda - Enough space - Counseling room	- 2 large waiting rooms - enough benches - 2 reception rooms
CONSULTATION ROOM	- 2 cubicles (large enough) - Posters and visual aids - Walls are dirty - 1 cubicle without lighting - Running water	- Privacy respected - Room large enough - Lighting sources - Running water	- Privacy respected - Adequate lighting	- 3 consulta-tion rooms - Privacy respected - 2 rooms without water - Lighting
REFERENCE DOCUMENTATION	None	None	None	(Time) None noticed
BUSINESS HOURS	Daily 8AM - 12 Noon	8AM - 12 Noon	8AM - 12 Noon	8AM - 4PM

Table 19: Status of Premises in the Centers Visited

THIES

	RANDOULENE	10 RIAOM	M'BOUR MCH	MALICOUNDA
WAITING ROOM	- 1 very narrow corridor - Not enough benches - No rest rooms - Counseling room (large reception area and file cabinets	- 1 waiting room doubles as counseling room - Not enough space	- Large enough - Enough benches - Benches - 1 counseling and reception room	- Veranda - Enough space
CONSULTATION ROOM	- Cramped - Sometimes 2 midwives consult simultaneously - Lighting - Running water	- Privacy respected - Lighting - Water	- Privacy respected - Lighting - Water	- Delivery room doubles as consultation room - Privacy
REFERENCE DOCUMENTATION	None	Available	None	None
BUSINESS HOURS	8AM - 12 Noon	Daily - Morning and Afternoon	3 days per week 8AM - 12 Noon	Morning and Afternoon

Table 20: Status of Equipment* in the Centers Visited

DAKAR

FINDINGS	MEDINA MCH	THIAROYE/ MER	DOMINIQU	ROI BAUDOIN	KASNACK	REGIONAL CENTER	KAFFRINE
Equipment	Insufficient	Sufficient		1 pair of scissors			Lacking speculum
Sterilization and equipment maintenance	Sterilization with flame	Time: 30 minutes	Sterilization with flame	*Poupinel* out of order Sterilization with flame	Sterilizer out of order Time: 30 minutes- 1 hour	Staff often unable to operate *Poupinel*	Pressure Time: 30 minutes Gloves & fingertips not sterilized

KAOLACK

THIES

	RANDOULENE	10 RIAOM	M'BOUR MCH	MALICOUNDA
Equipment	Insufficient	S Scissors are scarce	I Only 1 pair of scissors	S
Sterilization and equipment maintenance	*Poupinel* 20 minutes Temp. unknown	*Poupinel*	Sterilization with flame *Poupinel* Gloves not sterilized Time: 2 hours	Boiling: 1 hour Dust on scale and pan

* Equipment used for gynecological examination and IUD insertion.

S = Sufficient
I = Insufficient

Table 21 : Cost of Improvement and Renovation of Family Planning Clinics (FCFA)

Region de Dakar

1	Laboratoire de Bacteriologie de L'Hald	12,421,489
2	Case de l'Hôpital Abass Ndoa	1,235,988
3	Foyer du Village de Ngor	6,277,681
4	Foyer du Village de Malika	1,020,331
5	Institut d'Hygiene Sociale de Dakar IHS	10,952,443
6	Dispensaire Municipale de Ouakum	1,878,588
7	PMI de Thiaroye sur Mer	1,815,151
8	Maternité de Bargny	4,967,697
9	Maternité de Sebikhotane	2,094,713
10	CM Philippe Senghor Yoff	2,059,646
11	Bureau National du Recensement	3,107,130
12	Dispensaire N° 2 de Pikine Icotaf	4,078,566
13	Dispensaire Municipale 2 Av Pompidou	1,231,725
14	Dispensaire Nabil Choucair	1,621,740
15	Maternité de Guediawaye	3,003,985
16	Dispensaire de Grand Yoff	1,932,150
17	Bureau du Siège PSFP	126,430
18	Dispensaire de Thiaroye Gare	1,988,638
19	Dispensaire Touba Diacksao de Pikine	4,542,662
20	Maternité Harold Washington	680,797
21	Dispensaire Municipale Av Bourguiba	636,929
22	Centre PF Dispensaire de Ngor	620,476
23	Magasin PNA	2,767,964
24	Poste de Santé Arafat à Rufisque	697,000
25	Dispensaire Municipale N° 1 à Pikine	2,499,733
	Total	**74,259,652**

Table 21: (continued)

Region de Saint Louis

1	Dispensaire de Diamaguene	7,261,423
	Total	**7,261,423**

Region de Fatick

1	Maternité de Sokone	2,585,533
2	Local PF de Gossas	862,000
3	Maternité de Foundioune	3,945,544
	Total	**7,393,077**

Region de Kolda/Ziguinchor

1	Toill=ettes de Kande et Tenghory	1,932,172
2	Poste de Santé de Velingara	9,372,823
3	Poste de Santé de Oussouye	7,537,158
4	Collette Senghor	3,650,773
5	Plafonnage de Sedhiou	400,000
6	Poste de Santé de Gougomp	3,809,951
7	Centre PF de Thionck Essyl	9.734.176
8	Poste de Sante de Diouloulou	1,976,850
9	Maternité d'Adeane	4,140,167
10	Centre PF de Kandialang	9,840,570
11	Salle de Réunion CM Bignona	4,299,730
12	PMI Santhiaba	590.567
13	Région Medicale de Ziguinchor	6,079,167
14	PMI de Kounkane	5,781,013
15	Centre PF de Kolda	690,096
	Total	**69,835,213**

Table 21: (continued)

Region de Thies

1	Dispensaires de Tivaouane et Khombole	12,844,647
2	Dispensaire de Mboro	4,000,000
3	Maternité de Popenguine	12,708,220
4	Centre de Santé de Jaol	8,686,835
5	Magasin CM de Thies	937,700
6	Dispensaire de Kayar	4,662,220
7	Case de Santé de Hersent	659,960
8	Maternité de Mekhe	2,881,100
9	Poste CM de Pout	2,231,600
10	Centre de Santé de Tivaouane 1	5,518,930
11	CM Tivaouane 2	1,145,000
	Total	**56,288,212**

Region de Kaolack

1	Case-Foyer de Sara Ndiougary	6,842,721
2	Bureau Medecin-Chef CM de Kasnack	4,063,541
3	Dispensaire CM Kaffrine	6,863,108
4	CM Kasnack et PMI de Leona	13,109,246
5	CM Koungheul	1,418,435
6	Dispensaire de Gandiaye	8,363,641
7	Centre PF de Ndoffane	3,056,133
8	Maternité de Gandiaye	1,190,976
9	Dispensaire Medina Sabakh	10,457,132
	Total	**55,364,933**

- Thirty-six percent of the consultation and examination rooms may be considered inadequate because:

  - Patients' privacy is not respected (other patients and clinical staff walk freely into and out of the consultation rooms), and

  - Rooms are small, cramped and often used as storage.

- Public sector facilities are generally adequate but small renovations, such as enlarging facilities' space and improving visiting conditions are required at most facilities.

- Among Private and Para-Public Sector centers the physical facilities are in better condition and well maintained. This may be because they are part of private or parastatal organizations, such SOTRAC and PORT, which make funding available for improvement to physical facilities.

2. On equipment

- The equipment provided by the Project was technical equipment used for gynecological examination, IUD insertion, and some office furniture.

- While the number of consultations is increasing, insufficient equipment (speculums, scissors, forceps, gloves) is available in 67 percent of the centers.

- Equipment that is available in some centers is poorly maintained, i.e., broken with no facilities for making repairs, sterilization with flame.

- Basic sterilization procedures are not known or followed. Few of the staff in the centers visited (except for DANTEC and ASBEF) knew how to operate autoclaves.

D. Summary of Major Recommendations

- Address the condition of the physical facilities of the family planning service, including the buildings and equipment, under the items needing an increased level of supervision and inspection to improve the overall delivery of family planning services.

- Give priority to consolidating efforts to improve clinical services in existing family planning facilities over making expansions to the system. Provide sufficient budgetary resources to assure the success of the consolidation plan that is approved.

- Slow the rate of construction or renovation of new FP centers; instead, use funds to improve patient care, counseling, and to improve the contraceptive mix.

- Provide the centers with adequate equipment based on a complete physical inventory of available equipment and need. Train staff in operation and maintenance of the new equipment.

- Give increased attention to the availability, quality and use of family planning equipment. Develop a program that includes the carrying out of periodic equipment needs assessments, the preparation of standards and criteria on the number and type of equipment to be used, and develop protocols for the continued management and supervision of equipment use.

VIII. CONTRACEPTIVE LOGISTICS MANAGEMENT

A. Goals and Objectives

A principal goal of the Project is to provide safe, effective and adequate supplies of contraceptives so that 200,000 couples will be acceptors by the end of the Project. The objective of this Project activity is to help establish a logistics system which can deliver $2.7 million of commodities, and at least $1.5 million of contraceptives on time and where needed in the Project zone. The major outpost will be 100 trained logisticians and support staff who can maintain, handle, store, and deliver the planned commodity and contraceptive purchases. To evaluate Project effectiveness in meeting this objective, the evaluation team reviewed the operations of the major components of the Project's logistical system for purchase and distribution of contraceptives i.e., procurement of contraceptives; shipping and receiving; the distribution network; reporting and supply information; inventory systems; and utilization statistics.

B. Description

USAID/Senegal orders Project contraceptives through the A.I.D.'s Commodity Procurement Support Division (CPSD) by preparing a contraceptive requirements projection and ordering document called a Contraceptive Procurement Table (CPT). CPTs are prepared annually by USAID/Senegal. Since A.I.D. is restricted by law as to the types of contraceptives it can provide, donor coordination is necessary to analyze requirements and to arrange the most appropriate contraceptive method mix.

CPSD arranges air or sea shipments of contraceptives through MATRIX, its freight forwarder in the U.S. Sea deliveries require anywhere from two to twelve months; air freight is quicker. Shipments are tracked by the USAID/Supply Management Office (SMO) and the USAID/Health, Population, Nutrition (HPN) Division Project staff. Periodically, A.I.D. sends cables to all Missions, with the latest shipping and order status updates. Planning Logistics Management (PLM), an A.I.D. centrally-funded contractor which assists in logistics management, is contracted to send updated contraceptive shipping and financial statements (NEWVERNS) to Missions monthly. (USAID/Senegal indicated that it does not receive the NEWVERNS reports.)

USAID/Senegal/SMO is responsible for receiving and clearing contraceptives through Senegalese customs. SMO uses a local agent freight forwarding and customs clearance agent in Senegal (SOCOPAO) for this purpose. Once the contraceptives have cleared customs, the items are received by a local committee of ISTI, USAID and FHPP representatives. Contraceptives are received at the Project's central warehouse located at the National Pharmaceutical Supply Office (PNA) in Dakar.

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Contraceptives are transported from the central warehouse to the six Project regional warehouses using either a borrowed PNA truck or a Project pick-up vehicle. Due to a lack of transport capabilities at the regional level, clinics are often obliged to send someone to the regional warehouses to pick up their contraceptives. Management of commodities at the central warehouse is the joint responsibility of MCH and FHPP. The regional warehouses are under the control of the regional coordinators.

Project planning calls for the maintenance of a four months stock of contraceptives at the regional level, and a one month stock at the clinic level. Low and irregular stock levels, however, have resulted in periodic stock ruptures at different locations. More recently, due to improved projections of contraceptive requirements, the stock supply levels at the central warehouse have approached its planning level. Stocks at the regional and clinic levels are only adequate.

There is a printed inventory form on which to gather logistics information at the clinic and regional levels. Clinic level staff are supposed to complete the inventory forms on a monthly basis and submit the information to the regional coordinators. On a trimestrial basis, regional coordinators are to send regional inventory reports to the central level MCH coordinator, where the information is to be used for programming future contraceptive orders and deliveries. Reporting has not taken place as planned.

C. Analysis and Evaluation

1. Forecasting the need for and procurement of contraceptives

Contraceptive Procurement Tables (for 1989-91) were prepared for USAID/Senegal by a Center for Disease Control (CDC) consultant. In earlier years, contraceptive orders were prepared by a contractor, Family Planning International Association (FPIA). During 1990, an effort was made to involve personnel from FHPP, MCH, and donor agencies to help determine contraceptive requirements. Additional efforts are required by ISTI to train its own staff and those of MCH, FHPP, and USAID on techniques to prepare the annual CPTs, with an emphasis on involving all Project staff in the ordering process.

Additional training on how to analyze the impact of changes in the contraceptive method mix on the contraceptive ordering requirement would be helpful. This is an activity that CDC/FPLM consultants could undertake. Regional Coordinators and logisticians along with Project central level staff should be included in such training.

Currently, USAID and UNFPA dominate as Senegal's main contraceptive funders. Should either of these systems be disrupted, only the weak commercial sector remains as a safety net. In 1990, USAID and UNFPA agreed on a national contraceptive supply arrangement. USAID was to provide oral pills (Lo-Femenal and

Ovrette), condoms, IUDs and foaming tabs to all ten regions in Senegal. UNFPA was to supply injectables and standard-dose oral pills to the six regions in which the FHPP is located. This arrangement has yet to be implemented, with the exception of a few injectables made available to the FHPP Dakar region and 12,000 cycles of Lo-Femenal transferred by USAID to UNFPA.

It is important for USAID and UNFPA to act expeditiously on this contraceptive exchange. The lack of injectables, for example, in the six FHPP regions, will result in weakening the mix of contraceptives available to clients. The Project has recognized the need for donor coordination in preparing coherent contraceptive procurement plans. It has, therefore, organized a "Contraceptive Products Requirements Committee" to plan for 1990/91 requirements, as well as to assist the MPHSA in developing a five-year contraceptive requirements plan.

The GOS has proposed the creation of a new Family Planning Coordination Unit within the MPHSA structure. The new Unit would, inter alia, coordinate the flow of contraceptive orders by both the public and private sectors. The Unit should also address forecasting and procurement related problems such as:

- The present USAID/UNFPA contraceptive monopoly;
- Different forecasting methods used by different organizations;
- USAID's legal restrictions on the types of contraceptives it may provide;
- Intermittent national stock ruptures; and
- The World Bank's intention to provide 25 percent of Senegal's contraceptive requirements under its proposed new Project; and
- Inclusion of contraceptives on the official list of essential drugs (in order to avoid custom duties).

2. Budget

It has been difficult to obtain a firm picture of what the Project has obligated and disbursed for contraceptives. CPSD's contraceptive procurement system does not provide easily accessible financial data. The new Annual Operating Year Budget (OYB) transfer system and the Project's use of FPIA procured contraceptives, complicates the budget and financial management issue.

The original Project Agreement budgeted $1,668,000 for contraceptives. This was reduced to $1,425.000 in the First Amendment. As of March 31, 1991, the Project had earmarked $878,993 and disbursed $539,893. Data based on logistical

calculations, however, indicate that $524,528 worth of contraceptives have been delivered to the Project; $607,377 is in the pipeline for 1991/92 deliveries. An additional $325,000 to cover 1992 contraceptive requirements is already being programmed from the proposed new Population Project.

Contraceptive financial tracking is presently confined to USAID. One way for USAID to track the contraceptive budget is on a shipment-by-shipment basis. A tool which could be used by USAID/Senegal is the Family Planning International Association (FPLM) NEWVERN shipping and financial monthly statement which, as noted above, is not being received by the mission. Further efforts should be directed to including ISTI, MCH, and FHPP staff in the contraceptive forecasting, tracking, and budget monitoring system.

3. Shipping, receiving and warehousing

While the annual determination of contraceptive requirements rests mainly with ISTI, with some Project and MCH participation, the ordering, tracking, reception, and financial oversight of shipped contraceptives is primarily the responsibility of USAID/SMO.

Delivery can vary from two to over twelve months. A more efficient shipment tracking system needs to be devised by SMO and USAID Project staff. The key documents to be utilized are the periodic A.I.D. cables listing various shipping dates. These dates should be compared to the delivery schedules listed in USAID/Senegal's annual CPTs. Delivery dates as well as quantities to be shipped that diverge from those listed in the CPTs should be investigated by USAID. SMO may wish to request copies of the monthly FPLM/NEWVERN shipment chart as a basis to track shipments in the future.

In 1990, the Project took measures to centralize warehousing sites. This was largely in reaction to a critical A.I.D. audit conducted early in 1990. Before this action was taken, Project contraceptives were scattered among five Project warehouses throughout Dakar. Nevertheless, some problems still exist.

- There is a lack of inventory and bin cards at the central warehouse.
- There is no register of stock movements into or out of the central warehouse.
- A physical count of warehouse items is still incomplete. A recent count, for example, did not distinguish between Sultan Condoms and No-Logo Condoms.

- The Project storage area at PNA is inefficient. It is actually two separate warehouses with insufficient space to control or physically count the stocks, or to store the anticipated large contraceptive shipments scheduled during CY '91 and '92.

Although PNA has allocated space to the Project to store Project commodities, no protocols have been signed between PNA and the Project on the use of the space and management of the contraceptives. All PNA, FHPP, and MCH staff have keys permitting access to the storage sites, but it is not clear who controls the Project warehouses. Who, for example, is primarily responsible for correcting the deficiencies noted in this evaluation?

Because of the lack of Project competence in managing the contraceptives stock, and the Project's inability to correct the present difficulties at the warehouses, there has been some discussion about turning over control of the Project central warehouse and the stored contraceptives directly to PNA. One argument in favor of such an action emphasizes long-term institutional-building for PNA. Sooner or later, PNA will demand payment for both the warehouse space and the use of its trucks. If PNA were to manage Project commodities, they would request payment for this service as well. The budgetary impact of transfer of control and management of contraceptives to PNA must be considered carefully.

In the interim, the Project should adhere to the guidelines established in the new "Procedures Manual" naming the FHPP logistician as the sole person responsible for warehouse stocks. During the remaining period of the current Project, it is essential that acceptable inventory controls be instituted for the central and regional warehouses. At a minimum, inventory cards and a register recording stock movement should be introduced. The ISTI logistician should concentrate, during the next year, on providing logistics management training to the FHPP logistician. At the same time, PNA might be able to use its own staff to provide on-the-job training for Project staff.

4. The distribution network

a. Contraceptives

Five types of contraceptives are currently being distributed to over 100 service delivery points in Senegal. In April 1991, there were sufficient contraceptive stocks at the regional and central levels to meet only immediate needs. There are bottlenecks throughout the distribution network which need attention. For example, due in part to the largely non-functional logistics supply information system, central level staff make decisions on when and what contraceptive quantities are to be delivered to the regions without knowing what stocks exist at each of the locations. Major contraceptive deliveries are implemented at the direction of the MCH logistician without the benefit of stock information emanating from the regions. This is a top

down "push" system of contraceptives distribution. Before this point in the process, planning and budgeting were the responsibility of ISTI and USAID. At this point, the MCH assumes control over the distribution system.

Regional coordinators participate in a "pull" system of contraceptive distribution by requesting contraceptives re-supply through unscheduled orders to the NH/MCH National Coordinator. The National Coordinator, in turn, relays the request to the MCH logistician. The logistician obtains the approval of the MCH National Director before any action can be taken. Because of this cumbersome MCH procedure, orders and deliveries are often delayed at this key point in the distribution system. There are also delays because there is only one MCH staff member to handle Project distribution as well as other MCH commodity requests.

ISTI oversees the general process but FHPP staff are not significantly involved in the re-supply system. The FHPP logistician acts as a clerk processing requests issued by the MCH logistician. MCH has control over the movements of contraceptives, with the roles of FHPP and ISTI not clearly defined.

This has been a generally unresponsive distribution network highlighted by intermittent stock outages. The principle of security and working stocks is not clearly understood by MCH staff. Because of the lack of a functioning logistics supply information system, the central level often overstocks or understocks the regional levels. The distributions system has not achieved the aim to provide predetermined working and security stock amounts at the regions warehouses or at the clinic level.

MCH, FHPP and ISTI must establish a more coherent distribution system. The underlying principle should be to treat the central depot as a transit point in the system. Greater amounts of contraceptives should be provided to the regions and the clinic sites. This strategy fits with MPHSA's new decentralization policy and will help avoid the current supply bottlenecks at MCH and reduce the chances of stock ruptures.

The Project should reach the following stock levels as quickly as possible:

Central Level:	12 months security stock
Regional Level:	6 months stock, of which 4 months = working stock 2 months = security stock
Clinic Level:	3 months stock, of which 2 months = working stock 1 month = security stock

One way of overcoming the difficulties of an uncertain "push" situation and irregular "pull" system of distribution is for MCH to schedule periodic deliveries of commodities, four trips per year to "top-off" regional inventories. Distribution of contraceptives from the regional to the clinic levels should also be more flexible. This could be accomplished by a mixture of methods: clinical staff could schedule trips to the regions for re-supply and regional supervisors could schedule supervisory visits to clinics at which time commodities could also be delivered.

Lack of Project vehicles and fuel are widely stated as reasons for the supervision and distribution breakdown at the regional and clinic levels. A resolution must be forthcoming. The new USAID health and family planning project must assure a regional capacity to conduct this supervision and to transport commodities. While the present project may be able to continue to depend on PNA trucks or a light Project vehicle, this does not provide a long term, solid base on which to guarantee a set schedule of deliveries to the regions. Consideration should be given to purchasing a Project vehicle for the upcoming project, specifically to handle contraceptive distribution.

b. Medicines

The Project originally purchased medicines and pharmaceutical products. Midway through the project, the MCH National Director decided to discontinue this activity as a Project cost. He preferred that the clinics purchase these items on the local market from receipts generated from clinic clients. In general, this procedure was not implemented which left many clinics without needed medicines. This is an issue to be considered in the new health and family planning project.

c. Laboratory equipment

The Project assisted STD (Sexually Transmitted Disease) activities by purchasing a one-year supply of laboratory equipment and supplies (Annex G-1) for two national and ten regional labs. Technical assistance was provided by an ISTI consultant to start up the laboratories.

STD activities, however, do not fall under the direction of MCH and received little attention from the Project. Most of the suggestions provided by the ISTI consultant remain to be implemented. Much of the equipment and supplies remained in the Project warehouse since 1989. They are now being delivered to the laboratories, mainly in response to a 1990 A.I.D. audit. It remains unclear whether the Project should continue to provide supplies beyond the one-year supply currently in the central warehouse.

5. Reporting, management information, and inventory systems

The management information system established for the Project begins with a printed inventory form (Annex G-2), to be filled out at the clinical and regional levels. The data on the form, if properly collected, tabulated, and analyzed, could provide sufficient logistical commodity data for re-supply and other Project decisions. As already noted, the reporting system has not worked as planned. Many clinical staff do not complete the forms. Some regional coordinators forward the forms to Dakar; others file the reports at the regional offices. The MCH logistical person may or may not receive the inventory forms. The inventory forms that eventually reach Dakar are not always exploited or distributed by the MCH National Coordinator. What might have provided a credible basis for a "pull" system of inventory management has never gotten off the ground.

It is highly recommended that the Project request FPLM to introduce its LMIS (Logistics Management Information System), to replace the current, non-functioning inventory/ordering system. The FPLM LMIS is a simplified reporting system that combines, on the same form, both client service statistics and contraceptive inventory information. FPLM, an A.I.D. centrally-funded Project, should come to Senegal to train Project staff in the use of the LMIS.

Currently, when clinics or regions require supplies, they write their requirements on a piece of paper and send it forward. They neither keep a copy of their order nor create an ordering or inventory paper trail. The new "Procedures Manual" should be revised to include a commodities/contraceptives order form.

At the clinic level, and to a lesser degree, at the six regional levels, inventory control systems are deficient. Inventory cards with a stock register must be introduced to permit correct inventory management. The new system should allow for an increase of stock at the clinical level to the proposed three months of security/working stocks. FPLM has an excellent daily client service statistic registrar format, that also records inventory data, which is a part of their LMIS package.

The current logistic information system is so inadequate that ISTI is obliged to visit annually each region to collect service statistics data and contraceptive inventory stock balances. ISTI needs this information to prepare the CPTs. A joint FHPP/MCH/ISTI/USAID team is beginning to undertake clinic-by-clinic visits to ascertain exact inventories.

MPHSA provided technical assistance to the FHPP by introducing two computerized programs to track contraceptives and other Project inventories. The two FHPP staff trained by MPHSA have left the Project and the systems are no longer operational. The disks containing the programs, however, have been located and an operations manual still is available. It may be valuable to train the MCH and FHPP logisticians on how to operate these programs. This activity should be implemented

during the remaining life of the ongoing Project. The computerizing of contraceptive logistical data would be an ideal add-on to the proposed introduction of the FPLM LMIS.

The Project should prepare a logistics supervisory protocol based on the logistics questionnaire attached to this report. This protocol would give central and regional supervisors a checklist of logistic issues to be covered during their site visits, as well as provide a basis of performance review and feedback.

6. Contraceptive consumption statistics

The evaluation team attempted to compile logistics-based data in order to calculate Project totals for CYPs and users, and to compare these figures with those generated by ISTI and USAID (see Table 22). Logistics data were compiled from the actual contraceptives received, stock-on-hand, and quantities distributed. The ISTI data were collected from a variety of ISTI statistics. The draft ISTI 1990 Annual Report did not include statistics for the regions of Kolda and Ziguinchor. To adjust for this gap, USAID adds 5,471 for the two regions (see Tables 23 and 24).

Comprehensive data could not be collected because of the many gaps in the information, uncertainty as to its completeness, and knowledge of inaccuracies in the Project's data collection system. The evaluation team spent an inordinate amount of time searching for and attempting to verify inconsistent data. A number of team meetings were held in an attempt to agree on appropriate numbers to be used in the evaluation report. A key recommendation is for the Project to introduce a new logistics information system and a new unit in MPHSA to collect population service statistics. A brief analysis of commodity numbers follows.

a. Condoms

- There is a problem in clinic-level recording of condoms distributed. During 1990, one ISTI report listed 159,961 condoms distributed, while regional coordinators stated 255,731 as having been distributed. Another ISTI report lists 763,200 condoms distributed in 1990.

- All Project regions, except for Dakar, currently have over twelve months of condoms stocks. There are some 2,384,000 Project condoms stored in central and regional warehouses with 1,998,000 more due in 1991 and 1,550,000 in 1992.

- Project logisticians might consider reducing the pending shipments since warehousing that many condoms could put a strain on existing warehouse space.

Table 22: Logistics Based Data of Acceptors

Items	Quantity Distributed	Estimated Users	Use Impact C Y P
Condoms	3,027,100	30,271	30,271
IUDs	24,420	24,420	61,050
Orals (Lo-Femenal)	554,300	42,638	42,638
Orals (Ovrette)	24,800	1,907	1,907
Foaming Tablets	35,200	352	352
TOTALS		99,588	136,218

(NOTE: This Table, covering activities through April 1991, does not take into account contraceptive losses, client dropouts, or expired items. The figures assume that all contraceptive quantities distributed were fully utilized).

Table 23: ISTI Draft 1990 Annual Report of Contraceptive Use (Public and PPPS Sectors)

Items	Quantity Distributed	Estimated Users	Use Impact C Y P
Condoms	229,771	2,296	2,296
IUDs	18,455	18,455	46,137
Orals	-	11,570	11,570
TOTALS		32,321	60,003

(NOTE: To the 32,321 users in 1990, should be added approximately 5,471 users in Kolda and Ziguinchor. The CYP figure of 60,003 (after adjustments for Kolda and Ziguinchor), compares with 69,700 CYP in the ISTI 1990 annual report. However, the 1990 report also states, "70,000 women are participating in the program, using modern methods." This is double the 32,321 users mentioned in the same report. The Project Paper projects a total of 952,000 CYP for 200,000 users by the end of 1992 (Annex B). ISTI includes 1,329,000 CYPs for the 1988, 1989, 1990 period. One reason for the difference may be that ISTI calculates CYP based on CPT Projections. CYP is calculated using either program service statistics, population-based prevalence data, or calculations based on logistic data.)

Table 24: ISTI Data on Commodities Distributed

Items	Distributed 11/87-11/88	Distributed 1/88-6/89	Distributed 1990	TOTAL
Condoms	1,700,000	890,000	763,200	3,353,000
Orals	217,800	282,000	172,800	672,600
IUDs	16,000	18,900	6,433	41,333
Foaming Tabs	-	-	28,000	28,000

(NOTE: These ISTI data conflict with the quantities received by the Project. Divergencies might result from using unrecorded contraceptives remaining from the first USAID Project, borrowed FPIA stocks, or the validity of the statistics in the various ISTI documents. The data do not seem to agree with the ISTI 1990 report which lists 229,771 condoms distributed vs. the 763,200 listed above.)

o A summary of condoms received and to be received shows:

Received:	660,000	1985	Scheduled:	600,000	5/91
	756,000	1987		1,398,000	10/91
	1,998,000	1989		950,000	3/92
	600,000	1990		600,000	11/92

b. IUDs

o The Project received 24,420 IUDs; ISTI lists 41,333 as having been distributed. It is unclear where the "extra" IUDs were obtained.

o Four regional stock balances are very low. Approximately 10,147 IUD's are required at each region. There are 13,280 IUDs at the central warehouse with 27,000 scheduled for delivery in 1991.

o Thies regional inventory records show 3,420 IUDs distributed during the period 10/90 - 4/91; ISTI lists 3,186 IUD's distributed during CY 1990.

o A summary of IUDs received and to be received shows:

Received:	15,000	1989	Scheduled:	12,000	4/91
	3,000	1989		15,000	10/91
	6,000	1990		17,900	2/92
	16,000	4/91		28,000	6/92
				30,0001	2/92

c. Orals

o The Dakar region requires a re-supply of 114,800 cycles to have a twelve month stock. Dakar inventory records show 8,130 clients in 1990; ISTI lists 5.159 for the same period. There are 213,600 cycles in the central warehouse.

o The 495,000 cycles ordered for 1991 delivery and the 503.000 cycles for 1992 shipment seems excessive.

o Ovrette has been oversupplied to Fatick, Kaolack and Kolda regions, while Dakar and Thies are low in Ovrette stocks.

o A summary of pills received and to be received shows:

Lo - Femenal

Received:	364,400	1985	Scheduled:	240,000	6/91
	164,400	1989		255,000	10/91
	178,800	1990		253,900	6/92
	294,000	1/91		250,000	12/92

Ovrette

Received:	69,600	Prior	Scheduled:	60,000	3/91
	1,200	1987		63,000	7/91
	20,400	1990		16,900	2/92
	46,800	1/91		80,000	7/92
				90,000	12/92

d. Foaming tabs

o A summary of foaming tabs received and to be received is:

Received:	28,800	7/90	Scheduled:	163,200	1/91
	48,000	2/91		48,000	7/91
				100,000	10/91
	16,000	4/91		104,000	11/92

D. Summary of Major Findings and Conclusions

o In April 1991, there were generally sufficient contraceptive stocks at the central and regional levels. Periodic "stock outs" of selected contraceptives, however, were reported at all the family planning clinics visited by the team. In addition, there were reports of over or under supply of particular contraceptives. In the early years of the Project, "stock outs" were a result of overall stock shortages. More recently, supply problems result from weaknesses in the distribution system.

o Following the GOS and donor effort to coordinate contraceptive inputs, the Project has recognized the need for increased coordination in the preparation of the annual contraceptive procurement tables by forming a "Contraceptives Products Requirements Committee" among the donors. The system of coordination among donors, principally A.I.D. and UNFPA, however, does not yet work.

o Poor control of inventories exists at both the central (Dakar) and clinical levels. No clear control exists over the Project's central warehouse. No inventory cards or stock register books exist at the PNA warehouse or clinical sites. Regional and clinical methods for inventory controls vary considerably.

- The present logistic management information system does not produce the data and reports necessary to manage the logistic system. The established MPHSA and Project data collection system does not function as it should. ISTI has had to make special annual visits to the regions to collect contraceptive inventory data in order to plan and prepare annual contraceptive purchase orders.

- Data inconsistencies exist throughout the contraceptive logistic management information system. There is often a conflict on numbers of acceptors between logistics-based data and clinic-based reports. The Project, for example, has reported receiving 24,420 IUDs; but ISTI reports indicate 41,333 as being distributed.

- The system for tracking the purchase, shipment, delivery, and storage of contraceptives is weak. Since commodities are purchased under A.I.D.'s worldwide contraceptive procurement system, it is difficult to obtain firm financial data on disbursements for Project contraceptives.

- Lack of Project vehicles and fuel at the regional levels are often cited as the reasons for delay in the delivery of contraceptives to the clinic sites.

- Logistic staff have not been sufficiently trained in many basic concepts of logistics management such as first-in first-out, secure verses working stocks, push verses pull, as the guidelines to provision of stock.

E. Summary of Major Recommendations

- Introduce a logistics management information system and increase contraceptive stocks at the regional warehouses and clinics to a level that better approximates working needs and reasonable security stock to reduce periodic stock ruptures.

- Commission FPLM to develop and introduce a logistics management system for the Project.

- Stock contraceptive supplies at the following levels: central level, 12 months; regional level, 6 months; clinic level, 3 months.

- Implement the contraceptive commodity exchange agreement between USAID and UNFPA to allow a more complete mix of contraceptives, including injectibles and standard-dose oral pills to be used by the NFPP.

- Devise a more efficient shipment tracking system for contraceptives needs. Assure its use by SMO and USAID Project staff and broader dissemination of its information to MCH and FHPP staff.

- Designate the FHPP logistician as the person responsible for managing the Project central warehouse.

- Assure that the central and regional financial, logistic, and staff capacity exists for USAID to conduct supervisory visits and to transport contraceptives.

- Develop an internal order form, perhaps as part of the new Procedures Manual, whereby clinics, regional headquarters and warehouses, and central offices and warehouses use the same procedures and documentation to order and account for commodities and contraceptives.

- Devise a logistics supervisory protocol as a checklist for central and regional supervisors. (See Annex C as a guide for the preparation of such a protocol.)

- Reduce the quantities of condoms scheduled for 1991/1992 delivery and consider airfreighting a part of the IUDs scheduled for 1991 delivery.

- Make operational the computerized contraceptive and inventory program installed at PDFP by MSH. Train the MCH and FHPP logisticians to use the program.

- MPHSA, Project management, USAID and ISTI should organize a professional formal assessment of the needs for trained staff in management of the contraceptive procurement system and develop an organized, long-term, training program to help implement the above recommendations. Training should be provided in at least the following:

  - How to prepare CPTs and procure contraceptives;

  - Contraceptive forecasting techniques;

  - Collection, analysis and use of contraceptive supply data;

  - Correct logistics management procedures, including warehousing, storage, and transportation; and

  - Use of the computerized contraceptive and inventory information program.

IX. WOMEN IN DEVELOPMENT PROJECTS

A. Goals and Objectives

Women (WID) in Development sub-projects, financed under the Family Health and Population Project, were designed to help women through assistance to women's self-help organizations. The goal of these sub-projects, as stated in the Project Agreement, is to help integrate women into the rural development process, and at the same time to expose then to the beneficial effects of improved family planning and maternal and child health.

An additional objective, stated by Family Health and Population Project personnel, is to generate additional revenue to provide a stipend to village volunteer family planning workers (described in detail in the IEC chapter of this report). Such village volunteers currently receive no remuneration. Many observers of the family planning program in Senegal feel that the potential performance and impact of village volunteers has been limited by this lack of financial incentive. While commercial incentives, such as commission on contraceptive sales, have also been proposed as solutions to this problem (see both IEC and Social Marketing sections), community-generated stipends represent a legitimate alternative, particularly since the organizational framework in which the village volunteer works is the same structure in which the proposed WID projects are to operate--the groupements feminins.

B. Description

This Project component, funded at an initial level of $375,000, but later reduced to $350,000, was to include 62 sub-projects, carried out at the level of local women's groups, or groupements feminins, in all of the six Project regions. The maximum grant for each project was to be $7,500. The projects were to include garden projects, small livestock, community poultry-raising, small-scale craft activities, and information and educational activities promoting family planning and family well-being. Institutional organization, management, and financial control were to be significant features of the projects. Project inputs were to be financial and technical support to these projects.

Only four projects of the proposed 62 have been undertaken--all in the Region of Thies. According to USAID officials familiar with Project history, there was considerable dispute over the selection of the village groups, and concern over the disposition of funds provided to them. As a result, financial assistance was stopped, and no further projects were undertaken.

At the same time, discussions were held with the Ministry of Social Development to find a more suitable project framework. Both USAID and

Government of Senegal personnel agreed that a loan rather than a grant system would encourage financial responsibility and improve sub-project performance. To this end a detailed study by was commissioned by USAID to determine the feasibility of such credit schemes. See Sections D and E, below, for the results of that study.

C. Evaluation

1. Major issues and questions

a. Relevance of small scale sub-projects

Are small-scale local development schemes, such as those proposed by the Project, closely enough linked with the basic objectives of the Family Health and Population Project, to justify their continued existence within it, particularly given the many problems experienced and anticipated by the Consultant? Given that, in principle, all groupements feminins are to be served by village volunteers in their family planning IEC efforts, is this not sufficient to meet the objective of the Project Document: to expose women to messages about family planning?

b. Impact on village volunteers

If such schemes are acceptable and accepted, should they have a specific condition requiring them to financially support the family planning village volunteer?

c. Administrative link to FHPP

If the WID sub-projects do continue, but they are managed outside the Project structure (i.e. the subject of a separate project or included in another project, such as agriculture or rural development), can a family planning link be reasonably made?

d. Priority use of Project resources

In view of the above concerns and issues, and since all the funds budgeted for WID activities have not been earmarked, how can USAID justify adding an additional $155,000 in the proposed Project amendment?

2. Overall gender considerations

The new GOS National Family Planning Program (NFPP) and the present FHPP are almost exclusively directed towards women. While this is a natural and positive development, it has meant the temporary exclusion of men from the

family planning process. Men need to be involved for obvious reasons: first, they are important, if not the principal decision-makers in Senegalese families. Second, many, if not most, policy-makers in the country are men. Third, many men are in polygamous marriages and, therefore, responsible for paternity in more than one conjugal union; and fourth, the incidence and persistence of STDs and the unsettling increase of AIDS requires male action for protection, primarily through the condom.

The reasons for this primary Project focus on women and a secondary focus on men are largely related to the delivery of MCH services in the country. It is mainly, if not exclusively, women who bring their children to health clinics. Children account for the major number of health center visits. As a result of this tendency, family planning programs have understandably followed suit. They supply primarily female contraceptives and provide female family planning services.

To increase male family planning acceptors at Health Centers will not be an easy task. Family planning workers are overwhelmingly female; and men, unused to coming to health centers in any case, might be reluctant to ask for condoms from female employees. Experience in other countries has shown (see Population Reports, CSM edition, cited in Chapter XI) that men will travel far to purchase condoms either in pharmacies or from small retailers.

IEC mass media and educational materials programs have also been very women-oriented in their presentation and tone. Men are portrayed in family groups, but are rarely the subject of direct address (except for STDs).

Interpersonal education programs are similarly directed towards women. Most, if not all community volunteers are women, and the primary group covered for social action by these volunteers is the Groupement Feminin. The men reached by family planning outreach staff are usually young boys active in sports or other extracurricular activities. The Project has not been very active in this regard, but other projects, such as UNICOM (Ministry of Finance, Economics, and Planning with financial and technical support from UNFPA) have made an attempt to promote these activities. In other countries, all male military conscripts are given an orientation in family planning.

Since most family planning programs are directed primarily towards women, WID projects which attempt to increase the contact women have with family planning information, will probably have marginal results. They should be developed in their own right--that is, if sufficient economic and/or social justification can be made for them--but should not be considered primarily as ways to increase family planning exposure.

As Barbara Pillsbury has observed (see citation in Chapter 8), a number of changes favorable to the status of women and encouraging to family planning, have

been made in Senegal. Official law guarantees equality of women and equal pay for equal work. The 1972 Family Code assures a more equitable divorce settlement for women and child support and increases the minimum age of marriage for women to 16 (20 for men).

In 1985, Senegal ratified the International Convention for the Elimination of All Forms of Discrimination Against Women. However, some traditions and practices which tend to slow the effect of these positive factors persist. According to Pillsbury [25]: "Ethnic and religious traditions limit women's access to land, capital, and technology." The same 1972 Family Code which grants many women's rights also acknowledges the husband's right to forbid his wife to work outside the home. Laws limit the rights of women to their deceased husbands' wealth. Women still have little access to credit. Women are considered responsible for the health and care of their children and themselves and are often required to pay for this care out of their own resources. Female literacy is low--only an estimated 25 percent.

According to Pillsbury, anecdotal evidence shows that high rates of voluntary abortion exist in Senegal. If this evidence is corroborated by more rigorous investigation, it will cast doubts on the high number of desired children reported by women.

Improvement in these areas will clearly be of benefit to women generally and will increase the likelihood of their access to family planning services and facilities.

D. Summary of Major Findings and Conclusions

As noted, the team has not evaluated this WID Project component. A 1989 study presented a number of findings on the subject of credit. While this is only issue associated with WID activities, his findings may be useful to repeat here.

- Credit should not be a gift to women entrepreneur, but an incentive to help generate additional revenues for community volunteers. Few of the 62 WID projects envisioned under the original Grant Agreement would meet minimum credit criteria.

- The Government agency responsible for management of village-level development projects does not seem to be prepared to provide the management and staff resources to administer the WID sub-projects.

[25]. Pillsbury, B. Socio-Cultural Factors Influencing the Delivery and Use of Health and Family Planning Services in Senegal, USAID, Dakar, August 1990, p.12

- FHPP is not equipped to deal with the kind of institutional requisites necessary to manage the women's sub-projects certainly if they were as complicated as a full-scale, small enterprise, credit programs.

- These women's activities seem to be marginal to the central clinical thrust of the present family planning Project.

E. Summary of Major Recommendations

- Subject projects to rigorous technical and economic appraisal before funding them. Credit projects, for example, should be ranked according to potential profitability before selection and inclusion in the program.

- Install rigorous financial and management procedures before the disbursement of funds begins. Such procedures include the establishment Capital Replacement Accounts and Maintenance and Repair Accounts, establishment of clear disbursement procedures, etc.

- Organize a conference on small-scale and rural credit for organizations currently working with small-scale projects in Senegal in order to share with the Government of Senegal and Project officials prior local development experience.

- Hire specialized technical staff to run the component, or shift the funds to another GOS agency or to a PVO specially staffed to carry out such activities.

X. FAMILY PLANNING SERVICE STATISTICS, RESEARCH AND EVALUATION

A. Availability of Family Planning Service Statistics and Operational Information

Reliable clinical data on family planning services are needed to evaluate the progress of the family planning program and to determine clinical needs in terms of staff training, client counselling, contraceptive supplies, medical equipment and other logistical support. In principle, the Project data collection system is quite simple and should provide the necessary information. Family planning data is supposed to be collected at the clinics and reported on a monthly basis to the regional offices. The regional offices are then supposed to report these data to the national office at the MCH in Dakar on a quarterly basis. MCH is supposed to analyze and use the data to help manage the Project.

During the course of the evaluation a number of problems were identified in the system for collecting, analyzing and using, family planning service statistics at the clinical and operational levels of the Project, and in the availability of accurate, reliable, and timely data and information to fully understand and manage the Project. The Project Agreement and Logframe do not contain a separate component for improvement of the system for collection of population service statistics, and the scope of work for this evaluation does not request the team to look into the matter. However, it is so obviously a pressing concern that the team has elected to add a Chapter on the subject.

The problems include:

- Shortcomings in the training of health workers in data collection and reporting;
- Lack of management and supervision of data collection, reporting and analysis activities;
- Poor data quality and missing information on many key variables on the basic consultation forms that are filled out at the family planning clinics;
- Unavailability of consultation forms in some clinics;
- Wide variations in the organization of the recording and filing systems at the public and private sector clinic;

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- Incomplete coverage of clients visiting clinics;

- Incomplete or late reporting by clinics to the regional offices and regional coordinators;

- Misunderstanding of Project terms such as "active", "inactive", and "new acceptors" on the part of family planning workers;

- Problems in the complete and timely transmission of clinic data by the regional to the national MCH offices and national family planning coordinators;

- The lack of exploitation and diffusion of family planning clinical and operational data by the Project and MCH;

- Lack of understanding by family planning workers who fill out the clinic consultation forms of the importance and utility of the data collected--for themselves, for the family planning system, or for their clients;

- Omission by the national office of data from some project clinics in the region or from some regions in the various summary analyses;

- Lack of computers to process or analyze the data in the national office which receives the data from the regions; and

- Inadequate training of MCH or Project staff to analyze these data.

(Note: According to Madame Ba Oury, National Family Planning Coordinator, MCH/Medina was visited by the Institut du Sahel and offered a micro-computer and training for establishing a computerized management information system for family planning data. Madame Ba Oury expressed an interest, but was told by USAID/Senegal that the Institute's assistance would not be necessary because the entire MCH (not just family planning) was going to receive micro-computers and training. The Project office has a micro-computer which could possibly be used to process the clinic data. However, the logistician and accountant currently working for the Project do not have computer training and the micro-computer is sitting unused.)

As a result of the above cited problems, ISTI has assumed responsibility for directly collecting annual statistics from the family planning centers. ISTI does this by visiting the regional offices and centers in January and February each year to obtain end of the year statistics. These data are published in various forms and tables in the Project Annual Report currently prepared by ISTI.

While the ISTI field visits each January and February produce the most complete picture of annual statistics available, this is a costly and time-consuming process and only demonstrates the fact the family planning data collection system is not functioning as it was originally intended. (In 1990 the regions of Kolda and Ziguinchor were not visited by ISTI, nor did these regions report data to the national MCH office.) The role of ISTI is to provide technical assistance to the project to ensure that the project functions properly, not to do the work that should be carried out by clinic and Project personnel, regional coordinators, and staff at the national office of the project.

B. Summary of Statistical and Information Problems Found in Evaluating Other Substantive Project Components

Lack of reliable and consistent data, information and statistics not only make it difficult for USAID, GOS and FHPP personnel to manage the Project, but also made it difficult for the evaluation team to determine whether the project had met its quantitative or qualitative goals. A summary of the findings in the substantive Chapters relating to data and information, include the following.

- The accuracy and timeliness of the collection of family planning data at the clinical level have uncertain reliability and do not provide the basis to judge the quantity or quality of impact of the Project. (Chapter IV).

- Collection of reliable clinical data is subject to technical and management limitations. (Chapter IV).

- More technical assistance should have been provided to the FHPP to improve the reporting, data processing, analysis, and evaluation of the family planning data collected at the family planning clinics. (Chapter IV).

- Few reliable figures exist on the incidence of STD cases and treatment over the Project period. (Chapter V).

- The logistical management information system does not produce the data and reports necessary to manage the logistical system. (Chapter VIII).

- Data inconsistencies exist throughout the contraceptive logistic management information system. There is often a conflict on numbers of acceptors between logistics based data and clinic based reports. (Chapter VIII).

- Data are not exchanged among project components. (Chapter XII).

- Most research is heavily academic and insufficiently related to operational project needs. (Chapter VI).

- No pre- and periodic post-campaign audience evaluations were carried out. Such evaluations would have permitted an analysis of the appropriateness of mass and other educational media. No performance evaluations were carried out on personnel trained by the Project. Project staff were unable to accurately assess the success of their efforts. (IEC Chapter III).

C. Creation of a New Family Planning Statistics, Research and Evaluation Unit

To resolve the situation described above, the evaluation team proposes the establishment of a Family Planning Statistics, Research, and Evaluation Unit (FPSRE) within MPHSA's new National Family Planning Program, to be funded and supported by the USAID Project. Design of the new FPRSE should be included as part of the scope of work for the design of the next phase of the project.

The Family Planning Statistics, Research and Evaluation Unit should be responsible for guiding the collection of relevant data, processing data and information, conducting program-oriented operations research, evaluations, and analysis, report preparation and presentation, and diffusion of the clinical data on family planning. The FPSRE Unit staff would need competent family planning research, evaluation, design and methodology experts, data processing and statistical analysts, and sufficient availability of micro-computers to carry out in-depth and timely analysis.

Project funds should be available for the analysis, publication and dissemination of the family planning data. A standard data collection and reporting procedure should be established, with a manual of procedures available at each clinic. The FPSRE Unit would develop of indicators to measure progress in service delivery, prevalence, problems (side effects, discontinuation), and quality of care. Cost-effectiveness and cost-recovery studies should be initiated on client/user satisfaction, contraceptive discontinuation, and quality of care during the next phase of the project. Management information system and administrative and accounting procedures in the clinic should be standardized as much as possible. Studies of all aspects of clinic operations should be carried out as part of the family planning information system.

High quality family planning service statistics should be given a much higher priority than in the present project. Logistics statistical information on contraceptive and medical supplies could be included in the same family planning information system for analysis at the national level on microcomputer.

An alternative to the formal creation of a new information unit in MPHSA would be for the Project to hire a number of individual specialists to collect and analyze Project statistical data and to prepare studies and carry out evaluations on the basis of the data collected. This was a suggestion by BNR which is somewhat concerned with possible overlap of the new unit with BNR's own efforts.

BNR's concern is something for the new Project designers to consider. But instead of seeing BNR and FPSRE in competition with one another, these two organizations should be seen as complementary and supporting. While BNR is more concerned with macro level demographic data. FPSRE is concerned with micro level, operational data on individual client and clinic activity. BNR can assist FPSRE to design research and evaluation surveys and questionnaires and analyzing data, while FPSRE would be the inside unit bringing the results of BNRs policy level statistics to the attention of MPHSA policy makers.

For a successful family planning statistics and information system, technical assistance support would be necessary in the following areas:

- Techniques for development of an efficient data collection system;
- Motivation and incentives to family planning workers for collecting complete and accurate information and annual awards for quality of service statistics;
- Regional seminars on uses of data collected for the midwives, other family planning workers, Project and Ministry personnel;
- Regular and continuous training and monitoring in data collection;
- Periodic training seminars and workshops for midwives, doctors and regional coordinators in data collection, analysis and reporting; and
- More supervision, management, and monitoring of the entire system.

D. Summary of Major Recommendations

1. General recommendation

- Establish a Family Planning Statistics, Research and Evaluation Unit (FRSRE) in the new GOS NFPP and give this system a high priority in the future family planning Project.

2. Detailed recommendations

In the remaining months of the Project, emphasis should be placed on supervising the collection of clinical data and ensuring that it is reported to the regional and national level on a timely basis. Over the early years of the new project, the following action should be taken.

- Improve the collection of management oriented family planning data and information.

- Collect and process data and carry out analysis of family planning program statistics, and assure feedback to service monitors.

- Organize periodic training of clinic and other family planning systems staff in data collection and analysis.

- Improve supervision of data collection in family planning clinics.

- Consider incorporating the Project's operational research activities into the newly created FPSRE unit.

- Conduct program evaluation studies suggested in the logframe, as operation research, such as studies of quality of care and health issues related to contraceptive use.

- Place family planning technical assistance consultants directly under the responsibility of the FPRSE to meet the needs of the research program and to assist in training and institution building of this specialized activity.

- Publish and disseminate existing demographic survey data and family planning clinic data.

- Coordinate with BNR and other statistical units in the GOS on the collection and analysis of selected data.

- Develop ways to motivate midwives to collect complete and accurate data (e.g., show them results for their respective clinics and explain the purpose and uses of the data collected; offer annual awards to selected clinics for quality service statistics (according to pre-specified criteria for determining high quality, e.g., timeliness, completeness of forms.)

- Encourage FPSRE Unit to take advantage of the expertise available through USAID-supported organizations involved in family planning program research and evaluation. These organizations could provide technical assistance for research and training to the Unit, including the development of a long term research program and assistance in the execution of studies. These organizations include:

  - Population Council/Dakar for Operations Research in Family Planning, Management Information Systems, Quality of Care Research;

  - Family Health International for Clinical Studies, Program Evaluation, and Family Planning Service Statistics Data Collection and Analysis;

  - Center for Population and Family Health, Columbia University for Family Planning/MCH Operations Research Studies;

  - Management Sciences for Health for Family Planning Program Management and Evaluation; and

  - Centers for Disease Control for Family Planning Information System and Epidemiological Studies.

XI. THE PRIVATE AND PARA-PUBLIC SECTOR (PPPS) AND CONTRACEPTIVE SOCIAL MARKETING (CSM)

A. Goals, Objectives and Anticipated Outputs

This Chapter covers PPPS, one of the three major Project components identified in the A.I.D. Project Agreement and CSM, a program concept, carried out primarily through this component. The overall goal and objectives of the PPPS component and contraceptive social marketing are to encourage private voluntary organizations and other private sector participation in contraceptive distribution and sales, increase the number of family planning clinics and distribution points for contraceptives, and thereby, improve the access of more of the population, particularly those in remote rural areas, to family planning services.

The objectives of the CSM program are:

- To design and establish a product distribution system which reaches private pharmacies; the network of para-public corporations, such as CNSS and SOTRAC, beneficiaries of the PPPS program; small, private merchants; community-run depots; and pharmacies villageoises;

- To design and establish a pricing system which both guarantees an affordable price to consumers while assuring cost recovery as well; and

- To develop and implement a promotional and publicity system which advertises both concept (family planning) and product (contraceptives).

The expectation in the original Agreement was that by the end of the Project 500,000 people would be sensitized to family planning issues by the educational activities of the PPPS component and that about 30,000 persons would be acceptors of family planning service and contraceptive methods through the PPPS network.

B. Description

1. The private and para-public sector component (PPPS)

One-and-one-half million of the Project's $28 million was made available to directly assist private and para-public organizations such as those that provide family planning information to the community, that expand service delivery systems for integrated family planning, that train family planning and family health workers, and that carry out research on ways to improve service delivery, evaluate community or client satisfaction, or analyze relevant demographic variables.

Formal beneficiaries of this Project component are health structures that are part of private associations, para-public organizations, or other non-governmental institutions that carry out family planning activities. Other beneficiaries include private clinics, individual doctors in private practice, private dispensaries and laboratories. The present plan is that not more that the equivalent of $10,000 be provided to any one beneficiary within a two year period.

The illustrative dollar budget in the original Grant Agreement included the following proposed distribution. Only about one third of the planned budget has been expended by the time of the evaluation. Implementation of the PPPS component was slowed because of the financial and management crises and because the GOS does not yet fully support these activities.

Category	Budget	Expenditures	Unearmarked
Training	$ 600,000	$ 178,700	$ 421,330
Equipment, Supplies and Medicines	567,000	284,000	282,670
Contraceptives	300,000	8,330	281,700
Total	$1,467,000	$ 481,030	$ 985,670

Table 25 indicates the 27 PPPS organizations that have received support from the Project and the purpose for which the funds were used, i.e., training, equipment, medicines or contraceptives.

Present estimates are that 10,000 acceptors have resulted from PPPS activities. A recent PPPS report indicates that if the GOS were to release the unearmarked funds they would be used, as follows:

	Dollars
Reinforce Ongoing GOS FP actions	48,830
Assistance to new family planning groups	330,000
Social marketing of contraceptives	240,000
Internal studies	40,000
Outside study tours	36,700
Allocations to other NGOs	290,170
Total	985,700

2. A social marketing program

A contraceptive social marketing program has not yet been implemented by the Project and few expenditures for social marketing have been made against the budgeted amount in the Project Agreement. Considerable progress, however, has been made in the design and promotion of a CSM program for Senegal. These design and promotional activities were accomplished largely within the framework of the PPPS component.

The CSM program, as envisaged and planned by PPPS, is as follows: Contraceptives are imported free from the United States through USAID. The contraceptives are in turn sold to one or more Senegalese wholesalers (grossiste), who distribute them onward through the private pharmaceutical system (private wholesaler outlets--officines--larger pharmacies, and smaller village-level depots pharmaceutiques.

The price charged these wholesalers by USAID or its authorized agent (presently proposed to be SANFAM, a Senegalese PVO derived and constituted from the PPPS, whose term and financing expired in December 1990), is based on estimated consumer ability and willingness to pay; and the need for CSM operating revenues for overall management, promotion and publicity, and evaluation.

The price the wholesaler charges its retailers on Government-designated essential drugs (of which contraceptives are a part) is limited by a Government profit-margin cap of nine percent (compared to a permitted 33 percent on non-essential drugs and pharmaceutical products). Retailers are also limited by the nine percent cap on their sales to the public.

A second route of contraceptive distribution under the proposed CSM plan is directly through the PPPS network, larger para-public and private sector industries. Either the private wholesalers or SANFAM (in the event the private sector was unwilling to move out of its traditional distribution network) would supply contraceptives to these para-publics and private industries for sale in their clinics. Although the para-public family planning clinics have received contraceptives free of charge through the PPPS program, FHPP/PPPS officials feel that the new sales system would readily be accepted for two reasons: first, reliance on a private distribution network from which they would be able to freely choose among competitors, would guarantee uninterrupted contraceptive supplies.

A second and more important reason is cost reduction. The major insurers of workers --the Institution de Prevoyance des Maladies (IPM) which covers worker medical costs and the Caisse de Securite Sociale (CSS) which provides maternity benefits--would clearly benefit from the CSM program. The CSS currently provides millions of CFA in benefits under the allocation familiale system, in which parents with more than two children receive an allowance, and under the maternity leave benefit program whereby salaries of new mothers are paid for 3.5 months after delivery. It is clearly less expensive for the IPM to cover the cost of contraceptives rather than maternity costs; and certainly in the interest of the CSS to reduce its total maternity benefits.

A third route of CSM distribution would be to small private merchants who, along with matches, cigarettes, and other low-cost items, could also sell condoms.

A fourth route could be through pharmacies villageoises who would purchase contraceptives from either private officines or from the proposed SANFAM network, and who would charge their customers a small profit margin in order to provide an incentive to the village pharmacist and a small operating revenue to the pharmacy.

All contraceptives currently available in the country would be included in the CSM program, but this sale would be contingent on a number of factors. Firstly, IUDs would not be sold without a doctor's prescription. Secondly, the use of pills would have to be closely monitored to pick up complications before they caused personal harm and/or became a subject of negative community discussion. Thirdly, local merchants would be authorized to sell only condoms. Finally, pharmacies villageoises would be authorized to sell condoms and perhaps pills, depending on the availability of trained medical or paramedical personnel (infirmiers, the health personnel closest to the village, have only recently been given Government authorization to provide family planning services, and they could be a key link in the CSM system).

Private drug wholesalers have already been contacted by PPPS staff and assessed for interest and quality of service; seminars have been held for government officials, presenting to them the basic concepts and operating principles of CSM, and discussions held with the three major pharmacist associations in Senegal: the Ordre de Pharmaciens, the Association de Pharmaciens, and the Syndicat de Pharmaciens. Work on a logo has also begun. A number of consultants (Holmes, and Maher inter alia) have already worked with PPPS staff on the development of the CSM program.

Three sources of funds are available for the final design and establishment of a CSM program in Senegal: CFA 7.0 million given to PPPS to cover costs of the interim (PPPS-SANFAM) period; CFA 15.0 million in unspent FHPP funds; and a proposed CFA 60.0 million for the execution of the CSM program including advertising, technical assistance, sales agent training, etc. A project proposal has already been submitted to USAID for a CSM program that deals exclusively with condom sales [26]; and a cable sent to US consulting group to request technical assistance to help develop these initial ideas.

The Project has supported a number of study tours to countries with family planning projects that have used the private sector to distribute contraceptives. According to USAID, however, the CFA 7.0 million and the CFA 15.0 million reported available by PPPS/SANFAM, in fact are not available, and additional resources will have to be sought. According to USAID, $109,000 in TA funds and $64,000 in local costs have been "reserved" (set aside) out of FHPP funds. The use of these funds is a matter of further negotiation with the Government.

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[26] Population Services International, SANFAM Technical Assistance Proposal: Condom Social Marketing for AIDS prevention and Family Planning, September 1990

C. Analysis and Evaluation

1. The private and para-public sector (PPPS) component

Visits to five PPPS supported clinics indicated a high level of motivation on the part of the PPPS workers. The PPPS component has been quite active in expanding service delivery to the private sector. Facilities and equipment at these clinics seemed well used and maintained. While salaries paid to PPPS clinic staff are higher than amounts paid to public sector personnel, the extra cost was more than justified by a higher level of effort.

All the PPPS clinics expressed concern that with the completion of the Project's PPPS activities, they did not know how they would receive additional contraceptives. There are no apparent other funds that could substitute in any significant way to support PPPS clinics if U.S. funding were terminated. The Mission should continue with a PPPS experiment as one way to increase support from users and the private sector and to reduce the public sector financial and administrative burden. This issue requires early Project attention.

One way to encourage increased private sector family planning coverage is for the Project to investigate the possibility of expanding ASBEF model clinics to each of the Project's six regions. Model clinics, on a regional level, could be useful as training centers for the area's doctors and nurses and encourage the development of new privately funded family planning activities.

The Mission should study CPSD guidelines for the procurement of private/social marketing contraceptives. (See Chapter VIII on Logistic Management.) CPSD has different regulations for public versus private sectors. Private sector purchase and sale of contraceptives through a CSM mechanism or efforts with the private and para-public should be encouraged as a way to reduce some of the Government's burden for commodities that it could better apply to supervision and delivery of quality clinical services.

In designing a PPPS component in the next family planning Project, the design team should consider such questions as: How can the PPPS component reach populations that are not reached by the public sector alone? How can such a PPPS component leverage other resources from the private sector where these would not exist except for the Project? What should be the relationship between the public and private sectors? What kind of technical assistance should be provided to the private sector. How should management and financing of this component be institutionalized? What should be the relationship between the PPPS component and CSM activities? How should PPPS and CSM be better coordinated by the new GOS family planning program? The design team should also consider the value of expanding family

planning services via the private sector to complement the public sector. They should also consider the necessity of assisting private companies to sustain their activities, as well as the importance of adding new private organizations or strengthening existing site.

2. Contraceptive social marketing

Contraceptive Social Marketing has been an accepted way of increasing contraceptive distribution in many countries [27] since the early 1980s, and has been endorsed for Senegal in the Draft Population Sector Analysis and Proposed Strategies [28]. The Sector Analysis states:

> "To foster an expanded role for the private sector delivery of health and family planning goods and services, USAID should promote commercial delivery of modern contraceptives by developing a social marketing project to expand the present market for contraceptives. Social Marketing projects can take up where IEC campaigns leave off by promoting specific products and developing a consistent and accessible supply of products."

Interest in Contraceptive Social Marketing has been generated in Senegal because of a growing awareness of the AIDS problem in the country (see Clinical sections of this report for data). WHO has already assisted the national AIDS program in this regard. Recently (1989) in Senegal, WHO conducted a study of condom social marketing in the country in which wholesalers and retailers were interviewed to assess interest and capacity; prices and demand were analyzed to determine commercial expectations and consumer ability-to-pay; and potential target groups surveyed (prostitutes, bar patrons, etc.) to determine KAP towards AIDS and condom use [29].

To assist the National STD/AIDS program to implement a social marketing program, WHO provided two million condoms for free distribution among specially targeted at-risk groups (as noted above). These two million condoms were provided free under the proviso that all further condoms would be purchased. A national condom social marketing program, in which contraceptives would be sold to these high-risk groups is still under consideration.

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[27] See Population Reports, Population Information Service, Johns Hopkins University, Issue of 1984 (?) devoted entirely to CSM and translated into different languages.

[28] Harris, N., Hart, C., and Maher, S., Senegal Population Sector Analysis and Proposed Strategies DRAFT, USAID Senegal, January 1991

[29] This study was not made available to the Evaluation Team but, according to National STD/AIDS Program staff, will soon be available at their offices.

The plan set forth by the PPPS follows the classic CSM model--the identification of private wholesalers, and the establishment of a non-profit distributor (i.e., SANFAM), establishment of a pricing structure which provides retailer incentive, return-to-Project funds, and assures a reasonable consumer price. A number of issues which have been raised here and in other countries must be resolved before a CSM program can be implemented.

a. Government concurrence

Many governments have been hesitant to turn over even a portion of the family planning program to the private sector. They have felt that government, by legal statute is the only legitimate provider of health and family planning services and can best look out for client interests; that government services can provide goods at lower cost than the private sector, once efficiency is improved; and that private enterprises cannot always be trusted to maintain both reasonable price and quality service. Religious and social concerns have also been raised by certain governments, the Government of Senegal among them. An aggressive social marketing program, they argue, making condoms widely available and easily accessible to all, could come under unfavorable religious and social scrutiny from those who associate them with illicit sex and promiscuity. Because of this reticence, it is not clear to what degree the Government of Senegal is fully and finally disposed to the development of a private distribution network.

b. Medical concerns

Many doctors and other health professionals are concerned about the unlicensed sale and distribution of contraceptive pills. They feel that the risk of complications is high enough, particularly in the first three months, to warrant some kind of medical control. Many doctors, both within and outside of the public health system in Senegal, feel that pills cannot be made more widely available unless medical services are readily available. Since such medical personnel is not always available in rural areas (only larger villages, for example, have an infirmier), they are loath to commit themselves to a CSM distribution scheme which would encourage self-administration of drugs and contraceptives. Condom-only distribution is much less of a problem, but the demand for condoms is not full known in the country. A compromise might be to establish CSM programs in urban areas, where distances to health clinics are not extreme.

c. Government management and control

Few governments are willing to let contraceptives come in to the country through purely private channels and be distributed through them without some degree of monitoring and/or control. If USAID, for example, were to import contraceptives and negotiate directly with a private wholesaler (as was initially proposed in the USAID/Mali CSM program), thus avoiding the government network,

at least some opposition would be expected. Governments have legitimate concerns about product quality and protection. If USAID were to contract directly with a US NGO, a Senegalese NGO, licensed in the United States, or a Senegalese NGO affiliated with an American NGO, the problem would be less serious, but a potential point of contention nevertheless.

d. Community-based distribution

While often considered a different program from CSM, community-based distribution as envisaged for Senegal is really an extension of it. Existing pharmacies villageoises, set up as part of the Primary Health Care program, can potentially serve as depots for contraceptive sale. The village pharmacist would make a small commission on contraceptive sales. However, there is no reason why village-level sales cannot be purely private, with no affiliation with a village pharmacy. Village family planning volunteers, whose activities have been described in detail in the IEC section of this Evaluation Report, could be selected as local sales agents, with their commission considered compensation or remuneration for their volunteer family planning work. It is not clear whether Government would be receptive to a scheme which existed outside the Primary Health Care framework.

e. Purchase of contraceptives on the international market

Although CSM programs have been based on the principle of free importation of contraceptives (enabling the CSM projects to realize operating revenues from the onward sale), the CSM program could be purely private. Wholesalers are invited to purchase contraceptives on the international market and sell them at regulated prices while an externally-assisted project provides advertising and promotional support. The argument for this alternative is that eventually countries will have to purchase their contraceptives from the market, and that supporting them now, through advertising and promotional efforts, will facilitate that transition.

Contraceptives are already available on the private market and such a plan would simply provide advertising support for the extension of that market. However, as the above-mentioned Sector Analysis states, "The commercial market for contraceptives is weak because of the extremely limited size of the present market. Present pricing structures have emphasized skimming policies which direct sales to higher income consumers where profit margins are more attractive" [30]. The Sector Analysis also goes on to say, "However, commercial manufacturers and marketers are interested in supporting market development to lower income consumers", suggesting that a new and quite distinct marketing effort to reach these consumers would have to be undertaken. By whatever means, any CSM program carried out in Senegal will have to plan for the progressive decline in imported free contraceptives and the increased purchase of imported or locally-produced commodities.

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[30] Harris, N. et al, op. cit., p.32

f. SANFAM

SANFAM currently does not have authorized status to execute a CSM program. It needs US NGO accreditation or affiliation with a US firm or NGO. In principle SANFAM could affiliate with any of the many US NGOs or private consulting groups operating in Senegal. Accreditation would give the program the legitimacy that many proponents of Senegalese ownership of development programs desire; affiliation would provide a more conservative and perhaps quicker and more familiar solution to problems of management, financial control, and administration. During the period of the evaluation, the evaluation team met with another USAID funded team which was in Dakar to consider ways of assisting SANFAM to carry out these new activities.

g. Technical assistance

Technical assistance needs for the development of the CSM program need to be carefully assessed. From discussions held with PPPS staff, considerable progress has been made to date in structuring a CSM program. What is now required is the more delicate process of obtaining government approval, developing strict criteria for wholesaler selection, establishing a fair and reasonable pricing structure, carefully defining the distribution network and working out satisfactory compromises on retailer channels, medical controls, and government oversight.

h. Advertising and promotion

The IEC component of a CSM program differ considerably from that of a traditional family planning program in that specific products are promoted. In an ideal situation, Government (or its Project representatives) is responsible for "institutional advertising"-- the promotion of the program and the concept (family planning)--while the private sector is responsible for product advertising. However, at a low sales price and with a Government controlled and relatively low profit margin, the private sector may be unwilling to carry out even product advertising, unless and until it sees the volume of sales generated to be economically profitable. In the interim, the Project would likely have to provide product advertising. Such advertising, including new elements such as packaging, point-of-sale advertising, etc., often require the professional help of private advertising firms.

i. Participation by GOS/CSS

Since GOS/CSS sees CSM as being in its economic interest, and in the long-range self-interest of Senegal, it may be well disposed to providing funding for a significant portion of the advertising budget.

D. Summary of Major Findings and Conclusions

1. PPPS

- Visits to five PPPS supported clinics, indicated a high level of motivation on the part of the PPPS workers and facilities and equipment at these clinics that seemed well cared for. While salaries paid to PPPS clinic staff are often higher than amounts paid to public sector personnel, they seemed to be more than justified by a higher level of effort.

- The family health and population activities of private and para-public organizations generally conform with the health policies of Senegal and further the objectives of FHPP.

- Client satisfaction at PPPS FP clinics compared very favorably to client opinions at public sector facilities.

- There are no apparent funds that could substitute in any significant way to support PPPS clinics if USAID funding were terminated.

- Present estimates are that 10,000 new acceptors have resulted from PPPS component activities.

2. CSM

- Considerable effort has been made in the planning and design of a CSM program for Senegal, and the basic structure of the program has been outlined.

- Political support for a CSM program has been secured from key sectors, such as the CSS, the IPM, and pharmacists' associations; similar support must now come from the GOS and the medical establishment.

- Unspent component funds exist to permit considerable additional work in finalizing the CSM program and developing a suitable advertising and promotional program.

E. Summary of Major Recommendations

1. PPPS

- Continue support for a PPPS component as one way to increase support from users and the private sector and to reduce the public sector financial and administrative burden. The considerable energy and

physical infrastructure of the private, para-public and non-governmental sectors should be enlisted more directly to support the objectives of the GOS to improve the health and quality of life of the people of Senegal.

- Consider the recommendations for training of public sector clinical workers for training of PPPS personnel. Subjects to be covered in training should include improvement in the quality of service delivery, application of the GOS new rules on use of physical examinations, and coordination among clinics that are part of the same PPPS organization.

- Assure that the financial resources made available to the PPPS component in the Project Agreement are fully disbursed during the remaining life of the Project.

- Encourage continuation and expansion of the PPPS component, at least, as an experimental component for further study. In the long run, USAID/Senegal should assure that a PPPS component is included in the new family planning project to be designed.

2. CSM

- Begin formal negotiations with the GOS to permit the design and development of a small-scale contraceptive social marketing component under the new Project--either as part of an expanded PPPS component, through an NGO, or under public leadership worked out through MPHSA.

- Develop a detailed CSM work plan as part of the new family planning Project covering activities in the following categories: political mobilization; definition of a distribution network; establishment of a pricing system; establishment of a local packaging system (if necessary); development of a detailed institutional and product advertising program.

- Finalize institutional relationships and responsibilities with SANFAM, or another NGO, either under the family planning Project, or under the new umbrellas PVO Support Project, to bring private, para-public, and other non-governmental organizations into the CSM program.

- Support study tours for GOS, Project, NGO and PPPS personnel to neighboring countries, such as Mali, Gambia, and Togo, which have already embarked on CSM programs.

- Provide technical assistance, particularly in the areas of institutional organization (relationships among public, private, and NGO sectors), pricing, and advertising.

XII. ENHANCING THE DEMOGRAPHIC DATA BASE TO IMPROVE DEVELOPMENT PLANNING

A. Goals, Objectives and Outputs

This chapter examines the goals and activities of FHPP related to the improvement of demographic data for use in population policy development, planning and program evaluation carried out by BNR. The review and evaluation of BNR was carried out through discussions with staff at BNR, USAID/Senegal, ISTI, FHPP, the MCH, UNFPA, World Bank, and Project consultants from the U.S. Bureau of Census; and the Project demographic consultant; reviewing Project documents, annual reports, consultant trip reports, sector analyses, country program strategic plans and evaluations, budgets, and published and unpublished documents, reports, tables and other statistics relating to the 1986 DHS, 1988 Census of Senegal, 1990 EPF, and other special studies carried out under this component.

Output is measured in terms of surveys completed, reports published, people trained, and technical assistance provided. Evaluation of the organization, management and administration of the data improvement activities at BNR was made in terms of expenditures, timeliness of work programmed, availability of documentation, state of work facilities (micro-computers; printers; files) and the quality of the work produced, published and disseminated. An effort was made to assess both the quantity and quality of output by BNR and how these outputs were used to improve population and development planning and assist the family health program.

The Project document identified indicators for verifying that activity goals have been achieved. For example:

- Observed reductions in Senegal's crude birth rate from 48 to 42 births per 1000 by the end of the Project period;
- Reductions of 10 percent in the infant and maternal mortality and morbidity levels;
- Improvements in children's nutritional status; and
- Reductions by 30 percent in high risk pregnancies.

Verification of these reductions in fertility and mortality was to be achieved through the analysis of demographic survey data collected by the National Census Bureau and through this final Project evaluation.

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B. Description of Component Activities

1. Organization for data base development

In March of 1990 there was a restructuring of Ministries. The census office now falls under the Direction de la Prevision et de la Statistique (DPS) within the Ministere de l'Economie, des Finances et du Plan. The DPS is organized into three divisions: General Statistics; Economic Statistics; and Demographic Statistics. The national census office, known previously as BNR, is now called the Demographic Statistics Division (DSD) of DPS. The DPS is charged with the collection, centralization, coordination and dissemination of statistics necessary for the development and execution of economic and social policies and national development plans. The Bureau Informatique (BI) plays a key role in the processing of the census data. The BI is at the same administrative level as the BNR. They are both under the direction of the DPS (formerly Direction de la Statistique (DS)). The BI was responsible for the data entry and processing activities, as well as for the production of the data base that contains the geographic codes, names and housing and population counts for the census. It was in the BI building that the census questionnaires were received and coded. They are still stored there.

Senegal was one of the first African countries to use microcomputers to successfully process their census. This was due to the commitment of the Senegalese working at the Bureau Informatique and the support received by the BNR staff. However, the Senegalese would not have been able to computerize their census without the financial support provided by USAID through the Family Health and Population Project in the form of resources, training and technical assistance, including the participation of the U.S. Bureau of the Census.

In spite of the many difficulties that have been and are still being encountered, the Senegalese have already improved their performance as compared to their 1976 census. It was not until 1981, five years after the data were collected, that the tabulations were made available. This did not include demographic analysis which was done in subsequent years. For the current 1988 census, the BI tabulated the data based on a 10 percent sample by the summer of 1989. The BNR published the report based on these data in November of 1990. The BI started to make available in the summer of 1989 the tabulated data based on the 100 percent data by region. Unfortunately, these tabulations were not reviewed by the BNR staff until June 1990. The specified changes were incorporated into the tabulation programs. The BNR demographers are using these regional tabulations for demographic analysis. A census data dissemination seminar was scheduled for the winter of 1991, three and a half years after the data were collected. (Additionally, the BNR conducted a Post-Enumeration Survey (PES) to measure census content and coverage. Most of the analysis of the PES has been completed. The PES conducted during the 1976 census was never processed or analyzed.) If this schedule is retained, this will be a

significant improvement over the availability of the 1976 census tabulations in 1981. The coordination of technical assistance trips by the U.S. Bureau of the Census to assist the BI was well conducted and timely.

The U.S. Bureau of the Census found the BNR and BI staff to be well intentioned, taking professional pride in their work, and having a good overall level of expertise. BI is a separate entity from the BNR. The BI is at the same administrative level as the BNR under the direction of the Direction de la Prevision et de la Statistique. The BI is responsible for receiving, coding, keying and processing the census data.)

However, the BNR and, to a lesser extent, the BI staff were handicapped by poor organizational habits, unavailability of clearly defined priorities, lack of effective coordination, and low motivation due to low salaries and/or limited career advancement possibilities. This had a direct impact on the processing, analysis, and the dissemination of the census data. The generally accepted practice of doing other paying jobs (such as teaching, consultancies, and assistance to researchers) during work hours had a direct effect on the delays in obtaining census results.

2. Demographic data improvement and support for the BNR

Project support for improvement of the demographic data base for development planning is one of three major components of the Project and is comprised of support for the collection of census and survey demographic data; technical assistance in census methodology from the U.S. Bureau of the Census and special studies by special consultants; and training of demographers and statisticians in census and survey methodology and analysis.

3. Census and survey data collection

One of the purposes of the Project was to ensure that sufficient demographic survey and census data and analytic capability exist to inform policy makers of the impacts of rapid population growth. The 1988 census, periodic surveys, health and family planning service statistics, Project reviews, evaluations and monitoring reports serve as means of verifying the achievement of this purpose. It was assumed that the documents and study results would be available for analysis and that the GOS would publish the results of the census and surveys.

4. Training

a. Training of census demographers and statisticians

The BNR component of the Project included long- and short-term training of demographers and statisticians in census and survey procedures and techniques of analysis. The indicators for the output of demographers and statisticians trained in census methodology would be 35 statistician/ demographers trained during the Project period. A verification of this training would be the improvement in the demographic census and demographic survey data base. The success of the training of demographers and statisticians under this Project will depend on whether a sufficient number of personnel are interested and available for statistical training. (Two long-term overseas trained; seven seminar/workshops in computer/statistical methods in-country were planned for the Project period). Up to three micro-computer and/or statistical methods workshops were to be held in Senegal during the first four years of the Project. This again is to be verified through attendance at workshops. It was assumed that computer hardware and software would be available.

The "demographic data base" of census and survey data has not been organized and stored in one place using a data base software package such as dBASE. For maximum exploitation of the data, an organized, centrally located computer data base of relevant population, health and family planning data, with all the necessary documentation could be established in the future.

b. Training of development planners and policy-makers

The training component of the overall Project also includes the training of GOS planners and policy makers in relating population growth to development objectives. To achieve this goal during the Project period, 35 development planners were to be trained. This was to be verified through workshops and presentations made to high level GOS policy makers. An important assumption in the achievement of this Project goal was that GOS political leaders would be interested in Population and Development presentations. (Note: a more recent logframe for the Project listed only five development planners trained as the objectively verifiable indicator)

At least three seminars were to be held during the Project on impact of population growth on development in Senegal and the effect of cultural factors on family planning acceptance. The number of workshops/seminars planned in the original logframe to educate development planners throughout the GOS on the impact of rapid population growth on sectoral goals were as follows:

- One seminar per year through the first four years and

- Two seminars per year for the last three years.

These activities were to be verified by attendance at seminars and workshops and through monitoring reports. It was assumed that the content of the workshops would be relevant interest to GOS planners and policy-makers. Updated RAPID model/presentations for public and private sector audiences were to be completed by the end of year three.

5. Technical assistance

An important part of the development of a reliable demographic data base for evaluation and policy-making has been technical assistance to the BNR and BI provided by the U.S. Bureau of Census and special consultants. Technical assistance to be provided to the BNR and BI included the following activities:

- Technical assistance for the 1988 Census
  - Design and pretest of the questionnaire;
  - Production of updated census maps;
  - Installation of software packages and provide micro-computers to assist in the editing, tabulating, presentation and analysis of the 1988 census; and
  - Creation of a master sample frame.
- Workshops and seminars for development planners, demographers, and census statisticians and computer staff;
- Support for periodic surveys on Project family planning, MCH, and demographic trends;
- Support for a national DHS Reports;
- Updating of RAPID model/presentation for public and private audiences completed; and
- Support for seminars/research held during the Project on impact of population growth on development and the effect of cultural factors on family planning acceptance.

6. Quantitative summary of outputs

a. Census and survey data collection

- Field work for the 1986 Demographic and Health Survey was completed in 1986. Outputs included:

  - Two published reports;

  - Seven papers presented (BNR staff);

  - Thirteen papers in process (BNR staff); and

  - One dissemination seminar (1989).

- Field work for the 1988 Census was completed in June 1988. Outputs included:

  - Two census reports published: "Resultats Preliminaires" (September 1988) and "Le Principaux Resultats Provisions" (December 1989);

  - Fourteen Regional and Village level analyses and reports produced; and

  - Four special studies underway.

- Field work for the Post-Enumeration Survey 1988 was completed in June 1988. Preliminary analysis has been completed.

- Field work for the 1990 Urban Family Planning Survey was completed in 1990. Preliminary tabulations were conducted in 1990.

- No Regional Socio-demographic Surveys have been conducted.

- Other project studies and data analysis activities of BNR include:

  - Five special EMISPIK studies completed (USAID/FORD) and

  - Two village monograph studies.

b. Training

o The information available to the evaluation team showed that at least 39 demographers, statisticians, and computer specialists at BNR/BI/DPS received relevant training under the Project during the 1985-91 period. The break-down is as follows:

--	In-Country Training:	29
--	Short-Term Overseas Training:	6
--	Long-Term Overseas Training:	4

o Development planners and policy maker training outputs included:

-- 20 persons trained (Population policy and planning, study tours), including 2 cabinet directors and 2 technical advisors);

-- 23 RAPIDII demonstrations made to planners at various government ministries; and

-- 3 seminars held during the Project on the impact of population growth on development in Senegal and the effect of cultural factors on family planning acceptance.

c. Technical assistance

o Technical assistance activities provided to BNR and BI by the U.S. BUCEN included:

-- Sixteen U.S. Census bureau consultants on 31 missions (including TA trips, on-the-job training, and formal training) to BNR/Dakar during the 1985-1991 period;

-- Preliminary census design (questionnaire design; tabulation plan; principal definitions to be used in the Census);

-- CENTS 4 installation and workshop;

-- Editing and tabulation specifications;

-- Data processing systems design and programming support (in-country and in Washington, DC);

- -- Post-Enumeration Survey assistance in planning and implementation;
- -- Pilot census data processing assistance;
- -- Revision of computer programs and present CONCOR work-study;
- -- Census data processing assistance;
- -- Monitoring census production activities;
- -- Development of a master sample frame;
- -- Assistance with the planning, data processing and evaluation of the Post-Enumeration Survey results;
- -- Training on presentation of census data; and IMPS software training; and
- -- Thematic mapping training.

o Technical assistance provided to BNR and also to the FHPP by a demographic consultant included:

- -- 20 Missions over six years;
- -- General technical assistance in the coordination of research and secondary analysis of the 1986 DHS and the 1988 national census; and
- -- Technical assistance for the Village Monograph Studies conducted in Fatick and Thies (assistance in the design, fieldwork, analysis, and dissemination of the findings).

o Technical assistance was also provided by the U.S. Bureau of the Census in cartography. This assistance was funded by USAID/Senegal under a separate Project.

C. Analysis and Evaluation

1. Census and survey data

During the Project period significant progress was made in the improvement of demographic data available for documenting the level of fertility, mortality, population growth, and contraceptive knowledge and use in Senegal, and for the analysis of demographic trends in these parameters over time.

The 1986 Demographic and Health Survey was a well-executed representative sample survey which provided useful information on maternal and child health conditions, vaccination coverage, fertility, family planning and nutrition information that was previously not available at the national level in such detail. A second Demographic and Health Survey which will enable us to document changes in contraceptive knowledge and use and its impact on fertility during the Project period is planned for 1992. There was relatively free access of surveys results to researchers.

The 1988 national census produced data of relatively good quality based on the analysis of the Post-Enumeration Survey. The original Project logframe called for the results of the 1988 Census of Senegal (originally planned for 1986) to be published within three years after data collection.

Basic census tabulations and published reports were completed within three years of the census, as specified in the logframe. The census was almost two years behind schedule (due partly to funding shortages) and the data have not yet been fully exploited or analyzed in terms of fertility and mortality. Important demographic analyses are underway however, and these analyses should provide important information on the demographic situation in Senegal in 1988 and determining demographic trends between 1976 and 1988.

The 1990 Urban Family Planning Survey is another important contribution to the demographic and family planning data base. Only preliminary tabulations are available at present and the ultimate usefulness of the data will depend on whether the information is analyzed and disseminated adequately. The limitation of the survey is that it covers only urban areas in Senegal and even excludes some of the smaller urban areas which make up 15 percent of the total urban population.

The regional demographic surveys have not been carried out as planned. It is not likely that the BNR will be able to carry out these surveys (five regional surveys covering two regions in each survey) because of financial and time constraints. The utility of this survey is questionable in light of the fact that similar information will be collected in a national demographic surveys (DHS II) planned for 1992, and a large migration survey planned for 1991.

The rationale for the regional surveys was to get estimates of demographic, social and economic variables at the regional level. The information to be collected in the regional survey appears to be either redundant or not totally relevant to the PSFP program. The data will refer to different benchmark years making comparisons to other regions difficult, and the costs and demands placed on BNR are excessive. Furthermore, it is unlikely that these data will be analyzed adequately given the already heavy survey load of BNR (for example, a large migration survey is planned for 1991 and the DHS II for 1992). If the sample size is increased for the DHS II for 1992, it may be possible to obtain regional level estimates on demographic and family planning parameters.

The original logframe called for at least six surveys (one in year 1) over the Project period on family planning, MCH, and demographic trends. This would be verified through the examination of survey reports. It was assumed that the GOS would allow free access to survey results. If the 1986 EDS, the 1988 Post-Enumeration Survey, and the 1990 Urban Family Planning Survey are included that three surveys have been successfully carried out by BNR out of a total of at least six surveys planned. Two village monograph studies which included a quantitative survey component were also carried out under the Project with the assistance of ISTI demographic consultant.

The demographic and family planning data have not been adequately exchanged Project components. Not only are data not exchanged among Project components but with other data users. Like many other African statistical offices, the DPS/BNR/BI have concentrated their efforts in collecting and processing data. Sometimes the tabulation of these data would take years to obtain; sometimes never. Technological developments have allowed the tabulated data to be available much faster. Statistical offices are getting used to their new roles as data disseminators. The DPS/BNR/BI is no exception. The Project needs to establish a unit or group of persons that can take care of coordinating disseminating data on a full time basis. This includes presenting these data so that it is easily understood by persons of different backgrounds, particularly, policy makers. Additionally, this includes informing the users about the availability of these data.

2. Training

The in-country, long-term overseas and short-term overseas training provided by the Project was achieved as planned and have provided important and needed skills in the areas of demography, statistics, census cartography, census and survey data processing software, maintenance of computer hardware, software for presentation of census and survey results, and data base management. The training objectives were achieved during the Project.

Interest was expressed by some of the census staff in receiving training in survey sampling and design, and in multivariate statistical techniques and statistical packages for the micro-computer. Such training would increase the BNR's ability to carry out high quality sample surveys and to more fully exploit the census and survey data. Some of the BNR staff have already been trained to use ISSA and SPSS-PC and have effectively used these software programs to analyze survey data in Senegal.

Long-term training is important for the development of the BNR staff and the institution's research and technical capabilities, but the time allocated for training must be weighed against the workload of the BNR.

3. Technical assistance

The technical assistance provided by the U.S. Bureau of Census played a crucial role in the planning, execution, data processing, data analysis and evaluation of the 1988 Senegal Census. The technical training, advice and computer software provided by the more than 15 professionals from the U.S. BUCEN who visited Senegal during the 1985-91 period have enhanced the ability of the BNR to conduct a census of high quality in 1998.

Technical assistance provided during the 1985-1991 period by ISTI's the demographic consultant from the University of the Sorbonne Paris has contributed to the progress made in census activities (census tabulations and secondary analyses), in the execution of the FHPP village monographes and other socio-demographic studies co-financed by USAID, Ford Foundation and UNFPA, and in the establishment of collaborative arrangements for analysis of survey and census data with INED and the Sorbonne University in Paris. The disadvantage of having one demographic consultant assigned to BNR over the entire Project period was that it limited the flexibility of BNR and the FHPP to utilize the different kinds of expertise needed for the demographic and family planning service components of the Project (family planning program statistics evaluation, data base management, survey sampling, and a variety of applications of multi-variate statistical techniques and computer software). There appeared to be good coordination in the BNR institution building tasks performed by the U.S. BUCEN staff and the demographic consultant. From the perspective of the U.S. BUCEN monitor of BNR census activities and the BNR director, the ISTI demographic consultant provided welcomed, timely, and complementary assistance to the BNR staff, both in terms of increasing the research and organizing the capacity of the BNR staff and coordinating specific work tasks. The demographic consultant volunteered to assist in the census questionnaire development and in the design of the census tabulation plan even though these tasks were not originally included in his scope of work.

Consultancy visits to BNR by the demographic consultant were arranged between the consultant and BNR with approval from ISTI. The demographic consultant deserves credit for playing an important role in helping ensure that Project tasks were accomplished at BNR, despite a difficult working environment with limited resources available to BNR. He coordinated a number of studies based on the 1988 census DPS/WPS study and the village monograph studies.

BNR planning and preparation for the TA visits of U.S. BUCEN consultants to BNR were often insufficient, leading to inefficient use of TA's time during BNR visits. As a matter of fact, the U.S. Bureau of the Census staff grew impatient with the cycle of verifying the status of the activities the BNR was supposed to have accomplished before the proposed trip, the BNR assuring the U.S. Bureau of the Census that they had been accomplished, and then finding out upon arrival to Dakar that they had not been accomplished. This was particularly true for the development of edit and tabulation specifications, the review of table outputs, and the Post-Enumeration Survey.

However, this was not the case with the trips from the U.S. Bureau of the Census to assist the BI. As a matter of fact, the BI was able to enter, edit and tabulate the census data for the 10 percent by Summer 1989 and the 100 percent in early 1990.

4. Organization and management of BNR

Although progress was made in the improvement of the demographic data base, in the training of census staff, and in the quality of the technical assistance provided to the BNR, a number of problems were identified in the management, administration, and planning of Project activities by BNR. These problems included delays in the publication and analysis of census and survey data due primarily to a shortage of funds. BNR staff did not participate in some potentially useful training seminars in Dakar, Bamako, and Ouagadougou during the last three years of the Project, due to administrative delays and funding problems. This raises an even larger issue relating to the organizational structure of the DPS/BNR/BI. First, although the chief of the BNR and the BI both report to the Director of the DPS, the Director is occupied with many other responsibilities, limiting the amount of time dedicated to the closer coordination and guidance of the BNR and BI activities. Furthermore, the three organizations are physically in separate buildings that are miles apart. This makes the coordination of day-to-day activities hard and time-consuming, particularly between the BNR and the BI.

Some of the productivity problems were related to the unavailability of funds at the time of the planned activity, but other delays were clearly due to failure to follow time schedules or submit necessary documentation on time. Other problems identified were the lack of sufficient documentation of survey data files, coding manuals, and

sample design, a tendency for BNR to commit to doing too many surveys, while surveys already conducted have hardly been analyzed, and census study reports being behind schedule. Although BNR had access to micro-computers and software, some of the BNR micro-computers and the laser printer were not working at the time of the evaluation and computer paper was in short supply. Some of the management and administrative difficulties at BNR may have been compounded by reorganizations of the DPS and BNR and the fact that four different persons served as head of BNR during the 1985-90 period.

During the six years of the Project there have been four different heads of the BNR, two different heads of the FHPP, three different persons responsible for monitoring the Project at USAID and two different heads of the ISTI portion of the Project, and several reorganizations within BNR/DPS and other ministries. The frequent changes in management and organizational structure did not contribute to the coherence and coordination between the various components of the Project.

The director of BNR may need to concentrate more of his time on the management and planning of work activities of his Division and delegate more of the research responsibilities to his research staff. There are currently no one-year or five-year work plans operating for the BNR, only an inter-censal workplan. Although the quantity of output (surveys, reports, and publication) has been acceptable given the staff and resources available, more attention needs to be paid to the quality of the work and the timeliness of the output. BNR and BI need to determine a realistic workload and workplans on an annual basis. There has been a tendency to do a lot of surveys at BNR, but not enough analysis of the data collected. A precise work program needs to be developed and followed. BNR should avoid accepting and carrying out most surveys that are proposed to them and be more selective and targeted in the studies they undertake.

The demands for data collection and the need to train a relatively small census staff in demography, statistical, computers, data management and technical census operations come into conflict with the need for high quality in-depth analyses and reports for the family planning program and population policy makers. Frequent surveys and training abroad have contributed to delays in analysis and publication of research, but these are essential for the long term institutional development of BNR.

Although some meetings have been held between BNR and USAID/HPN, the FHPP, and ISTI, more effort is necessary in the coordination of BNR research activities in relation to the family planning and population data needs, and technical assistance needs of the FHPP and the MCH. The roles of ISTI, FHPP, BNR and USAID in the selection of Project activities and in the financial management of the data base improvement part of the Project are not clearly defined which has added to the planning and management problems of BNR component of the Project. The FHPP staff needs to play a larger role in the selection of studies and analyses undertaken by the BNR and the Project demographic consultant relevant to the family planning

program. For example, greater involvement of the Project IEC staff in the design, analysis and diffusion of the village monograph studies of family planning attitudes and IEC issues in Thies and Fatick may have led to better use of the study results for program purposes.

5. Budget

The estimated budget for the Improvement of the Demographic Data Base was $3,076,000 or approximately 15 percent of the total budget for the Project (as of 22 August 1986). These funds are divided into six major categories:

Technical Assistance	$ 554,000
Training	$ 437,000
Commodities	$ 340,000
Local Costs	$ 847,000
PASA to BUCEN	$ 585,000
Inflation Costs	$ 313,000
TOTAL	$3,076,000

As of March 31, 1991 a total of $2,388,000 of the BNR budget was disbursed or 78 percent of the total allocated. For the rest of 1991 expenses totaling $149,000 are anticipated, and from January to September 30, 1992 the end of the Project, another $273,000. However, all money has apparently now been spent on other line items, and therefore the remaining $422,000 dollars needed to complete the BNR component must be obtained from outside of the Project. The two regional surveys planned for the last year and a half of the Project are Projected to cost $280,000. These surveys could be canceled without seriously affecting the Project.

Training is included in in-country training costs and short-term and long-term foreign training costs. Technical assistance and coordination of some BNR research activities was provided by the demograpphic consultant from the University of Paris, implemented through an ISTI contract, and a number of U.S. BUCEN consultants paid through a PASA agreement between the U.S. Bureau of Census and USAID. In-country census and survey costs such as commodities (gas, micro-computers), survey team salaries, in-country seminars and training and local publication costs were usually paid for with Project money through ISTI.

6. Population policy development and training of planners

- At least two dozen RAPIDII demonstrations were conducted for government planners and policy-makers in different agencies of the government. A special presentation on Population was made to the President of Senegal, using data collected in the DHS I.

- At least 20 planners/policy makers were trained in population policy or participated in population policy and program study tours.

- Data collected in the DHS II and the 1988 Census (funded by Project) are being used in Population Policy Development and Planning. However, these data need to be more fully diffused and used by the various ministries of the government.

- The problems of population growth and the options available to the government of Senegal were communicated to the President of Senegal and the planners and policy makers in the different ministries of the government.

- At least three seminars were held in Senegal highlighting the impact of population growth on development and the effect of cultural factors on family planning acceptance. The content of the models and seminars presented were viewed by the evaluation team to be relevant and appropriate topics for presentation to the GOS policy makers, planners and population specialists.

D. Summary of Major Findings and Conclusions

- The 1986 Demographic and Health Survey was a well-executed representative sample survey which provided useful information on maternal and child health conditions, vaccination coverage, fertility, family planning and nutrition information that was previously not available. A second Demographic and Health Survey is planned for 1992 which will document changes, in contraceptive knowledge and use, and its impact on fertility during the Project period.

- Basic census reports were published within three years of the census as specified in the Project logframe. The census was almost two years behind schedule and the data have not yet been fully exploited or analyzed in terms of fertility and mortality. Important demographic analyses are underway which should provide important information on demographic trends between 1976 and 1988. Important demographic questions were not included in the 1988 census questionnaire which limits the demographic parameters that can be estimated from census data.

- Data are not exchanged among Project components. Information, for example, such as the DHS prepared by the BNR Project component has not been adequately diffused to, or used by, the clinical sub-components and other data users. Existing surveys and census data have not been

fully exploited to assist the family planning program in planning and evaluation of impact.

- The regional demographic surveys have not been carried out as planned. It is now unlikely that the BNR will be able to carry out these surveys (five regional surveys covering two regions in each survey).

- In-country, long-term overseas and short-term overseas training provided by the Project was achieved as planned and appears to have provided needed skills to census staff in the areas of demography, statistics, census cartography, census and survey data processing software, maintenance of computer hardware, software for presentation of census and survey results, and the development of a sound system of documentation and data base management. The training objectives were achieved during the Project. However, new training needs have been identified, and the BNR missed opportunities to participate in two regional seminars on census analysis and population models because of its delay in initiating necessary paperwork.

- BNR planning and preparation for some of the visits of U.S. BUCEN consultants to BNR were insufficient, often leading to inefficient use of their time during BNR visits.

- During the Project period the BNR had four (4) different Directors and undergone a number of reorganizations which has disrupted the continuity and coherence of the BNR component of the Project.

- More technical assistance should have been provided to the FHPP to improve the reporting, data processing, analysis, and evaluation of the family planning data collected at the family planning clinics.

E. Summary of Major Recommendations

1. General recommendation

- Continue selected support to macro-demographic data collection and analysis through BNR and improve GOS's institutional capacity to carry out such activities.

2. Data collection and analysis

- Give high priority to conducting the Demographic and Health Survey II (DHS II) in 1992. Increase the sample size so that regional level estimates and analysis of fertility, mortality, and contraception can be obtained. Include male sub-sample for the 1992 DHS. Questions on maternal mortality should be included. Conduct a national DHS III again in 1997 (with large sample size). The additional costs of

increasing the sample size and adding a male sub-sample to the DHS II will need to be allocated in the next five year Project. Install software such as REDATAM for improving BNR's data analysis capability at the district, village, and neighborhood level.

- Assure that adequate funds are allocated for the full exploitation, analysis, and dissemination of the fertility, mortality and family planning data from the 1986 DHS, 1988 Census, 1990 EPF, and the DHS II planned for 1992. Include a question on the number of children ever born (CEB) in the 1998 census for estimation of fertility from census data. Family planning survey data collected by BNR should be more fully exploited with respect to IEC issues (e.g., obstacles to family planning acceptance), access to contraception, fertility desires and contraceptive method preferences, and problems associated with contraceptive use (e.g., side effects, method failure, discontinuation).

- Do not conduct Regional Demographic Surveys. They are redundant to the DHS Survey Program or cover topics (e.g., migration) that are not a priority for the FHPP program. Furthermore, a national migration survey of 6000 household is already planned for 1991 funded by IDRC, and a national demographic and health survey is planned for 1992 (DHS II). Thus, the regional surveys would also place a strain on BNR infrastructure, would be of limited utility, and the timely analysis of the results would be unlikely.

- Encourage more collaboration/coordination between BNR and the FHPP and MCH in the future on data collection and analysis needs (e.g, joint effort on questionnaire design; BNR assistance on analysis of family planning program statistics. (Note: In Chapter VIII establishing a Statistical Research and Evaluation Unit in the FHPP/MCH is recommended for data processing and program-oriented analysis of family planning program statistics and for conducting program evaluation studies. BNR staff could provide valuable technical assistance in the establishment of this Research and Evaluation Unit, particularly in the areas of questionnaire design, sampling, interviewer training, field operations, data coding, editing, and analysis.

3. Training

- Conduct training in management procedures for the BNR Director and Division Heads at BNR and at BI (e.g., training in how to plan annual work programs for data collection, analysis, publication and seminars and training; planning for technical assistance visits; setting work priorities; delegation of responsibilities and division of labor; intra-office communication; conduct of staff meetings; and delegation of authority when director and/or division heads are travelling).

- Support the participation of BNR in Regional Census Methodology and Analysis Seminars (e.g., seminars sponsored by CERPOD; UNFPA; U.S.BUCEN; RAPIDII) and improve planning for participation in these seminars and the availability of funds for participation.

- Provide training to selected BNR Staff in data use and dissemination, survey sampling techniques, multivariate statistical analysis techniques, and the use of survey statistical packages for micro-computers. This could be done in-country or as short-term training abroad (e.g., U.S. BUCEN; University of Chicago; University of Michigan summer program; IRD-DHS, or University of Montreal). Training in the statistical software REDATAM for improving data base management capabilities and analysis at BNR.

4. Technical assistance

- Provide technical assistance for the 1998 Census of Senegal during the 1992-1997 period. This includes costs for census planning and preparation, consultation with data users, questionnaire design and table outlines, the development of computer programs and, especially, mapping. Substantial funds are needed for training, staff, computers, etc. for the three years preceding the 1998 census. For the short term (i.e., the current Project), better planning is needed on the part of BNR for technical assistance missions of U.S. BUCEN staff to BNR (e.g., preparation of work agendas for visits; exchanging progress reports and analyses completed prior to the visits; and ensuring availability of BNR staff during the TA visits). In the future more BNR technical assistance should be provided directly to the FHPP/MCH for the collection, data processing, analysis, evaluation and dissemination of the family planning survey data and family planning clinical service statistics.

- Encourage BNR to take advantage of technical assistance from selected USAID Cooperating Organizations (funded by USAID central funds), provided that collaboration with these organizations is be for the purpose of achieving specific objectives of the FHPP Project and consistent with the work program defined by BNR under the Project.

- Provide funds to BNR for the purchase of two new printers and to pay for analysis, publication and dissemination of results from the 1988 Census and the 1990 urban family planning survey.

- Encourage the BNR and the FHPP to identify specific technical assistance needs and have the flexibility to chose the most appropriate organization(s) and/or consultant(s) to provide this assistance.

5. BNR internal and external management

- Adopt a one-year and a five-year work plan and carry out an annual evaluation of the execution of the annual plan.

- Pay more attention to the following issues:

  -- Programming of time and keeping to work deadlines;

  -- Over-committing in survey data collection;

  -- Documentation of work accomplished;

  -- Processing financial paperwork, timely requests for training to USAID;

  -- Preparation for visiting consultants;

  -- Documentation of data files;

  -- Adequate arrangements with USAID or GOS for the maintenance of micro-computers, bernoulli disks, laser and other printers; and

  -- BNR Director's attention to Management and Administrative issues at BNR.

6. Population policy development and training of planners

- Seek central AID/W funding and encourage the use of Project funds to assist in population policy development including the practical applications of RAPIDII type models (e.g., INTEGRA and TARGET) so that the government can set realistic targets and goals and incorporate population factors in development plans in the areas of family planning, health, education, employment, housing, water and natural resource management, agriculture, transportation, and social services.

Addendum A

MEASURING PROJECT IMPACT ON DEMOGRAPHIC VARIABLES

The logframe for the Project set targeted changes in demographic indicators as a means of verifying achievement of Project goals during the Project period. It is not clear how these targets were chosen or what implications these targets would have for service delivery in order to achieve these targets. At the same time, some important indicators of progress of the Project were not requested in the logframe (e.g., a contraceptive prevalence rate for specific methods; a certain level of method continuation rates. Nevertheless, an attempt is made here to respond to the logframe and evaluation mandate to be impact oriented. In some cases, it will not be possible to measure Project impact on the variables specified in the logframe because the appropriate data were not collected at all; because the data is available for only one point in time during the Project period and thus measurement of trends or changes in demographic parameters is not possible; because some of the data collected is of questionable quality and/or completeness (e.g., the data from the PSFP clinics); or because the data has not yet been analyzed (e.g., 1988 census and the 1990 Urban Family Planning Survey).

1. Crude Birth Rate

Indicator: Reduction in Senegal's crude birth rate (CBR) from 48 to 42 births over the end of the Project.

Comment: Between 1978 and 1988 the crude birth rate declined very little, from 48 births per 1000 in 1978 to an estimated 46 births per 1000 in 1986 (1978 ESF; 1986 DHS). The EDS/DHS II planned for 1992 will provide an estimate of the crude birth rate for the end of the FHPP Project period. Changes in the crude birth rate depend not only on contraceptive use levels but also on changes in the age composition of the population, proportions married, and patterns of breastfeeding.

2. Infant and Maternal Mortality and Morbidity

Indicator: Reduction of 10 percent.

Comment: Infant mortality has been declining over the past two decades from 120 infant deaths per 1000 live births during the 1971-1975 to 86 infant deaths per 1000 in 1981-85 (1986 EDS). There are no recent national estimates of infant mortality during the Project period. Data collected during the Project do not permit an estimation of the direct impact of the Project on infant mortality. Infant mortality estimates for the end of the Project period will be available from the EDS/DHS II planned for 1992.

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3. Maternal Mortality

Indicator: Undefined

Comment: Maternal mortality in Senegal for the early 1980s is roughly estimated to be around 600 maternal deaths per 100,000 live births (PRB Options Database, 1990). No reliable national population-based estimates of maternal mortality are available and it is therefore not possible to measure change in the maternal mortality ratio over the Project period. If the EDS/DHS II planned for 1992 includes special questions on maternal mortality it would be possible to obtain a national estimate.

Although it is quite possible that infant and maternal mortality declined by 10 percent during the 1985-91 period, we will have to wait for the DHS II to be carried out in 1992 to measure changes in mortality over the period.

4. Improvement in Children's Nutritional Status

Comment: In 1986, 22 percent of infants between ages 6 months and three years of age suffered from chronic moderate or severe malnutrition. Malnutrition levels were higher in rural areas and in the north-east and central regions of the country. Children spaced farther apart showed lower levels of malnutrition that children born closer together. (1986 EDS)

The EDS/DHS II planned for 1992 will enable us to determine whether the prevalence of malnutrition for children has declined during the Project period (assuming anthropometric measurements will again be taken). However, we will not be able to say definitively that the family planning program and increased birth spacing contributed to an improvement in nutritional levels.

5. Reduction by 30 Percent in High Risk Pregnancies

Indicator: Reduce high risk pregnancies by 30 percent.

Comment: Family planning statistics for a sample of 11,300 active users at 20 PSFP family planning clinics in the six Project regions show that a significant proportion of high-risk women are using effective family planning methods provided by the Project. One-fifth of the family planning users were between the ages 35 and 49 years old, and 41 percent of the users had five or more live births (Columbia University, 1989). Since women in these age and parity categories are at a considerably higher risk of pregnancy complications and maternal death, it is very likely that their use of effective modern contraception has reduced the number of high risk pregnancies and prevented a number of maternal deaths. However, the percent reduction in high risk pregnancies cannot be calculated with available data.

6. Couple Years of Protection

Indicator: Safe and Effective Contraceptive Services Provided by the Public and Private Sector to 200,000 Couples

Comment: According to the latest analysis of family planning statistics for the Project, 61,376 women are active users of modern contraceptive methods. This figures includes users from public, private and commercial sector, but excludes condom users from these sources. Given the decline in the rate of increase in new acceptors and the general slowdown in all areas of the service program since 1989, it is very unlikely that the Project will reach 200,000 couples by the end of the Project period in 1992.

7. Availability of Family Planning Services

Indicator: Family Planning Services Available in all 10 Regions:

Comment: Family planning services are now available in all ten regions. Six regions are covered by the USAID-funded PSFP (approximately 92 public clinics and 32 VSPP and ASBEF private clinics operating in 1990); and 4 regions are covered by the UNFPA-funded BEF Project (29 centers operating in 1990).

8. Censuses Processed

Indicator: 1987 census will be fully processed and analyzed and published within three years.

Comment: The 1988 Census of Senegal was fully processed and all basic analyses were completed within three years. Two published census reports, 14 regional and subregional tabulation documents were completed. The remaining analyses are special studies of fertility and mortality, migration and urbanization, employment, and social characteristics. These special studies are currently underway or will begin this summer.

9. Access to Family Planning Clinics

Indicator: 25 Percent of Health Posts Providing Family Planning Services by the end of the Project

Comments: 62 out of 435 health posts (or 14.3 percent) provide FP services. Of all health posts in the country (urban and rural), the Project is currently providing family planning services in 14 percent of them.

10. STD Treatment

Indicator: STD provided treatment to at least 30,000 patients:

Comments: The STD Project is incomplete and of questionable quality. Data are not available for all Projects centers and although the numbers of consultation visits for STDs is estimated, it is not possible to determine from the service statistics how many of the clients received proper treatment (e.g., medication provided by the Project) for the STDs. STD data are discussed in more detail in Chapter V (Dr. Thiem).

11. NGO Acceptors

Indicator: 30,000 Acceptors by end of Project: (Non-governmental sector Family Planning Activities implemented by PVOs and a variety of other organizations).

Comment: VSPP/ASBEF by end of 1990: 9,111 active contraceptors
Commercial Sector in 1990: 19,269 couple-years of protection

Total: 28,380 estimated active users in private/commercial sector (excludes condom users)

Thus, if we include data from the commercial sector the goal of 30,000 acceptors from the non-governmental sector was nearly achieved by the end of 1990. If we exclude the commercial sector figures we observe that only one third of the Project goal has been achieved.

12. Number of Couple-Years of Protection Provided

Indicator: 200,000 CYPs by the end of the Project from all modern methods including condoms

Comment: 70,000 CYP in 1990 (Public sector plus VSPP)
2,500 CYP in 1990 (ASBEF)
23,500 CYP in 1990 (Commercial sector)
96,000 CYP in 1990 (All sectors)

13. Number of Births Averted in 1990 Directly from the Program

Indicator: Undefined

Comment: If we assume that four couple years of protection equals one birth averted we have: CYP/4 = number of births averted; then, 70,000/4 = 17,425 births averted in 1990 as result of Project. 22

Estimated total births in Senegal in 1990: (.046 X 7,327,000) = 337,042.The 17,425 births averted in 1990 implies a five percent reduction in the number of births. This means that the birth rate in 1990 would have been be 2.4 points higher (or a CBR of 48.4 births per 1000) without these couple-years of protection. If we include contraceptive users from the commercial sector, the estimated number of births averted in 1990 would be higher. With the data available to the team, it was not possible to estimate the total number of births averted during the entire Project.

14. Contraceptive Continuation/Discontinuation Rate

Indicator: Undefined

Comment: A crude measure of dropouts is the ratio of contraceptive acceptors who drop out during the year divided by the total number of active contraceptors at the end of year. Below are the estimated ratios of inactives in 1990 (i.e., dropouts during the year) per 100 actives users at the end of the year (1990), by region, based on service statistics for all program methods combined (except condoms):

Dakar	1125/15169 X 100 = 7	inactives per 100 actives
Thies	974/4068 X 100 = 24	inactives per 100 actives
Kaolack	724/3940 X 100 = 18	inactives per 100 actives
Fatick	255/1040 X 100 = 25	inactives per 100 actives

Thus, according to these data, for every 100 active contraceptors in Fatick clinics in 1990 there were 25 acceptors who dropped out during the year.

15. Discontinuation of Pill Use

Indicator: Undefined

Comment: Preliminary estimates of discontinuation among a sample of 341 pill users at selected Project clinics in the Dakar Region show that 30 percent of pill acceptors dropped out after two months of use, increasing to 65 percent of pill users dropping out by 12 months of use (Diop, 1991). This analysis will be expanded to include a larger sample of pill users, and will also be done of IUD users, using life table techniques

16. Level of Knowledge of Modern Contraception

Indicator: Undefined

Comment: Percent Having Knowledge of Modern Contraception (CMW 15-49)

	1978		1986		1990
	Total	Urban	Total	Urban	Urban
Pill	18		51		81
IUD	9		29		71
Condom	8		26		61
Any Modern	20		68	88	89
Any Method	60	70	92	97	95

Note: The 1990 Urban Family Planning Survey covered only urban areas including 85 percent of the total urban population of Senegal. CMW = currently married women.

17. Level of Use of Modern Methods (total and by method) Among Married Women of Reproductive Age

Indicator: Undefined

Comment: Percent Ever Using Modern Contraception (CMW 15-49)

	1978		1986		1990
	Total	Urban	Total	Urban	Urban
Pill	0.7		3.5		14.2
IUD	0.2		1.5		5.8
Condom	0.2		1.4		6.7
Any Modern	1.0		5.7	15.4	19.7
Any Method	11.0	9.3	37.9	41.8	46.6

Note: The 1990 Urban Family Planning Survey covered only urban areas including 85 percent of the total urban population of Senegal. CMW = currently married women.

Percent Currently Using of Modern Contraception (CMW 15-49)

	1978		1986		1990
	Total	Urban	Total	Urban	Urban
Pill	0.3		1.2	3.6	5.7
IUD	0.2		0.7	2.2	2.9
Condom	0.1		0.1	0.2	0.8
Any Modern	0.6		2.4	6.7	10.4
Any Method	3.9		11.3	14.3	21.4

Note: The 1990 Urban Family Planning Survey covered only urban areas including 85 percent of the total urban population of Senegal. CMW = currently married women. Data for 1990 are provisional.

18. Prevalence of Modern Contraceptive Use

Indicator: Undefined

Comment: If we take the estimated number of users of modern methods in 1990 from program statistics and the commercial sector (61,376 plus 7000 condom user) and divide it by the total number of women ages 15-49 in Senegal in 1990 (1,680,000) we obtain a national prevalence of modern method use of 4.1 percent in 1990. This estimate compares to an estimated prevalence of modern contraceptive use for all women ages 15-49 of 2.6 percent in 1986 from the 1986 EDS. Modern methods include the pill, IUD, condoms, injectables, sterilization and vaginal contraceptives.

The estimate of urban contraceptive prevalence of modern methods from the 1990 Urban EPF is 10.4 percent, compared to 6.7 percent estimated for urban areas in 1986 (EDS). This represents an increase of more than 50 percent between 1986 and 1990 in modern contraceptive use in urban areas.

19. Change in Ideal Family Size

Indicator: Undefined

Comment:

	1978	1986
Desired Family Size (Currently Married Women 15-49)	8.8	7.2

20. Need for Family Planning

Indicator: Meet unmet need

Comment: Although 11 percent of currently married women were currently using contraception, an additional 12 percent of women stated they wanted no more children and an additional 25 percent said they would like to space their births (1986 EDS).

21. Total Fertility Rate (average births per woman)

Indicator: Decline

Comment:

	1978	1986	1988
Total Fertility Rate (Women 15-49)	7.1	6.6	6.3*

* Provisional estimate based on 1988 census.

According to these independent estimates, total fertility has declined by 11.3 percent between 1978 and 1988, and by 4.5 percent between 1986 and 1988. Decline in the total fertility rate may be due to a rise in the age at marriage, changing age compositions, and an increase in contraceptive use. The amount of decline due to contraceptive use alone has not been estimated.

Addendum B

TIME FRAME: ACTIVITIES AND OUTPUTS BY YEAR

1985:

Project Signed and Initiated

Two Planning technical assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN) (Three main areas identified for U.S. BUCEN technical assistance were cartography, data processing and analysis, and design of a master sample frame). technical assistance given on the development of the census questionnaire and the tabulation plan.

Two technical assistance trips by ISTI's demographic consultant from University of Paris

Planning and technical assistance for the 1986 Demographic and Health Survey (DHS)

National Seminar on Census Mapping held during 9-22 September 1985 (organized by U.S. BUCEN)

1986:

Senegal Demographic and Health Survey (DHS I) fieldwork carried out 21 April-19 July 1986

One Planning trip to Dakar for the 1988 Census of Senegal (USBUCEN)

Three technical assistance trips to BNR by ISTI's demographic consultant

One the job training at the U.S. Bureau of the Census in Washington, DC for two BI data processors.

Training of 11 BNR/DPS staff in CENTS4 (Census Tabulation System Version 4) was in a workshop in Dakar 20 January-7 February, 1986, organized by the U.S. Bureau of Census.

1987:

Four technical assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN): cartography; questionnaire design, data processing and post-enumeration survey (PES).

During the period 1985-1987 20 staff members of BNR received census or statistical training, which included a workshop on census cartography. Four of those trained received overseas training (1987 Annual Report, FHPP).

Nineteen government planners and policy makers received training in population policy in the form of study tours.

Two technical assistance trips to BNR by ISTI's demographic consultant.

1988:

Five Technical Assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN)

Two technical assistance trips to BNR by ISTI's demographic consultant

Senegal National Census conducted 21 May-June 3 1988 (about 28 percent of the $7 million cost of the census was funded by the Project and most financing being expended in 1988.

Senegal Census Post Enumeration Survey (PES) conducted 16-30 June.

Report on the Preliminary Results of 1988 Census, September 1988.

Population Planning (Univ. of Michigan), C. Diop, 18 Sept-1 Oct

DHS I Final Report Published March 1988

DHS I Resume Report Published December 1988

Five Demographic Studies carried out by BNR and supported by the Project were presented at the African Population Conference in Dakar, 7-12 November, 1988.

1. Nuptiality and Fertility in Senegal - K. L. Ndiaye, A. Sadio, I. Sarr, and Y. Charbit.
2. Recent Evolution of Nuptiality in Senegal - Salif Ndiaye and I. Sarr.
3. Recent Evolution of Fertility in Senegal - Salif Ndiaye and I. Sarr.
4. Development of Demographic Research in Senegal - Y. Charbit.
5. Child Health in Senegal - Salif Ndiaye and Malik Diame.

Three census staff received foreign training under the Project in 1988.

1. Census Training, Ivory Coast, Statistician, BNR, 25 Feb.-4 March.
2. Census Data Processing, Niger, Chief of Data Processing, Statistics Directorate, 23 April-4 May. (Data Entry using Bernouli Boxes)
3. Microcomputer Workshop in Chicago 5-30 Sept, BNR.

1989

1990 Urban Family Planning Survey designed and pre-tested.

Seminar on the Presentation and Dissemination of the Results of the 1986 Senegal Demographic and Health Survey held in Dakar, 6-8 March, 1989. (7 papers presented that were supported by the Project)

1. Communication on Mortality - M. Gueye and P. D. Diouf
2. Maternal and Child Health - F.G. Mbodji
3. Communication on Nuptiality and Exposure to the Risk of Pregnancy - I. Sarr and B. Mane.
4. Communication on Fertility - A. Gaye and P. N'Gom.
5. Communication on Fertility Preferences - Rodriquez
6. Contraception and Family Planning - H. Ba.
7. Communication on the Methodology of the Survey - Salif Ndiaye.

Five Applied research Projects co-financed by the Project were completed:

1. Family Structure in Dakar (Landing Savane)
2. The Informal Sector in Dakar (Mamadou Ba)
3. The Role of Training in Youth Employment (W. Badiane)
4. Population Dynamics and Food Production Problems in Senegal (Babacar Mane)
5. Survey of Abortion in Pikine (Papa Demba Diouf)

Four Technical Assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN): data processing and PES.

Six technical assistance trips to BNR and for Village Monographs by ISTI's demographic consultant.

Collaborative Study by PSFP, BNR, and the Center for Population and Family Health (CPFH) at Columbia University was completed in July 1989, entitled "Analyse des fiches de Consultation des Centres de Planning Familiale en Tant Qu'Outil de Gestion du Programme".

Preliminary Results based on monval counts of the 1988 Census published, December 1989.

Two census staff received demographic and computer training (one short term - Cheihk Gueye on managing information systems on computers at the Center for Social Development in Chicago 17 August to 22 September; and one long term--received masters training in demography at Brown University)

Seven BNR/BI/DPS staff were trained by U.S. Bureau of Census consultants in the use of ATLAS*GRAPHICS and ATLAS*DRAW software to produce thematic census maps.

First Village Monograph Study conducted in Thies on demography, IEC and family planning in rural areas. Field work was completed and report was finished during the year.

1990

Urban Family Planning Survey 1990 fieldwork carried out (March-June 1990).

Methodology for regional demographic studies was completed and design for a regional demographic survey in St Louis and Louga was prepared.

Six Technical Assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN); thematic mapping, data processing, PES, master sample design and editing software programs CONCOR and CENTS4.

Three technical assistance trips to BNR and for Village Monographs by ISTI's demographic consultant

Two long-term training of census staff began in 1990: Chief of data processing at the Bureau Informatique of DPS started a Master's program in management information systems and another staff member began a training program of maintenance and repair of micro-computers and elaboration of computer systems.

Two staff members of BNR/BI/DPS participated in a summer workshop organized by U.S. BUCEN on IMPS.

Work-study visit of a statistician from the BNR to prepare to co-teach with a statistician from the U.S. Bureau of Census a seminar in data presentation techniques.

In-country seminar/workshop/training on census data presentation was held from 3-10 August, which included 11 regional staff members from DPS. It was co-taught by the U.S. Bureau of Census and a statistician from BNR.

1991 (Accomplished and planned activities)

Three technical assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN). Two of them from a Data Processing Advisor in January and June and one from a Mathematical Statistician. The purposes of these trips were to obtain final census tabulations, to assist in implementing the master sample design and the final coverage and content of PES tabulations, and to assist with Integrated Microcomputer Processing System (IMPS) software applications for ESAM.

Work study visits to BUCEN by two DED staff members for demographic analysis of census data for six weeks.

Second Village Monograph Study field work completed (Thies and Fatick) and seminar held in January 1991.

Between 1988 and 1991: Sixteen 1988 census reports and documents were produced by BNR. In addition to the census reports already published, four special analyses of the census data are now underway or planned for the summer 1991:

1. Fertility and Mortality Analysis-Salif Ndiaye (INED/Paris)
2. Migration and Urbanization - Cheihk Gueye (CERPOD/Bamako)
3. Employment - Momodou Ndiaye (CERPOD/Bamako)
4. Social Characteristics - Edmond Rodriquez (BNR/Dakar)

BUCEN statisticians are planning to present two workshops at DPS: a data users and producers workshop (concerning census data dissemination); and a statistical analysis workshop with emphasis on the 1988 census data.

Dissemination Seminar of 1988 Census results and special analyses is planned for December 1991.

U.S. Bureau of the Census statistician/demographer to provide technical assistance to the DPS in establishing a database on women's statistics using the census data.

Two technical assistance trips to BNR and for Village Monographs by ISTI's demographic consultant.

FINAL EVALUATION OF

FAMILY HEALTH AND POPULATION PROJECT

(685-0248)

VOLUME II - ANNEXES

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ANNEX A

IQC Delivery Order Statement of Work

ARTICLE I - TITLE

Family Health and Population - (685-0248)

ARTICLE II - OBJECTIVE

The purpose of this final evaluation is to assess project impact and to review the progress made towards achieving the outputs and the objectives of the project after five years and five months of implementation. This evaluation will answer programmatically important questions about project design, program management, the level and appropriateness of technical assistance as well as the timeliness and appropriateness of project inputs. Finally, this evaluation will recommend future interventions in family planning/family health that should be supported.

ARTICLE III - STATEMENT OF WORK

ACTIVITY TO BE EVALUATED

- Project Name: Family Health and Population
- Project Number: 685-0248
- Authorization Date:
- Grant Agreement (G.A.) dated July 31, 1985 $9,450,000
- G.A. Amendment No. 1 dated August 22, 1986 $10,550,000
- G.A. Amendment No. 2 dated June 10, 1987 $600,000
- Life of Project (LOP) funding:
  - Total USAID: $20,600,000
  - GOS, in kind and counterpart: $7,400,000
- Life of Project Funding:
- Amount obligated:
  - USAID: $20,600,000
  - GOS: $220,000 + in-kind contribution
- Project Assistance Completion Date (PACD): June 30, 1992.

The Evaluation Team will:

A. Review data from the Demographic Health Survey (DHS) 1989, the Urban Knowledge, Attitude and Practice (KAP) 1990, 1988 Census data and other existing documentation in order to assess the project impact on fertility reduction. Review project data in order to project contraceptive utilization, couple year protection (CYP), and number of births averted as to review the "drop out survey" initials results to project continuation rates.

B. Review the nature and level of planned outputs as identified in the Project Paper and the Logframe in terms of feasibility and importance to the program purpose. Determine whether key assumptions remain valid. Recommended any changes in quality or quantity, and any additions or deletions that appear appropriate.

C. Review the level and timeliness of planned inputs, both GOS's and USAID's in terms of feasibility and of importance to the attainment of the purpose. Determine whether key assumptions remain valid. Recommend any changes in quality or quantity, and any additions or deletion that appear appropriate.

QUESTIONS D-E SHOULD BE ANSWERED SEPARATELY FOR FAMILY PLANNING CLINICAL SERVICES (BOTH PUBLIC AND PRIVATE); STD/AIDS; IEC; DATA BASE ACTIVITIES AND WID COMPONENT (as appropriate).

D. Assess strategy and plans for attaining the purpose and generating anticipated outputs over the remaining life of the project. Determine whether key assumptions remain valid. Are the purposes likely to be met and the outputs produced in the time, and with the resources available? Identify any areas that appear weak, and any that may appear over-emphasized. What changes, if any, are recommended.

1) In the context of strategy, give attention to:

* training/staffing;
* public/private sector emphasis;
* "quality" vs "quantity" of centers of services;
* "inactives" (the drop-outs);
* IEC methodologies, e.g. mass media vs personal contact;
* GOS policy/attitude change;
* sustainability issues:
  - treatment;
  - drugs, diagnostic and contraceptive supplies;
  - recurrent costs (administrative).
* use of technical assistance.

2) Assess the roles attributed to MSPAS, BNR, VSPP and assess implementing strategy for each of the project components; of ISTI and the U.S. Bureau of the Census (BUCEN) for data base activities.

3) In reviewing plans for attaining the project purpose and generating anticipated outputs over the remaining life of its project, focus on the nature and completeness of the planning as well as the content. Do plans clearly show that levels of input (including key staff time) required for various activities are known and taken into account, particularly as the pace of implementation accelerates?

E. Review current GOS/ISTI/USAID management structures, practices and relationships in terms of how helpful they are for the successful attainment of purpose and output targets. Identify and action that might be taken to make them more effective. Give particular attention to the following items:

1) PLANNING: Process. Participants and roles. Communication. Implementation of plans. Follow-up.

2) SERVICE DELIVERY: Definition of the type of performance. Indicators and standards; monitoring process. Quantity and quality of services; corrective processes.

3) SUPPLY SYSTEM: Effectiveness: central, regional and local. Appropriateness for expected levels of activity.

4) MANAGEMENT INFORMATION SYSTEM (MIS): How adequately/correctly does it describe resource use, outputs and progress? How is it used by management?

F. Identify any policies, practices, structures or other aspects of involved government agencies that may be (or may become) impediments to the successful attainment of purposes and output targets. Identify any offsetting or corrective actions that should be considered. Issues for attention include at least:

* inter-ministerial coordination/collaboration;
* staff transfer practices;
* supervision (process vs results oriented)
* pharmaceutical supply system;
* role of different service providers in family health/planning services.

G. Assess the project purpose. Do the indicators anticipated appear to be reasonable? What changes, if any, should be made? How can this evaluation help design of the new project? Recommend future potential of USAID assistance in this sector.

H. Assess what has worked and what has not worked and the relative effectiveness of the various interventions to assist USAID in planning for our future role in the population sector.

I. <u>Selected Issue</u>

Given the importance of gender considerations in assessing the "people level impacts" of the Family Health and Population project in the future, the Evaluation Team will document the differential participation of men and women at each level of project activity subject to the availability of data. Special attention will be given to documenting on a gender disaggregated basis the participation by men and women in project activities/components. Based on this analysis, the Evaluation Team will draw conclusions regarding the principal constraints to effective participation by men and women in project activities, and will draw conclusions regarding opportunities to maximize effective participation by men and women in Population activities in future A.I.D. - funded projects in Senegal.

ARTICLE IV - REPORTS

The questions to be answered in the SOW are extensive and cannot all be addressed to the same level of detail and completeness. Therefore, the evaluation team will meet with a joint USAID/MSPAS advisory group to assess the relative importance of the expected evaluation and prepare a modified SOW (Table of Contents of evaluation report) for review by the advisory group at the end of week 1.

The preliminary conclusions and recommendations will be orally presented in English and French at a pre-departure briefing organized by USAID, and a draft report in English and a draft Project Evaluation Summary will be submitted to USAID prior to the departure of the team. Five copies of the final report in English will be submitted to USAID/Dakar for review and comment within 45 days of departure of the Team Leader.

The Evaluation Team Leader will be responsible for completing the Abstract and Narrative sections of the A.I.D. Evaluation Summary form. Detailed instructions for completing theses sections of the form will be provided to the Contractor in USAID/Dakar together with A.I.D.'s required format for evaluation reports.

ARTICLE V - TECHNICAL DIRECTIONS

Technical directions during the performance of this delivery order will be provided by USAID/Senegal Evaluation Officer , pursuant to Section F. 3 of the IQC contract.

A. Under the supervision of USAID/HPNO and the general guidance of the USAID Evaluation Officer, Chief of Party will direct contractor and Senegalese members of evaluation team.

B. Cooperating Country Liaison Officials: Commandant Aboubakry Thiam, CT Family Planning; Commandant Lamine Cisse Sarr, Directeur de la Sante Publique; Dr. Alassane Nakoulima, MSPAS; Mme. Marieme Diop, MSPAS; Mme. Awa Thiongane, MEFP/DPS.

C. A.I.D. Liaison Officials: Dr. Mary Ann Micka, Chief HPNO under the direction of USAID's Deputy Director and Director and in coordination with USAID's Evaluation Officer; Contractor: ISTI (Tim Rosche). Linda Lankenau, Deputy Chief HPNO will backstop the team and provide day to day guidance.

ARTICLE VI TERM OF PERFORMANCE

A. The effective date of this delivery order is March 27, 1991 and the estimated completion date is June 27, 1991.

B. Subject to the ceiling price established in this delivery order and with prior written approval of the Project Manager (see block 5 of the Cover Page), Contractor is authorized to extend the estimated completion date, provided that such extension does not cause the elapsed time for completion of the work, including furnishing of all deliverables, to extend beyond 30 calendar days from the original estimated completion date. The contractor shall attach a copy of the Project Manager's approval for any extension of the term of this order to the final voucher submitted for payment.

C. It is the contractor's responsibility to ensure that Project Manager-approved adjustments to the original estimated completion date do not result in costs incurred which exceed the ceiling price of this delivery order. Under no circumstances shall such adjustments authorize the Contractor to be paid any sum in excess of the delivery order.

D. Adjustments which will cause the elapsed time for completion of the work to exceed the original estimated completion date by more than 30 days must be approved in advance by the Contracting Officer.

ANNEX B

Project Logframe

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ANNEX B-1

Original Logframe

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PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

Life of Project:
From FY 85 to FY 92
Total U.S. Funding 20,000,0
Date prepared: 5/13/85

Project Title & Number: Family Health and Population (685-0248)

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Inputs:	Implementation Target (Type & Quality)		Assumptions for achievi inputs
I. USAID			
1. Technical assistance	348 pm LTTA 50 pm STTA	Financial and monitoring reports. Evaluat° & project reviews.	
2. Training	240 pm LT training 500 pm ST 70 in-country seminars & workshops.		
3. Commodities a) contraceptives b) other	 $1,667,000 $2,457,000		
4. Construction (renovation)	106 health facilities renovated.		
5. IEC activities	$1,082,000		
6. Operating expenses	$2,727,000		
7. Accounting/financial management	$500,000		
8. Evaluation	$150,000		
9. Contingency and inflation	$3,311,000		
II. GOS			
1. Personnel	$7,457,000 By 1992 550 personnel (profesional and non professional) equivalent working on project activities.	Functioning centers and headquarters.	GOS will make time of personnel available.
2. Facilities	By 1992, family health services being provided in 126 facilities for which GOS is paying operating cost $ 639,00 $8,096,000	Monitoring reports. Site visits.	GOS will provide facilitates & assure an increase proportion of basic operati xpenses

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
. LONG TERM GOAL: Achieve population growth rate which does not exceed projected increases in agricultural output & GOS ability to provide	Reduction in Senegal's Crude Birth rate (CBR) from 48 to 42 births over 1000 by the end of the project.	Demographic surveys by BNR. Final project evaluation.	GOS continues support for family planning program.
Project goal: Improve health of Senegalese women and their children through more effective birth spacing and to achieve population growth rates consistent with GOS ability to provide for basic health and social services.	Reductions of 10% in infant & maternal mortality and morbidity. - Improvement in children's nutritional status. - Reduction by 30% in high risk pregnancies.	Demographic surveys by BNR. Final project evaluation.	Basic preventive health programs for children suceed in lowering infant mortality rate.
. PURPOSE:) Public and private sector carrying out an effective nationwide family planning program by 1992.	1a) Safe and effective contraceptive services provided by the public and private sector to 200,000 couples.	Periodic surveys & statistics & collection of statistics. Project evaluations. Monitoring reports Availability of documents-results.	GOS will provide staff & facilities necessary for family planning project.
) Sufficient demographic survey and analytic capability exists to inform policy makers of the impacts of rapid population growth.	1b) Family planning services available in all 10 regions. 2) 1987 census will be fully processed & analyzed & published within three years.		GOS will allow publicat° of census.
. OUTPUTS: . Nationwide system of family health services delivery.	1a) Consolidation & expansion of service delivery in the 22 original centers.	Periodic survey & statistics & collection of service statistics.	Private/public sector interested in & capable of involvement in family planning.
. Consolidation & expansion of service delivery.	1b) Expansion of number of MSD/MOH centers in original 6 regions by 10 per year to a total of an additional	Project monitoring/site visits. Annual project reviews.	MPHSA continue to collaborate.
	1c) In years 1989-1992, addition of 2 2 MSD/MOH centers in each of last 4 regions (8 centers) in coordination with UNFPA.	Project evaluation.	
	1d) Renovation & minor construction as needed for the above 92 centers.	Engineer inspections.	
	1e) Commodities delivered on time, where needed.	Receiving reports submitted.	SMO can handle procurement of contraceptives; contractor, other procurement.
	1f) Establishment of commercial ratail	Visits to retail outlets.	
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
) Training) Physicians trained in family planning & treatment of sexually transmitted diseases and infertility.	a) At least 20 physicians trained.	2. (all points) - Project monitoring reports and evaluations. Annual project reviews.	2a. Sufficient number of physicians available and interested in family planning.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
) Nurses and midwives trained in clinical skills program in management, and in pedagogical skills.	b) 140 nurses, 140 midwives, 140 auxiliary trained in clinical skills - 50 trained in FP management, record keeping & data collection. - 20 nurse/midwives trained as trainers.	Participation in workshops.	2b. Sufficient number of midwives & related personnel interested in & available for FP trg.
) Logistics, supply, & statistical staff in handling/storing commodities & in keeping records.	c) 100 logisticians & support staff trained.	Improved record keeping systems.	2c. Trainees will continue work in family planning.
) IEC personnel in all aspects of developing and managing a complete IEC program.	d) 140 IEC agents trained in-country, including outreach workers and national level mass media specialists, & 35 IEC agents trained overseas.	National/regional family planning radio programs, product° of IEC materials, knowledge of FP.	2d. MSD will allot a sufficient number of outreach-workers for family planning.
) Pharmacists & other private groups in providing family planning materials and information.	2 workshops/year for pharmacists & other private & parastatal sector groups.	Workshops held. NGO projects funded.	2e. content of workshops relevant for Senegal.
) Health post & health hut personnel in family planning concepts.	25% of health posts providing family planning services.	FP availability in rural areas.	2f. GOS will approve nurses increased role in FP provision.
) Demographers (BNR) in census methodology.	- 2 long-term overseas trained. - 7 seminars/workshops on computer/statistical methods in-country.	Improved demographic data base.	2g. Sufficient personnel interested in & available for statistical training.
) GOS planners and policy makers in relating population growth to development objectives.	5 development planners trained.	Workshops & presentations to high level GOS policy makers.	2h. GOS political leaders interested in Pop/Development presentations.
) Natural family planning (NFP).	An annual workshop on FP.		
. IEC materials & activities:) Information, materials & programs made available through clinics, community education & special groups.	3a) IEC training, preparation and distribut° of IEC materials will be occuring in all 2 of the MSD/MOH existing at the beginning of the project.	3a 1) Project monitoring & visits. 2) Inspection of IEC materials. 3) Project evaluations.	3a) MSD will allot a sufficient number of IEC personnel.
) Use of radio, TV, newspaper & magazines.	By the end year 7, the full range of IEC activities will be occuring in 10 regions.		
) Family life education for youth.	3b) By year 3, regional radio broadcast; by the project mid-national level level radio broadcasts; & televised broadcasts. Implement IEC efforts through establishing televised broadcasts.	3b) TV & radio broadcasts.	
	Establishing family health educat° program for secondary school students.	3c) Monitoring reports Inspection of curriculum.	3c) GOS will permit family health education program.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
) In-service, pre-service training and study tours of project staff & political & religious leaders.	3d) Renovat° & provis° of equipment as required in the MSD/MOH centers participating in the project. 70 political & religious leaders & project staff sent on study tours.	3d) Monitoring reports Debriefing and reports of participants.	Collaborating countries will permit visits.
. Treatment of sexually transmitted diseases (STD) and infertility.	a) Provide STD treatment to at least 30,000 patients. 4a) 5 physicians & medical faculty trained in STD and infertility 3.5. m. per year. b) two regional centers equiped and materials provided. c) Improved referrals from health centers & health posts to STD centers. d) Refurnish & equip STD center at Le Dantec Hospital. e) Equip 27 health center for STD diagnosis.	For all items under 4: Monitoring reports Project reviews and evaluations.	
. Support to women's groups for income-generating activities combined with family health educat°.	5a) 62 small projects over LOP.	Monitoring reports Project reviews.	IEC regional coordinators take responsibility to
. Undertake operations research.	a) OR study to assess the effectiveness of integrated community based program (in Pikine, Kaolack, Fatick). b) Feasibility study to assess a national &adequate distribution of contraceptives. c) Bio/medical/psycho social research studies as needed.		initiate projects.
. Non-governmental sector Family planning activities implemented by PVOs and a variety of other organizations.	B. 30,000 acceptors by and of project.		
. Enhanced demographic data base to improve development planning.	C. Assist 1987 Census by: 1)- design & pretest question - produce updated census maps - install software packages & provide micro computers to assist in the editing, tabulating, presentation & analysis of the 1987 census	N.B. Project monitoring reports evaluations, and project reviews. 1) Project monitoring reports.	1) GOS will publish results of census & surveys

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
	2) Workshops/seminars to educate development planners throughout the GOS on the impact of rapid populat° growth on sectoral goals.	2) Attendance at seminars; monitoring reports.	2) Content of workshops relevant to GOS planners.
	3) Support periodic surveys on project on family planning, MCH, & demographic trends.	3) Attendance at workshops.	3) Availability of computer hardware and software.
	4) Support a national DHS. reports.	4) Examination of survey reports.	4) GOS will allow free access to survey results.
	5) Updated RAPID model/presentation for public & private sector audiences completed.	5) Attendance at presentat°	5 + 6 Models and seminars are relevant to Senegal &
	6) Support seminars/research held during project on impact of rapid population growth on development in and the effect of cultural factors on on family planning acceptance.	6) Attendance at seminars.	

ANNEX B-2

Amendment of May 13, 1985

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PROJECT [illegible] SUMMARY

LOGICAL FRAMEWORK

Life of Project:
From FY 85 to FY 92
Total US Funding 20,000,000
Date prepared 5/13/85

Project Title & Number: Family Health and Population 685-0248

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
I. LONG TERM GOAL: Achieve population growth rate which does not exceed projected increases in agricultural output and GOS ability to provide for basic health and social services.	Reduction in Senegal's Crude Birth rate (CBR) from 48 to 42 births over 1000 by the end of the project.	Demographic surveys by BNR. Final project evaluation	GOS continues support for family planning program.
Project goal: Improve health of Senegalese women and their children through more effective birth spacing and to achieve population growth rates consistent with GOS ability to provide for basic health and social services	Reductions of 10% in infant and maternal mortality and morbidity - Improvement in children's nutritional status. - Reduction by 30% in high risk pregnancies	Demographic surveys by BNR. Final project evaluation	Basic preventive health programs for children suceed in lowering infant mortality rate

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NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
II. PURPOSE: 1) Public and private sector carrying out an effective nationwide family planning program by 1992. 2) Sufficient demographic survey and analytic capability exists to inform policy makers of the impacts of rapid population growth.	1a) Safe and effective contraceptive services provided ~~by the~~ by the public and private sector to 200,000 couples. 1b) Family planning services available in all 10 regions. 2) 1987 census will be fully processed and analyzed and results published within three years.	Periodic surveys and statistics and collection of service statistics. Project evaluations. Monitoring reports Availability of documents-results	GOS will provide staff and facilities necessary for family planning project. GOS will allow publication of census.
III. OUTPUTS: A. Nationwide system of family health services established. 1. Consolidation and expansion of service delivery.	1a) Consolidation and expansion of service delivery in the 22 original centers. 1b) Expansion of number of MSD/MOH centers in original 6 regions by 15 per year to a total of 128 by 1992. 1c) In years 1989-1992, addition of 5 MSD/MOH centers in each of last 4 regions (20 centers).	Periodic surveys and collection of service statistics Project monitoring/site visits Annual project reviews Project evaluation	Private/public sector interested in and capable of involvement in family planning MOH/MSD continue to collaborate.

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
	1d) Renovation of 106 centers completed by 1992	Engineer inspections	
	1e) Commodities delivered on time, where needed.	Receiving reports submitted	SMO can handle procurement of contraceptives; contractor, other procurement
	1f) Establishment of commercial retail sales project if study indicates appropriate.	Visits to retail outlets	

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
2. Training			
a) Physicians trained in family planning and treatment of sexually transmitted diseases and infertility.	1. At least 50 physicians trained	2 (all points) Project monitoring reports and evaluations Annual project reviews	2a. Sufficient number of physicians available and interested in family planning
b. Nurses and midwives trained in clinical skills program in management, and in pedagogical skills.	370 nurse/midwives trained	Participation in workshops.	2b. Sufficient number of midwives and related personnel interested in and available for family planning training
c. Logistics, supply, and statistical staff in handling/storing commodities and in keeping records.	50 logisticians and support staff trained	Improved record keeping systems	2c. Trainees will continue work in family planning
d. IEC personnel in all aspects of developing and managing a complete IEC program	350 IEC agents trained, including outreach workers and national level mass media specialists	National/regional family planning radio programs, production of IEC materials, knowledge of family planning	2d. MSD will allot a sufficient number of outreach-workers for family plan-

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
e. Pharmacists and other private groups in providing family planning materials and information	400 persons in non-Gov. sector trained	Workshops held. NGO projects funded	2e. Content of workshops relevant for Senegal
f. Health post and health hut personnel in family planning concepts	70 community level workers trained	F.P. availability in rural areas	2f. GOS will approve nurses increased role in f.p. provision
g. Demographers (BNR) in census methodology	35 statistician/demographers trained	Improved demographic data base	2g. Sufficient personnel interested in and available for statistical training
h. GOS planners and policy makers in relating population growth to development objectives	35 development planners trained	Workshops and presentations to high level GOS policy makers	2h. GOS political leaders interested in Pop/Development presentations

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
3. IEC materials and activities a. Information, materials and programs made available through clinics, community education and special groups b. Use of radio, TV, newspaper and magazines c. Family life education for youth	3a) By the end of year 2, IEC training, preparation and distribution of IEC materials will be occurring in all the existing MSD/MOH centers By the end of year 7 the full range of IEC activities will be occurring in all 10 regions.	3a 1) Project monitoring and visits 2) Inspection of IEC materials 3) Project evaluations.	3a MSD will allot a sufficient number of IEC personnel
	3b. By the end of year 2, regional radio broadcasts; by the end of year 4 national radio broadcasts; By year 5, televised broadcasts.	3b. TV and radio broadcasts.	
	3c. By the end of year 3, design of a family health education program for secondary school students; program used in schools by year 5 of project.	3c. Monitoring reports Inspection of curriculum	3c. GOS will permit family health education program
d. In-service, pre-service training and study tours of project staff and political and religious leaders	3d. Political and religious leaders 10 a year on study tours	3d. Monitoring reports Debriefing and reports of participants	Collaborating countries will permit visits

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
4. Treatment of sexually transmitted diseases (STD) and infertility	4a) 5 physicians and medical faculty trained in STD and infertility 3.5 m. per year b) Two centers equipped and materials provided. c) Improved referrals from health centers and health posts to STD centers	For all items under 4: Monitoring reports Project reviews and evaluations	
5. Support to women's groups for income-generating activities combined with family health education	5a) Not fewer than 50 small projects over LOP b) Improved IEC efforts through project c) Improved coordination between regional IEC and clinical coordinators	Monitoring reports Project reviews	IEC regional coordinators take responsibility to initiate projects
B. Non-governmental sector family planning activities implemented by PVOs and a variety of other organizations	B. 10,000 acceptors through NGOs by year 4; 30,000 acceptors by end of project		

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
C. Enhanced demographic data base to improve development planning	C1) 1987 Census results published within 3 years after data collection	N.B. Project monitoring reports evaluations, and project reviews 1. Project monitoring reports	1. GOS will publish results of census and surveys
	2) Workshops/seminars to educate development planners throughout the GOS on the impact of rapid population growth on sectoral goals. 1 seminar/year; through year 4 2 seminars/year last 3 years	2. Attendance at seminars; monitoring reports	2. Content of workshops relevant to GOS planners
	3) Up to 3 micro-computer and/or statistical methods workshops held in Senegal during first 4 years of project	3. Attendance at workshops	3. Availability of computer hardware and software
	4) At least 6 surveys (1 in year 1) over project on family planning, MCH, and demographic trends	4. Examination of survey reports	4. GOS will allow free access to survey results

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Outputs:	Magnitude of Outputs		Assumptions for achieving Outputs:
	5. Updated RAPID model/presentation for public and private sector audiences completed by end of year 3.	5. Attendance at presentation	5+6 Models and seminars are relevant to Senegal and of interest to policy makers
	6. At least 3 seminars held during project on impact of rapid population growth on development in Senegal and the effect of cultural factors on family planning acceptance	6. Attendance at seminars	

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

Life of Project:
From FY 85 to FY 92
Total US Funding 20,000,000
Date prepared 5/13/85

Project Title & Number: Family Health and Population 685-0248

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Inputs:	Implementation Target (Type and Quantity):		Assumptions for achieving inputs
C. USAID			
1. Technical assistance	348 pm LTTA 50 pm S-TTA	Financial and monitoring reports. Evaluations and project reviews	
2. Training	240 pm L-T training 500 pm S-T 70 in-country seminars and workshops		
3. Commodities a) contraceptives b) other	 $1,667,000 $2,457,000		
4. Construction (renovation)	106 health facilities renovated		
5. IEC activities	$1,082,000		
6. Operating expenses	$2,727,000		

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
ACHIEVEMENTS	INDICATORS	VERIFICATION	ASSUMPTIONS
Inputs:	Implementation Target (Type and Quantity): Magnitude of inputs		Assumptions for achieving inputs
7. Accounting/financial management	$ 500,000		
8. Evaluation	$ 150,000		
9. Contingency and inflation	$3,311,000		
II. GOS			
1. Personnel	$7,457,000 By 1992 550 personnel (professional and non professional) equivalent working on project activities	Functioning centers and headquarters	GOS will make time of personnel available
2. Facilities	By 1992, family health services being provided in 126 facilities for which GOS is paying operating cost $ 639,000 $8,096,000	Monitoring reports Site visits	GOS will provide facilities and assure an increase proportion of basic operating expenses

ANNEX C

Evaluation Questionnaires

ANNEX C-1

Family Planning Clinical Services

ANNEX C-1

Evaluation Questionnaire--Family Planning Clinical Services

A. Family Planning Sites

At the PF Center

1. Is there a waiting room in the center?

2. Is there enough space for the consultants (patients)?

3. Toilets for the consultants?

4. Posters and other visual aids?

5. Leaflets and booklets for the consultants?

6. Consulting Room

   •Preservations of the consultants privacy?
   •Availability of contraceptive samples (for demonstrations)?
   •Availability of booklets, leaflets, magazines for service providers?
   •Light?
   •Water supply?

7. Restoration or construction work carried out in the center?

8. Quality of the existing infrastructure?

9. Does the center need improvements?
   •if yes, in which area?

At the laboratory

1. Is there adequate space for lab activities?
   •if yes, why?

2. Is there adequate equipment?
   •if no, what is missing?

3. Have improvements been made?
   •if yes, in which area?

4. Note other constraints.

Family planning equipment

1. Is there enough equipment for the center to provide good quality services?

2. List of needed standard equipment as compared with the existing equipment.

3. Which sterilization process is used for FP equipment? Indicate the process, the time, the temperature, etc. for:

   •syringes and needles
   •metal equipment (speculum, forceps, scissors etc...)
   •gloves
   •examination table

4. Special problems and constraints.

B. Training

1. Number of people trained in key professional categories such as family planing clinical services, health and population management, communications, etc.

   •Doctors
   •Midwives
   •Nurses
   •Social workers
   •Others

2. Number and types of training seminars. Determine objectives of seminar and number and types of trainees.

3. Number and types of study missions. Determine places visited, profile of trainees and objectives of mission.

4. Number and type of retraining services. Determine types of training and trainees.

5. Who decides on the curriculum of health agent's training and which agents participate in the training?

SFE	?
IDE/AS	?
TS	?
Doctors	?
Other	?

6. Which areas need further attention?

   •Clinical (theory and practice)
   •IEC
   •Management
   •Training
   •Other

7. Are there problems which specifically relate to this training? Which are they?

8. What do trainees think about the training they were are provided? How could training be improved?

9. What is the curriculum and training modules introduced into FP training centers?

   •SFE
   •IDE
   •CESSI
   •Medicine
   •ISED

10. Problems relating to the introduction of FP in training centers.

11. How was FP integrated in the school curriculum?

12. If yes

    •number of hours
    •scheduling
    •ratio of theory to practice

13. Had students been previously trained in family planning?
    •if yes, how many?

14. How have trainees performed in the field?

15. What support has the project given for the introduction of FP in the training schools' curriculum?

C. Clinical services

Contraception

1. Days and schedule of FP activities?

2. Numbers and percentages of hours for FP activities?

3. Organization of activities

•reception
•registration of consultants (patients)
•counselling and examination
•prescription of methods
•follow-up activities

4. Are there systematic laboratory examinations in this center?

5. Types of available contraceptive productions and cost services?

6. Performance of the agents--very good; good; average?

•Reception
•Counselling
•Questioning
•Clinical examination--general breast, gyneco, etc.

7. Selection of the appropriate method

•Administration of the method
- contra-indications
- introductions
- IUD insertion technique
- injection technique (Depa-Noristerat)

•Follow-up activities

- control the follow-up parameters
- satisfaction with the method
- DDR, weight, TA
- correct use of the method
- CAT for side-effects
- periodicity of the follow-up activities

•Is there a system for finding consultants who did not come to their appointments? If yes, describe the system?

8. What is the relationship of the PF Center with other SMI services?

•Maternity
•Nutrition
•CNP
•PEV
•Consultation of deceased children

9. What is the integration of FP in MCC (SMI) activities?

STD--Infertility

1. What is the frequency of STDs among consultants?

2. Performance of the agents in the diagnosis and treatment of STDs and infertility?

3. What is the relationship of clinical personnel with the lab service and the importance of lab analysis in the diagnosis and treatment of STDs and infertility?

4. Is a sufficient supply of appropriate drugs available for the treatment of STDs?

5. Do clinicians systematically treat all other contacts for each STD case?

D. The Health Information System

1. Is there a patient card-index system?

2. What is the organization;n of this system.

3. Is there a manual for the elaboration of files, registers and periodic reports?

4. Evaluate the cards, registers or other bases of the report you are sing in this program? (content, format, etc.)

5. Describe the types of consultants

•New
•Old
•Active
•Withdrawal

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6. How are consultants called who attended the center in the past and comes back?

7. How are consultants counted who attended another center and comes to a new center for the first time?

8. A consultant who benefitted from the services of another center and comes to your center for temporary services?

9. A consultant who uses a contraceptive method which is not available in the center and has a prescription? Is she registered?

10. What were the numbers in the latest (December 1990) report?
    FP _____ Consultants Total _____
    STD _____ Consultants Total _____
    Infertility ____

11. Is there report on FP only?

12. If no, is it part of the other SMI activities?

13. What is the purpose of this data collection?

14. To whom are reports sent?

15. Is there any feed-back from higher authorities?

16. Do PF Centers carry out an initial analysis of the data collected?

17. If yes, do they help you make better decisions for the improvement of services?

18. Problems and constraints in the collection of population service data?

19. Suggestions for the improvement for services.

E. Supervision

1. Is there a supervision system?
   •if yes, describe the system (actors and components)

2. FP Center
   - Who supervises the Center?
   - Frequency of the supervising activities?
   - Is there a supervision instrument?
   - Is it an integrated approach (FP only)?
   - If no, does it involve other SMI components?
   - Is there a feed-back mechanism?
   - If yes, describe the mechanism

3. Which sectors of activity constitute the object of supervision during your visits to the FP center?

4. What are the constraints to the execution of supervision programs?

F. Reference Systems

1. Are some cases sent into a reference structures?

2. If yes, which cases?

   - ligatures
   - norplant
   - STD
   - infertility
   - other

3. What is the reference structure?

4. Is there any feed-back concerning those cases?

G. Questions For Doctors and Coordinators

1. What are your activities in relation to PSFP?

2. Time dedicated to FP (%)

3. Did you get any FP training?

4. If yes, which type of training and when?

5. Did you have any recycling session

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6. Could you describe your supervising system?

7. Did you ever get any results of the various studies which have been carried out on SMI/PF? If yes, which results?

8. Did you use those results to make decisions destined to improve the implementation of FP programs?

9. Make a brief description of the current situation in the delivery of FP services in your region (Programs, management, epidemics and public health)

10. Problems and constraints at all levels.
    •Region
    •Center

H. Questions for Consultants (Patients)

1. How long have you been using a modern contraceptive method?
   1 year
   > 2 years ≤ 5 years
   > 5 years

2. Do you think that the opening days and hours of the clinic are convenient?

3. Are you satisfied with the services provided?
   •explain

4. Are you satisfied with the reception you get at the clinic?
   •explain

5. What do you think of your relationship with the person?
   •explain

6. What do you think of the cost of services?
   •very expensive; reasonable; cheap?

7. How long do you wait before service is provided?
   - 14 - 30 mn
   - 30 - 60 mn
   - > 1 hour

8. Do you have any suggestions for the improvement of the services?
   •if yes, indicate your suggestions

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9. Do you think that it is good to separate FP from other SMI activities?
•explain

10. Do you think that FP is good for the health of mothers and/or children?
•explain

11. Would you recommend your daughter or your or your sister to practice FP?

12. Did you need or have your husband's approval for the use of an FP method?
•explain.

13. Is there any other person, besides your husband who influence your decision (for or against) to use a modern FP method? Indicate whom.

I. Questions for Community Leaders

1. What do you think of FP?

2. What is your relationship with FP centers?

3. What do you think of services provided by MCC/FP (SMI/FP) centers?

4. Do you have suggestions for the improvement of FP services?
•if yes, which suggestions?

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ANNEX C-2

Commodity and Contraceptives Logistics

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ANNEX C-2

Evaluation Questionnaire-Commodity and Contraceptives Logistics

A. What types and quantities of contraceptives are currently in stock? If more than one manufacturer per item, indicate so.

B. How are the contraceptives stored? (e.g., thrown together in a desk drawer; sorted by item in a locked cupboard.) Are there different types of storage systems, e.g., a daily/weekly stock maintained separately from a larger stock?

C. Are inventory/bin cards maintained for each type of contraceptive? Are they kept up to date? Which clinic staff member is responsible for filling out inventory cards. Is there any supervisory controls over the inventory system? If bin cards are not used describe the way stock movements are controlled.

D. Review receiving/issuing documents on contraceptives - if any.

E. Perform a sample physical count of 2 or 3 items to check veracity of inventory cards or other inventory system maintained.

F. Are any contraceptives expired - or close to being expired? Is the expiration date listed on the inventory cards? Do the clinic staff follow the "First-In - First-Out" principle?

G. If clinics have received more than one shipment of any one single type of contraceptive with different lot or manufacture dates - do they maintain separate bin cards for these items?

H. How does the SMI/PF clinic site receive/order contraceptives?

- Does the clinic initiate the contraceptive order? (full system.)
- If so - what order forms do they use; from whom do they order (describe the ordering procedure, i.e.: clinic -> medecin chef -> regional/district coordinator -> central level) and what approvals are required?
- On what time frame basis are contraceptives ordered, i.e.: as needed: every month; every six months, etc? How long does it normally require to receive the commodities after placing the order?
- Does the clinic staff understand the principle of safety/security stocks as against working stocks? How many months of stock do they maintain?
- Do they always receive the same quantities as they ordered -if not, why not?

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I. How are the contraceptives delivered/transported to the clinic site? (Describe any problems in the transport system and discuss options to perform this task, i.e. commercial/private vehicles?)

J. Do stock outages/ruptures occur? If so at what frequencies? What does the clinic do if outages occur - what are the reasons/causes for any stock ruptures? (In such cases can they "borrow" items from another source - issue 'ordinances' to private pharmacies/clinic?)

K. The Regional coordinators - do they utilize a push system or combination push/pull?

- •Do they maintain their clinics stock separate from other clinics in their region stocks? Months of supply on-hand; how ordered and frequency from central level?
- •How (and based on what information/reports/statistics) do they supply the clinics in their region? Do they always provide quantities ordered. If not, why not? What do they do when their own stocks are low/ruptured?
- •How do they distribute/transport contraceptives to clinics in their region if their vehicle/fuel is not available? What are other options? Do they schedule regular deliveries? What are the frequencies?
- •On what basis do they report to the central level - what forms/frequencies - is logistical/inventory information contained in the reports - is there any central level feedback on the reports they send? What feedback does the receiving officer give on the reports she receives from the clinics under her control?)

L. At the clinic level what types (and frequencies) of supervisory visits do they receive? (From Regional Coordinators, MPHSA/Central level, USAID, ISTI, others?) Are supervisory protocols used? Are any inventory management controls undertaken during these supervisory visits?

M. Do they receive contraceptives from other donors? i.e.: UNFPA, IPPF, Pathfinder, etc? (List items and quantities) If a client desires a method not in stock, i.e. injectables -what does the clinic do?

N. 19 project staff were trained in logistics - are there any at the clinic? - if so, have them describe the training. Do they require additional training? What is their opinion of the training (quality and subject) that they received?

O. Project Coordination: What are the present decisions mode re commodities by GOS, Project, ISTI, USAID? Are there any coordination/responsibility/budgetary issues?

P. Service Statistics: Attempt for the past six or twelve months to quantify the actual amounts of individual contraceptives distributed to clients, i.e.: X IUDS, X condoms, etc. Reconcile these totals from amounts received by the clinics (use shipping/reception documents) and stocks-on-hand. The purpose of this exercise is to

determine the amount of "losses" and any explanations there-of.

Other General Logistical Issues to be Investigated

1. How does the central level provide contraceptives to the regions? (push, pull, or combination)

2. Which new or improved reporting should be recommended?
   - •Describe the path reports take emanating from the regional coordinators. What does the National Coordinatrice do with the quarterly reports she receives? What should she do with them? (e.g. involvement or distribution to the Project, ISTI, AID, technical or clinical directors.)
   - •Are there sufficient logistical/inventory data contained in the regional reports to enable central level to determine quantities to be sent to the regions?
   - •On what basis does the central level distribute contraceptives to the regions?
     - a) based on reports?
     - b) based on quantities in the central warehouse?
     - c) Is there a set schedule for deliveries to the regions? i.e. every six months?
     - d) Who prepares actual distribution plans (i.e., Technical Directors, Project, National Coordinator, ISTI, Project, AID?) What is the role of each of the above in the preparation of contraceptive distribution plans; who approves; who receives copies, etc.
     - e) Who initiates/arranges for transport - prepares shipping documents, arranges PNA truck, fuel, laborers?
     - f) Review shipping forms - who receives/controls the returned copies?

2. What does the central level do when informed of stock outages in a region?

3. How are annual contraceptive orders (CPTS) prepared? Who is involved in the process - using what data - what percent for expansion, preparation/sending of CPTS? Who receives and controls shipment? Are the 2-way memos sent back?

4. In response to the informal logistics audit what is the current status of the central warehouse? Are inventory cards filled-out; who has keys; how many people are responsible for items in the warehouse and commodity movements in/out of the warehouse? Is there a precise understanding of the responsibility process?

5. Transport: Can we continue to rely on PNA for their trucks to transport Project commodities? If items are lost during shipping - who is responsible? Should we budget for 'rented' transport?

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6. Using the latest service statistics and contraceptives distributed to date, determine CYP totals to date.

7. Review all contraceptive orders to date, compare to quantities received and review contraceptive budget allocation to determine amount balance of funds remaining.

8. Attempt to reconcile amount of contraceptives received, distributed to clients, stocks on-hand to determine amount of losses.

9. Address the issue of approximately 800.000 condoms, many from the Project, being sold on black-market. Address the issue of Project staff misappropriating contraceptives for personal sales/profit.

10. To relieve dependance on AID provided contraceptives, and their cost, review the potential for increasing the cost to the client to at least recover costs of contraceptives.

11. Is UNFPA distributing, or and plans to distribute, non-AID available contraceptives to Project regions? How does the Project determine contraceptive needs for the four UNFPA regions? What will be the impact of the World Bank's proposal to supply 25% of Senegal's contraceptive needs under their new project?

12. Review logistical training needs for project staff.

13. Review supervisory protocols, schedules, trip reports of central level staff and problems, i.e., no fuel, per-diems, etc.

14. Review ordering of social marketing condoms (500.000 units) under public sector instead of the private sector.

15. Investigate possibility instituting within MPHSA <u>one</u> Division only responsible coordinating all FP activities for ordering of contraceptives for both public/private sectors.

16. Push to introduce <u>L MIS</u> (L = logistics) reporting system for Project i.e.: one form that contains both service statistics <u>and</u> inventory information.

NOTE: Many of those, some questions will be asked as regards to private sector purchase, distribution, storage and sale of contraceptive. An attempt will be made to compare quality, service and cost between the public and private sectors.

ANNEX C-3

Information, Education and Communication

ANNEX C-3

Evaluation Questionnaire--Information, Education and Communications

A. Strategy

1. What is the overall strategy of the Project IEC program?

- is it directed to increasing acceptance?
- increasing continuance?
- is it different for urban and rural areas?
- is there a special strategy for men? women? Urban men? Urban women?
- is there an attempt to promote a particular contraceptive method, or are all equally promoted?
- what is the communications strategy: child spacing, health of mother, economic benefit, child health?
- have different themes been developed for different audiences, such as men, young women, etc.?
- of the 6 Project regions, is there a different strategy for each; if so, what is it and on what socio-economic differences has it been based?
- what research was carried out to provide information about the target population and how was this research used to develop a communications strategy?

2. What is the media/educational strategy designed for each target group of the population, defined as in #1, above?

- for whom are the mass media intended? All groups? Influentials only?
- what is the specific purpose of the mass media? To inform, to increase knowledge, to effect a positive attitudinal shift? To influence behavioral change?

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- who are the interpersonal agents in the program and why were they chosen?

- what are the relationships among the public, private, and voluntary sectors in the project?

B. Implementation

1. How are mass media, interpersonal, audio visual elements of the IEC program developed?

   - how are they conceived, and by whom? Project staff? Consultants? National radio and television personnel? Other, relevant ministries?

   - how are they produced? Private sector? Public sector? Did consultants play a role?

   - how are they disseminated? What is the interpersonal program: who are the key actors and who are their supervisors? For mass media, what are the formal agreements between producers and disseminators (i.e., the Project and National Radio and Television; or the Project and the press)? Are dissemination fees charged? For audio-visual and print materials, what distribution plan has been established: what materials are distributed, in what numbers, to whom, and over what period of time? Are materials distributed in series, or simply additional copies of the same material?

   - how are those involved in any of the IEC program elements trained? Where are they trained, by whom, for how long, with what curriculum?

2. Is the IEC program integrated; that is, functionally relating elements of mass media, interpersonal communication, the use of audio-visual and print materials?

   - have distinct, functional goals been set: i.e., so many new acceptors per Region, per length of time?

   - what are the monitoring procedures put into place to determine program performance?

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3. What is the institutional/management framework of the IEC component? What institutions - Project, public, parastatal, private, community - must work together and under what agreements?

- how are Project elements supervised?
- managed?
- financially controlled?

4. What non-IEC factors constrain the IEC program?

- the organization and management of health center staff?
- logistics - the availability and regularity of delivery of contraceptives?
- administrative, bureaucratic, political environment?

C. Program details

1. Interpersonal

- What staff, at what institutional level are the IEC agents?
- What training have they received? and what measures of the quality, appropriateness, or sufficiency of this training have been developed and applied?
- Was the training comprehensive, and did it focus on: family planning, educational methods, the use of educational materials?
- What supervisory system was set up to monitor interpersonal activity?
- Was re-training envisaged and carried out in the Project?

2. Mass Media

- Who was responsible for conception, development, production, dissemination, evaluation?
- What kind of research, pre-testing was carried out?
- What was the final media mix and how was it determined?

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- What was the final frequency plan? How many spots, for example, over what period of time, using how many stations?

- What was the specific target audience?

3. Other educational material

- What educational materials were developed for the Project and what did they cost (low cost-benefit has been a particular problem for such materials)?

- For whom were the material intended? For what specific groups? For what use were they intended? Reminder media? As teaching materials?

- Who produced the material?

4. Management

- Overall Project IEC responsibility?

- Coordination of public, private, volunteer activities?

- Supervision?

- Data collection? Reporting procedures?

ANNEX C-4

Data Base Improvement

ANNEX C-4

Evaluation Questionnaire--Data Base Improvement

A. BNR - Development of Demographic Data Base

1. How many census reports have been published during the project period? On what topics? Has the census data been used for making population policy, development planning, and population projections? Have study findings been disseminated?

2. How many training seminars/workshops on census methodology and analysis have been held in Senegal for demographers and statisticians?

3. How many demographers have received short-term and/or long-term training abroad during the project period?

4. How many demographic and health surveys were carried out by BNR during the study period? Were the results used for population policy development and for the family planning program? Were the findings disseminated? Has the quality of census and survey data been good, or improved, during the project period? What is the function and utility of the regional surveys and how many have been conducted?

5. How much TA was given to the BNR by the U.S. Bureau of Census and in what areas? Was it useful TA and appreciated?

6. What special demographic studies were conducted during the project period (demographic, bio-medical, psycho-social)? Were the results published and disseminated? Were the special consultants useful (village monographes)?

7. Has the BNR budget been expended according to schedule (for data collection, training, TA, publication and dissemination)? Did the Senegalese government pay for publication, staff, gas?

8. Are fertility and mortality data/tables available from the 100% results of the 1988 census?

9. Are fertility and family planning data/tables available from the 1990 Urban family Planning/KAP study? If so, what are the results?

10. What do the national census data, the 1986 DHS, 1990 Urban FP/KAP study and the family planning service statistics, and data on training tell us about the progress of the SFHP project during the 1985-91 period? Has contraceptive prevalence increased during the period? Has the total fertility rate and infant mortality rate been reduced in the project and non-project areas during the period and if so, by how much?

11. How does the BNR interact with the PSFP, ISTI, and Ministry of Public Health in the collection and dissemination of health, family planning and population data? Should coordination and cooperation be increased between these organizations?

12. Has the BNR kept to their deadlines for collecting and analyzing census and survey data, and publishing census and survey results?

13. What are the BNR, the Ministry of Public Health, and the Family Health and Population Project staffs' perceptions regarding the technical assistance provided by ISTI and other NGOs supported by USAID (training, computer software, management evaluation advice, research and data analysis, provision of contraceptives and IEC information, local currency support for data collection, etc.)?

14. Who makes the decisions on the workplan and execution of the BNR activities under the Senegal Family Health and Population Project? Does BNR have an annual workplan (regarding studies, training, and TA) ?

15. What are the demands placed on the BNR, the Ministry of Public Health family planning project centers, and the VSPP center activities from other donors (World Bank, UNFPA, IDRC, WHO, private foundation) and NGOs (e.g., Population Council, FHI, MSH, JSI, Futures Group, JHU, PRB, IRD)? Do these other activities complement or compete with the SFHP project activities? Could they be coordinated better?

B. <u>Population Policy Development - RAPID II Program</u>

16. What has been the progression in the development of population policy for Senegal during the 1985-91 project period? Has population, family planning and demographic change become an integral part of development planning and policy?

17. What precise demographic targets have been adopted for the country (if any), e.g., increase in life expectancy, reduction of infant, child and maternal mortality, reduction of fertility and rate of population growth, increase in contraceptive prevalence? Are the targets realistic/achievable? Have the targets been achieved or on course to be realized?

18. How many RAPID II presentations and impact of population growth seminars have been held during the project period?

C. Family Planning Information System PSFP/SNSMI

19. How many births were averted as a result of the PSFP?

20. What are the number of contraceptive acceptors of each contraceptive method, by year and center (govt/SNSMI and private/VSPP)? (new acceptors and active acceptors)

21. What is the total couple-years of contraceptive protection provided by the government centers, the private sector/VSPP, and the commercial sector (use imports/distribution/sales figures for commercial sector).

22. Has contraceptive continuation and user satisfaction improved during the period? Has knowledge and attitudes towards family planning improved during the period? Have the quality and availability of family planning services improved during the project period?

23. What are the standard forms (fiches) used at the government and private centers for collecting information on acceptors (e.g., client characteristics, counseling, follow-up visits, side effects, drop-outs,etc)? What are the basic data collected on these forms? Are the data used for program decision-making?

24. How do the family planning center staff record, tally, and forward these statistics to the regional centers and national headquarters for the project?

25. Are PF center staff satisfied with these forms and the system of record keeping? If no, what would they like changed in the forms or procedures for reporting? Should the forms be simplified? Is more training needed in record keeping/data collection? Should the family planning data collection be more fully integrated into the general system for the collecting and reporting of health data from government health centers?

26. Have many centers have standardized data collection systems in place (i.e., using standard forms)? How many have computerized data bases for monthly, quarterly reporting of statistics?

27. How many nurses, doctors, health workers, clerks, and sages femmes have received training under this project, by year of training and duration of training?

28. Who is responsible in the centers, and at the regional and national level for the family planning service statistics reporting system? Have there been supervision problems in filling out the forms? Are they a low priority?

ANNEX C-5

Private and Para-Public Sector

ANNEX C-5

Evaluation Questionnaire--Private and Para-Public Component

A. Determine and analyze the goals for each of the categorize of the private and para-public organizations (VSPP) that receive assistance from the FHPP.

- Local NGOs
- International PVOs
- Private Doctors
- Private Clinics
- Private Pharmacies
- Private Enterprises that support FP with
  -payment programs
  -SMI/PF centers
- Religious Organizations
- Semi-Public Organizations

B. What type of FP and health related activities are carried out by the above VSPP organizations? How do actual activities relate to their potential role.

- IEC
- Policy development assistance for policy makers
- Individual FP Counseling and Advice
- Other health and medical services including vaccinations
- Free or subsidized distribution of contraceptives
- Commercial sale or distribution of contraceptives
- Pre and post natal SMI
- MST analysis and treatment

C. Determine and analyze the amount and type of external donor, public budget and private resources that flow through the above VSPP organizations. What portion of VSPP financing comes from the project? What is the relative effectiveness of each?

D. What is the attitude of participants and beneficiaries for the involvement of the private sector in FP activities? E.g., quality, quantity and demand.

- Senegal's political leadership
- Ministry officials concerned with
  -health, and
  -family planning
- Private Sector Actors
- Present and Potential Users of FP Services

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E. What has been the relative impact and cost effectiveness of private and para-public sector PF activities?

- on population planning indicators
- relative cost and quality of private sector services
- comparison with similar public sector services
- means of verification exist for evaluating the impact.

F. What new, different, expanded, or reduced role should be proposed for the private and para-public sector in a future FP project? To what extent could the private and par-public sector in Senegal substitute for public services or reduce the cost of public services?

G. Should VSPP be a core, portion of Senegal's national family planning effort, or should it have a lower priority than some other components in a future project?

H. What role could the VSPP component play in a national social marketing program?

I. What would happen to the PF activities of the private and para-public organizations, if the project no longer provided them with some measure of support? Are there alternative sources of financing?

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ANNEX D

Justification for, and Notes on, a Field Trip to Kolda and Ziguinchor

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UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
USAID · BP 49 DAKAR, SENEGAL

Dakar, le 23 avril 1991

Madame Marième Diop
Directeur
Projet Santé Familiale
s/c ISTI
Point E
DAKAR

AID/HPNO/91-0197

Madame le Directeur,

Dans le cadre de l'évaluation du PSFP, M. Jack Packard, expert en logistique, se rendra en mission à Kolda et à Ziguinchor du 28 avril au 1er mai 1991. L'équipe d'évaluation sollicite votre assistance pour effectuer un test du système logistique durant cette visite.

Pour déterminer l'efficacité du système de distribution du PSFP et tester la possibilité d'accroître les stocks au niveau régional, nous vous saurions gré de bien vouloir prendre les dispositions suivantes :

- Contacter les coordinatrices régionales de Kolda et Ziguinchor en vue de déterminer leurs besoins en contraceptifs pour un approvisionnement de six mois. (Un objectif principal de ce test est de déterminer la faisabilité de la mise en place d'un stock de travail/sécurité de six mois dans les régions).

- Affréter un camion de la PNA pour transporter les contraceptifs dans les deux régions. Le camion devra être chargé le samedi 27 avril 1991.

Avec l'arrivée de 163.000 Conceptrol le 20 avril 1991, il y a suffisamment de stocks de Conceptrol, de préservatifs et de Lo-feminal disponibles dans le magasin de la PNA de Dakar pour assurer un approvisionnement de six mois aux deux régions. D'autre part, il ne semble pas y avoir un stock suffisant pour un approvisionnement de six mois en stérilets et en ovrettes. Par conséquent, le nombre exact sera déterminé avec les logisticiens du MSPAS et du PSFP et M. J. Packard les 22 et 23 avril 1991. Un nombre approprié de gants (stériles et non stériles) sera également distribué après concertations.

M. Jack Packard, le membre de l'équipe chargé de la logistique, vous serait reconnaissant de bien vouloir l'associer étroitement à toutes les étapes du test notamment le déplacement avec le camion dans les deux régions (l'USAID s'occupera de l'obtention de l'ordre de mission de M. Packard). Au cours de la mission, M. Packard évaluera également la situation logistique/ clinique dans ces deux régions.

Vous remerciant à l'avance de votre assistance dans cette affaire, nous vous prions d'agréer, Madame le Directeur, l'expression de nos salutations distinguées.

Linda Lankenau
Responsable des Programmes
de Population

Ampliations

Dr. A. Nakoulina, SN/SMI
Dr. A. Thiam, CT8/MSPAS
M. T. Rosché, ISTI

N.B. : Mme. Diop étant en mission hors du pays, nous comptons entièrement sur l'assistance du Dr. Nakoulima et de Mr. Laty Guéye NDoye pour la réussite de cette opération.

ANNEX D

NOTES ON FIELD TRIP TO KOLDA AND ZIGUINCHOR

During the last days of the evaluation, at the urging of Mission management, one evaluation team member, the logistician, visted clinics and warehouses in the Kolda and Zinuinchor regions. Beacause his visit was completed affter most of the evaluation report was drafted and because team members did not have an opportunity to fully consider the information learned on this trip, the trip report is included as a refrence in this annex

1. Kolda

It requires eight hours to drive from Dakar to Kolda. No security problems were encountered as some had feared. From the information that was obtained during the brief visit, the project in this Region appears to be in serious difficulty. The situation is nowhere being attacked since supervisory visits to the Regions have not been made to the 11 clinic in the region in almost 2 years by Dakar-based staff or by the Regional Coordinator . Some of the more important observations on the situation at Kolda are listed below:

- the Regional Coordinator stated she had not visited the 11 clinics for over a year and a half due to the cutoff of Project fuel,
- only two visits were made by Dakar-based staff during the past year and a half, and these were by the SMI logistician delivering supplies,
- only four of the 11 clinics reported 1990 service delivery statistics; and the Regional Coordinator had not sent the Kolda region's 1990 data to Dakar,
- no contraceptives have been distributed during 1991 from the regional warehouse,
- 98,100 condoms are stored in a hot, unventilated, regional warehouse in Kolda; these should be tested for quality in the Dakar laboratory before further distribution is made,
- if the condoms prove to be in good condition, most of them should be transferred for use in Zinguinchor or another Region,
- there is no inventory control systems at the regional warehouse, and no inventory records,
- at only four of the 11 clinics have staff been trained in family planning.

2. Ziguinchor

Due primarily to a dynamic Regional Coordinator, the Project in Ziguinchor appears to be operating fairly smoothly. The Coordinator has taken advantage of weekly visits of a French doctor based at the regional hospital to regularly visit most of the 11 clinics. While inventory control systems were found to be inadequate, the Coordinator is aware of the problems and is in the process of correcting them.

Contraceptives and other supplies are delivered by military airplane on a monthly basis from Dakar.

The MIS is operational in Ziguinchor.

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ANNEX E

Government of Senegal Declaration of Population Policy, April 1988

REPUBLIQUE DU SENEGAL
UN PEUPLE - UN BUT - UNE FOI

INI TERE DU PLAN ET DE LA COOPERATION
D ECTION DES RESSOURCES HUMAINES

DECLARATION
E LA POLITIQUE
E POPULATION

DAKAR, AVRIL 1988

Imp. Editions Excel

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1. - PREAMBULE

Le Gouvernement du Sénégal, conscient de l'importance des problèmes démographiques et de l'enjeu qu'ils représentent face à ses objectifs de développement, convaincu que la population, tant dans ses aspects quantitatifs que qualitatifs, doit être considérée comme partie intégrante et fondamentale du développement dont elle est à la fois l'initiatrice et la bénéficiaire, a décidé d'élaborer cette politique de population qui a été adoptée après examen par la Commission Nationale de la Population, à la suite de larges consultations et débats, et approuvée par le Président de la République en conseil interministériel.

Les problèmes de population, touchant par nature à la fécondité, la mortalité, la reproduction, la famille, le taux de croissance, la mobilité et la localisation des personnes, ont ceci de particulier qu'ils interpellent à la fois l'individu dans ce qu'il a parfois de plus intime et, dans le même temps, la communauté toute entière. C'est ce qui justifie leur prise en charge par les individus eux-mêmes qui opèrent des choix personnels conformes à leur situation, leurs valeurs et croyances, leurs aspirations, et par l'Etat qui a obligation de promouvoir le développement du pays et de favoriser le bien-être des individus et des groupes.

Les pouvoirs publics, depuis plusieurs années déjà, ont pris d'importantes mesures dans le domaine de la population, pour une meilleure maîtrise des problèmes démographiques dans une approche intégrée du développement.

Au niveau des institutions politiques de l'Etat, le Gouvernement a mis en place un système de protection en faveur de la femme dans un contexte de promotion sociale générale apte à créer les conditions d'un bien-être social et familial. A l'heure actuelle, plusieurs ministères sont impliqués dans la politique de population : Développement Social, Santé Publique, Plan et Coopération, Développement Rural, Education Nationale, etc... Le Ministère du Plan et de la Coopération, tutelle de la politique de population, abrite une Direction des Ressources humaines et une structure consultative, la Commission Nationale de la Population (CONAPOP) qui, depuis sa création en 1979, a vocation de faire des recommandations au Gouvernement en matière de population.

La création de ces supports institutionnels a suscité bon nombre de séminaires, de conférences et de projets qui ont contribué à entretenir une réflexion féconde sur les problèmes de population. Parmi les projets, on peut citer ceux de l'Unité de Communication, l'Unité de Population, avec l'appui du FNUAP et, actuellement, le Projet Santé Familiale en collaboration avec l'USAID, etc... Plusieurs ONG et associations féminines, impliquées dans ces problèmes, se sont mobilisées et mènent des actions de sensibilisation et de vulgarisation auprès des populations tant urbaines que rurales.

- Dans le domaine de la législation, des dispositions ont été prises pour favoriser cette politique de population. Parmi les plus importantes, on peut noter :

* le code de la famille, adopté en 1973, qui s'est préoccupé de protéger la cellule familiale et ses membres, particulièrement la femme et l'enfant. Il a porté l'âge au premier mariage de la femme à 16 ans et amélioré certaines dispositions concernant le mariage et le divorce;
* l'abrogation, en 1980, de la loi de 1920 interdisant la propagande anti-conceptionnelle et l'usage des contraceptifs. Cette importante décision a permis l'intégration des programmes et services modernes de planification aux services de santé maternelle et infantile dispensés dans les établissements publics.

D'autres facteurs contribuent favorablement à la réalisation de cette politique, notamment l'adoption de la stratégie des soins de santé primaire et d'un schéma national d'aménagement du territoire.

Toutes ces actions et mesures témoignent clairement de la volonté du Gouvernement de résoudre les problèmes de population que connaît le Sénégal et qui constituent encore de sérieux obstacles à son développement.

Il convient donc de reconsidérer, de manière plus systématique, toutes les questions de population en les intégrant davantage dans une stratégie globale de développement. L'élaboration et la mise en œuvre d'une politique de population cohérente et efficace apparaît comme une nécessité d'une grande actualité.

2. - POPULATION ET DEVELOPPEMENT : LA PROBLEMATIQUE AU SENEGAL

2.1. LES FACTEURS SOCIO-CULTURELS

La population sénégalaise est composée de groupes différents dans leurs conditions de vie, leur conception du monde, leur philosophie, leur religion, la vision de leur avenir. Cependant, une longue cohabitation et interpénétration ont forgé, au cours de l'histoire, un fonds culturel qui leur est commun.

2.1.1. Les Traditions

Les principales caractéristiques traditionnelles de nos sociétés peuvent se résumer ainsi :

- Ce sont des groupes ruraux, pratiquant une économie de subsistance de type agraire dans leur grande majorité, avec des systèmes d'exploitation et de mise en valeur basés sur des techniques souvent élaborées mais reposant sur l'énergie humaine.

- Ces groupes possèdent une organisation fortement communautaire permettant de compenser la faiblesse technologique de l'agriculture, et d'assurer la production dans le cadre du travail collectif où la femme joue un rôle important.

Dans un tel système, avant l'introduction de la loi sur le domaine national, la terre était propriété commune de la famille, du lignage ou du village.

- Ces sociétés adhèrent à des croyances et cultes du terroir exaltant la solidarité du groupe, ainsi que la fécondité et la fertilité, favorables à leur survie. Le mariage y est précoce, la fécondité est très importante et la polygamie répandue.

Elles adoptent une attitude fondamentalement nataliste. Celle-ci trouve sa justification historique dans le niveau élevé de la mortalité infantile et dans leurs systèmes et modes d'exploitation, agraires en particulier. L'enfant contribue assez tôt à la production familiale et constitue une garantie de sécurité pour les parents dont il perpétue la lignée.

Ces sociétés qui valorisent la fonction procréatrice de la femme ont, cependant, le souci de la santé de la mère et de l'enfant, c'est-à-dire du bien-être familial. Elles connaissent des pratiques d'espacement des naissances, l'utilisation de méthodes traditionnelles anti-conceptionnelles, comme l'éloignement des époux après accouchement de la femme et l'abstinence post-partum jusqu'au sevrage de l'enfant; l'allaitement prolongé est considéré comme prévenant les grossesses rapprochées.

2.1.2. Les Mutations en cours

Ces caractéristiques ne sont pas figées.Les traditions se sont adaptées face aux contraintes de l'environnement et au nouveau contexte socio-économique et socio-culturel pour permettre aux groupes de résoudre leurs problèmes de survie et de s'épanouir.

Toutes nos sociétés ont connu des transformations profondes, surtout depuis l'époque coloniale. Celle-ci a favorisé, par l'introduction brutale de l'éducation et de l'économie modernes, la désorganisation des "équilibres" antérieurs créant ainsi des situations et des aspirations nouvelles.

L'adoption de l'économie de marché et ses corollaires, l'introduction de l'élément monétaire et du salariat, l'intégration dans les circuits économiques et les réseaux de transport et de communication mondiaux ont contribué au bouleversement des systèmes de solidarité et d'échanges traditionnels.

L'urbanisation est certes un facteur de promotion économique et social, d'émancipation collective et individuelle. Cependant, elle est de plus en plus liée à l'exode rural et non à un développement conséquent des activités économiques et des structures urbaines elles-mêmes, constituant ainsi, pour le plus grand nombre, une source de multiples contraintes, de mutations socio-culturelles aux effets négatifs, voire de déviances des comportements dans un contexte où la survie de l'individu dépend principalement de son revenu monétaire.

Toutes ces crises qui affectent la société se cristallisent dans sa cellule fondamentale, la famille. La notion de famille a évolué dans son organisation et sa fonction. La communauté familiale, naguère étendue, s'est réctrécie du fait des transformations économiques et socio-culturelles.

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Les relations du couple sont affectées par ces changements qui concernent, en particulier, les rôles et statuts respectifs des conjoints, changements qui sont sources de conflits s'ils sont mal assumés.

Les relations d'autorité entre parents et enfants, ainsi que le contenu de l'éducation de ces derniers, sont de plus en plus remis en cause. Les modèles éducatifs, les valeurs à transmettre sont en crise.

La place de l'enfant reste importante dans la famille, mais les changements intervenus dans la structure et la fonction de celle-ci se traduisent par une autre conception de la famille dans son rôle d'éducation. Elle éprouve de plus en plus la nécessité d'assurer à l'enfant, dans son propre intérêt, un développement physique, mental et affectif harmonieux.

Jeunes et femmes aspirent à un statut meilleur. Ils veulent être mieux éduqués, mieux informés et avoir une plus grande maîtrise sur leur propre vie.

Les religions révélées, le Christianisme et particulièrement l'Islam, ont eu une influence certaine sur nos sociétés et ont favorisé les mutations socio-culturelles. Il convient de noter qu'elles se préoccupent, aussi bien dans leurs principes que dans leurs pratiques,du bien-être familial des populations.

Il faut relever aussi l'ouverture d'esprit des Sénégalais qui les rend particulièrement réceptifs aux innovations.

2.2. LA SITUATION DEMOGRAPHIQUE

La population du Sénégal se caractérise d'abord par sa grande jeunesse et son accroissement rapide qui sont dûs à un niveau élevé de fécondité associé à un niveau de mortalité qui reste, malgré une baisse certaine, encore trop élevée. Le Sénégal est un pays relativement urbanisé qui connait encore un exode rural important en dépit des programmes de développement rural.

2.2.1. Le volume de la population

Au recensement du 15 Avril 1976, la population du Sénégal était de 4.997.885 hbts; elle était estimée à 6.784.000 au premier Juillet 1986. Selon les projections démographiques officielles, cette population s'établira à 9.865.000 hbts en l'an 2000 (hypothèse moyenne).

2.2.2. La structure par âge et par sexe

La population du Sénégal est très jeune, puisque 47 % des Sénégalais ont moins de 15 ans, 57 % ont moins de 20 ans, alors que 4 % seulement ont 60 ans et plus. C'est dire que le coefficient de dépendance est élevé. Il correspond à 104 personnes inactives (moins de 15 ans et 60 et plus) pour 100 personnes actives (15 à 59 ans). On note, par ailleurs, que le nombre des femmes est légèrement supérieur à celui des hommes; le rapport de masculinité est de 98,5 hommes pour 100 femmes.

2.2.3. La répartition géographique de la population.

La population du Sénégal est inégalement répartie. Elle est concentrée pour l'essentiel à l'Ouest du pays, tandis que l'Est et le Nord sont faiblement peuplés. La densité de la population est de 34 hbts au km². La région de Dakar est, de loin, la plus densément peuplée. Sa population est estimée à 1.482.612 hbts au 1er Juillet 1986, soit près de 22 % de la population totale sur une superficie représentant 0,27 % seulement de celle du pays, alors que le Sénégal oriental, qui représente un tiers de la superficie, ne regroupe que 6 % de la population. Le Sénégal est un des pays les plus urbanisés d'Afrique de l'Ouest, avec un taux d'urbanisation estimé à 40 % environ en 1986.

2.2.4. La dynamique de la population

Elle comporte deux aspects essentiels : les mouvements naturels de la population et les migrations.

2.2.4.1. Les mouvements naturels

L'accroissement naturel ou accroissement démographique est estimé à 3 % par an, pour la période 1976/1986.Il résulte de la différence entre les taux de natalité (48 pour mille) et de mortalité (18 pour mille). Il faut noter que le taux d'accroissement naturel n'était estimé qu'à 2,2 %, dans les années 60. Le potentiel d'accroissement de la population sénégalaise reste important d'autant plus que la mortalité demeure élevée.

1. La fécondité est élevée au Sénégal du fait de la précocité du premier mariage (plus de la moitié des femmes se marie avant 16 ans) et de la forte intensité de la nuptialité (au-delà de 30 ans, le célibat des femmes est pratiquement inexistant).

D'ailleurs, les femmes passent plus de 90 % de leur période féconde (entre 15 et 50 ans) dans le mariage. La descendance finale des femmes est estimée à 7,1 enfants.

2. Le taux de mortalité a baissé, passant de 26 p. mille en 1960 à 19,3 p. mille en 1978. Estimé à 18 p. mille en 1988, il reste cependant trop élevé. Ceci est dû essentiellement au niveau élevé de la mortalité infantile et juvénile. Le quotient de mortalité infantile est, en effet, estimé à 91 p. mille et le quotient de mortalité juvénile à 130 p. mille, pour la période 1976/1986. Au total, 58 % des décès observés correspondent à des décès d'enfants de moins de 5 ans.

De plus, selon les statistiques hospitalières, 20 % des décès de femmes en âge de procréer ont pour origine la grossesse, l'accouchement et les suites de couches. Il faut, cependant, reconnaître que les données relatives à la mortalité sont beaucoup moins fiables et complètes que celles disponibles sur la fécondité.

2.2.4.2. Les migrations

1. Les migrations intérieures ont une grande ampleur dans un pays sahélien comme le Sénégal et sont diversifiées. En effet, on observe, à côté de l'exode rural qui alimente l'urbanisation, des migrations rurales des régions enclavées et défavorisées ou frappées par la désertification vers des régions qui offrent de plus grandes potentialités. Quelques régions (Fatick, Kolda et Tambacounda) ont un faible solde migratoire. Mais les données relatives aux migrations restent très grossières et le phénomène mérite d'être mieux étudié. Les migrations de travail telles que le navétanat et le nomadisme doivent retenir aussi l'attention.

2. Les migrations internationales sont importantes mais mal connues et leur solde est généralement négligé dans les projections démographiques. L'émigration touche certaines ethnies ou communautés (Hal pulaar et Soninké au départ et de plus en plus les Baol-Baol et les Casamançais). Elle a un impact démographique qui n'est pas bien connu, il est vrai, mais une influence réelle sur la situation socio-économique des régions de départ de ces migrants. L'immigration concerne principalement les pays voisins (Mali, Guinée, Mauritanie, notamment) mais aussi certains pays non africains (Liban, France, etc...). Ces flux sont mal connus, de même que leur impact économique, démographique et social.

2.3. LES FACTEURS SOCIO-ECONOMIQUES

Il existe une véritable controverse, au plan international et national, sur les relations entre la croissance de la population et la croissance économique. Tous admettent, néanmoins, que l'amélioration du niveau de vie des populations ne peut être assurée que si les ressources supplémentaires créées par l'économie augmentent à un taux supérieur au taux de croissance de la population. De même, un niveau de développement suffisant peut certainement avoir une incidence sur les comportements en matière de fécondité.

Si l'on examine, dans le cas du Sénégal, l'évolution du PIB durant la décennie 1970-1980, on constate qu'il n'a augmenté que de 2,7 % en moyenne par an alors que, dans le même temps, la population s'accroissait à un taux de l'ordre de 2,8 % par an. Ainsi, globalement, les performances économiques ont été annihilées par l'accroissement de la population. C'est dire que le revenu par tête a quasiment stagné pendant cette période.

En plus, le pays a connu de sérieux déséquilibres intérieurs et extérieurs pendant la période et une forte stagnation, voire une régression de la croissance.

Afin de renverser cette tendance défavorable, exacerbée par l'action de facteurs négatifs tels que la sécheresse, la crise économique mondiale et l'inégalité des termes de l'échange, l'Etat a pris un certain nombre de dispositions qui ont conduit à l'application d'un Plan de Redressement Economique et Financier (PREF) en 1980 et, depuis 1985, d'un Programme d'Ajustement structurel à Moyen et Long Termes (PAML).

Les résultats obtenus durant cette période de redressement et d'ajustement sont déjà encourageants.

C'est ainsi que le taux de croissance de la Production Intérieure Brute s'est sensiblement amélioré, se situant à un niveau moyen annuel de 4 %, depuis 1985, et dépassant même l'objectif fixé par le PAML (3,5 %).

Cependant, ces résultats risquent d'être encore compromis par une croissance rapide de la population à laquelle il est urgent de porter remède, si l'on veut consolider durablement nos bases de développement qui reposent sur l'amélioration des performances de production des secteurs clés de notre économie.

Dans la définition d'une politique démographique rationnelle, il convient d'attacher une attention particulière à la production céréalière, base de l'alimentation de la population. Or, cette production n'a augmenté, en moyenne, que de 1 % entre 1961 et 1985.

Sa croissance relativement favorable, dans les années 60, a été compromise, dans les années 70, par les effets des sécheresses répétées qui expliquent, en grande partie, les mauvaises performances agricoles puisque l'essentiel de la production est issue de l'agriculture pluviale fortement dépendante des aléas climatiques.

Malgré la réalisation d'investissements importants qu'exigeait le secteur agricole, les importations agro-alimentaires ont augmenté de façon considérable, au cours des années 70 et 80, pour combler les déficits de la production et concourir à la mise en œuvre d'une stratégie de sécurité alimentaire.

Cependant, il existe encore au Sénégal d'importantes superficies de terres cultivables qui ne sont pas exploitées. Certes, l'agriculture sénégalaise est peu diversifiée et est dominée par les cultures pluviales, mais c'est essentiellement le manque d'eau qui a entravé son développement et compromis les objectifs d'autosuffisance alimentaire.

C'est pour cela qu'un vaste programme d'aménagement de terres et de construction de barrages a été mis en œuvre, parallèlement au programme de forages. Il est ainsi prévu l'aménagement de 300 000 ha de terres dans les régions périphériques du pays.

La politique actuelle cherche à alléger les contraintes d'ordre sociologique, écologique et sanitaire qui risquent d'entraver la réalisation correcte d'un tel programme. Ainsi, par exemple, s'effectue la réallocation des terres au bénéfice des populations les plus défavorisées des régions concernées.

De même, des actions pour prévenir les conséquences néfastes des grands barrages sur la santé des populations et la survie de certaines espèces halieutiques seront entreprises.

Durant le VIe Plan, le taux de couverture des besoins céréaliers a été de 52 %. Les efforts prévus d'ici l'an 2000 (augmentation des rendements de mil, du sorgho et du maïs, augmentation des superficies irriguées et intensification des cultures correspondantes) devront porter ce taux à 80 %.

Par ailleurs, selon l'analyse contenue dans le plan céréalier, l'aménagement du territoire qui est un élément fondamental de la politique de décentralisation économique du Sénégal peut ouvrir des possibilités réelles d'amélioration de la situation agricole par une redistribution optimale de la population. En effet, actuellement, 43 % du territoire national (Bassin arachidier, zone sylvo-pastorale, Dakar et ses environs) correspondent à des zones dont les capacités d'accueil des populations à l'avenir restent réduites; alors que les autres zones (Sénégal Oriental, Bassin du Fleuve Sénégal, Casamance) représentant 57 % de la superficie du pays ne regroupent, malgré leurs potentialités réelles, que 27 % de la population.

Malgré tous ces efforts déployés, la production agricole ne parviendra pas à résorber le déficit alimentaire au Sénégal qui risque même de s'aggraver au rythme où va l'accroissement démographique du pays.

Le développement des secteurs sociaux est, lui aussi, particulièrement influencé par la croissance démographique.

2.3.1. Education et Formation

Les activités d'éducation et de formation entreprises, depuis une décennie, ont entraîné une hausse sensible des dépenses budgétaires consacrées à ce secteur.

En effet, celles-ci ont augmenté environ de 7 points, entre 1970-71 et 1984-85, passant ainsi de 18 % à 25 % des dépenses du budget de l'Etat.

Selon les statistiques du Ministère de l'Education Nationale, le taux brut de scolarisation dans l'enseignement élémentaire est de l'ordre de 52 %, tandis que le taux net est de 39,6 %. En terme d'effectifs, cela s'est traduit par un doublement du nombre d'élèves de l'enseignement élémentaire entre 1970-1971 et 1984-1985. Durant cette période, les effectifs de l'enseignement élémentaire sont passés de 283.276 à 565.439 élèves dans l'ensemble des établissements publics et privés du Sénégal.

Malgré ce doublement des effectifs et les moyens financiers consentis par l'Etat, le taux net de scolarisation n'atteint pas 40 %. Ce qui montre qu'un effort doit être entrepris pour maîtriser la population scolarisable, si l'on veut arriver à l'objectif de scolarisation universelle en l'an 2000. Signalons que le taux d'alphabétisation a atteint 28 % en 1984/85.

Il faut, par ailleurs, noter que d'autres actions de formation ont été initiées. Ainsi, la formation permanente, mais surtout la formation professionnelle, avec la création de l'Office National de Formation Professionnelle (ONFP), confirment l'option des autorités pour le développement des ressources humaines.

Enfin, bien que difficilement maîtrisable, du point de vue statistique notamment, l'éducation non formelle confessionnelle, eu égard au nombre élevé d'enfants qui la fréquente, mérite une attention plus grande.

2.3.2. Santé

Le secteur de la Santé connaît encore, lui aussi, des problèmes liés à la faiblesse relative des ressources budgétaires qui lui sont consacrées (5,5 % du budget national). Ce taux est encore loin des 9 % préconisés par l'OMS.

Néanmoins, on a pu diversifier les infrastructures. En effet, depuis les années 70, d'importants moyens financiers ont été consacrés à la multiplication des maternités rurales, des cases et postes de santé, des centres de protection maternelle et infantile, des dispensaires et hôpitaux, etc... Mais des difficultés persistent dans la mise en œuvre du système de soins de santé primaire, du fait de l'insuffisance du personnel et des moyens financiers, malgré une participation importante de la population.

Il faudrait, sans doute, continuer à mettre davantage l'accent sur certains domaines liés à la prévention : l'éducation sanitaire, l'hygiène du milieu, l'assainissement, la lutte contre la malnutrition et l'amélioration de l'environnement, la planification familiale et la sensibilisation aux dangers potentiels des maladies sexuellement transmissibles (MST) et du SIDA.

Mais on doit avoir à l'esprit que l'amélioration de l'état de santé des populations, qui est leur vœu le plus cher, se traduira, à court et moyen termes, par une augmentation du taux d'accroissement de la population si des mesures ne sont pas prises, au même moment, pour réduire la fécondité. Or, cette dernière demeure élevée et la baisse apparue à travers les résultats provisoires de l'Enquête de Démographie et de Santé (baisse de 7,2 à 6,6 enfants par femme entre 1978 et 1986) restent à être confirmées. Des enquêtes devront vérifier, par ailleurs, la tendance à une adoption plus large des méthodes contraceptives modernes utilisées en 1986 par 6 % des femmes (Enquête de Démographie et de Santé) contre 1 % seulement en 1978 (Enquête Sénégalaise sur la Fécondité). De même, l'évaluation continue du programme de planification familiale mis en œuvre dans le pays, depuis 1973, s'impose.

C'est dire que les problèmes de santé, posés dans la perspective du développement du pays sont inséparables du problème de maîtrise de la fécondité.

2.3.3. Habitat

L'Habitat, en tant qu'environnement immédiat de l'individu, mérite évidemment une attention particulière. L'habitat planifié (SICAP, OHLM, HAMO) ou l'auto-construction (par des personnes privées

ou morales) rencontrent de grandes difficultés liées à leur coût élevé et aux difficultés de financement. Ces problèmes se posent essentiellement en milieu urbain, en particulier à Dakar.

On prévoit, entre 1980 et l'an 2001, 1.820.000 hbts supplémentaires dans la seule région de Dakar correspondant à un besoin de 230.500 logements supplémentaires. Or, de 1980 à 1987, l'offre n'a représenté qu'environ 50% des besoins de la période. Là encore, on voit qu'il faudra faire face à de grandes difficultés pour résoudre les problèmes de logements dans les années à venir.

Devant cette situation, l'Etat a pris des mesures visant à promouvoir la construction de logements sociaux pour répondre à la majorité des demandeurs à revenu modeste.

Ces mesures se sont traduites non seulement par la création de la Banque de l'Habitat du Sénégal (BHS), chargée de collecter l'épargne, mais aussi par l'aménagement de parcelles assainies, la promotion de sociétés privées de construction immobilière et de l'autoconstruction.

Des programmes d'habitat en direction du monde rural, qui représente 60 % de la population totale, méritent d'être développés.

Mais l'amélioration de l'efficacité de la politique sociale du gouvernement passe nécessairement par la maîtrise de l'évolution du taux de croissance démographique et du mouvement de la population.

2.3.4. Emploi et Sécurité Sociale

L'insuffisance des données statistiques fiables rend malaisée l'étude des tendances de l'emploi au Sénégal. Cependant, les informations disponibles permettent de se faire une idée sur la situation de ce secteur et sur les efforts qui ont été déployés pour atténuer le chômage dans le pays. Des progrès notables ont été accomplis en matière de création d'emploi, aussi bien dans le secteur public que dans le secteur privé, au cours des quinze dernières années.

Ainsi, l'effectif du secteur public a triplé durant cette période, passant de 22.900 à quelques 70.249 agents. Dans le même temps, le secteur privé connaissait un doublement de son effectif qui était estimé, en 1987, à 100.000 agents, alors qu'il n'était que de 52.094 agents en 1970/71.

Au total, l'effectif du secteur moderne a doublé entre 1970/71 et 1987, passant de 75.000 à 190.000 agents. Mais ces effets sont presque passés inaperçus, à cause de la croissance rapide de la population active sénégalaise, surtout entre 1976 et 1985, période pendant laquelle elle a augmenté environ de 22 %, correspondant à quelques 400.000 individus.

L'augmentation des actifs urbains a été la plus importante, avec un taux de croissance annuel de 4,4 % contre 1,6 % par an pour la population active rurale. Cette situation est à l'origine de la hausse sensible de la demande d'emplois et du niveau de chômage que connaît le pays.

Afin d'améliorer le niveau de l'emploi, tout en tenant compte de la conjoncture économique que traverse le pays, le Gouvernement a pris des séries de mesures dont l'une des plus importantes est la création d'un Fonds National de l'Emploi en faveur des travailleurs déflatés, des jeunes diplômés à la recherche de travail, des émigrés de retour, des agents de l'Etat candidats à un départ volontaire.

L'effort en matière d'emploi doit être soutenu, de même que la politique de sécurité sociale doit être revue en fonction des orientations et objectifs de la politique de population.

Certes, les taux actuellement pratiqués en matière d'allocations familiales sont bas et les acquis doivent être sauvegardés, sinon renforcés.

Il reste, cependant, que l'extension de la couverture à tous les enfants en matière d'allocations familiales comme pour toutes les prestations sociales, ajoutée aux allègements fiscaux et autres avantages tels que la prolongation retardant la mise à la retraite du travailleur ayant des enfants en bas âge, n'est pas de nature à décourager la recherche d'une progéniture nombreuse.

Une politique de population tendant à réduire la croissance démographique devrait inverser la tendance en cette matière, d'autant plus que cette politique n'est pas incompatible avec une amélioration de la qualité des services sociaux offerts aux populations.

2.3.5. Environnement

Le secteur de l'environnement connaît aujourd'hui une situation critique.

En effet, la demande en charbon de bois et bois de chauffe (4.250.000 M³ en 1976 et 6.760.000 M³ environ en 1986) s'est accrue considérablement par le fait de l'explosion démographique et d'une exploitation abusive des écosystèmes naturels.Celle-ci a entraîné une déforestation devenue un fléau national et la disparition de certaines espèces fauniques.

Par ailleurs, la facture pétrolière qui n'a cessé de croître grève lourdement notre Balance Commerciale (5 milliards en 1973 et 85 milliards en 1984). Cette situation est due, certes en grande partie, à la flambée du prix du pétrole, mais également à l'augmentation de la demande en énergie.

Enfin, la pollution par les déchets (solides et liquides) surtout dans la région de Dakar (1 200 t de déchets solides par jour en 1986/87 et plus de 120.000 M³ d'eaux usées par jour en 1985/86), qui est déjà préoccupante, évolue vers une situation incontrôlable si des mesures appropriées ne sont pas prises.

3. - LA POLITIQUE DE POPULATION DU SENEGAL

3.1. FONDEMENTS ET PRINCIPES DE BASE

3.1.1. Fondements

L'intervention de l'Etat dans ce qui peut apparaître comme un problème individuel se justifie et se légitime par le rôle qui lui est dévolu par la Constitution même. Ce rôle peut être apprécié de deux manières :

- D'abord, il appartient au Gouvernement de traduire en actes concrets les politiques définies par le Président de la République dans tous les secteurs de la vie nationale. Il lui revient donc la charge de mettre en œuvre une politique de population comme il le fait, par ailleurs, dans le domaine de l'hydraulique, de l'agriculture ou de la pêche.

- Ensuite, l'Etat est lié par un certain nombre d'obligations spécifiques vis-à-vis de la famille qu'il reconnaît, avec le mariage, comme la base naturelle et morale de la communauté humaine. En effet, l'Etat a l'obligation de respecter et de protéger la personne humaine (Art. 6 de la Constitution). Il doit protéger la famille et veiller à sa santé physique et morale. Même si l'article 16 reconnaît que les parents ont le droit naturel et le devoir d'élever leurs enfants, il stipule clairement cependant qu'"ils (les parents) sont soutenus dans cette tâche par l'Etat et les collectivités publiques".

Par ailleurs, l'adoption d'une politique de population est un élément de la stratégie visant le redressement économique et social de l'Afrique dans son ensemble . Il est permis d'affirmer qu'à l'échelle africaine, aujourd'hui, il s'est dégagé un consensus pour considérer que, quelle que soit la position idéologique des Etats face à la crise actuelle, la population doit être intégrée comme une composante fondamentale dans la stratégie africaine pour le redressement économique et le développement autonome du continent.

C'est pourquoi, à l'issue de la deuxième Conférence africaine sur la population, tenue à ARUSHA en Janvier 1984, un programme d'action dit "Programme de KILIMANDJARO concernant la population" a été adopté. Il concerne tous les Etats africains, y compris le Sénégal qui a, par ailleurs, souscrit aux différentes recommandations issues des conférences africaines comme mondiales.

Dans le préambule de ce programme, il est dit que les Etats africains notent "avec inquiétude l'accroissement rapide de la population au cours des dernières années, les pressions et contraintes qu'il exerce sur les efforts de développement des gouvernements africains et sur les maigres ressources". Ils reconnaissent que "les problèmes démographiques entravent à l'heure actuelle le développement de la région africaine".

Il est donc logique, dans ce contexte, que le Programme Prioritaire pour le Redressement économique de l'Afrique pour la période1986-1990, adopté par l'OUA, recommande, entre autres mesures ayant un effet direct ou indirect sur la population, l'élaboration de politiques démographiques appropriées.

En choisissant donc d'asseoir une politique de population, le Sénégal met en pratique une recommandation africaine et, tout en visant la solution de problèmes nationaux , contribue à l'effort de redressement entrepris à l'échelle du continent.

Si le Sénégal a adhéré aux recommandations africaines en cette matière, c'est bien parce que les problèmes identifiés au niveau africain sont ceux-là même auxquels il est confronté e que, sur les points essentiels, les analyses sont convergentes.

Le diagnostic des experts nationaux étayé par des études et un ensemble de données pertinents, ainsi que la situation de crise économique sévère dans le court, voire le moyen terme, font apparaître comme une nécessité l'élaboration d'une politique définie et volontariste dans le domaine de la population. Une telle politique permettrait aussi de concevoir, dans un cadre cohérent, toutes les activités ayant un impact direct ou indirect sur la population comme le vœu en a été maintes fois exprimé.

3.1.2. Principes

Cette politique de population, dont l'élaboration obéit à des nécessités de développement prenant entièrement en compte les facteurs démographiques, économiques, sociaux et culturels, doit reposer sur des principes qui guident l'action. L'importance de ces principes est d'autant pus grande que cette politique concerne les individus et les groupes jusque dans leur vie intime.

Les principes retenus sont les suivants :

- Respect des droits fondamentaux de la personne humaine, tels que ces droits sont définis dans la Constitution et les Textes internationaux auxquels le Sénégal a souscrit;
- Nécessité de préserver la cellule familiale, entité de base de la société et cadre privilégié d'épanouissement des hommes, des femmes et des enfants;
- Respect du droit des individus et des couples à choisir la taille de leur famille et à maîtriser leur fécondité;
- Appel à la responsabilité des individus en tant qu'époux et parents, face à leur procréation et aux exigences du développement national;
- Respect du droit des enfants à la survie, la santé, l'éducation et la formation;
- Respect du droit des individus à accéder à l'éducation et à l'information objective en matière de population, ainsi qu'aux moyens de maîtriser leur fécondité;
- Nécessité de considérer qu'il y a des relations d'interdépendance entre les variables démographiques et les facteurs économiques et socio-culturels, impliquant une approche intégrée du développement;
- Nécessité de considérer que la population est un élément fondamental dans les stratégies et plans de développement et que le Sénégal a le droit et le devoir de résoudre ses problèmes démographiques nationaux;
- Recherche d'un large consensus dans la définition et l'application des objectifs d'une politique de population;
- Respect des engagements pris par le Sénégal, d'une part auprès de la communauté africaine, pour assurer le redressement économique et le développement du continent, dans le cadre de la solidarité africaine affirmée en tête du préambule de la Constitution, d'autre part auprès de la Communauté internationale.

3.2. OBJECTIFS

La politique de population se fixe les objectifs suivants que la mise en œuvre de **Programmes d'Actions et d'Investissements Prioritaires** devront permettre d'atteindre :

3.2.1. Objectifs généraux

- Améliorer la qualité de la vie et favoriser l'instauration d'un bien-être pour toutes les catégories de la population. Cette action sera le fruit des progrès obtenus dans les domaines économiques et sociaux, grâce à la réalisation d'une meilleure adéquation entre les ressources humaines, en termes quantitatifs et qualitatifs, et les possibilités de développement du pays;
- Réduire la morbidité et la mortalité, en particulier celle des mères et des enfants par la mise en œuvre de programmes de santé maternelle et infantile incluant la planification familiale;
- Réduire le taux de fécondité et le rythme de croissance démographique par l'adoption de mesures appropriées;
- Appuyer toutes les actions tendant à accroître la mise en valeur des régions et l'amélioration de la qualité de vie dans celles-ci, afin de freiner l'exode rural et d'assurer une meilleure répartition de la population sur le territoire;
- Améliorer la qualité de vie des populations de toutes les régions par une meilleure couverture des besoins de base dans les domaines de l'alimentation et de la nutrition, de la santé, de l'assistance sociale, du logement, de l'éducation, de la formation, de l'environnement, mais aussi de l'information, des activités culturelles et des loisirs;
- Améliorer les compétences nationales dans le domaine des sciences de la population par le biais de la formation;

- Améliorer sans cesse la connaissance des problèmes de population en entreprenant des recherches appropriées dans les domaines de la démographie, de la sociologie, de l'histoire, de la planification du développement, etc...

C'est dire que le Sénégal préconise une approche globale de ses problèmes de population et que la planification familiale ne constitue, dans ce contexte, qu'une composante de la politique nationale de population.

3.2.2. Objectifs démographiques : Perspectives

S'il est prématuré de déterminer des objectifs démographiques quantifiés pour la politique nationale de population faute de données scientifiques fiables, il n'en reste pas moins qu'il est utile d'analyser les perspectives démographiques pour éclairer les choix futurs à opérer permettant d'atteindre les buts que le Sénégal s'est fixés.

Ainsi, les projections démographiques du Projet RAPID II - Sénégal ont retenu deux variantes significatives, une variante moyenne et une variante basse dont nous rappelons ci-dessous certains éléments, à titre d'illustration.

Variante moyenne : TABLEAU I

Indicateur	Année		
	1986	2001	2011
Descendance finale	7,10	6,44	5,80
Espérance de vie à la naissance	48,7	56,0	60,9
Population totale en (milliers)	6.821	11.179	15.403
Population urbaine (%)	40,2	48,4	53,7
Prévalence contraceptive requise (%)	4,90	15,30	24,04

Variante moyenne : TABLEAU II

Indicateur	Période		
	1986-91	2001-06	2006-11
Taux de natalité (pour mille)	49,5	43,5	41 7
Taux de mortalité (pour mille)	17,1	11,4	9,9
Taux d'accroissement naturel (% par an)	3,24	3,21	3,18

Il faut remarquer que cette variante moyenne privilégie considérablement la baisse de la mortalité qui favorisera certainement celle de la natalité, et démontre qu'une stratégie dynamique de promotion de la planification familiale peut permettre d'obtenir des résultats meilleurs en terme de baisse de la fécondité, donc de ralentissement du rythme d'accroissement de la population.

A côté de ce premier scénario, en usant de la même stratégie, la variante basse de RAPID II donne une évolution différente des indicateurs précédents :

Variante basse : TABLEAU I

Indicateur	Année		
	1986	2001	2011
Descendance finale	7,10	5,75	4,50
Espérance de vie à la naissance	48,7	57,5	63,4
Population totale en (milliers)	6.821	10.976	14.500
Population urbaine (%)	40,2	48,5	53,9
Prévalence contraceptive requise (%)	4,90	28,97	46,57

Variante basse : TABLEAU II

Indicateur	Période		
	1986-91	2001-06	2006-11
Taux de natalité (pour mille)	49,0	38,8	35,3
Taux de mortalité (pour mille)	16,8	10,1	8,5
Taux d'accroissement naturel (% par an)	3,22	2,87	2,68

Mais il faudra attendre les résultats des programmes et des études, actuellement en cours sur la planification familiale, pour préciser les objectifs quantitatifs qui, en tout état de cause, devront viser la baisse significative de la fécondité.

3.3. LES STRATEGIES EN MATIERE DE POLITIQUE DE POPULATION

3.3.1. Santé de la mère et de l'enfant

La mortalité de l'enfant et de l'adulte est une préoccupation pour les services de santé publique. Néanmoins, la santé de la mère et de l'enfant demeure la première priorité.

On sait, grâce aux enquêtes effectuées, que 58 % des décès annuels concernent les enfants de moins de 5 ans et que les maladies diarrhéiques sont la première cause de mortalité infanto-juvénile. Selon les statistiques du Ministère de la Santé, les principales causes de mortalité et de morbidité chez les enfants de 0 à 5 ans sont le paludisme (39 %), les diarrhées (23,8 %) et les maladies infectieuses, à savoir les maladies respiratoires (23 %), la rougeole (10,9 %), le tétanos (5,4 %) et la méningite (3,5 %).

La mortalité maternelle est très élevée. Elle est estimée, par des recherches récentes, à 530 décès pour 100 000 naissances vivantes. Les principales causes de ces décès sont les hémorragies du post-partum, les dystocies et les infections. La mortalité maternelle est, par ailleurs, fortement affectée par les dangers liés aux naissances multiples et rapprochées, ainsi qu'aux grossesses de femmes très jeunes (moins de 20 ans) ou âgées (plus de 40 ans).

L'amélioration de l'état de santé des enfants est une condition de leur santé à l'âge adulte qui est un des éléments importants de leur productivité. Il existe, en effet, une corrélation directe entre l'état de santé dans l'enfance et l'état de santé à l'âge adulte. De plus, la mortalité des jeunes adultes est une perte pour un pays où le coefficient de dépendance est élevé.

Ceci est aussi particulièrement vrai pour la santé des mères. En effet, les femmes jouent un rôle central dans la cohésion de la famille et l'éducation des enfants. Elles sont aussi des agents économiques de tout premier plan.

L'amélioration de la santé de la mère et de l'enfant passe par l'adoption des mesures suivantes :

1. Renforcement des services d'éducation sanitaire et familiale et organisation régulière de campagnes au niveau national;

2. Renforcement et généralisation des services de consultation prénatale, postnatale et infantile;

3. Intensification et amélioration de la formation du personnel chargé des services de santé maternelle et infantile. Organisation de stages périodiques de recyclage à leur intention, avec une prise en charge appropriée des accoucheuses traditionnelles;

4. Extension de la couverture vaccinale à tous les enfants du pays;

5. Amélioration et extension du programme nutritionnel, information sur l'allaitement maternel et artificiel, l'alimentation des enfants en bas âge et les conditions du sevrage;

6. Promotion et diffusion, à l'échelle nationale, de la thérapie de réhydratation par voie orale;

7. Poursuite de l'intégration des services d'espacement des naissances au sein de l'ensemble des centres de santé maternelle et infantile;

3.3.2. Fécondité et espacement des naissances

La descendance finale des femmes sénégalaises est parmi les plus élevées au monde. Elle comporte des risques graves pour la santé de la mère et de l'enfant. C'est pourquoi l'espacement des naissances constitue un volet important de la politique d'amélioration de la santé de la mère et de l'enfant.

De plus, la multiplication des avortements provoqués incite à la promotion de la planification familiale pour une meilleure maîtrise de la fécondité, pour la sauvegarde de l'harmonie de la famille et de la société, pour le plein épanouissement des hommes et des femmes. A cet effet, les mesures préconisées sont les suivantes :

1. Renforcement et amélioration des programmes d'information et de communication destinés à diffuser une bonne connaissance des méthodes contraceptives et des possibilités qu'elles donnent en matière d'espacement des naissances;

2. Renforcement et amélioration de programmes d'éducation en matière de population, dans le but de sensibiliser la population, à tous les niveaux, sur les avantages médico-sanitaires, socio-économiques et socio-culturels de la planification de la famille;

3. Introduction systématique de l'éducation en matière de population, dans les programmes scolaires et dans les cours de formation des formateurs;

4. Renforcement, amélioration et extension des services de planification familiale, à toutes les régions, avec une prise en charge des trois volets : espacement des naissances, lutte contre la stérilité et lutte contre les maladies sexuellement transmissibles;

5. Renforcement des cours et des stages de formation et de recyclage en planification familiale à l'intention du corps médical et paramédical, pour une mise en œuvre optimale des programmes nationaux.

6. Harmonisation et intégration des programmes gouvernementaux de planification familiale, en vue de leur rationalisation, pour une plus grande efficacité;

7. Adoption de mesures appropriées pour la sensibilisation à l'application effective du code de la famille, dans le sens d'une protection réelle de la femme et de l'enfant et de la préservation de l'harmonie de la cellule familiale;

8. Organisation de campagnes périodiques d'explication sur les méfaits des grossesses précoces et en faveur d'une parenté responsable;

9. Appui approprié aux entreprises publiques et privées, aux ONG, aux associations privées, en somme, à toutes personnes physiques et morales qui exercent des activités significatives dans le domaine de la planification familiale;

10. Evaluation continue des programmes et des services de planification familiale pour une plus grande efficacité.

3.3.3. Promotion de la femme

Elle est une condition essentielle du succès de toute politique de population. Au Sénégal, en dépit des lois et mesures qui ont été adoptées, le statut de la femme sénégalaise devrait être amélioré. Pour cela, il faut renforcer la politique de la promotion de la femme sénégalaise par l'adoption des mesures ci-après :

1. Adoption de dispositions particulières destinées à accroître le taux de scolarisation et d'alphabétisation des femmes et leur niveau d'instruction;
2. Adoption de mesures appropriées destinées à promouvoir la formation technique et professionnelle des femmes;
3. Adoption de dispositions particulières destinées à promouvoir l'emploi des femmes, leur responsabilisation et leur épanouissement professionnel, de même que leur accès au crédit;
4. Organisation de campagnes de sensibilisation et d'éducation des femmes et des hommes sur la planification de la famille et les autres problèmes de population;
5. Diffusion plus large de technologies destinées à alléger les tâches domestiques et les travaux industriels et agricoles généralement exécutés par les femmes;
6. Soutien aux organisations et groupements féminins;
7. Multiplication des crèches et garderies d'enfants, en milieu urbain et rural, pour favoriser la participation des femmes aux activités productives et à l'ensemble des activités socio-culturelles;
8. Organisation continue de campagnes d'informations destinées à promouvoir une image positive de la femme en tant qu'agent dynamique et créatif du développement économique et social.
9. Adoption de mesures spécifiques en direction des femmes chefs de famille.

Certaines de ces mesures sont préconisées dans le Plan d'Action de la Femme adopté au cours de la décennie de la femme; il reste à suivre leur mise en œuvre.

3.3.4. Promotion des jeunes

Les jeunes constituent plus de la moitié de la population du Sénégal. De leur naissance à leur entrée dans la population active, ils constituent une préoccupation majeure pour la population adulte qui doit assurer la satisfaction de tous leurs besoins (alimentation, santé, éducation,loisirs, habillement, logement, notamment).

Du fait des difficultés rencontrées, beaucoup de jeunes adolescents ne réunissent pas, à l'âge adulte, les conditions nécessaires à leur épanouissement mental et physique, moral et matériel.

Du fait surtout de la déperdition scolaire importante, de l'analphabétisme, de l'absence de débouchés pour les diplômés, du chômage et du sous-emploi en milieux rural et urbain, beaucoup de jeunes sont réduits à l'oisiveté. Cette réalité existentielle est la cause de la délinquance, de l'alcoolisme et de la toxicomanie, particulièrement en milieu urbain.

Il est donc indispensable d'adopter des mesures appropriées pour favoriser l'épanouissement des jeunes, à savoir :

1. Poursuite de l'application du Plan d'Action Décennal pour les jeunes;
2. Intégration dans la formation scolaire et extra-scolaire des enfants et des jeunes d'éléments d'éducation à la vie familiale pour les préparer à une conduite responsable à l'âge adulte;
3. Soutien aux organisations de jeunes et mise sur pied d'un mouvement de la jeunesse capable d'offrir aux jeunes des perspectives de mobilisation, de concertation et de loisirs qui s'inscrivent dans le cadre de leur épanouissement et de leur participation au développement national réel;
4. Mise en place d'un programme de lutte contre la déperdition scolaire et l'analphabétisme des jeunes et préparation à leur insertion dans la vie professionnelle;
5. Multiplication, équipement et décentralisation des infrastructures scolaires, sanitaires, socio-éducatives et socio-culturelles destinées à favoriser l'épanouissement des jeunes;
6. Recherche d'une meilleure compréhension entre parents et enfants par l'instauration d'un dialogue autour des problèmes de la société;

7. Sensibilisation des jeunes sur les risques liés à la sexualité et la maternité précoce;

8. Mise en œuvre de programmes de sensibilisation sur les dangers tels que le banditisme, la drogue, la prostitution, le vagabondage;

9. Création d'emplois prioritairement destinés aux jeunes afin d'assurer leur pleine participation à l'œuvre de développement national.

3.3.5. Promotion des personnes du 3ème âge

Pour assurer la promotion et la santé des personnes du 3ème âge, il convient de prendre les mesures ci-après :

1. Mettre en place, conformément au Plan d'Action Mondial sur le Vieillissement, des politiques et programmes d'éducation, de formation et d'insertion des personnes du 3ème âge dans le processus de développement économique et social;

2. Mettre en œuvre des programmes de recherches en matière de gériatrie et de gérontologie sociale;

3. Former le personnel médical et paramédical pour une meilleure prise en charge des besoins des personnes du 3ème âge.

3.3.6. Préservation de la famille

La famille, entité économique, sociale et culturelle, est dans notre contexte africain le cadre de vie et d'épanouissement des individus.

En milieu urbain comme en milieu rural, la famille sénégalaise est à la recherche d'un nouvel équilibre entre la tradition et la modernité. C'est pourquoi, il importe aujourd'hui, plus que jamais, de la protéger et de la promouvoir.

Outre les actions spécifiques à entreprendre en direction des enfants, des femmes, des jeunes et des personnes du 3ème âge, il convient d'engager toutes les actions tendant à assurer l'harmonie et un meilleur équilibre au sein de la famille, à savoir :

1. Revalorisation de la famille comme cadre d'éducation, de concertation et de dialogue entre hommes et femmes, parents et enfants.

2. Lutte contre les phénomènes destabilisateurs de la famille, pour une meilleure protection de l'intégrité de la cellule familiale.

3. Recherches et sensibilisation sur la nature et les problèmes de la famille actuelle.

3.3.7. Migrations, Urbanisation et Aménagement du territoire

Historiquement, le Sénégal se caractérise par d'importants mouvements migratoires qui ont déterminé, en partie, la répartition spatiale de sa population. L'économie coloniale de traite avait contribué à concentrer une grande partie de la population dans le centre et l'ouest du pays (bassin arachidier et région de Dakar). Par ailleurs, les besoins de l'administration territoriale ont déterminé, en partie, l'implantation des principales zones de peuplement.

Depuis l'indépendance, les méfaits de la sécheresse ont entraîné une accentuation de l'exode rural, une croissance urbaine plus rapide et un déséquilibre régional plus grand, particulièrement sensible entre la région de Dakar et le reste du pays. La mise en œuvre de projets de développement rural, dans le sud, et surtout les grands barrages, dans le nord, vont entraîner de nouveaux mouvements et concentrations démographiques. Ainsi, l'urbanisation s'accélère, tandis que de vastes régions se vident et risquent de connaître un déclin durable. Pour redresser cette situation, les mesures suivantes sont préconisées :

1. Finalisation et application du Plan National d'Aménagement du Territoire et des plans régionaux de développement intégré qui seront des instruments essentiels de politique en matière de répartition de la population. Ceci devra entraîner la constitution progressive de véritables pôles régionaux de développement économique, social et culturel où seront impulsées des activités de production et de création qui stabilisent la population locale et freinent la migration vers la région de Dakar;

2. Adoption de mesures incitatives pour l'implantation de petites et moyennes entreprises à l'intérieur du pays, et d'activités nouvelles dans les villes secondaires en vue d'une répartition plus équilibrée de la main-d'œuvre nationale et d'une atténuation de l'exode vers Dakar;

3. Aménagement rationnel des zones de grands barrages pour leur utilisation adéquate, au bénéfice des populations locales, d'abord, mais aussi de l'ensemble de la communauté nationale;

4. Restructuration des équipements urbains, des réseaux d'assainissement et d'alimentation en eau dans les quartiers d'habitat spontané, à Dakar et en banlieue, afin d'améliorer les conditions sanitaires et de vie des populations qui y résident;

5. Adoption de mesures efficaces, pour faciliter le retour des travailleurs émigrés et leur réinsertion dynamique dans l'économie nationale.

3.3.8. Emploi

Il constitue, aujourd'hui, une préoccupation essentielle des Sénégalais. En milieu rural, le sous-emploi est structurel, du fait du caractère saisonnier de la production agricole (l'hivernage ne dure que quelques trois à six mois). En milieu urbain, le chômage n'a cessé de se développer, avec l'aggravation de la crise économique et des difficultés rencontrées par les entreprises. Par ailleurs, de nombreux jeunes diplômés des instituts de formation professionnelle et du supérieur ne peuvent plus être recrutés par la Fonction Publique, sans pour autant trouver une insertion dans les projets d'activités économiques appuyés par le Gouvernement.

Or, sans assurer aux Sénégalais un emploi stable et rémunérateur, il sera difficile d'obtenir le succès de la politique nationale de population. C'est pourquoi, il est important de promouvoir les mesures ci-après, que du reste le Gouvernement a initiées, notamment dans le cadre de la Nouvelle Politique Agricole (NPA), de la Nouvelle Politique Industrielle (NPI), et plus généralement, de la Nouvelle Politique Economique (NPE) :

1. Amélioration et valorisation effective des résultats de la recherche agricole;

2. Réorganisation du marché des produits agricoles (produits vivriers et produits de rente) de façon à favoriser une politique d'autosuffisance et de sécurité alimentaire conforme aux priorités dégagées au plan national;

3. Réorganisation des coopératives agricoles et appui aux groupements d'intérêt économique (GIE) pour une responsabilisation plus effective dans la définition, la mise en œuvre et le contrôle des politiques de développement rural;

4. Promotion à l'échelle nationale, en privilégiant les régions de l'intérieur, d'investissements à forte intensité de main-d'œuvre;

5. Promotion, encadrement et protection du secteur informel, grand pourvoyeur d'emplois;

6. Promotion du crédit en direction de l'agriculture, du secteur informel et de la petite et moyenne entreprise;

7. Adoption d'une fiscalité adaptée, pour favoriser la relance de la production nationale et de la demande en biens et services;

8. Planification rigoureuse des ressources humaines, pour leur adaptation aux besoins réels de développement de la société;

9. Renforcement du Fonds National de l'Emploi.

3.3.9. Etudes et Recherches

En dehors des opérations réalisées par les organismes parapublics et privés, le Sénégal a exécuté deux enquêtes démographiques nationales, un recensement général de la population, une enquête sur la fécondité, une enquête démographique et de santé, une enquête sur la mortalité infantile en milieu rural et prépare le second recensement général de la population prévu en 1988.

D'une façon générale, de grands progrès ont été faits dans la connaissance de l'état de la population, ainsi que de la fécondité, mais des lacunes significatives demeurent pour ce qui est de l'étude de la mortalité et des migrations. Or, les données sur la natalité, la mortalité et les migrations doivent être simultanément prises en considération pour définir une politique nationale de population.

A un autre niveau, on manque de données sur les activités qui sont menées au plan national ou régional dans le domaine de l'espacement des naissances. Or, ces données sont essentielles pour suivre ces activités et connaître leur impact, pour une meilleure orientation des efforts nationaux e locaux.

On ne dispose que de quelques recherches approfondies sur les problèmes d'urbanisation et d'aménagement du territoire, alors que ces questions sont importantes au Sénégal.

Ainsi, il reste beaucoup à faire pour promouvoir une meilleure connaissance de l'ensemble de ces problèmes et leur intégration dans les plans de développement.

Les mesures suivantes pourront y contribuer :

1. Réorganisation et renforcement de l'état-civil, pour un meilleur enregistrement des événements vitaux qui permettront une connaissance plus approfondie des niveaux et tendances démographiques;
2. Production, diffusion et évaluation régulière des statistiques d'état-civil;
3. Réalisation périodique (tous les dix ans) du recensement général de la poplutation;
4. Amélioration des recensements administratifs;
5. Réalisation périodique d'enquêtes et de recherches sur la fécondité, mais surtout sur la mortalité et les migrations pour une bonne connaissance des mouvements de population;
6. Intensification de la collecte et de l'exploitation des statistiques courantes : santé, éducation, emploi, logement etc... pour une meilleure planification du développement et un meilleur suivi de la politique de population;
7. Promotion de types d'enquêtes et de recherches plus performants, capables de favoriser la collecte régulière d'informations sur la population et le développement : enquêtes niveaux de vie, budget-consommation, main-d'œuvre, etc...;
8. Réalisation d'études approfondies sur les relations entre les variables démographiques et les autres variables socio-économiques;
9. Elaboration de méthodologies d'intégration poussées des variables de population dans les plans de développement national et régional;
10. Etudes sur l'intégration des questions de population dans l'ensemble du système éducatif, de l'élémentaire au supérieur;
11. Elaboration de programmes spéciaux d'information, d'éducation et de communication en matière de population.

3.3.10. Information, Education, Communication en matière de population

Pour réaliser la performance qui consiste à sensibiliser une population dont la majorité est encore non alphabétisée et non scolarisée, il est nécessaire de promouvoir des formes appropriées de communication qui soient susceptibles de faire progresser la lutte contre la mortalité et la morbidité, les naissances nombreuses et rapprochées et divers autres maux répandus au sein des populations et, plus particulièrement, de la jeunesse. Il s'agit d'impliquer toutes les composantes de la société et les mobiliser pour la réalisation des objectifs fixés en matière de santé et de planification familiale, mais également pour la concrétisation des autres volets de la politique de population. Dans cette perspective, le recours aux langues nationales sera privilégié. Les mesures préconisées en conséquence sont les suivantes :

1. Renforcement et extension à tout le pays des programmes d'alphabétisation fonctionnelle en langues nationales;
2. Elaboration d'une documentation et de matériaux appropriés pour l'information et l'éducation des hommes, des femmes et des jeunes sur les problèmes liés à l'espacement des naissances et tous les autres volets de la politique de population;
3. Mobilisation des médiats, des associations culturelles, des centres de formation féminine, des groupements de promotion féminine et autres centres socio-éducatifs, afin d'informer, tout particulièrement, les femmes pour le succès de la politique de population;
4. Sensibilisation des hommes sur l'importance des questions de population, d'éducation à la vie familiale et d'éducation de leurs enfants;
5. Sensibilisation des décideurs, des notabilités politiques, coutumières et religieuses pour leur pleine participation à la mise en œuvre de la politique de population, dans toutes ses composantes;

6. Développement de banques de données et autres réseaux destinés à fournir des informations complètes et actuelles sur les problèmes de population et de développement;

7. Renforcement et coordination des activités communautaires destinées à promouvoir la planification familiale.

3.3.11. Mesures législatives et réglementaires

Au regard des textes existants, il est recommandé de réviser ou de préciser certaines orientations, afin de favoriser la mise en œuvre de la politique de population.

En effet, le régime fiscal et social en vigueur favorise les familles nombreuses et, à ce titre, a une orientation pronataliste évidente.

Il favorise les salariés ayant une progéniture nombreuse ou de lourdes charges sociales, aussi bien en période d'activité que de retraite. Il convient donc de corriger une telle orientation et prévoir, au besoin, des mesures dissuasives.

Il faut réviser la fiscalité dans le sens de la réduction de la discrimination à l'égard des célibataires et des familles peu nombreuses, car l'importance de la réduction de la charge fiscale, selon le statut matrimonial et le nombre d'enfants, encourage la formation de grandes familles.

En outre, la révision du code de la famille, dans ses dispositions pertinentes, peut concourir, elle aussi, au succès de la politique de population, si des mesures appropriées sont prises pour en assurer l'application effective.

Enfin, il importe de réviser la loi sur les délais de déclaration des faits d'état-civil, pour assurer un meilleur enregistrement de ces données.

4. - LE CADRE INSTITUTIONNEL

La politique de population est promue à travers plusieurs sortes d'organes :

4.1. Un organe de décision :

Le conseil interministériel sur la population présidé par le Chef de l'Etat. Le décret organisant la Commission Nationale de la Population indique que les recommandations en matière de politique de population sont examinées en conseil interministériel.

4.2. Une structure consultative nationale :

La Commission Nationale de la Population (CONAPOP) a vocation d'assister le Gouvernement dans la définition de la politique en matière de population. Cette commission est créée auprès du Ministre du Plan qui en assure la présidence. Le Directeur des Ressources Humaines en est le Secrétaire.

4.3. Un organe de planification, de coordination, de suivi et d'évaluation :

La Direction des Ressources Humaines du Ministère du Plan et de la Coopération créée lors du remaniement ministériel de 1986. Cette direction comporte une Division des Etudes et de la Politique de Population et propose la politique en matière de population en rapport avec les autres services concernés.

4.4. Plusieurs structures d'exécution dont les principaux sont :

1. Le Ministère du Développement Social qui comporte des directions ayant un rôle essentiel dans la mise en œuvre de la politique sociale du Gouvernement : Directions de la Condition Féminine et du Bien-Etre Familial, notamment. En ce qui concerne l'espacement des naissances, la collaboration instituée, en la matière, entre les ministères du Développement Social et de la Santé Publique doit être renforcée et au besoin élargie;

2. Le Ministère de la Santé Publique, maître d'œuvre dans le domaine de la protection maternelle et infantile;

3. Le Ministère de l'Intérieur, responsable de l'état civil et de l'aménagement du territoire;

4. Le Ministère Délégué Chargé des Emigrés étudie les problèmes liés à l'émigration;

5. Le Ministère de la Fonction Publique et du Travail;

6. Le Ministère de l'Education Nationale;

7. Le Ministère de la Jeunesse et des Sports;

8. Le Ministère de l'Urbanisme et de l'Habitat;

9. Le Ministère de la Culture;

10. La Délégation à l'Insertion, à la Réinsertion et à l'Emploi.

4.5. Des structures nationales d'étude et de recherche :

- Le Ministère de l'Economie et des Finances (Direction de la Statistique) chargé essentiellement de la collecte et de l'analyse des données démographiques;

- L'Université de Dakar, le Centre d'Etude des Civilisations, les Archives Culturelles du Sénégal, l'Ecole Nationale d'Economie Appliquée, l'Institut Islamique et les autres structures ayant des programmes importants de recherche dans le domaine socio-économique et la population.

4.6. Des structures d'étude et de recherche en coopération :

Dans le cadre de la coopération scientifique bilatérale ou multilatérale, des structures de recherche étrangères mènent ou soutiennent des programmes de recherche en matière de population au Sénégal.

4.7. Des structures de contribution :

Les associations privées et les organisations non-gouvernementales.

La conduite de la politique de population doit être menée dans un cadre institutionnel apte à donner une efficacité maximale à la coordination, au suivi, et à l'évaluation des activités découlant de cette politique. La multiplicité des domaines et des structures concernées, la rapidité d'exécution indispensable imposent cette nécessité.

Aussi, les structures de coordination et de décision mises en place devraient elles être redynamisées.

Ainsi, la CONAPOP, qui est une instance de concertation et de coordination, devrait être restructurée et renforcée par des antennes régionales et la Direction des Ressources Humaines, chargée d'en assurer le secrétariat, dotée de moyens logistiques et humains adéquats.

Enfin, il apparaît opportun d'envisager la tenue régulière du conseil interministériel sur la population présidé par le Chef de l'Etat.

5. - SUIVI ET EVALUATION

Avec l'adoption d'une politique nationale de population, il devient indispensable de mettre en place des structures efficaces de suivi et d'évaluation dont les tâches consisteraient à assurer :

* Le suivi et l'évaluation périodiques et continus des politiques, programmes et projets nationaux et sectoriels en matière de population sur la base d'objectifs initialement et clairement définis;

* Une mobilisation et une utilisation rationnelle des compétences et des moyens matériels et financiers disponibles pour organiser des études socio-économiques et démographiques visant à déterminer l'impact des différents programmes sur la population pour opérer les réajustements éventuels;

* La promotion de la participation des communautés de base à l'évaluation des programmes de population.

A cette fin, il apparaîtra utile de mettre sur pied un Comité Technique de suivi des projets de population. Ce Comité regroupera les représentants de structures et institutions exécutant des projets de population.

RECAPITULATIF

	RECOMMANDATIONS	MAITRES D'ŒUVRE	DECISIONS DU CONSEIL INTERMINISTERIEL	ECHEANCES
OBJECTIFS ET STRATEGIES	1. Santé de la mère et de l'enfant	MSP* MDS	Sous la coordination du MPC, les Maîtres d'Œuvre désignés traduiront en actions et projets les objectifs et stratégies décrits dans la déclaration de politique de population et élaboreront à cet effet un Premier Programme d'Actions et d'Investissements Prioritaires en Matière de Population	Mai 88 à Mars 1989
	2. Fécondité et espacement des naissances	MSP - MDS* - MEN - MES		
	3. Promotion de la femme	MDS* - MEN - MFPT - MEF - SGPR (DIRE) - SGPR (BOM)		
	4. Promotion des jeunes	MJS* - MEN - MES - MDS - M. Cult. - MFPT - SGPR (DIRE) - MSP - SGPR (BOM)		
	5. Promotion des personnes du 3ème âge	MDS* - MSP - SGPR (FNAS) MFPT		
	6. Préservation de la Famille	MDS* - MJ - MSP - M. Cult. MJS - MEN - MES		
	7. Migrations, Urbanisation et Aménagement du Territoire	MI (DAT)* - SGPR (BOM) - MPC SGPR (DIRE) - MUH - MDE - MPN		
	8. Emploi	SGPR (DIRE)* - MDR - MDE - MDS - MEF - MPC - MJS - MFPT		
	9. Etudes et Recherches	MI (DAT) - MEF - MPC* - MES MSP - MEN - M. Cult. - Structures de rech. en matière de population		
	10. Information, Education, et Communication en matière de population	MPC* - MDS - MJS - MEN - M. Communication - MSP - MES M. Cult. - MI		

	11. Mesures législatives et réglementaires	MPC* - MDS - MFPT - MJ - MEF - MI - MSP	Le MPC réunira la Commission Nationale de la Population (CONAPOP) qui évaluera la législation et la réglementation fiscales et sociales et proposera au Gouvernement des mesures devant contribuer à un meilleur enregistrement des faits d'état civil et en général au succès de la politique de population.	Mai 88 à Octobre 1989
CADRE INSTITUTIONNEL	Renforcement de la CONAPOP	MPC	Le MPC soumettra un projet de décret actualisant la composition de la CONAPOP et renforçant celle-ci par des antennes régionales.	Juillet 1988
	Renforcement de la DRH	MPC	Le MPC étudiera les possibilités de renforcer en moyens logistiques et humains la DRH, afin de lui permettre de mieux assumer ses tâches de coordination et de suivi de la politique en matière de population.	
	Tenue régulière du Conseil Interministériel sur la population.	MPC	Le MPC prendra les dispositions utiles en rapport avec les départements concernés pour la tenue, au moins tous les 2 ans, d'un Conseil Interministériel sur la population.	
SUIVI ET EVALUATION	Création d'un Comité Technique de Suivi des projets en matière de population.	MPC	Après avoir consulté la CONAPOP, le MPC prendra un arrêté créant et organisant le Comité de Suivi des Projets en matière de population.	Janvier 1989

* Chef de file.

ANNEX F

Government Decrees

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ANNEX F-1

MPHSA Order of February 12, 1991, Concerning the Establishment and Organization of the Family Health and Population Project

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ANNEX

REPUBLIQUE DU SENEGAL
Un Peuple - Un But - Une Foi

MINISTERE DE LA SANTE PUBLIQUE
ET DE L'ACTION SOCIALE

ANALYSE : DECRET ORGANISANT LA SANTE MATERNELLE ET INFANTILE.

LE PRESIDENT DE LA REPUBLIQUE,

VU la Constitution, notamment en ses articles 37 et 65 ;

VU la Loi n° 66-069 du 04 Juillet 1966 relative à l'exercice de la Médecine et à l'ordre des Médecins ;

VU le décret n° 60.247 du 13 Juillet 1960 organisant la Protection Maternelle et Infantile (PMI) ;

VU le décret 79.416 du 12 mai 1979 portant organisation du Ministère de la Santé Publique, modifié par le décret 90.349 du 27 mars 1990, modifié par le décret n° 91.437 du 8 avril 1991 ;

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VU le décret n° 91-423 du 7 avril 1991 portant nomination du Premier Ministre ;

VU le décret n° 91-429 du 8 avril 1991 portant nomination des Ministres ;

VU le décret n° 91-430 du 8 avril 1991 portant répartition des services de l'Etat ;

VU l'Arrêté n° 000252 du 7 juin 1985 abrogeant et remplaçant l'Arrêté n° 003187 du 27 mars 1980, portant organisation de la DHPS ;

VU l'Arrêté n° 002216 du 25 février 1989 fixant la nomenclature des actes professionnels des auxiliaires médicaux ;

VU l'Arrêté n° 002216 du 4 mars 1991 complétant l'arrêté n° 002651 du 25 février 1989 ;

VU la circulaire n° 120 du 09 novembre 1964 portant organisation des services des Ministères Publics ;

VU la circulaire n° 00120 du 21 janvier 1991 relative aux examens complémentaires dans la contraception ;

SUR le rapport du Ministre de la Santé Publique et de l'Action Sociale ;

DECRETE

ARTICLE PREMIER : La dénomination Santé Maternelle et Infantile (SMI) répond à une définition opérationnelle et englobe toutes les activités : curatives, préventives, éducationnelles et promotionnelles de santé visant à promouvoir la santé et le bien-être des femmes et des enfants.

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ARTICLE 2 : La Santé Maternelle et Infantile est placée sous la responsabilité d'une division de la Direction de la Santé Publique dénommée Division de la Santé Maternelle et Infantile (D.S.M.I.).

ARTICLE 3 : La Division de la S.M.I. est chargée d'impulser, d'animer et de coordonner sur l'ensemble du territoire national, toutes les activités de S.M.I.

Elle fixe les normes et évalue toutes les actions entreprises.

ARTICLE 4 : La Division de la S.M.I. est subdivisée en trois bureaux :

- Bureau Planification Familiale ;
- Bureau Prévention Mortalité Maternelle ;
- Bureau Surveillance post-natale du couple Mère-enfant.

ARTICLE 5 : Les activités de santé maternelle et infantile couvrent les domaines d'intervention spécifiques qui sont :

A. La Planification Familiale dont l'objectif est :

- d'espacer les naissances pour sauvegarder la santé de la mère et celle de l'enfant ;

- de permettre aux couples de choisir le nombre d'enfants qu'ils désirent selon leur propre programmation ;

- de lutter contre les maladies sexuellement transmissibles et la stérilité.

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B. La prévention de la Mortalité Maternelle par :

- une surveillance de la grossesse en assurant à chaque femme enceinte au moins trois consultations ;

- une assistance à l'accouchement par un personnel compétent et bien formé à cet effet.

C. La surveillance post-natale du couple Mère-Enfant dont l'objectif est :

- pour les mères : d'assurer à toutes les femmes accouchées récentes au moins une consultation du post-partum par mois pendant trois mois ;

- pour les enfants : d'assurer des soins néo-nataux et une surveillance des enfants jusqu'à l'âge pré-scolaire.

ARTICLE 6 : Toutes interventions dans le cadre de la santé maternelle et infantile doivent être accompagnées et soutenues par des actions d'information, de sensibilisation et d'éducation des femmes sur les nuisances auxquelles la mère et l'enfant sont les plus exposés et sur les manières de les prévenir.

ARTICLE 7 : L'organisation et l'exécution effective des activités de SMI doivent être conçues à tous les niveaux du système national de santé sur un modèle intégré privilégiant la stratégie des soins de santé primaires qui exige l'implication des populations et des autres secteurs de développement.

ARTICLE 8 : L'enseignement de la Santé Maternelle et Infantile sera intégré dans les curricula de toutes les écoles et instituts de formation en santé publique.

La formation continue en SMI devra être assurée à tous les niveaux du système pour tous les agents impliqués dans l'exécution des activités de SMI.

ARTICLE 9 : La Direction de la Santé Publique est chargée d'organiser et de coordonner l'ensemble des actions de santé maternelle et infantile menées par les autres institutions sanitaires publiques et privées qui ne relèvent pas du Ministère de la Santé Publique et de l'Action Sociale.

Au niveau des régions, cette coordination est assurée par le Médecin-Chef de région.

ARTICLE 10 : Toutes dispositions antérieures à celles du présent décret et relatives à la Santé Maternelle et Infantile, notamment le décret n° 60-247 du 13 Juillet 1960 organisant la protection maternelle et infantile sont abrogées.

ARTICLE 11 : Le Ministre des Forces Armées, le Ministre de l'Intérieur, le Ministre de l'Education Nationale, le Ministre de la Santé Publique et de l'Action Sociale, le Ministre de la Femme, de l'Enfant et de la Famille sont chargés, chacun en ce qui le concerne, de l'application du présent décret, qui sera enregistré, publié et communiqué partout où besoin sera.

Fait à Dakar, le

Par le Président de la République

Abdou DIOUF

Le Premier Ministre

Habib THIAM

ANNEX F-2

MPHSA Draft Order Establishing

the National Family Planning Program

REPUBLIC OF SENEGAL

MINISTRY OF PUBLIC HEALTH

AND SOCIAL AFFAIRS

Dakar, February 12, 1991

Order concerning the establishment and organization of the Population and Family Health Project (PFHP)

The Minister of Public Health and Social Affairs

- Considering the Constitution

Considering the decree N° 65-857 dated 12/4/65 relating to the delegation of the powers of the President of the Republic concerning civil servants appointment, administration and management modified by the decrees N° 69.1303 and 70.774 dated 11/18/69 and 6/24/70.

- Considering the Grant Agreement N° 685-0248 dated July 31,1985 between the Government of the Republic of Senegal and the United States Government for the Population and Family Health Project (PFHP).

- Considering the modified decree N° 79416/MPH dated May

19,1979 relating to the organization of the Ministry of Public Health.

- Considering the decree N° 90.332 dated March 27,1990 relating to the designation of Ministers.

- Considering the decree N° 90.333 dated March 27,1990 relating to the spreading of State services ;

Order

Article One : A department has been established in the Ministry of Public Health and Social Affairs to take charge of the Family Health and Population Project (FHPP) or FHPP National Cell.

Article Two : Its headquarters are located in Dakar, on "Route du Front de Terre". They could be transferred to any other location upon decision of the Minister of Public Health and Social Affairs.

Article Three : The Project Management or National Cell is a coordinating and implementing body of the project. It is responsible for :

* The planning, the implementation and the assessment of all activities carried out in the various components of the project (IEC, clinical, VSPP, BNR).

* Elaborating the work schedule and the annual budgets of the project in collobaration with USAID technical assistants ;

* Organizing the training programs and ensuring the planning and coherence of the general implementation of the project.

Article four : The Project Management or National Cell consists of the following :

* One (1) project Director and coordinator
* One (1) Deputy - director who is also responsible for the supervision of the Administrative and Financial Office (AFO)
* Two (2) management experts working for the Administrative and Financial Office who are respectively responsible for financial accounting and stock inventories.
* Five (5) senior executives working in technical services : IEC (2), Clinical (1), Surveys Research and Assessment (2)

support staff consisting of :

* Two (2) secretaries
* Three (3) Drivers
* Two (2) Caretakers
* One (1) Cleaner

Article Five : The purpose of the Population and Family Health Project is to improve the quality of family life as well as the child and mother health status.

Article Six : PFSP activities will be carried out in all the country.

Article Seven : The objectives of the Population and Family Health Project include :

* The establishing of a favorable environment for Family Planning through Information, Education and Communication programs for the population by using interpersonal communication and mass-

media.

2. The training of the following staff in Family Planning, Management or IEC.

* Midwives
* IEC agents
* Auxiliaries
* Nurses and health agents
* Medical Doctors

3) The delivery of child spacing services for people who are of reproductive age

4) The detection and treatment of patients suffering from sexually transmitted diseases (STDs) or Male and Female Infertility.

5) The delivery of FP services in Child and Maternal Health Centers and any other state approved organizations working under the Project ;

6) Establishing of huts and meeting places as sensitization and information sites for population problems and the orientation of women towards FP services ;

7) Material support for women's promotion groups ;

8) The implementation of accompanying projects for women's organizations.

9) support for the private and parastatal sectors and FP service delivery for the population.

10) The carrying out of FP operational research and support for bio-medical and psycho-social research ;

11) Participation in the improvement of the demographic data base ;

12) To make policy makers and planners understand the importance of the population factor in the development process.

Article Eight : PSFP activities are coordinated by a Director designated by order of the Minister of Public Health an Social Affairs.

Article Nine : The Director of the Population and Family Health Project is responsible for the implementation of this order which will be officially published.

Copies

- GS/PR
- SCM
- All Ministries and delegate Ministries
- All MPHSA services
- DDI/MEFP
- JORS
- Archives

The Minister of Public Health and Social Affairs

ASSANE DIOP

ANNEX F-3

Transmittal Letter from the Minister of Public Health Requesting Approval of GOS Decree Establishing the National Family Planning Program

ANNEX G

Annexes on Contraceptive Logistics

REPUBLIQUE DU SENEGAL
Un Peuple - Un But - Une Foi

MINISTERE DE LA SANTE PUBLIQUE
ET DE L'ACTION SOCIALE

RAPPORT DE PRESENTATION

Le décret n° 60-247 du 13 Juillet 1960 organisant la Santé Maternelle et Infantile avait comme principaux objectifs :

- sauvegarder la santé des femmes au cours de la grossesse et pendant l'allaitement ;

- assurer un accouchement normal tout en donnant naissance à des enfants sains ;

- garantir une surveillance sanitaire suivie et des soins médicaux pour tous les enfants, depuis la naissance jusqu'à l'âge de 6 ans ;

- assurer le bien-être de l'enfant dans son milieu familial.

Ainsi, les activités étaient essentiellement axées sur :

- la consultation pré et post natale ;
- la consultation des enfants sains ;
- la vaccination ;
- la nutrition ;
- l'éducation et l'information des mères.

Depuis la Conférence d'Alma-Ata en 1978, l'accent est mis sur la promotion des soins maternels de base aux niveaux familial et communautaire, la disponibilité géographique des services d'orientation/recours pour les grossesses à risque et les urgences, l'accessibilité à la Planification Familiale.

Cette nouvelle composante qu'est la planification familiale, partie intégrante de la Santé Maternelle et Infantile, ainsi que l'adoption d'une politique de population nous ont amenés à procéder à une mise à jour des objectifs et des activités assignés à la Santé Maternelle et Infantile.

Par ailleurs, dans le souci de se conformer à la réglementation en matière d'organisation des services des ministères et de suivre les directives visant à moderniser notre administration pour la rendre mieux structurée et plus efficace, nous proposons le terme de Division à la place de Service National pour dénommer l'Unité de la Direction de la Santé Publique chargée de gérer au niveau national la santé maternelle et infantile.

Initialement basées au niveau des Centres de Protection Maternelle et Infantile, les activités de SMI devront désormais être disponibles à tous les échelons de la pyramide sanitaire avec un corollaire, l'implication à des degrés divers du personnel de santé, depuis le médecin jusqu'à l'agent de Santé Communautaire.

Dans le cadre de la collaboration intersectorielle, différents ministères seront désormais intéressés dans la mise en oeuvre des activités de planification familiale et devront apporter leur participation dans la conception, l'exécution ou l'évaluation des programmes de santé maternelle et infantile.

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Aussi ce projet de décret a-t-il été élaboré pour lever toutes les contraintes antérieures pouvant constituer un frein à l'atteinte des objectifs assignés à la Santé Maternelle et Infantile.

Telle est, Monsieur le Président de la République, l'économie du présent projet de décret que j'ai l'honneur de soumettre à votre approbation.

Le Ministre de la Santé Publique
et de l'Action Sociale

Assane DIOP

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ANNEX G-1

Equipment Purchased for STD Laboratories

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ANNEX G

MEDICAL EQUIPMENT/SUPPLIES	QTY
1. Clotrimazole 500 mg Vaginal Tablets	6000 jars
2. Aspirin tablets USP 5 Grain	875 jars
3. Acetaminofen tablets USP 5 Grain 1000 Tablets	750 units
4. Ibuprofen Tablets USP 500 MG 500 Tablets Per Unit	245 jars
5. Ferrous Sulfate Tablets USP 325 MG 1000 Tablets Per Unit	2400 jars
6. Folio Acid Tablets USP 1 MG 1000 Tablets Per Unit	300 jars
7. Chloroquine Phosphate Tablets USP 500 MG 1000 Tablets for Unit	300 jars
8. Spectinomycine hydrochloride Sterile USP 2651 2G (5ml) Per VIAL	4800 ea
9. Metronidazole tablets USP 250 MG 500 Tablets Per Unit	170 jars
10. Tetracycline Hydrochloride Capsules USP 500 MG. 1000 Capsules Per Unit	216 jars
11. Ampicillin Capsules USP 500 MG, Trihydrate 500 Capsules Per Unit	1000 jars
12. Probenecid Tablets USP 500 MG 1000 Tablets Per Unit	113 jars
13. Erythromycin Stearate Tablets USP 500 MG 100 Tablets Per Unit	935 jars
14. Sulfamethoxazole 800 MG and Trimethoprim 160 MG Tablets USP, 500 Tablets EA	300 jars
15. Sterile Penicillan G Benzthine Suspension, 2.400.000 units per 4 ml disposable syringe,in packages of 10.	1000 pkgs

ANNEX H

ITEM	LEVEL	QTY	UNIT	UNIT COST	TOTAL COST
AUTOCL CLEANER (SP)	W	2	BX	$69.60	$139.20
AUTOCL DOOR HANDLE (SP)	W	6	EA	$6.50	$39.00
AUTOCL FUSES (SP)	W	60	EA	$2.60	$156.00
AUTOCL GASKETS (SP)	W	24	EA	$37.50	$900.00
AUTOCL HEATER (SP)	W	3	EA	$185.00	$555.00
AUTOCL RECORDER MOTOR (SP)	W	3	EA	$115.00	$345.00
AUTOCL SOLENOID REP KIT (SP)	W	6	EA	$48.00	$288.00
AUTOCL STEAM TRAP (SP)	W	6	EA	$57.45	$344.70
AUTOCL THERMOSTAT (SP)	W	6	EA	$9.90	$59.40
AUTOCL TIMER (SP)	W	3	EA	$79.00	$237.00
AUTOCL TUBING (SP)	W	60	FT	$0.25	$15.00
AUTOCL VALVE (SP)	W	4	EA	$22.50	$90.00
AUTOCLAVE INK CARTRIDGE	R	22	EA	$11.20	$246.40
AUTOCLAVE RECORD PAPER	R	11	BX	$26.00	$286.00
AUTOCLAVE, BENCHTOP	R	11	EA	$2,051.00	$22,561.00
BALANCE, METRIC	N, R	13	EA	$82.72	$1,075.36
BEAKER, 100ML	N, R	1	CS	$43.71	$43.71
BEAKER, 250ML	N, R, D	3	CS	$40.87	$122.61
BEAKER, 50ML	N, R	1	CS	$40.87	$40.87
BEAKER, 600ML	N, R, D	4	CS	$46.15	$184.60
BEEKER, 1000 ML	N, R	3	CS	$58.41	$175.23
BOTTLE, DROPPER	N, R, D	7	CS	$51.25	$358.75
BOTTLES, REAGEANT	N, R	6	CS	$34.50	$207.00
BOTTLES, WASH 500ML	N, R, D	10	CS	$40.50	$405.00
BOX, MICROSLIDE	N, R, D	2	CS	$240.00	$480.00
BRUSHES, TEST TUBE	N, R, D	10	PK	$3.75	$37.50
BRUSHES, TEST TUBE	N, R, D	10	PK	$3.65	$36.50
BURNER, ALCOHOL	D	50	EA	$2.40	$120.00
BURNER, BUNSEN	N, R	20	EA	$4.80	$96.00
CENTRIFUGE BRUSH KIT	R	15	EA	$10.60	$159.00
CENTRIFUGE ROTOR	R	15	EA	$157.00	$2,355.00
CENTRIFUGE SHIELDS & CUSHIONS	R	180	EA	$7.55	$1,359.00
CENTRIFUGE, BENCH TOP	R	15	EA	$426.30	$6,394.50
COPLIN STAINING JAR	N, R, D	21	CS	$65.12	$1,367.52
CULTURE TUBE	N, R	5	CS	$88.40	$442.00
CULTURE TUBE, SCREW CAP	N, R	15	CS	$126.89	$1,903.35
CULTURE TUBES	N	3	CS	$71.89	$215.67
ERLEN FLASK &CAP	N, R	5	CS	$70.05	$350.25
ERLEN FLASK 1000ML	N, R	3	CS	$51.92	$155.76
ERLEN FLASK 500ML	N, R	3	CS	$47.76	$143.28
FORCEPS, LG.	N, R, D	14	PK	$5.59	$78.26
FORCEPS, MED, SERRATED	N	3	CS	$10.00	$30.00
FREEZER BATTERY, 12 V (SP)	W	1	EA	$29.75	$29.75
FREEZER COMPRESSOR(SP)	W	1	EA	$348.00	$348.00
FREEZER RELAY (SP)	W	1	EA	$46.25	$46.25
FREEZER RELAY, SOLID STATE (SP)	W	1	EA	$25.40	$25.40

W=Warehouse; N=National; R=Regional; D=Departmental

ITEM	LEVEL	QTY	UNIT	UNIT COST	TOTAL COST
FREEZER SEPARATOR AC&R (SP)	W	1	EA	$47.85	$47.85
FREEZER SERVICE ASSEMBLY (SP)	W	1	EA	$103.35	$103.35
FREEZER TIME DELAY (SP)	W	1	EA	$41.35	$41.35
FREEZER FAN BLADE (SP)	W	1	EA	$4.65	$4.65
FREEZER FCU404 C BOARD (SP)	W	1	EA	$297.25	$297.25
FREEZER HINGE ASSEMBLY (SP)	W	1	EA	$27.20	$27.20
FREEZER, LATCH & STRIKE (SP)	W	1	EA	$47.85	$47.85
FREEZER, SENSOR SERVICE 240V-K (SP)	W	1	EA	$112.05	$112.05
FREEZER TIMER (SP)	W	1	EA	$27.20	$27.20
FREEZER, ULTRA LOW TEMPERATURE	N	1	EA	$4,464.10	$4,464.10
FUNNEL, FILLING 150mm	N, R	3	CA	$80.00	$240.00
FUNNEL, HIGH-SPEED, 100mm	N, R	3	CA	$18.00	$54.00
GRADUATE, 1000ML	N, R	3	CS	$139.75	$419.25
GRADUATE, 2000ML	N, R	3	CS	$122.30	$366.90
GRADUATE, 500ML	N, R	2	CS	$117.50	$235.00
HOLDER FOR INOC. LOOP	N, R	100	EA	$5.90	$590.00
INCUBATOR (SM) CIRCUIT BRK (SP)	W	3	EA	$11.75	$35.25
INCUBATOR (SM) COMPRESSOR (SP)	W	2	EA	$196.50	$393.00
INCUBATOR (SM) DISPLAY (SP)	W	3	EA	$60.25	$180.75
INCUBATOR (SM) FAN (SP)	W	3	EA	$18.70	$56.10
INCUBATOR (SM) HEATING ELT (SP)	W	3	EA	$12.35	$37.05
INCUBATOR (SM) PILOT (SP)	W	3	EA	$11.75	$35.25
INCUBATOR (SM) SWITCH (SP)	W	3	EA	$11.75	$35.25
INCUBATOR (SM) THERMOSTAT (SP)	W	33	EA	$53.00	$1,749.00
INCUBATOR, BOD 18 CU FT	N	2	EA	$2,120.00	$4,240.00
INCUBATOR, UNDER-COUNTER	R	11	EA	$829.00	$9,119.00
MICRO SELECTAPETTE 10-30	N, R	20	EA	$102.50	$2,050.00
MICRO SELECTAPETTE 50-100	N, R	20	EA	$101.25	$2,025.00
MICRO SPATULA	N, R	1	CS	$113.00	$113.00
MICROSCOPE CARRYING CASE	D	30	EA	$51.75	$1,552.50
MICROSCOPE COVER	D	30	EA	$0.00	$0.00
MICROSCOPE DARKFIELD ACCESSORIES	R	10	EA	$0.00	$0.00
MICROSCOPE FUSES (SP)	W		EA	$0.00	$0.00
MICROSCOPE ILLUMIN. BULBS (SP)	W	90	EA	$6.95	$625.50
MICROSCOPE ILLUM. TRANSFORMER	D	30	EA	$30.50	$915.00
MICROSCOPE ILLUMINATOR	D	30	EA	$96.60	$2,898.00
MICROSCOPE TRANSPORT CASE	R	10	EA	$95.00	$950.00
MICROSCOPE AURAMINE & RHADOMINE	N	2	EA	$277.00	$554.00
MICROSCOPE, BINOCULAR]	R	10	EA	$2,071.00	$20,710.00
MICROSCOPE FLUORESCENCE EQUIPMENT	N	2	EA	$4,711.00	$9,422.00
MICROSCOPE, MONOCULAR	D	30	EA	$456.80	$13,704.00
MORTAR PESTLE	N, R	3	CS	$57.00	$171.00
MORTAR, PORCELAIN	N, R	3	CS	$73.00	$219.00
PETRI DISHES	N, R	60	CS	$95.27	$5,716.20
PIPETTE BULB, 2ML	N, R	5	PK	$8.50	$42.50
PIPETTE FILLER, SAFETY TYPE	N, R	72	EA	$4.99	$359.28

W=Warehouse; N=National; R=Regional; D=Departmental

ITEM	LEVEL	QTY	UNIT	UNIT COST	TOTAL COST
PIPETTE JAR	N, R	3	CS	$170.00	$510.00
PIPETTE WASHER&BASKET	N, R	3	CS	$204.00	$612.00
PIPETTE, PASTEUR	N, R	10	CS	$11.00	$110.00
PIPETTE, SEROL 10ML	N, R	360	EA	$1.50	$540.00
PIPETTE, SEROL 2ML	N, R	360	EA	$1.75	$630.00
PIPETTE, SEROL 5ML	N, R	360	EA	$1.30	$468.00
PIPETTE, SEROL1ML	N, R	420	EA	$1.20	$504.00
PIPETTOR AUTOMATON 25uL	N, R	20	EA	$55.10	$1,102.00
PIPETTOR, AUTOMATON 50uL	N, R	28	EA	$55.39	$1,550.92
RACK, TEST TUBE 16mm	N, R, D	13	CS	$64.00	$832.00
ROTATOR, RPR CARDS	N,R	17	EA	$235.20	$3,998.40
ROTATOR,VARIABLE	N	2	EA	$760.00	$1,520.00
CULTURE TUBE SCREWCAPS	N	2	CS	$15.51	$31.02
SPATULA, 10"	N, R	3	PK	$43.00	$129.00
SPATULA, 5"	N, R	3	PK	$21.50	$64.50
STERIL BOX PIPETTES	N, R	3	CS	$215.50	$646.50
STERIL BOX PETRI DISHES	N, R	6	CS	$479.50	$2,877.00
STOOL, LAB	N, R, D	50	EA	$41.50	$2,075.00
TEST TUBE RACK	N, R	70	EA	$8.50	$595.00
THERMOMETER, INCUB & WBATH	N, R	30	EA	$10.75	$322.50
THERMOMETER, REF/FRZ	N, R	20	EA	$2.85	$57.00
TIMER	D	28	EA	$29.00	$812.00
TUBE, CARDBOARD	N, R	10	CS	$25.00	$250.00
TUBING, LATEX 1/4"	N, R	4	CS	$13.50	$54.00
WASH BOTTLES 250ML	N, R, D	54	PK	$5.91	$319.14
WATERBATH (SM) HEATER ELT. (SP)	W	3	EA	$39.73	$119.19
WATERBATH (SM) LAMPS&BULBS (SP)	W	6	EA	$9.25	$55.50
WATERBATH (SM) RHEOSTAT (SP)	W	6	EA	$45.38	$272.28
WATERBATH (SM) THERMOMETER (SP)	W	3	EA	$4.95	$14.85
WATERBATH COVER, LG	N	2	EA	$74.05	$148.10
WATERBATH COVER, SMALL	R	11	EA	$63.00	$693.00
WATERBATH, LG	N	2	EA	$527.00	$1,054.00
WATERBATH, SMALL	R	11	EA	$372.00	$4,092.00
WIRE, NICKEL CHROMIUM	N, R	5	CS	$18.00	$90.00
					$157,182.35

W=Warehouse; N=National; R=Regional; D=Departmental

ITEM	LEVEL	QTY	UNIT	UNIT COST	TOTAL COST
AGAR, GC BASE	N,R	20	PK	$17.90	$358.00
AGAR, PURIFIED	N,R	7	EA	$46.00	$322.00
AMMONIUM OXALATE	N,R	2	CS	$262.35	$524.70
ANTI AB GROUP SERA	N	2	PK	$61.50	$123.00
ANTI B GROUP SERA	N	2	PK	$61.50	$123.00
ANTI D GROUP SERA	N	2	PK	$196.14	$392.28
ANTI-A GROUP SERA	N	2	PK	$61.50	$123.00
APPLICATOR STICKS, WOOD	N,R	2	CS	$29.00	$58.00
AUTOTRAY, 120 WELLS, MHATP	N	12	CS	$99.00	$1,188.00
BANDAIDS	N,R	50	PK	$2.50	$125.00
BROTH, TRYPTICASE SOY	N,R	14	EA	$26.00	$364.00
CALGISWAB, PK OF 1, ALUM	N,R,D	3	CS	$206.00	$618.00
CALGISWAB, PK OF 2, WOOD	N,R,D	5	CS	$95.00	$475.00
CAMBRIDGE HIV AGGLUT TEST	N	800	EA	$1.75	$1,400.00
CANDLES, PARAFFIN	N,R,D	2	CS	$69.00	$138.00
CEFINASE DISCS	N,R	20	PK	$19.50	$390.00
CHEESE CLOTH, FINE WEAVE	N,R	2	CS	$230.00	$460.00
COTTON, NON-ABSORBENT	N,R	12	CS	$89.00	$1,068.00
COVERSLIPS	N,R,D	10	CS	$16.00	$160.00
CRYSTAL VIOLET STAIN	N,R,D	5	CS	$176.00	$880.00
DETERGENT	N,R	6	CS	$50.00	$300.00
FILTER PAPERS	N,R	2	CS	$26.00	$52.00
HEMOGLOBIN, DRIED BOVINE	N,R	7	PK	$31.90	$223.30
HEPATITIS B SURFACE ANTIGEN	N	3	KIT	$680.00	$2,040.00
IODINE CRYSTALS (STAIN)	N,R,D	2	CS	$189.00	$378.00
ISOVITALEX ENRICHMENT	N,R	25	BX	$36.40	$910.00
LAV1-EIA TEST KIT	N	4	KIT	$127.80	$511.20
LAV2 EIA TEST KIT	N	15	KIT	$158.40	$2,376.00
LENS PAPER	N,R,D	50	PK	$3.25	$162.50
MHATP TEST KIT	N	5	KIT	$71.40	$357.00
MICRO-SELECTAPETTE TIPS 270	N,R	10	CS	$55.00	$550.00
MICRO-SELECTAPETTE TIPS 271	N,R	10	CS	$54.50	$545.00
N-N-DIMETHYL P PHENYLDIAM	N,R	15	EA	$25.30	$379.50
NEISSERIA KIT, MINITEK	N	10	KIT	$128.00	$1,280.00
OIL, IMMERSION, CARGILLE	N,R	3	CS	$103.00	$309.00
PENECILLIN G 10U DISCS	N,R	20	PK	$29.00	$580.00
POTASSIUM HYDROXIDE PELLETS	N,R,D	1	CS	$45.00	$45.00
POTASSIUM IODIDE	N,R	4	EA	$69.85	$279.40
RPR CARD TEST KIT	N,R	10	KIT	$95.18	$951.80
RPR CONTROL CARDS	N,R	90	PK	$13.73	$1,235.70
SODIUM CHLORIDE CRYSTALS	N,R,L	5	CS	$25.95	$129.75
SPECTINOMYCIN HCL DISCS	N	100	PK	$2.40	$240.00
STERILIZER INDICATOR TAPE	N,R	3	CS	$23.00	$69.00
SWABS, ALCOHOL	N,R	2	CS	$24.00	$48.00
SYRINGES, 10cc.	N,R	4	CS	$76.35	$305.40
TRIMETHOPRIM LACTATE	N	50	AMP	$32.00	$1,600.00

N=National; R=Regional; D=Departmental

ITEM	LEVEL	QTY	UNIT	UNIT COST	TOTAL COST
V-C-N INHIBITOR	N,R	15	BX	$36.40	$546.00
VACUTAINER NEEDLE	N, R	6	CS	$101.40	$608.40
VACUTAINER TUBES	N,R	3	CS	$87.55	$262.65
WEIGHING PAPER	N,R	2	CS	$20.25	$40.50
					$26,605.08

N=National; R=Regional; D=Departmental

ANNEX G-2

Printed Inventory Forms

PROJET SANTE FAMILIALE ET POPULATION

RAPPORT TRIMESTRIEL

ANNEX I

REGION
COORDINATRICE
.... TRIMESTRE

DESIGNATION	CONDITION NEMENT	ORIGINE	DATE DE PEREMPTION	UNITE	SOLDE DEBUT TRIMESTRE	REÇU DURANT LE TRIMESTRE	SORTIE DURANT LE TRIMESTRE	SOLDE FIN DE TRIMESTRE	CONSOM. MOYENNE	JOUR DE CONSOM. DISPONIBLE	STOCK DE SECURITE
NORIDAY	CYCLE										
LO FEMINAL	CYCLE										
CPPER T	UNITE										
CONDOM	UNITE										
DIAPHRAGME	UNITE										
CREME	TUBE										
GELEE	TUBE										
NILSTATIN	TABLETTE										
ASPIRINE	FL. de.....										
AMPICILLINE	FL. de.....										
TETRACYCLINE	FL. de.....										
EBUPHROM	FL. de.....										
CHLOROQUINE	FL. de.....										
METRANIDAZOL	FL. de.....										
ERYTHROMICINE	FL. de.....										
SULF FER	FL. de.....										
TROBICINE	FL. de.....										
ACETAMINOPHENE	FL. de.....										
STREPTOMYCINE	FL. de.....										
TRIMETHOPRIME	FL. de.....										
GANTS	PAIRES										
SERINGUES	...DC										

CE RAPPORT SERA REMPLI TRIMESTRIELLEMENT PAR LA COODINATRICSMI/PFONALE SMI/PF SUR LA BASE DES FICHES DE STOCK

CE RAPPORT SERA ETABLI EN 3 EXEMPLAIRES

- 1 copie pour classement
- 1 copie pour le siège du projet à Dakar
- 1 copie pour le médecin chef Régional

Au début de chaque trimestre, ces rapports seront remis aux coordinatrices qui auront à remplir les colonnes suivantes:

- reçue pendant le trimestre; ceci concerne les transferts en provenance de Dakar
- sortie pendant le trimestre; cette colonne concerne les transferts en des centres

les autres colonnes seront directement calculées par l'ordinateur.

ANNEX G-3

Sample Contraceptives Consumption Statistics

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ANNEX I

Annual Report: Senegal Family Health and Population Project

I Development of Service Delivery in 1990 - Outputs and Inputs, Progress and Problems

This chapter concerns development of the FP service delivery system in Senegal under the Family Health and Population Project in 1990. It deals with results (outputs) achieved in, inputs invested in the program, progress and problems encountered. It also reviews needs for 1991 and after.

A. Results Achieved (Outputs) in 1990

1. Couple Years of Protection and Contraceptive Prevalence

a. Couple Years of Protection (CY-P)

In 1990, large increases occurred in the consumption of contraceptives supplied by the public sector and by commercial imports. Figure 1 recapitulates caculations of couple years of protection (CY-P) as a result of the use of these contraceptives. The data, which also include estimates of CY-P derived from tubal ligations and Norplant implants, and use of condoms, show a surprising increase in CY-P in 1990 compared to 1989 of 69.9%. The increase indicates that the number of couples practicing modern methods of contraception increased significantly over the year. Data for consumption based on supplies from the public sector are derived from the annual Contraceptive Procurement Tables (CPTs) reported to AID/W by USAID. Data for consumption based on commercial imports are based on the surveys of commercial distributions prepared annually by ISTI. Data for consumption based on imports provided by voluntary agencies (IPPF, FPIA) are derived from an analysis of estimates of contraceptors served by the Senegal Association for Family Well Being (ASBEF).

Fig. 1 Couple-Years--Protection(Modern Contraceptives)

	1988	1989	1990
		(in thousands of CY-P)	
Public Sector(Incl. VSPP	28.5	34.7	69.7
Commercial Sector	19.3	19.3	23.5
ASBEF	2.1	2.5	2.8
Total	49.9	56.5	96.0
% Increase		+13.2.%	+69.9%

Source: ISTI. See also Annex A.

b. Contraceptive Prevalence (CP) and the 1990 Urban KAP Survey

The Demographic and Health Survey carried out circa June 1986 found that nationally, approximately 14.2% of married urban women using a contraceptive method, About 6.7% of them were using a modern method, while about 7.5 % were using a traditional method. [The EDS does not provide data on the proportion of all urban women of reproductive age using a method (modern or traditional) of contraception.]

The number of FP service centers established in the private and parastatal sector rose slightly, from 28 to 32 (See Chapter III). This figure does not include ten "natural" family planning service points supported by the VSPP.

FP service centers established with UNFPA assistance in the regions of St. Louis, Diourbel, Louga and Tambacounda and listed by the Family Well Being Project as of August 1990 total 27. 129 153

The number of FP service points in operation in Senegal as of December 1990 is therefore estimated at 151. Service statistics show a continued increase in clientele in 1990 (except in Thies). Based on partial data for 1990, registered contraceptors at public and VSPP-supported service centers increased by about 21% from the level of 32,500 women reached in December 1989. It is widely observed that many service points serve more clients than the centers show as registered. Reasons for this probably include lack of client folders and registers, which has occurred frequently, lack of training and supervision, and parallel activity of health agents. There is also some under-estimating of registered clients as a result of poor record keeping. Taking into account female contraceptors served by private practionners and clinics, and by the parallel circuits involving public health agents, it appears that the total number of women practicing family planning probably exceeded 67,000 in 1990. This data is presented in some detail in **Annex C**, both in summary sheets for the country as a whole and by region.

A more complete survey of register contraceptors as of the end of 1990, beginning of 1991, will become available in the second quarter of 1991.

Note on the Project Goal of Providing Safe and Effective Contracptive Services by the Public and Private Sector to 200, 000 couples by the end of the project.

The Project Paper establishes a goal of FP service delivery reaching 200,000 couples by the private and public sector. This goal was predicated on outputs, including IEC activities underway in all ten regions, establishment of a total of 128 public centers in the six regions and another 20 public centers in the four regions and generating 30,000 acceptors by the end of the project by NGOS (under the VSPP program). Whether the goal included action by the commercial sector is not clear in the project paper. The Project Agreement diminished the funding level foreseen in the Project Paper, and diminished the output target for total public centers to 92 in the six region and 8 (in collaboration with UNFPA) in the four regions, but it retained the purpose of attaining safe and effective contraceptive services provided by the public and private sector to 200,000 couples. This Annual Report is being drafted approximately five and one half years through the seven year project. At this stage in the project, it appears that a goal of 200,000 couples will probably not be attained. Available statistics indicate that as of December 1990, close to 70,000 women are participating activitly in the program, using modern methods (other than condoms). These data for couple-years of protection from condom use indicate protection for 20,000 couples. The outlook for 1992 is for substantial growth in contraceptive prevalence, but based on the present situation and planned inputs, it does appear that a target for 1992 of up to 150,000 couples is more likely. This estimate is based on plans for contraceptive supply by the public sector and projections of use (See figure 4 below), plus an assumption of a ten percent increase per year in commercial imports. As noted in section C of this chapter, substantial gains in couples practicing family planning are likely to come from increased use of existing urban centers.

in January 1991

position during 1991 with respect to orals, iuds and condoms and ISTI's logistical advisor accompanied Government representatives on a field trip to distribute additional supplies in the regions. One weakness, the supply of spermacides was corrected with a large shipment which arrived in February 1991.

Under arrangements endorsed by the National Contraceptive Supply Committee, which met in December 1990, USAID is to supply total public requirements of orals and iuds, and UNFPA is expected to supply injectables in quantitites sufficient to allow all regions to gain more experience with them. As of Februrary, it was reported by the Head of the National Family Planning and MCH Service that UNFPA was planning to import injectables and that discussions were underway in New York on quantities. As discussed below, USAID has made arrangement to insure adequate supplies through 1992. It has also made provision to increase the supplies of Norplants whose use in the U.S. and for supply by the U.S. to other countries was made possible by action of the US Department of Health late in 1990.

a. Shipments received

Contraceptives shipped by AID and received in 1990 - including supplies received on January 4, 1991 - represent a value of approximately **$235,000.**

Fig. 3. USAID Deliveries of Contraceptives Received in 1990

Lo Feminal:	**178,000 cycles** [28, 800 were received in June and 150,000 were received in July. In addition, **294,000 cycles** intended to arrive in December 1990 actually were received on January 4, 1991.]
Ovrette:	**20,400 cycles** ordered in 1989 arrived in July. In addition, **46,800** cycles in transit in 1990 arrived 4 January 1991.
Conceptrol:	**28,800 tablets** (6 cases of 4800 doses) were received in July. These were used up in the third quarter. A shipment of 48,000 tablets arrived in Feb ruary 1991.
IUDs:	**6000 units** were received in July 1990. **16,000** units were received January 4, 1991.
Condoms: -1	**600,000 units** (Sultans) were received in July 1990.
Condoms - 2	**1,398,000 condoms** [no logo, no color] were received 1/4/91.

Source: ISTI, March 1990

b. Consumption of Contraceptive Products in 1990

Data on the distribution of contraceptive products to the regions correlated with data on beginning and end of year stocks, indicate large increases in the consumption of orals and iuds during 1990. The analysis carried out in December 1990 indicates that:

- The use of orals, including Ovrette, increased by 66%
- The use of IUDs increased by 141%

Annex D

Rough Estimates of Costs of Contraceptive Procurement

Pills at 4 cents each - $293,800

1990: $41,860 (322,000 cycles)
1991: $64,220
1992 $93,860
1993 $93,860 (one year supply as of December 1992)

IUDs at 101.6 cents each - $95,500

1990: 14,220 (14,000 units)
1991: 20,320
1992: 30,480
1993: 30,490 (one year supply as of December 1992)

Spermacides at 10cents per foaming tablet - $115,000

1990: $16,500 (1650 users)
1991: $25,500
1992: $37,000
1993; $37,000(one year supply as of December 1993).

Source: ISTI, August 1989

Aussi semble-t-il raisonnable de prévoir pour la fin de 1989 un total de 24.000 utilisatrices pour le secteur commercial (pilules, injectables, DIUs, spermicides) dont 2.000 porteuses de DIUs - **L'Annexe A** contient la liste des cliniques privées et des médecins privés faisant des prestations de service de PF dans le pays.

IV - Distribution de produits contraceptifs en 1988 et 1989 - Secteur Public et VSPP (ASBEF incluse)

A. Distribution de produits contraceptifs (oraux et pilules)

Du 1er janvier 1988 au 1er juin 1989 le PSFP a distribué près de 282.000 cycles de Lo-Feminal (dont 24.000 arrivés à péremption à la date du 31 Mars 1989) et d'Ovrettes, ainsi que 17.120 DIUs (**Annexe B**). L'ASBEF a distribué près de 10.100 cycles de contraceptifs oraux et 1 900 DIUs environ (**Annexe C**).

Tableau I : **Distribution de contraceptifs oraux et de DIUs en 1988/1989**

	Contraceptifs Oraux (000,s)			DIUs (unités)		
	Total Juin-Déc 1988	1989		Total Juin-Déc 1988	1989	
PSFP	221	50	271	6 110	11 010	17 120
ASBEF	6	5	11	1 080	700	1.780
UNFPA	nd	-	nd	nd	-	nd
Total	227	55	282	7 190	11 710	18 900

Source : données collectées par ISTI, Août 1989

B. Distribution de préservatifs (condoms)

Au cours des 18 derniers mois, 890.000 condoms ont été distribués aux hommes et aux femmes par l'ASBEF et le PSFP. Le Comité National pour la Prévention du SIDA en a également distribué 400.000 en 1988/89. La demande effective de condoms au Sénégal reste inconnue. Pour 1990, des quantités beaucoup plus importantes seront distribuées par le programme PF national et le Comité National pour la Prévention du SIDA. Un programme plus important de distribution par le secteur commercial (magasins SONADIS et pharmacies) est entrain d'être élaboré et doit démarrer en 1989/90.

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1. Evaluation de l'utilisation des contraceptifs oraux d'après les quantités distribuées en 1988 et 1989

Comme le montre le tableau ci-dessous, le total des cycles distribués et utilisés en 1988 et 1989 dans le secteur public (y compris le VSPP et l'ASBEF) est estimé à 322 000.

Tableau III : **Distribution de contraceptifs oraux (pilules) dans le secteur public**

	1988	1989+	Total
PSFP/VSPP			
Lo-Feminal	197 000*	100 000	297 000
Ovrette	-	18 000	18 000
ASBEF	5 800	11 200**	17 000
Total	202.400	129 200	322 000

Source : ISTI, Août 1989

* Ne Comprend pas les stocks reportés en 1989 de 24 000 cycles périmés en mars 1989.
\+ Comprend les projections pour les derniers mois de 1989 et il n'y a pas de reports.
** Comprend les distributions effectuées dans des organismes extérieures dont le FNUAP.

2. Evaluation de l'utilisation des contraceptifs oraux en 1988 et 1989 d'après les statistiques de service

Le nombre d'utilisatrices de pilules a été estimé respectivement à près de 10 000 et 13 500 personnes en 1988 et 1989, comme l'indique le **tableau IV** ci-dessous : ces estimations correspondent à celle de la consommation mensuelle actuelle qui se situe entre 13 000 et 14 000 cycles (période mars-septembre 1989). Pour assurer une protection contraceptive de 25 300 clientes années, en 1988 et 1989 il faudra se procurer des quantités de pilules équivalant à 25 300 x 13 = 328 900. Ce chiffre est assez proche du total distribué qui est de 322 000 (**Tableau III**). Le fait que beaucoup de services PF aient dû prescrire des ordonnances de pilules à leurs clientes pendant la période de rupture de stock survenue en 1989, aide à démontrer que les quantités consommées sont plus importantes que celles qui ont été distribuées.

Tableau IV : **Evaluation du nombre d'utilisatrices de pilules**

	Déc 87 Est	Déc 88 Est	Déc 89 Proj.	Déc 90 Proj.
PSFP	7 000	10 300	15 000	26 000
FNUAP	nd	nd	800	
VSPP	600 ?	1 200	1 900	3 000
ASBEF	500	500	900	1 500
Total	8 100	12 000	18 600	30 500
Augmentation en %	+ 53 %	+ 60 %		+ 60 %
Total Moyen	10 000	15 300		24 550

Source : ISTI, Août 1989

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Annexe B: Distribution de Produits Contraceptives par PSFP en 1988 et 1989

Contraceptives Distributed by PSFP, 1988 & 1989

Produit Product	Jan-Dec 1988 Realise	Jan-Juin 1989 Realise	Juil-Dec 1989 Estime	1988-1989
Copper T	6110	11010	-	17120
Lo Feminal	197298#	49600	60000	306898
Ovrette	-	18000	-	18000
Total(oraux)	197298#	57600	60000	324898

#Ne comprennent pas environ 24,000 en stock en mars 1989 etaient retires a cause de la date de peremption.

Source: ISTI/PSFP, Aout 1989.

Annexe C: Distributrion des Produits Contraceptifs Par ASBEF, 1988 et 1989

Produit	En 1988	En Jan - Juin 1989
DIU(unites)	1080	700
Condoms(unites)	136400	38800
Oraux (plaquettes)	5838	5369
Spermacides		
-Tubes(de 20 comprimes)	6015	1662
-Flacons (de mousse)	554	117

Source: ISTI, Septembre 1989, basee sur les rapports d'ASBEF

Memorandum 10 December 1990

To Dr. Mary Ann Micka, Chief HPNO

From: Albert R. Baron, ISTI

Subject: Use and Requirements of Contraceptive Products.

There was a large increase in the distribution of contraceptive products in 1990 to public and vspp centers in the ten regions. **This increase in use of modern contraceptives suggests significant increase in numbers of oral and iud contraceptors in public/vspp centers.** There was also an increased use of condoms. Some observations (based on the CPTS):

A. Oral Contraception: up sharply:

o Use of Lo Feminal seems to have increased by 50% last year. Total product use is estimated at 216,600 cycles (but 10% is assumed as a loss factor). By contrast in 1989 we used 162,000 cycles with the loss estimate equal to 32000 because out of date pills had to be destroyed. Actual consumption is estimated at 195,000 in 1990 vs 130,000 in 1989, an increase of 50%.

o Significant use of ovrettes for the first time: a total of 19,000 cycles used. We project that 20% of pill users serviced by public/vspp centers will be using ovrettes in 1991 and after.

o Pill consumption in 1990, including all pills provided by UNFP, is estimated at 253,000 cycles, with a wastage/loss factor of 10%. By contrast, in 1989, we estimated total distribution of commerically imported pills by pharmacies at 213,000 cycles.

o We estimated about 13 or 14000 regular pill users serviced by public/vspp centers as of December 1989 (all regions). Clearly, the increased consumption of pills in these centers points to a large increase in the number in 1990 (probably over 50%, even taking into account the fact that one new client in three probably drops out after a first visit or two, and a significant percentage of oral contraceptors will stop each year to have a child). It will be interesting to see what end of year service statistics show.

o For planning purposes, we assume that total pill consumption needs for public/vspp service points will increase by 50% per year from the base of 253,000 cycles in 1990. We assume that 20% will be ovrettes, 75% Lo Feminal and, in accordance with the national Contracptive Supply Committee which met last Friday, 5% would be a high dose pill (supplied presumably by other donors or by local purchase).

B. Contraception by IUD - up sharply: We had a product consumption of 8,000 in CY1989. Including about 1,400 iuds used by Bien Etre Familiale, product consumption expanded in CY 1990 to 17,400 (est.) units, an increase of over 100%. For the CPTS, we have projected annual increases of 50% in iud product use.

C. Spermacides - Conceptrol introduced: Conceptrol was introduced for the first time. The 26,000 tablets brought in were distributed and consumed in a period of ab out 3 months. We have assumed that annual consumption in 1991 would be four times 26,000 and that it would increase by 20% in 1992 and again by 20% in 1992. The resultant amounts are really quite small compared to the numbers of contraceptors being serviced.

D. Condoms - up sharply: Distribution of condoms apparently increased to 1.7 million units, from a few hundred thousand. We need to look at service statistics to confirm this.

L'Utilisation et Les Besoins des Produits Contraceptifs Au Senegal en 1990, 1991 et 1992

(Ce rapport indique la situation en ce qui concerne le PSFP (et VSPP) dans les six Regions. Les donnees concernant la BEF et les 4 Regions pourraient etre ajouteees plus tard.)

I. Situation en 1990

Le programme PSFP a distribue 199,800 cycles de Lo Feminal, 18,000 cycles d'Ovrette, 16,000 DIU et 28.000 tablettes de Conceptrol, et _____ condoms.

La quantite de pilules et de DIU distribuee indique un accroissement important dans la prevalence contraceptive au Senegal et dans le nombre de consultantes - pilules et consultantes - Diu pendant l'annee.

A. Contraception Orale en 1990

L'utilisation de 217,000 cycles de pilule suggere 15,100 couple annees de protection, c'est a dire qu'en moyenne 15,100 femmes se protegaient par la contraception orales en 1990. (Le calcul estime une perte de 10% et 13 cycles de pilules par femme).

Les statistiques de service indiquent un nombre de consultantes sous pilule fin 1989 d'environ 12,000 (PSFP et VSPP). Un nombre en moyenne de 15,100 durant l'annee indique un accroissement pendant l'annee et un nombre total a la fin de 1990 de 17,800*.

B. Contraception par Dispositif Intra-uterine en 1990.

Une distribution de 16000 Diu (meme avec une perte de 10%) indique 14,400 x 2,4 = 34,560 couple annees de protection.

Les 14,400 dispositifs inserers devaient servir pour 1,440 anciennes (des dius remplacees) et pour **12,960 nouvelles.** D'apres les statistiques de services, le nombre de consultantes-diu fin Decembre 1989 etait de 18,107. Si l'on considere une perte de 20% des anciennes pendant l'annee, on arrive a un total de **14,416 anciennes consultantes - diu** fin December 1990.

Ainsi on est emmene a estime le nombre total de consultantes diu fin Decembre 1990 a 12,960 + 14,416 = 27,446.

C. Augmentation des Consultatntes Diu et Pillules en 1990

On estime le nombre de consultantes diu et pillule en fin Decembre 1989 a 12,000 pilules et 18,107 soit un total et 30,107. On estime d'apres les calculs ci-dessus un total fin Decembre 1990 de 17,800 consultantes pilules et 27,446 Diu, soit un total de 45,246. L'augmentation des consutlantes diu et pilules en 1990 semble etre a peu pres de 50%.

* $\underline{(12,000 + X) = 15,100}$; 2 X = 30,200 - 12,000 = 17,800

D. Les stocks disponibles (8 Decembre 1990)

DIU T 380 A	0
Conceptrol	0
Condoms	820,000 unites
Ovrettes	0
Lo Feminal	38,900 plaquettes

E. Les Produits commandes et en travail

DIU T 380	16 000 unites
Conceptrol *	0
Condoms	1,998,000 unites
Ovrettes	46,800 plaquettes
Lo Feminal	294,000 plaquettes

* 48,000 tablettes par avion et 163,200 tablettes par bateau vont etre commandees.

F. Les Besoins en 1991 et 1992

Pour evaluer ces besoins on estime :

- o La demande des contraceptifs oraux et les Diu va augmenter de 50% par an.
- o Les ovrettes doivent constituer 20% en 1991.
- o Les besoins de conceptrol seront de 115,000 tablettes en 1991 (contre 28,800 consommees en 3 mois en 1990) et 172,500 tablettes en 1992. C'est normalement une methode d'attente.
- o Les stocks de fin d'annee devront atteindre l'equivalent des besoins (consommation prevue) pour l'annee suivante.
- o Les besoins en condoms ??

ANNEX G-4

ISTI Report on Contraceptive Use by Family Planning Centers

ANNEX N

SITUATION DES ACTIVES
(Coûts des prestations, nbre de retraits et de condoms dans les centres de PF
EN 1990
DAKAR

CENTRES	NOMBRE ACTIVES				NOMBRE INACTIVES			NOMBRE DE RETRAITS	NDRE DE CONDOMS DISTRIBUES	COUTS DES PRESTATIONS	
	PIL	DIU	AUTRES	TOTAL	PIL	DIU	TOTAL			CONSULTATIONS	CONDOM
GEORGES LAHOUD	49	166	-	215	39	-	39	23	890	300-100	25
BOURGUIBA	17	32	-	49	2	-	2	2	885	200-1000	25
GRAND YOFF	150	278	-	428	-	-	-	29	3900	200-700	12,5
BEL AIR	69	292	-	361	10	0	10	47	3684	225	20
KHAR YALLAH	110	78	8	196	45	0	45	12	1382	200-1000	12,5
NABIL CHOUCAIR	261	149	-	410	86	1	87	19	2520	300	20
PHILIPPE SENGHOR	52	129	-	181	20	3	23	19	1108	200	GRATUIT
NGOR	8	3	-	11	3	5	8	-	419	200	25
PS OUAKAM	142	69	-	211	48	-	48	-	-	300	20
IHS	32	44	-	76	3	-	3	1	-	100-500	GRATUIT
CM FONCTIONNAIRE	40	41	-	81	-	-	-	8	487	GRATUIT	GRATUIT
CAMP ABDOU DIASSE	43	17	-	60	3	-	3	3	1530	GRATUIT	GRATUIT
ABASS NDAO	201	1128	582(LT)	1911	48	12	60	134	553	GRATUIT	20
NORADE	98	89	-	187	44	-	44	18	514	2000-1000	25
PMI MEDINA	443	2743	-	3186	69	47	116	196	25202	100-200	25
H.A.LE DANTEC	170	146	346	662	-	-	-	-	-	100-500	25
MATERNITE BARGNY	122	206	-	328	50	-	50	21	2084	200-500	25
SEBIKOTANE	78	59	-	137	29	-	29	7	2900	200-500	25
MATERNITE RUFISQUE	231	177	0	408	23	0	23	20	230	200-500	25
PMI RUFISQUE	123	251	-	374	51	0	51	23	3300	200	25
PS ARAFAT	45	78	3	123	13	0	13	3	-	-	25
THIAROYE GARE	30	100	-	130	-	-	-	-	-	300	25
DOMINIQUE	1191	1508	2	2702	167	44	211	190	6700	300	-
GUINAW RAIL	6	2	0	8	-	-	-	-	-	500-1000	25
TOUBA DIAKSAO	89	51	2	142	27	0	27	6	1386	300-1000	GRATUIT
BAUDOUIN	152	337	0	489	82	0	82	65	660	300	25
MATERNITE GUEDIAWAYE	42	67	0	109	36	0	36	5	-	300	25
MUNICIPAL II	174	90	0	264	58	0	58	8	1195	300	25
NIMZATT	91	218	0	309	17	0	17	49	505	300	25
DIAMEGUENE	206	241	0	447	40	0	40	16	2672	300	25
SICAP M'BAO	32	10	-	42	0	0	0	0	0	300	25
WAKHINANE	31	-	-	31	-	-	-	-	-	300	-
DEGGO	30	-		30	-	-	-	-	-	300	25
THIAROYE MER	601	270		879	0	0	0	6	540	300	25
TOTAL	5159	9069	943	15169	1013	112	1125	930	65246		

NB ; (-) données non disponibles

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SITUATION DES ACTIVES
(Coûts des prestations, nbre de retraits et de condoms dans les centres de PF
EN 1990
THIES

CENTRES	NOMBRE ACTIVES			NOMBRE INACTIVES			TOTAL	NOMBRE DE RETRAITS	NDRE DE CONDOMS DISTRIBUES	COUTS DES PRESTATIONS	
	PIL	DIU	AUTRES	TOTAL	PIL	DIU				CONSULTATION	CONDOM
Xème	103	874	2	979	227	43	270	18	10404	100	4 pour 100
RANDOULENE	36	1037	2	1075	79	43	122	45	5800	100	4 pour 100
HOPITAL THIES	55	345	-	400	93	-	93	12	6000	300	4 pour 100
M'BOUR	128	225	-	353	292	31	323	11	5866	100	5 pour 100
KHOMBOLE	3	72	-	75	-	-	-	12	700	100	4 pour 100
JOAL	100	50	34	184	-	-	-	10	2300	100	4 pour 100
M'BORO	22	44	1	67	16	-	16	5	-	100	4 pour 100
THIADIAYE	4	47	-	51	47	-	47	2	864	100	gratuit
TIVAOUANE 1	74	26	1	101	40	-	40	15	1500	100	4 pour 100
TIVAOUANE 2	97	254	-	351	13	-	13	4	-	300	gratuit
MEKHE	17	33	-	50	4	-	4	4	2130	gratuit	8 pour 100
POUT	92	151	-	243	30	-	30	14	1800	200	10 pour 100
KAYAR	25	25	0	50	-	-	-	3	375	100	4 pour 100
POPENGUINE	86	3	-	89	13	3	16	-	-	150	8 pour 100
TOTAL	842	2396	40	~~4066~~	854	120	974	234	37739		

NB : (-) DONNEES NON DISPONIBLES 3186

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SITUATION DES ACTIVES
(Coûts des prestations, nbre de retraits et de condoms dans les centres de PF
EN 1990
VSPP

CENTRES	NOMBRE ACTIVES				NBRE INACTIVES			NOMBRE DE RETRAITS	NDRE DE CONDOMS DISTRIBUES	COUTS DES PRESTATIONS	
	PIL	DIU	AUTRES	TOTAL	PIL	DIU	TOTAL			CONSULTATIONS	CONDOM
RCFS	320	28	56	404	58	-	58	5	6840	gratuit	gratuit
CSPT	112	202	-	314	2	-	2	45	3697	gratuit	gratuit
PAD	53	47	39	139	6	-	6	-	4590	gratuit	gratuit
UCAD (COUD)	75	31	3	109	32	-	32	5	6300	gratuit	gratuit
SONATEL	42	16	2	60	7	-	7	1	1840	gratuit	gratuit
SENELEC	9	87	2	98	-	-	-	1	700	gratuit	gratuit
MALICOUNDA	45	-	-	45	-	-	-	-	1600	100f	100
CR PIKINE	74	101	2	177	13	-	13	13	2000	400 à 1000	400 à 1000
CR GOUTTE DE LAIT THIES	110	99	-	209	29	-	29	7	4000	200	200
CR LIBERTE V	159	48	29	206	24	-	24	-	4600	200	200
CR AMITIE II	5	20	1	26	-	-	-	-	500	100	100
SANDIAL	101	44	7	152	23	-	23	7	2326	gratuit	gratuit
SONACOS	41	41	-	82	19	-	19	4	1800	gratuit	gratuit
VSOS KAOLACK	32	81	8	121	46	-	46	-	1950	100	8 pour 100
DIAMAGUENE (ST-LOUIS)	58	19	-	77	69	-	69	-	1935	100	8 pour 100
GUET N'DAR	84	11	-	95	20	-	20	1	1137	100	8 pour 100
PIKINE (ST-LOUIS)	185	84	-	269	159	-	159	4	2450	100	8 pour 100
GOXUMBAAC	33	97	-	0	20	-	20	8	700	gratuit	gratuit
SOTRAC OUAKAM	82	52	-	134	9	-	9	12	-	gratuit	gratuit
SOTRAC THIAROYE	162	215	-	377	10	-	10	7	-	200	25
CS HANN	201	104	3	308	48	-	48	4	475	300	25
HAROLD WASHINGTON	34	57	-	91	1	-	1	-	-	gratuit	gratuit
PMI OUAGOU NIAYES	106	151	-	257	12	10	22	-	-	gratuit	gratuit
COLOBANE	51	175	-	226	16	-	16	-	-	gratuit	gratuit
IPRES	3	23	-	26	-	-	-	-	-	gratuit	gratuit
HOPITAL PRINCIPAL	-	460	-	460	-	-	-	-	-	gratuit	gratuit
CLINIQUE JABOOT	34	17	66	117					500		
CLINIQUE JAMM	78	10	-	88					3000		
CABINET M CAP SIKIRRING	75	4	13	92					2000		
CABINET M SERGE ROCHE	30	4	-	34					900		
CLINIQUE NABOU	227	17	44	288					800		
CABINET M VENN	30	25	-	55					500		
SOTIBA	300	15	-	315					500		
A.S.R.E.P											
TOTAL	~~2051~~	2385	275	5451	623	10	633	124	67,810		

NB (-) données non disponibles 5201 3655 2275 9111

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SITUATION DES ACTIVES
(Coûts des prestations, nbre de retraits et de condoms dans les centres de PF
EN 1990
KAOLACK

CENTRES	NOMBRE ACTIVES				NOMBRE INACTIVES			NOMBRE DE RETRAITS	NDRE DE CONDOMS DISTRIBUES	COUTS DES PRESTATIONS	
	PIL	DIU	AUTRES	TOTAL	PIL	DIU	TOTAL			CONSULTATIONS	CONDOM
KAOLACK											
KASNACK	821	696	135	1652	57	52	109	19	1200	100	4 pour 100
CENTRE REGIONAL	232	593	80	905	262	43	305	37	10000	10	8 pour 100
LEONA	239	336	-	575	223	8	231	24	2190	100	10 pour 100
MEDINA BAYE	97	39	3	139	22	0	0	0	1100	100	10 pour 100
KAFFRINE	-	-	-	200	-	-	-	24	2328	100	4 pour 100
KOUNGHEUL	101	119	1	221	10	-	10	14	3100	100	4 pour 100
NIORO	67	168	1	236	17	-	17	2	3800	100	10 pour 100
GANDIAYE	75	7	1	83	7	0	7	0	700	100	20 pour 100
NDOFFANE	57	16	7	80	32	0	32	0	640	100	10 pour100
MEDINA SABAKH	22	26	1	49	13	0	13	0	2390	100	gratuit
TOTAL	1711	2000	229	~~3940~~	643	~~103~~	724	120	38248		
NB (-) données non disponibles	1831	2080		4,94		108					

FATICK											
CM FATICK	254	233	-	487	69	1	70	8	-	200	10POUR200
FOUNDIOUGNE	70	28	11	109	26	-	26	11	6750	200	5POUR100
SOKONE	77	164	6	247	68	10	78	24	3740	100	10POUR100
GOSSAS	52	41	1	94	47	-	47	5	6150	200	10POUR100
GUINGUENEO	56	19	-	75	34	-	34	2	2085	200	10POUR200
PASSY	28	-	-	28	-	-	-	-	-		
TOTAL	537	485	18	1040	244	11	255	50	18728		

NB (-) DONNEES NON DISPONIBLES

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ANNEX H

Profile of Key FHPP Project Personnel

ANNEX

PERSONNEL P.S.F.P.

(PROFIL AGENTS) - Novembre 1990

PRENOMS ET NOM	FONCTION ACTUELLE	QUALIFICATION	AUTRES ETUDES FORMATIONS OU STAGES	EXPERIENCE PROFESSIONNELLE	STATUT
Mme Marième-DIOP	- Directrice P.S.F.P.	- Sociologue	Planification nutritionnelle (Manille - 1980) Santé Communautaire et et Développement Social (Bordeau 1985)	- Directrice Collège animation de l'ENEA - 1971-90 - Professeur psychologie Sociale ENEAS (1972-77) - Professeur Sociologie du Développement et Andragogie à l'ENAM (1981-90) - Elaboration projet création du Centre d'Education Polyvalente des adultes (CEPA) financé par l'UNESCO. - Evaluation auprès des bénéficiaires de projets financés par l'USAID au Sénégal. (Santé Rurale - Projet Céréalier- Périmètres irrigués, élevage Bakel) financé par l'USAID/MPC - Situation socio-économique des femmes migrantes de basse Casamance à Dakar (Demandé par NCMW financé parUSAID sur fonds FIDAC. - La non insertion urbaine cas des femmes migrantes,saisonnières à Dakar (publié par l'ORSTOM - 1989).	- Fonctionnair Mle de Solde 58 258/B

PRENOMS ET NOM	FONCTION ACTUELLE	QUALIFICATION	AUTRES ETUDES - FORTIONS OU STAGES.	EXPERIENCE PROFESSIONNELLE	STATUT
Fatou TALL DIALLO	- Secrétaire Bilingue	- Secrétaire Bilingue	- BEPA - Institut Sénégalo Britannique - Cours Pratiques d'Anglais Commercial. - CAP Sténodactylo Méthode Speedwriting. Cours Pigier.	- Stage à l'OMS (Organisation Mondiale de la Santé). Octobre 81 à Décembre 81 - Projet Santé Familiale et Population depuis le 1er Mars 1982.	- Contractuelle
Aminata LY AW	- Secrétaire	- Secrétaire	- BEPS au collège St. Michel CAP Dactylo à ASAFIN	- Stage à la SENELEC à la Direction du Contrôle de Gestion et au Département financier - PSFP depuis 87	- Contractuelle
Cheikh Ahmed Tidiane SECK	- Chauffeur	- Chauffeur		- PSFP - 1982-90	- Contractuel
Papa Madiama DIALLO	- Chauffeur			- A effectué plus de 20 années de service dans l'Administration Direction Animation Service régional MDS.PSFP (83-90)	- Décisionnaire
MBar FAYE	- Chauffeur	- Chauffeur		- 15 années de service dans l'Administration Cabinet MDS - Garage MDS- SRDS - PSFP (84-90)	- Décisionnaire
Doudou SYLLA	- Gardien	- Gardien		- PSFP - 1984-1990	- Contractuel
Baba MANGANE	- Gardien	- Gardien		- Projet Santé Familiale et Population - 1981-90.	- Contractuel

PRENOMS ET NOM	FONCTION	QUALIFICATION	AUTRES ETUDES-INFORMATIONS OU STAGES	EXPERIENCE PROFESSIONNELLE	STATUT
Issatou SAMB (suite)			- Séminaire axé sur la Communication en collaboration avec l'Université John-Hopkins. - Formation en IEC (Santa CRUZ) - Programme des femmes Gestionnaires de programmes PF CEDPA-WASHINGTON - Recherche Elaboration-Communication (Baltimore) - Supervision CEDPA WASHINGTON.	- Organisation Campagne de sensibilisation PF - Formation à l'intention des cadres, des agents de l'Etat, du Secteur Privé et des auxiliaires.	-Fonctionnair 365 486/Z
Cheikh Amadou Bamba DIOP	- Socio-économiste.	-Assistant-Social	- Maîtrise administration Economique et Sociale/Option Développement Social Aix en provence - Diplômé des Hautes Etudes en pratiques Sociales Aix. - Diplôme Supérieur en travail social international Aix.	- Instituteur (1975-78) - Chef de division - DAS - Adjoint au Directeur de l'Action Sociale (1981-85) - Conseiller Technique au Ministère du Développement Social chargé des affaires sociales (1988-90)	- Fonctionna Mle de sol 383 629/O

.../...

PRENOMS ET NOM	FONCTION ACTUELLE	QUALIFICATION	AUTRES ETUDES- FORMATIONS OU STAGES.	EXPERIENCE PROFESSIONNELLE	STATUT
Marie Victoire ALBIS GOMIS	Coordinatrice Nationale Clinique.	- Sage-femme d'Etat	- Formation en PF (théorie et pratique) à Santa CRUZ-Californie USA. - Formation des formateurs. - Education à la vie familiale - Santa CRUZ-USA. - Management en PF - JH-PIEGO. Baltimore - Santa-CRUZ - USA - IEC - DAKAR. - Supervision - DAKAR - Cours intensif sur micro-ordinateur-(Zaïre).	- Sage-femme Hôpital A.Le Dantec - Monitrice à l'Ecole Nationale de l'Ecole des Sages-femmes d'Etat (12ans). - Chef de bureau de la PF PF à la Direction du Bien-Etre Familial (MDS) - Coordinatrice des activités cliniques au PSFP. - Formatrice Superviseur - Formatrice au centre d'Etudes pour la famille Africaine (CEFA/CAFS-DAKAR) - Vacataire au CESTI en IES/PF (Information,Education en santé maternelle et infantile et en planification familiale etc.	-Fonctionnaire. Mle de so de 18298/F
- Papa Birame SANGHARE.	Chargé des Projets d'accompagnement.	- Attaché d'Administration.	- Maîtrise en Sciences politiques.	- Adjoint secrétaire Général GOPEC - Secrétaire Général GOPEC au MDS (1986-89)	-Fonctionnaire.Mle Solde 385 157/
- Iba SENE	Comptable des deniers.	- Secrétaire Comptable	- Stage sur la conservation des grains - Séminaire : formation sur la gestion administrative et financière. - Séminaire sur la Comptabilité des matières.	- Chef de BAF-DBEF- 1982-85 - Chef de BAF DFDF 1988-1990.	-Fonctionnaire Ml 48 348/C
- Sidy FALL	Comptable des matières.	- Secrétaire d'administration.		- Chef de BAF - DARU - Chef de service Personnel MDS - Adjoint/SAGE - Intendant ENETF.	-Fonctio naire M Solde 351375/

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ANNEX I

Description of Maternal and Child Health and Family

Planning Component of Proposed World Bank Project

AIDE MEMOIRE
MISSION DE SUPERVISION DE L'ETUDE SUR LA CONTINUITE
ET L'EFFICACITE DES SERVICES DE PLANIFICATION FAMILIALE

1 AU 5 AVRIL 1991

1. Une mission de la Banque Mondiale conduite par M. Edward Brown a séjourné au Sénégal du 1 au 5 Avril 1991 pour suivre l'état d'avancement de l'étude sur la continuité et l'efficacité du programme du planning familiale menée conjointement par le Ministère de la Santé Publique et la Banque Mondiale, avec l'assistance technique du Bureau du Population Council, Dakar. A part l'équipe du Population Council, Dakar, dirigée par M. Papa Syr Diagne, la mission a eu des entretiens avec les responsables du Gouvernement impliqués dans l'étude, ainsi que les représentants du FNUAP et de l'USAID. La mission exprime ses sincères remerciements aux Autorités Sénégalaises et à l'équipe du Population council pour leur collaboration et pour la franchise dont elles ont fait preuve au cours des discussions. Cet aide-mémoire résume l'état d'avancement de l'étude et les accords intervenus sur les prochaines étapes afin d'achever l'étude dans les meilleurs délais.

L'Objet de l'étude

2. Comme décrite dans le "Issues Paper", l'étude porte sur les questions liées à l'efficacité de la pratique contraceptive et de la continuité ou l'abandon de l'utilisation des méthodes contraceptives. Il est espéré donc que l'étude atteindra ses deux objectifs principaux, à savoir:

(a) fournir des informations sur les attitudes et les expériences des personnes pratiquant actuellement les différentes méthodes contraceptives, afin de mettre au point une mesure empirique de l'efficacité d'utilisation et des taux d'échecs; on en profitera pour rassembler des données sur ces méthodes du point de vue de l'impact psychosocial de leurs effets secondaires imprévus et des effets perçus sur la santé, et cela afin de mieux comprendre les attitudes et les comportements liés à l'évolution des motivations qui déterminent les différentes pratiques contraceptives;

(b) déterminer les taux d'interruption en rassemblant des données sur les clientes qui ne viennent pas aux visites de suivi aux points de prestation des services. Cela englobera des données sur les taux d'abandon, leurs caractéristiques socio-démographiques et économiques et l'expérience de la pratique des méthodes contraceptives par les femmes qui ont arrêté l'utilisation de la contraception.

3. Il est envisagé donc que l'étude permettrait de déterminer l'incidence du programme de PF et, en particulier, d'aider les responsables de l'élaboration et de l'exécution des programmes à en définir et/ou en modifier les stratégies et le contenu. Cela permet aussi de guider les décisions concernant la sélection des méthodes, la téneur des conseils prodigués, le contenu des messages et des techniques de suivi de la demande globale ainsi que les differences d'attitude entre les divers groupes-cibles.

4. La relation entre cette étude et celle du "plan d'action visant à améliorer la mise en oeuvre de programmes de population en Afrique subsaharienne au cours des années 90" a été discutée avec les responsable de la dite étude. Etant donné que cette dernière étude n'a pas encore démarée, le Ministère de la Santé indique qu'il tirera des leçons des résultats de la présente étude du point de vue méthodologique, mais surtout qu'il évitera les doubles emplois.

L'Approche de collecte des données et le cadre de travail

5. L'étude utilise deux méthodes de collecte des données: l'une quantitative et l'autre qualitative. Elle est basée sur un échantillon de 2000 fiches de consultation des acceptrices de la planification familiale dans les régions de Dakar et Thiès. Afin d'assurer un niveau satisfaisant de l'efficience de l'échantillonnage, deux décisions méthodologiques ont été prises, à savoir:

(a) l'univers de l'étude a été limité aux centres de prestations de services de planification familiale qui ont été fonctionnels avant 1989. Seules les femmes qui ont accepté la contraception durant la période Juillet 1988-Juin 1990 sont éligibles à l'inclusion dans l'échantillon: cette restriction répondant au souci de maximiser l'information pour l'analyse de la continuité des services. La clientèle de ces centres représentait plus de 95 pour cent des utilisatrices des services de planification familiale dans les deux régions concernées.

(b) l'univers de l'étude a été stratifié en trois strates: (i) strate 1, 'secteur public de la region de Dakar'; (ii) strate 2, 'secteur public de la région de Thiès'; (iii) strate 3, 'secteur parapublic et privé des deux régions'. La taille de l'échantillon des strates est respectivement de 1 000, 500, et 500 fiches de consultation. La stratification répondait à l'intérêt d'obtenir des informations représentatives autant sur le secteur public que sur le secteur privé et sur l'expérience de la continuité des services dans une zone moins urbanisée que la région métropolitaine de Dakar. (le détail des méthodologies de collecte est décrit en annexe).

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L'état d'avancement et les résultats préliminaires

6. Concernant le volet quantitatif, la collecte des données dans la région de Dakar a débuté depuis le 11 Février 1991 dans les strates 1 et 3 (voir para 5b). A la date du 30 Mars 1991, la collecte des données est complète dans sept (7) centres, incluant les grands centres où 200 fiches sont sélectionnées; en d'autres termes, la collecte des données est à 50 pour cent complète dans les trois strates.

7. Les activités de collecte des données seront terminées dans la région de Dakar à la mi-Avril. Il est prévu de finaliser la phase de collecte dans la région de Thiès à la fin du mois d'Avril. La saisie informatique des fiches des centres complétés est en cours Le développement des programmes de transformation et de tabulation des données est réalisé simultanément avec l'entrée des données. Ainsi vers le milieu du mois de Mai, les analyses statistiques des données seront réalisées; le rapport sur le volet quantitatif et qualitatif sera finalisé fin Mai.

8. Concernant le volet qualitatif, trois formes de questionnaires ont été développées couvrant différents aspects de la gestion et de la prestation des services: le questionnaire des cliniques, le questionnaire du personel FP, et le questionnaire des clientes. L'administration des différents questionnaires a été terminée dans la région de Dakar. La collecte des données dans la région de Thiès est prévue entre la mi-Avril et la fin-Avril.

9. L'enquête qualitative prendra un peu plus de temps que prévu à cause de l'intérêt d'une documentation des causes d'abandon. Cela exige une enquête supplémentaire à Dakar dirigée sur le groupe-cible des femmes qui ont arrêté la PF. On estime donc que toutes la phase de collecte des données sera terminée au plus tard à la fin-Avril 1991.

10. A ce stade de l'étude, quelques faits notables sont révélés sur l'organisation et l'administration des services de planification familiale (PF) dans la région de Dakar et l'intensité et le schéma du phénomène d'abandon de l'utilisation des services de planification familiale. Parmi les plusieurs constats préliminaires, on peut résumer les suivants:

(a) la majorité des fichiers des clientes sont très difficile à exploiter. Il n'apparait pas que l'administration des services PF ait été soutenue par et développé sur une formation technique adéquate du personnel (sage-femme, auxiliaires de santé) impliqué dans le processus de prestation des services PF. Il apparaît une variation dans la formation du personnel des services PF;

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ceci se reflète dans le manque d'homogénéité dans le niveau des standards et de la qualité des prestations.

(b) l'abandon de l'utilisation des services PF est très intense dans la région de Dakar. Bien que a ce stade de l, on ne peut pas fournir une estimation du taux d'abandon, les observations preliminaires suggèrent que durant les premiers mois du contact avec les services de PF une forte majorite de nouvelles acceptrices abondonnent la contraception avec les centres du secteur public ou les centres assistés par le Volet Secteur Prive et Parapublic du Projet Santé Familiale et Population. Ce phénomène est plus accentué chez les acceptrices de la contraception orale. La rétention des DIU est relativement beaucoup plus persistante, signalant ainsi une acceptabilité relativement importante du DIU chez les utilisatrices des service FP dans la région de Dakar. Il est intéressant de voir si cette acceptabilité relative est lie à la qualité et l'organisation des services, aux coûts privés dont font face les utilisatrices des services FP. Cependant, il sera difficile d'arriver a une conclusion définitive sur le statu d'abandon de la contraception des femmes qui ont arrêté le suivi dans les dits centres. Il n'est pas exclu qu'une partie de ces femmes soient absorbées par le secteur commercial: la prévalence d'une telle alternative serait cependant limitée à cause des coûts élevés dans le dit secteur.

Les prochaines étapes

11. Bien que l'étude soit bien avancée, il reste beaucoup à faire. Les prochaines étapes suivantes ont été convenues:

(a) au plus tard le 30 Avril 1991 finaliser la phase de collecte des données quantitatives dans la région de Thiès;

(b) au plus tard le 30 Avril 1991 finaliser l'enquête qualitative dans la région de Thiès et les interviews supplémentaires des femmes qui ont abondoné la contraception. Les centres de santé de la région de Thiès etant plus dispersés que celles de Dakar, plus de temps que prevu sera necessaire pour finaliser l'etude.

(c) au plus tard le 30 Mai 1991 finaliser le rapport preliminaire de l'etude.

12. Afin d'arriver à une collaboration plus etroite entre le Ministere de la Santé et l'équipe technique du Population Council, le Ministère a nommé Mme Caroline Mané de la Direction du Projet Santé Familiale et Population de travailler dans le volet qualitatif de l'étude avec Dr Viola Vaughn et Mme Yassine

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Seck/Mme Albis du Service SMI/PF de travailler dans le volet quantitatif de l'étude avec Dr François Diop pour la finalisation de l'étude.

13. Il est convenu de diffuser les résultats dans le cadre de deux séminaires:

(a) un séminaire de diffusion des résultats auprés des décideurs du Ministère de la Santé Publique et de la communauté des bailleurs de fonds;

(b) un séminaire de diffusion des résultats auprés du personnel du Ministère de la Santé Publique, plus particulièrement les coordinations régionales et départementales de SMI/PF et IEC/PF et les sage-femmes qui administrent les services de PF.

le 5 Avril 1991
A:eswfp.sen

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ANNEX J

Annexes Supporting Chapters on Clinical Services

ANNEX J-1

Sample Consultation Forms

PROJET SANTE FAMILIALE ET POPULATION
RAPPORT MENSUEL D'ACTIVITES

MOIS DE .....
CENTRE DE .....
RESPONSABLE .....

à remplir en tenant compte des définitions ci-dessous

A : CONSULTATIONS

	PILULES	DIU	DIAPH	CONDOMS	SPERMIC	COND + SPER	AUTRES METHODES	AUCUNE METHODE		TOTAL
								INFO	BILAN	
NOUVELLES										
ANCIENNES										
TOTAL										

NOMBRE DE VISITES D'URGENCE :
NOMBRE CONDOM DISTRIBUES AUX HOMMES :

NOMBRE DE POSES DE DIU :
NOMBRE DE RETRAITS :
NOMBRE DE REJETS

B : CONSULTANTES

METHODES	PILULES	DIU	DIAPH	CONDOMS OU SPERM	SPERM SEULS	AUTRES	TOTAL
ACTIVES							
INACTIVES							
TOTAL							

DEFINITIONS DES TERMES :

CONSULTATION = PRESTATION DE SERVICE

CONSULTANTE = PERSONNE QUI SE PRESENTE AU SERVICE POUR UNE PRESTATION

CONSULTANTE ACTIVE = CLIENTE QUI UTILISE UNE METHODE CONTRACEPTIVE MODERNE QUELCONQUE

CONSULTANTE INACTIVE = CLIENTE QUI N'EST PLUS SOUS METHODE CONTRACEPTIVE AU NIVEAU DU CENTRE
POUR LA PILULE : EN CAS DE NON REAPPROVISIONNEMENT
POUR LE DIU : AU BOUT DE 2 ANNEES D'ABSENCE OU SI LE DIU PORTE EST PERIME

VISITE D'URGENCE = CONSULTATION POUR UNE URGENCE (même en dehors de la date de RV)

C : MALADIES SEXUELLEMENT TRANSMISES

1) HOMMES

NBRE DE NOUVEAUX CAS	ULCERATIONS	URETHRITES	GONO	TRICHO	CANDIDA	SERO +	HIV +	AUTRES

– Nbre de cas guéris dans le mois

a) cliniquement
b) paracliniquement

– Nbre de cas sous-traitement (anciens et nouveaux cas)
– Nbre de cas referés

2) FEMMES

2.1

NBRE DE NOUVEAUX CAS	CERVICITES	VAGINITES	ULCERATIONS	GONO	TRICHO	CANDIDA	SERO +	HIV +	AUTRES

Nbre de cas guéris dans le mois

a) cliniquement
b) paracliniquement

Nbre de cas sous-traitement (anciens et nouveaux cas)
Nbre de cas referés

2.2. Frottis de Papanicolaou

NOMBRE DE FROTTIS NORMAUX CLASSE 0	NOMBRE D'INFECTIONS + INFLAMMATIONS CLASSE I	NOMBRE DE DYSPLASIES LEGERES CLASSE II	NOMBRE DE DYSPLASIES SEVERES ET (+) CLASSE III ET +	TOTAL

D : STERILITE

NOMBRE DE NOUVEAUX CAS	NBRE DE CAS SOUS-TRAITEMENT (ANCIENS + NOUVEAUX CAS)	NOMBRE DE CAS GUERIS	NOMBRE DE CAS REFERES

ANNEX J-2

Status of Training Among Family Planning Workers

SITUATION FORMATION DU PERSONNEL EN PF
Clinique et IEC
EN 1990
DAKAR

CENTRES	MEDECIN		SAGE-FEM		A. SOCIAUX		INFIRMIER		LABORANT		AIDE-INFIR		AUTRES	
	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF
G. LAHOUD	0	0	3	0	0	0	0	1	0	0	0	5	0	2
BOURGUIBA	0	0	3	0	0	0	0	1	0	0	0	8	0	1
GRAND YOFF	0	0	1	2	0	0	0	2	0	0	0	4	0	1
BEL AIR	1	0	5	3	0	0	0	8	0	0	0	3	0	3
KHAR YALLAH	0	0	3	0	0	1	0	3	0	0	0	7	0	1
NABIL CHOUCAIR	1	0	2	0	0	0	0	5	0	0	0	2	0	1
PHILIPP SENGH	1	0	2	4	0	0	0	3	0	0	0	3	0	2
NGOR	0	0	1	2	0	3	0	2	0	0	0	6	0	1
OUAKAM	0	0	1	2	0	0	0	2	0	0	0	3	0	1
IHS	0	1	4	2	0	0	0	0	0	0	0	2	0	0
CM FONCTION	0	0	3	3	0	1	0	2	0	*	0	0	0	0
ABDOU DIASSE	0	1	1	1	0	0	0	15	0	1	0	0	0	0
ABASS NDAO	1	*	4	12	0	0	0	6	0	0	0	2	0	0
NORADE	0	0	2	6	0	1	0	4	0	0	0	2	0	1
PMI MEDINA	1	2	18	0	1	5	0	9	0	0	0	14	0	5
MALIKA	0	0	1	0	0	0	0	1	0	0	0	1	0	3
LAS PALMAS	0	0	1	0	0	0	0	1	0	0	0	1	0	2
KEUR MASSAR	0	0	1	0	0	0	0	1	0	0	0	1	0	2
NIAGA	0	0	1	0	0	0	0	0	0	0	0	3	0	0
BARGNY	0	0	2	0	0	0	0	1	0	0	0	6	0	1
SEBIKOTANE	0	0	2	0	0	0	0	2	0	0	0	2	0	2
MATERNITE RUF	0	1	4	3	0	0	0	2	0	0	0	8	0	2
PMI RUFISQUE	0	0	3	1	0	1	0	5	0	0	0	7	0	2
ARAFAT	0	0	1	0	0	0	0	2	0	0	0	2	0	1
THIAROYE GARE	0	0	1	0	0	0	0	2	0	*	0	2	0	2
DOMINIQUE	1	0	6	11	0	3	0	10	0	2	0	15	0	7
GUINAW RAIL	0	0	2	2	0	0	0	1	0	0	0	8	0	0
TOUBA DIAKSAO	0	0	2	1	0	0	0	4	0	0	0	2	0	1
ROI BAUDOUIN	1	2	3	6	0	2	0	9	0	0	0	10	0	3
MAT GUEDIAW	0	0	1	2	0	0	0	1	0	0	0	11	0	10
MUNICIPAL II	0	0	1	0	0	0	0	1	0	0	0	1	0	4
NIMZATT	0	0	1	0	0	0	0	2	0	0	0	2	0	5
DIAMAGUENE	0	0	2	1	0	0	0	0	0	*	0	0	0	18
SICAP MBAO	1	0	2	0	0	0	0	1	0	1	0	0	0	5
RAMBYLOR	1	0	0	0	0	0	0	0	0	0	0	0	0	2
THIAROYE/MER	0	0	1	0	0	0	0	3	0	0	0	0	0	5
THIAROYE /MINA	0	0	1	0	0	0	0	3	0	0	0	1	0	6
YEUMBEUL	0	0	1	0	0	0	0	0	0	0	0	4	0	6
HLM LAS PALMAS	0	0	1	0	0	0	0	2	0	0	0	2	0	1
TOTAL	**9**	**7**	**94**	**63**	**1**	**14**	**0**	**117**	**0**	**4**	**0**	**150**	**0**	**104**

NB :* données non disponibles

SITUATION FORMATION DU PERSONNEL EN PF
Clinique et IEC
EN 1990

CENTRES	MEDECIN		SAGE-F		A. SOC		INFIR		LABORAN		AIDE-INF		AUTRES	
	F	NF	F	NF	F	NF	F	NF	F	NF		NF	F	NF
THIES														
Xème	0	0	2	2	0	0	0	0	0	0	0	0	0	0
RANDOULENE	0	0	2	2	0	0	0	2	0	0	0	5	0	0
HOPITAL REG	0	0	6	8	0	1	0	1	0	1	0	8		
PMI MBOUR	0	0	2	0	0	0	0	6	0	0	0	3	0	0
KHOMBOLE	1	0	2	0	0	0	0	7	0	1	0	2	0	1
JOAL	0	1	2	1	0	0	0	6	0	0	0	4	0	3
MBORO	0	0	1	0	0	0	0	2	0	0	0	3	0	0
KAYAR	0	0	1	0	0	0	0	1	0	0	0	2	0	0
THIADIAYE	0	1	3	0	0	0	0	7	0	1	0	9	0	8
TIVAOUANE I	0	0	3	1	0	1	0	6	0	0	0	4	0	0
TIVAOUANE2	0	1	4	0	0	0	0	3	0	0	0	4	0	0
MEKHE	1	0	1	1	0	0	0	6	0	0	0	3	0	0
POPENGUINE	0	1	2	0	0	0	0	5	0	0	0	3	0	0
POUT	0	0	1	0	0	0	0	2	0	0	0	5	0	0
TOTAL	**2**	**4**	**3 2**	**1 5**	**0**	**2**	**0**	**5 4**	**0**	**3**	**0**	**5 5**	**0**	**1 2**

SITUATION FORMATION DU PERSONNEL EN PF
CLINIQUE ET IEC
EN 1990

CENTRES	MEDECIN		SAGE-FEM		A. SOCIAUX		INFIRMIER		LABORANT		AIDE-INFIF		AUTRES	
	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF
KAOLACK														
Kasnack	1	0	4	0	0	2	0	6	1	0	0	6		
C. Regional	0	0	2	0	0	0	0	1	0	0	0	1		
Région Medic.	0	1	0	0	0	0	1	3	0	0	0	0		
Léona	0	0	3	1	0	0	0	3	0	0	0	2		
Médina Baye	0	0	1	0	0	0	0	1	0	0	0	4		
N'Doffane	0	0	0	1	0	0	0	1	0	0	0	4		
Nioro	0	1	2	1	0	1	0	5	0	1	0	4		
Koungheul	0	1	2	0	0	0	0	6	0	1	0	3		
Kaffrine	1	0	1	0	0	0	0	7	0	1	0	4		
Gandiaye	0	0	1	0	0	0	0	2	0	0	0	3		
Médina Sabakh	0	0	1	0	0	0	0	2	0	0	0	5		
H. Régional	0	1	0	8	0	0	0	3	0	0	0	6		
SOUS-TOTAL	2	4	17	11	0	3	1	40	1	3	1	42		
FATICK														
PMI Fatick	0	0	5	2	1	0	0	11	0	1	0	1	0	2
Foundiougne	0	1	1	1	0	0	0	2	0	1	0	1	0	1
Sokone	0	1	1	2	0	0	0	7	0	1	0	1	0	1
Gossas	1	0	2	3	0	2	0	10	0	1	0	1	0	2
Guingueneo	1	0	2	1	0	0	0	5	0	1	0	0	0	2
Passy	0	0	0	1	0	0	0	2	0	0	0	0	0	1
SOUS-TOTAL	2	2	11	10	1	2	0	37	0	5	0	4	0	9

SITUATION FORMATION DU PERSONNEL EN PF
Clinique et IEC
EN 1990
(VSPP)

CENTRES	MEDECIN		SAGE-FEM		A. SOCIAUX		INFIRMIER		LABORANT		AIDE-INFIR		AUTRES	
	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF	F	NF
RCFS	1	0	1	0	0	0	0	0	1	1	0	5	0	0
CSPT	1	0	1	0	0	0	0	3	0	0	0	0	0	0
MALICOUNDA	0	0	1	0	0	0	0	1	0	0	0	8	0	0
GOUTTE DE LAIT	0	0	2	0	0	1	0	0	0	0	0	3	0	0
DIAMAGUENE	0	0	1	0	0	0	0	2	0	0	0	1	0	0
NGUET NDAR	0	0	1	0	0	0	0	2	0	0	0	1	0	0
PIKINE	0	0	1	0	0	0	0	2	0	0	0	1	0	0
GOKHOU MBATT	0	0	1	0	0	0	0	1	0	0	0	1	0	0
VSOS	1	1	0	2	0	0	0	1	1	0	40	0	0	0
SONACOS	0	1	1	0	0	0	0	1	0	3	0	2	0	0
PAD	0	1	1	0	2	1	0	0	0	0	0	5	0	0
UCAD	1	4	3	0	0	4	0	5	0	2	0	4	0	0
SONATEL	0	1	1	0	0	1	0	2	0	0	0	2	0	1
SENELEC	0	3	1	0	0	0	0	3	0	1	0	3	0	0
CR Pikine	0	0	2	0	0	0	0	0	0	0	0	3	0	2
CR Amitié II	0	0	3	0	0	1	0	0	0	0	0	0	0	15
SANDIAL	0	0	2	1	0	0	0	4	0	0	0	5	0	4
LIBERTE V	0	0	1	0	0	0	0	1	0	0	0	0	3	4
H. WASHINGTON	0	0	3	3	0	0	0	0	0	0	0	0	1	1
OUAGOU NIAYES	0	0	2	0	0	1	0	0	0	0	6	5	5	1
COLOBANE	1	0	4	0	0	1	0	0	1	0	12	0	0	1
HANN	1	0	2	5	0	0	0	0	0	0	0	0	0	3
SOTRAC THIAROYE	0	1	2	0	0	0	0	2	0	2	4	3	3	2
SOTRAC OUAKAM	0	1	2	0	0	0	0	1	0	2	1	7	7	2
SOTIBA	0	1	0	0	-	1	0	1	0	1	-	1	0	2
TOTAL	**6**	**14**	**39**	**11**	**2**	**12**	**0**	**32**	**3**	**12**	**63**	**55**	**19**	**39**

ANNEX J-3

Status of Equipment of Family Planning Clinics

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
DAKAR 1

MATERIEL	G LAHOU		BOURGU		G YOFF		BEL AIR		K YALLA		CHOUCAI		SENGHOR		N'GOR		OUAKAM		IHS		CM FONCT	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	1		1		1			1	1		1		1		1		1		1		1	
Fauteuil	1		1		1			0		1	1		1		1		1		1		1	
Chaises Visiteurs	5		4		2		4		0		3		4		3		5		4		1	
Table gynécologique	1		1		1		1		1		2		1		1		1		1		1	
Escabeaux	1		1		1		1		1		2		1		1		1		1		1	
Tabouret à HV	1		1		1		1		1		1		1		1		1		1		1	
Boite de pose	1		1		1		1		1		2		1		1		2		1		1	
Boite de retrait	0		0		0		0		0		0		0		0		0		0		0	
Speculum	0		0		8		0		0		0		0		0		0		0			1
tensiomètre	1		1		1		1			1	1		1		1		1		1			1
Stéthoscope	1		1		1		1		1		1		1		1		1		1		1	
Stérilisateur électrique	0		1		1		1		1		1		1		1			1	0		1	
Pèse Personne	0		1		1		1		1		1		0			1			0		1	
Armoire à 2 battants	1		1		1		1		2		1		0		1		1		1		1	
Armoire de rangement	0		0		0		1		0		1		0		0		1		0		0	
Fichier à 4 tiroirs	0		1		1		0		1		1		1		0		0		0		1	
Rayonnage	0		0		0		0		0		0		0		0		1		0		0	
Réfrigérateur	0		1		1		1		1		1		1		0		1		0		1	
Sceau à pédale	0		0		0		0		1		1		0		0		1		0		0	
Lampe Gynécologique	0		1		1		1		1		1		1		1		0		1		1	
Ventilateur	0		1		0		0		0		1		0		0		1		0		0	
Poissionnière	0		0		0		0		0.		1		0		0		1		0		0	
Minuterie	0		1		0		0		0		0		0		0		1		0		0	
Corbeille à papier	0		1		1		0		0		1		0		0		0		1		1	
Réchaud à gaz	1		0		1		1		1		1		1		0		1		1		0	
Banc d'attente	0		0		2		2		0		2		0		0		0		0		0	
Chariot à instrument	1		1		1		1		0		1		1		0		0		1		1	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
DAKAR 2

MATERIEL	A.DIASSE		A. N'DAC		NORADE		PMI ME		HALD		G. MEDIN		BARGNY		SEBIKO		PMI RU		ARAFA		T GARE	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	1		2		0		5				1		1		1		2		1		1	
Fauteuil	1		0		0		1				1		1		1		1		1		0	
Chaises Visiteurs	2		6		0		11				5		0		0		5		7			
Table gynécologique	1			1	0		0				1		1		1		1		1			
Escabeaux	0		1		0		4				1		1		1		1		1			
Tabouret à HV	1		1		0		2				1		1		1		1		1			
Boite de pose	1		2		1		6				0		1		1		2		1			
Boite de retrait	0		0		0		6				0		1		0		0		0			
Speculum	25			1	1		20				0		0		0		17		10			
tensiomètre	1		1		1		2	2			1		1		0		1		1			
Stéthoscope	1		1		0		4				1		1		0		1		1			
Stérilisateur électrique	0		1		1		1				0		1		1		1		1			
Pèse Personne	1		1		1		1				1		1		1		1		1			
Armoire à 2 battants	1		1		0		5				1		1		1		2		1		1	
Armoire de rangement	0		2		1		2				0		0		0		1		0			
Fichier à 4 tiroirs	1		0		1		1				0		1		1		0		0			
Rayonnage	0		2		0		0				0		0		0		0		0			
Réfrigérateur	0		1		0		1				0		1			1	1		0			
Sceau à pédale	1		1		1		4				0		0		0		1			1		
Lampe Gynécologique	0		1		0		6				1		1		1		1		0			
Ventilateur	0			1	0		3				0		0			1	1		1			
Poissionnière	0		0		0		1				0		0		0		0		1			
Minuterie	0		0		0		1				0		0		0		1		0			
Corbeille à papier	0		1		1		5				0		0		0		2		0			
Réchaud à gaz	0		1		0		1				1		0		0		0		1			
Banc d'attente	0		3		0		5				0		0		1		0		0			
Chariot à instrument	0		0		0		5				1		1		1		0		1			

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
DAKAR 3

MATERIEL	DOMINIQ		G RAIL		T. DIAKS		BAUDOU		MAT GUE		MUNCIP		NIMZATT		DIAMAG		S M'BAO		WAKHIN		DEGGO	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	2		1		0		1		1		1		1		0		0		1		1	
Fauteuil		1	1		1		1		1		1		1		0		0			1		1
Chaises Visiteurs	6		5		4		4		4		4		4		0		0		4	1	4	
Table gynécologique		1	1		1		1		1		1		1		0		0		1		1	
Escabeaux	1		1		1		1		1		1		1		0		0		1		1	
Tabouret à HV	1		1		1		1		1		1		1		0		1		1		1	
Boite de pose	2		1		1		1		1		1		1		1		1		1		1	
Boite de retrait	1		0		0		2		0		0		1		1		0		0		0	
Speculum	0		0		0		1		0		8		0		0		0		8		8	
tensiomètre	1		1			1	0			1	1		1		0		0		1		1	
Stéthoscope	1		1		1		1			1	1		1		0		0		1		1	
Stérilisateur électrique	1		1		1		1		1		1		1		1		0		1		1	
Pèse Personne	1		1		1		0		1		1		1		0		1		1		1	
Armoire à 2 battants	1		1		0		0		0		0		0		1		0		1		1	
Armoire de rangement	0		0		0		0		0		0		0		0		0		0		0	
Fichier à 4 tiroirs	-	3	0		0		0		0		1		1		1		0		0		0	
Rayonnage	0		0		0		1		0		0		0		0		0		0		0	
Réfrigérateur	1		0		0		0		0		1			1	1		0		0		0	
Sceau à pédale	1		1		0		1		0		0		0		0		1		1		1	
Lampe Gynécologique		1	0		1		1		1		1		1		1		0		0		0	
Ventilateur	0		0		PL			1	0		PL		0		0		0		0		0	
Poissionnière	1		0		0		0		0		0		1		0		0		1		1	
Minuterie	4		1		0		0		0		0		0		0		0		0		0	
Corbeille à papier	1		0		0		0		0		1		1		0		0		0		0	
Réchaud à gaz	1		1		1		0		1		1		1		0		0		0		0	
Banc d'attente	2		0		0		0		0		0		0		0		0		0		0	
Chariot à instrument	1		1		0		0		1		1		1		0		0		1		1	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
DAKAR 4

MATERIEL	THIAR/MER		YEUMBEUL		BAMBILOR		NIAGA	
	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	1		1		1		1	
Fauteuil	1		1		1		0	
Chaises Visiteurs	1		5		5		4	
Table gynécologique	1		1		1		1	
Escabeaux	1		1		1		0	
Tabouret à HV	1		1		1		1	
Boite de pose	2		0		1		1	
Boite de retrait	0		0		0		0	
Speculum	0		5		0		0	
tensiomètre		1	1		1		1	
Stéthoscope	1		1		1		1	
Stérilisateur électrique	1		1		0		1	
Pèse Personne	1		1		0		1	
Armoire à 2 battants	1		1		1		0	
Armoire de rangement	0		0		0		0	
Fichier à 4 tiroirs	2		0		0		0	
Rayonnage	0		0		0		0	
Réfrigérateur	1		0		1		0	
Sceau à pédale	0		1		1		1	
Lampe Gynécologique	1		0		1		0	
Ventilateur	PL		0		1		0	
Poissionnière	0		0		0		0	
Minuterie	0		1		0		0	
Corbeille à papier	0		0		0		0	
Réchaud à gaz	1		1		1		0	
Banc d'attente	0		0		0		0	
Chariot à instrument	1		1		1		1	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
THIES

MATERIEL	Xème		RANDOU		H THIES		M'BOUR		KHOMBO		JOAL		M'BORO		THIADIA		TIVA 1		TIVA 2		MEKHE		POUT		KAYAR		POPENG	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	4			2	2		2	1	1		1		1		1		1		1		1		2		1		1	
Fauteuil	4		2		1		1		1		1		1		1		1		1		1		1		1		1	
Chaises Visiteurs	8		2	1	4		5		4	1	1		1		4		1		5		3	1	3		0		2	1
Table gynécologique	2		1		1		1		1		1		1		1		1		1		1		1		1		1	
Escabeaux	4		1		1		1		1		1		1		1		1		1		1		0		1		1	
Tabouret à HV	4		1		1		1		1		1		0		1		1		1		0		1		1		1	
Boite de pose	2		1		1		1		2		1		0		1		0		2		1		1		1		1	
Boite de retrait	2		1		1		2		0		1		0		1		0		0		0		1		0		0	
Speculum	0		0		12		0		0		6		0		0		0		0		3		8		4		2	
Tensiomètre	1			1	1			2	1		0		1		1			1	1		1		1			1		1
Stéthoscope	1			1	1			2	1		0		1		1		1		1		0		1		1		1	
Stérilisateur électrique		1	1		1		1		1				1		1		1		1		1		1			1		1
Pèse Personne	1		1		1		1		1		1		1		1		1		1		1		1		1		0	
Armoire à 2 battants	2		1		1		1		1		1		1		1		1		1		0		1		1		1	
Armoire de rangement	2				1		1		0		0		0		0		0		0		1		0		0		0	
Fichier à 4 tiroirs	0		2		1		2		1		1		1		0		0		1		0			1	1		1	
Rayonnage	2		3		0		0		0		0		0		0		0		0		1		0		0		0	
Réfrigérateur		1	1		1		1		1		1		1		1		1				0		1		1		1	
Seau à pédale	0		1		1		1		1		0		0		1		1		1		1		0		0		0	
Lampe Gynécologique	2		1		0	1	1		1		1		1		1		1		1		1		1		1		1	
Ventilateur	1		1		0		1		1		3		1		0		1			1	0		1		0			
Poissionnière	1		0		1		1		0		0		0		1		1		1		1		0		0		0	
Minuterie	1		0	1	1		1		1			1	1		1		0		1		1		1		0		1	
Corbeille à papier	0		1		1		1		1		0		0		1		1		1		1		0		0		0	
Réchaud à gaz	1		1		1		1		0		1		1		0		1		1		1		0		0		0	
Banc d'attente	4		2		1	1	2		0				0		0				0		0		3		0		0	
Chariot à instrument	0		0		1		0		0		0		0		0		0		1		0		0		0		0	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
FATICK

MATERIEL	CM FATICK		FOUNDIOUGNE		SOKONE		GOSSAS		GUINGUENEO	
	BE	ME	BE	ME	BE	ME		ME	BE	ME
Bureaux	2		1		1		1		1	
Fauteuil	1		1		1		1		1	
Chaises Visiteurs	4		2		5		5		2	
Table gynécologique	1		1		1		1		1	
Escabeaux	1		1		1		1		1	
Tabouret à HV	1		1		1		1		1	
Boite de pose	0		2		0		2		0	
Boite de retrait	0		2		2		1		0	
Speculum	0		13		0		1		0	
tensiomètre	1		1		1		1			1
Stéthoscope	1		1		1		1			1
Stérilisateur électrique	1		1		1		1	1		1
Pèse Personne	1		1		1		1		1	
Armoire à 2 battants	1		1		1		1		1	
Armoire de rangement	0		0		0		0		0	
Fichier à 4 tiroirs	1		1		1		1		1	
Rayonnage	0		0		0		0		0	
Réfrigérateur		1		1		1	1		1	
Sceau à pédale	1		1		1		1		0	
ampe Gynécologique		1	1		1		1		1	
ntilateur	0		1		1		1		0	
sionnière	1		1		1		1		1	
erie	1		0		0		1		0	
e à papier	1		0		1		1		0	
gaz	0		1		1		1		1	
nte	1		0		0		3		0	
strument	0		0		0		0		0	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
(KAOLACK)

MATERIEL	KASNACK		LEONA		C REG K		MED BA		M. SABA		KAFFRI		NIORO		KOUNG		N'DOFF		GANDIA	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	1	2	2		5		1		1		1		2		1		1		1	
Fauteuil	1		1		1	1	1		1		1		1		1		1		1	
Chaises Visiteurs	3	1	2		6		4		4	1	3	1	1		3		2		1	1
Table gynécologique	2		1		2		1		1		1		1		1		1		1	
Escabeaux	2		1		2		1		1		1		1		1		1		1	
Tabouret à HV	1	1	2		1		1		1		1		1		1		1		1	
Boite de pose	4		4		4		1		1		1		2		2		1		1	
Boite de retrait	4		4		0		1		1		1		2		1		1		1	
Speculum	0		13		0		10		3		8		2		0		7		12	
tensiomètre	1		1		0		1		1		1		1		1		1		0	
Stéthoscope	1		0		0		1		1		1		1		2		1			1
Stérilisateur électrique		1	1		2			1	1			1	1		1		1		1	
Pèse Personne	1		1		1		1		1		1		1		1		1		1	
Armoire à 2 battants	2		1		2		1		0		1		0		0		0		1	
Armoire de rangement	1		1		1		0		1		0		1		1		1		1	
Fichier à 4 tiroirs	1		1		1		0		0		1		1		1		1		1	
Rayonnage	2		0		3		0		0		0		0		0		0		0	
Réfrigérateur	1			1	1		1		1			1	1		0		1		1	
Sceau à pédale	3		1		2		1		1		1		1		0		0		0	
Lampe Gynécologique		2		1	1	1	1		1		1			1	1		1		1	
Ventilateur	0		1		0		0		2		1			1	0		0		3	
Poissionnière	1		0		0		1		1		1		1		2		1		1	
Minuterie	1		1		0		1		0		1		2		0		0		1	
Corbeille à papier	0		2		0		1		1		0		2		0		0		0	
Réchaud à gaz	1		1		1		1		0		1		1		1		1		1	
Banc d'attente	2		2		0		0		0		0		0		0		0		0	
Chariot à instrument	0		0		0		0		0		0		0		0		0		0	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
(VSPP) 1

MATERIEL	RCFS		CSPT		PAD		UCAD		SONATEL		SENELEC		MALICOUN		CR PIKINE		CR GLAI		SANDIAL	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	1		1		0		1		1		1		1		1		1		1	
Fauteuil	1		1		2		1		1		1		1		1		1			1
Chaises Visiteurs	5		5		10		10		1		20		7		20		0		6	4
Table gynécologique	1		1		2		1		15		1		1		1		2		1	
Escabeaux	1		1		2		1		1		1		1		1		2		1	
Tabouret à HV	0		1		2		1		1		1		1		1		2		1	
Boite de pose	1		2		2		1		1		2		1		12		0		1	
Boite de retrait	0		0		1		1		2		2		1		0		1		0	
Speculum	10		6		35		10		25		25		0		7		0		10	
tensiomètre	1			1	3		1		1		1		1		1		1		1	
Stéthoscope	1		1		3		1		1		1		1		1		1		1	
Stérilisateur électriqu	0		1		2		1		1		1		0		1		1		1	
Pèse Personne	1		1		1		1		1		1		1		1		1			1
Armoire à 2 battants	2		1		2		1		1		1		2		1		0		1	
Armoire de rangement	0		0		0		0		2		0		0		0		0		0	
Fichier à 4 tiroirs	2		2		0		1		0		1		0		0		1		1	
Rayonnage	0		0		0		0		1		0		0		0		0		0	
Réfrigérateur	1		1		1		1		0		2		1		1		0		1	
Sceau à pédale	0		1		2		1		1		2		0		0		1		1	
Lampe Gynécologique	1	1	0		2		1		1		1		0		1		2			1
Ventilateur	0		0		0		1		2		0		0		1		1			1
Poissionnière	1		0		1		0		0		1		1		0		1		0	
Minuterie	0		0		0		0		0		0		0		0		0		0	
Corbeille à papier	0		0		0		1		1		0		0		0		0		0	
Réchaud à gaz	0		0		0		0		0		0		0		0		0		0	
Banc d'attente	3		1		0		0		8		10		3		2		0		1	
Chariot à instrument	0		1		3		0		1		1		0		0		0		1	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
VSPP2

MATERIEL	VSOS		SONACOS		CR LIBV		H WASHIN		S/THIA		S/OUAKAM		CS HANN		CR AMI 2		OUA NIAYES	
	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME	BE	ME				
Bureaux	1		1		1		1		0		0		1		1		0	
Fauteuil	2		1			1	1		0		0		1		1		0	
Chaises Visiteurs	10		5		14	1	4		6		6		8	1	6		0	
Table gynécologique	1		1		4		1		0		0		1		1		0	
Escabeaux	1		1		1		1		0		0		1		1		0	
Tabouret à HV	1		1		0		1		0		0		1		1		0	
Boite de pose	1		2		0		1		1		1		1		1		0	
Boite de retrait	1		1		1		0		1		1		0		1		0	
Speculum	20		0		1		0		0		0		16		-		0	
tensiomètre	1		2		1		0		1		1		1		1		1	
Stéthoscope	1		2		1		0		1		1		1		1		1	
Stérilisateur électrique	1		1		1		1		0		0		1		1		1	
Pèse Personne	1		0		0		1		0		0		1		1		0	
Armoire à 2 battants	1		2		0		0		0		0		1		1		0	
Armoire de rangement	0		0		0		0		0		0		0		0		0	
Fichier à 4 tiroirs	1		2		1		1		1		1		1		1		1	
Rayonnage	0		0		1		0		0		0		0		0		0	
Réfrigérateur	0		1		1		1		0		0		1		1		0	
Sceau à pédale	2		0		1		1		0		0		0		0		0	
Lampe Gynécologique	1		0		0		PL		1		1		1		1		0	
Ventilateur	0		1		0		1		0		0		0		0		0	
Poissionnière	0		0		0		0		0		0		0		0		0	
Minuterie	0		0		0		0		0		0		0		0		0	
Corbeille à papier	0		0		1		1		0		0		0		0		0	
Réchaud à gaz	0		0		1		0		0		0		0		0		0	
Banc d'attente	0		2		2		0		0		0		0		0		0	
Chariot à instrument	0		1		1		1		0		0		0		0		0	

SITUATION DU MATERIEL DANS LES CENTRES DE PF
EN 1990
(VSPP) 3

MATERIEL	DIAMAGUE ST-L		PIKINE ST-L		GOXUBAAC ST-L		GUET N'DAR	
	BE	ME	BE	ME	BE	ME	BE	ME
Bureaux	1		1		1		1	
Fauteuil	1		1		1		1	
Chaises Visiteurs	6		6		5	1	5	1
Table gynécologique	1		1		1		1	
Escabeaux	1		1		1		1	
Tabouret à HV	1		1		1		1	
Boite de pose	1		1		2		1	
Boite de retrait	0		0		0		0	
Speculum	0		2		0		5	
tensiomètre		1	1		0		1	
Stéthoscope		1	1		0		1	
Stérilisateur électrique	1		0		1		1	
Pèse Personne	0		1		1		1	
Armoire à 2 battants	1		1		0		1	
Armoire de rangement	0		0		0		0	
Fichier à 4 tiroirs	1		1		1		1	
Rayonnage	0		0		0		0	
Réfrigérateur	1		1		0		1	
Sceau à pédale	0		0		1		1	
Lampe Gynécologique	1		0		1		1	
Ventilateur		1	1		1			1
Poissionnière	1		1		1		1	
Minuterie	0		0		0		0	
Corbeille à papier	0		0		0		0	
Réchaud à gaz	0		0		0		0	
Banc d'attente	1		2		1		2	
Chariot à instrument	1		1		1		1	

ANNEX K

Remarks for Oral Presentation to the Government of Senegal

on the Draft Evaluation's Findings and Recommendations

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ANNEX K

Remarks for Oral Presentation to The Government of Senegal on the draft evaluation findings and recommendations of Family Health and Population Project

1. Introduce individual team members. The team represents not only different skills, but many points of view. The evaluation report will reflect this diversity of view.

2. I want to note particularly the participation of the evaluation team co-President, Dr. Abou Thiem. Without his help this evaluation could not have been as successful as it was. He wrote sections of the report, but just as important, he acted as interlocutor with the Government, a guide in the villages, and as a translator, when that was necessary. While the foreigners on the team spent full time on the a evaluation, Dr. Thiem and (and Julian Mendy) had other responsibilities. We know the Minister made requests on Dr. Thiem that often conflicted with his work with evaluation team. I ask, Mr. Deputy Minister, that you convey our thanks to the Minister for letter Dr. Thiem work with us, and our apologies to him, if there was a conflict.

3. The original Agreement for this Project was executed on July 31, 1985, and amended on August 22, 1986 and again on June 10, 1987. The Project is a seven year $28 million project, $20.6 million to be provided by AID, the FCFA equivalent of $7.4 million in cash and kind was to be provided by the GOS.

4. The purpose of the Project is to provide comprehensive support to integrated maternal and child health services and family planning (FP), improve the existing capacity of the country to provide safe and effective contraception to 15% of married women of reproductive age, improve the demographic data base so that more effective planning can take place, and increase the awareness of policy makers and planners of the impact of rapid population growth on the economic development of the country.

5. The Project called for three evaluations. The first was to be carried out at the end of the second year. It was to have reviewed whether procedures and institutional arrangements were in place for the proper implementation of the Project. The second evaluation, was to have been carried out in the fourth year of the Project. It was to have moved beyond management and administrative consideration to focus on performance, policy development and demographic data collection.

5. The final evaluation - the present one - is being carried out during the sixth year of the Project. It was to build on the first two evaluations and study how the Project had resolved implementation problems identified in earlier evaluations and focus on the impact of the Project.

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6. The present evaluation took place between March 28 and we will complete our work in Senegal, Friday, May 10. During this period the team interviewed over 100 people in Dakar, Kaolak, Fatick, Thies, Kolda and Zinguinchor. We spoke with public health officers, administrators, doctors, mid-wives, nurses, and clients. We spoke with other bilateral and multilateral donors, other government officials, private business people and representative of non-governmental organizations. A report annex will contain a complete list of those interviewed.

7. We appreciate the full cooperation given to evaluation team members where ever they went--in Dakar and in the regional offices, in the clinics, and in villages--and by professional staff of the Project and by the women and men who are the clients and direct beneficiaries of this Project.

8. A limitation on this evaluation is the fact that the first two evaluations were never completed. Because this is the first formal evaluation in almost 6 years, many issues that could have been spotted earlier in the Project have now become "built in" and accepted as normal.

9. At the same time, the turnover of Project personnel has been such that it was difficult to get first hand information of what went on in the past, particularly before the crises following the financial audits of 1988.

10. We list 70 findings in our Summary and almost 100 recommendations. Many recommendations are specific; others are more general. But all are intended to have impact on improving implementation of the present Project, and point USAID and the GOS in directions to be considered in designing the new health and population already proposed by the USAID Mission.

11. It will, of course, be difficult to review all the draft findings and draft recommendations this morning. We therefore seek dialogue with you now on key issues to help the team prepare its evaluation report. The team will remain at the Hotel Novotel tomorrow morning if anyone would like to correct numbers that may be in error. The draft report will be available next week and you will have another opportunity to comment on the written findings and recommendations. We hope to send you the final report approximately 30 days after receiving your written comments on the draft report.

13. Each of the team members will now give a 3-5 minute summary of the sections of the evaluation for which they were responsible. Permit me first give my own general observation. I have three points:

    a. First, it is clear the Project has facilitated the access of couples to modern family planning methods. For example:

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- the number of active contraceptive acceptors increased from 7,500 in 1985 to 29,890 in 1990 at public sector clinics; and

- against the original project goal of 200,000, in 1990 there were reported to be over 60,000 acceptors in all sectors (public, VSPP, commercial and UNFPA) using modern contraceptive methods.

On the other hand, there was a slowdown in the rate of increase of active clients from 1988-1990. At the same time, family planning data at the clinical level have uncertain reliability. Indicators such as the number of new acceptors, levels of STD, infertility, or women who have abandoned contraception do not give the team the confidence to judge the quantity or quality of impact of the Project on the basis of these indicators.

b. Second, the fact that there are 70 specific findings and 95 specific recommendations means that much effort will be needed to assure that Senegalese women and men receive quality service. But there is a more basic problem. That is, the lack of focus on overall management problems. We suggest that key people in AID and the government assume greater responsibility for achieving positive results.

c. Third, the financial integrity of the project must be ensured. If two partners, in this case Senegal and the United States, agree that certain financial commitments are necessary to complete an activity, and they sign an agreement to carry out that commitment, each partners must make every effort to meet its obligations.

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ANNEX L

Evaluation Indicators of Quality and Quantity

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MEMORANDUM

DATE: April 17, 1991

TO: Population Evaluation Team

FROM: Irving

SUBJECT: Evaluation Indicators of Quality and Quantity

At our last team meeting we brainstormed the quantitative indicators we should be looking for to help us evaluate the project. I have recorded the results of our work on the following pages. I have taken the liberty of adding a few more indicators that I picked up from a further review of the logframe.

I attempted a further analysis of these indicators by adding columna A to H to try to determine, from a management point of view, who was responsible for each of these indicators. I would like your comments on this further analysis.

At our Monday morning (April 22 at 8:30) I would like a brainstorming session on qualitative measures for our evaluation. I found Ron's suggested Table, page 3, showing the relationship of quantitative measures to one another, as an excellent framework also to look at qualitative measures. Please think of these in advance of our meeting.

Note: I repeat my desire for your lists of questions on disks so I can get them to the translator now before the end-of-project logistic nightmare.

Thanks.

Quantity Indicators of Output to be Collected and Evaluated

COMPONENT	CLINIC						D	P
Activity	A	B	C	D	E	F	G	H
Number of buildings constructed and renovated		x						
Number of people trained (and months of training)								
-clinical (doctors, mid-wives, etc)		x						
-communication				x				
-logistic			x					
-GOS policy types					x			
-management					x		x	x
-STD	x				x			
-census methodology							x	
-demography							x	
-service data collection/analysis		x				x		
Number of reports from family planning centers	x			x		x		
Number of statistical surveys made				x			x	
Number of psycho-social studies published				x		x		
Number of operational research reports published				x	x			
Number of RAPID presentations made					x			
Number of population policies changed/effected	x	x	x	x	x	x	x	x
Number of consultations *		x		x				
Number of new contraceptive acceptors (annual)*		x	x	x			x	
Number of active acceptors (CYP) *		x	x	x				
Number of MWRA acceptors *		x	x	x				
Number of abandons *		x	x	x				
* each by region								
Number of operational family planning centers		x	x	x				
Number of hours/days of clinical services		x						

A-MPHSA UNIT(S) RESPONSIBLE FOR IEC SERVICES
B-MPHSA UNIT RESPONSIBLE FOR CLINICAL SERVICES
C-MPHSA UNIT RESPON. FOR PUBLIC SECTOR CONTRACEPTIVE LOGISTICS
D-MPHSA UNIT RESPONSIBLE FOR COLLECTING/ANALYZING POP MGMT DATA
E-MPHSA UNIT RESPONSIBLE FOR OVERALL PFP PROJECT MANAGEMENT
F-MPHSA UNIT(S) RESPONSIBLE FOR OTHER POP RELATED FUNCTIONS
G-GOS UNIT RESPONSIBLE FOR DEMOGRAPHIC DATE COLLECT/ANALYSIS
H-PPPS COMPONENT
D-DATA BASE IMPROVEMENT COMPONENET
P-PRIVATE AND PARA-PUBLIC SECTOR COMPONENT

Number of consultations per service provider		x						
Number of geographic regions served					x			
Number of management coordination meetings	x	x	x	x	x	x	x	x
Number and type of supervision activities					x			
Number, types and use of management reports					x			
Number and type of contraceptives ordered		x	x					
" " " " " " " used		x	x					
" " " " " " " in stock		x	x					
" " " " " " " ruptured		x	x					
Number of people who know about contraceptives	x	x						
Number, type and effectiveness of LTTA					x			
Number, type and effectiveness of STTA					x			
Number of commercial retail outlets established								x
Cost of service delivery, public sector					x			
Cost of service delivery, private and para-public					x			
Number of inter-health/family planning references			x					
Number of womens' sub project	x							
Macro-demographic data on fertility and changes							x	
" " " " " crude birth rate							x	
" " " " " morbidity and changes							x	
" " " " " mortality and changes							x	
" " " " " family size/changes							x	
" " " " " # of births averted							x	
" " " " " state of health of women							x	
" " " " " " " " " children							x	
" " " " " "nutritional status				x				
" " " " " "high risk pregnancies				x			x	

Interrelationships Among Types of Data Collected or Potentially Available for Collection Under the Project as a Basis for Determining Level of Project Activity and Providing a Basis for Evaluating Project Efficiency and Effectiveness

Data Level	Examples of Activity Types	Examples of Quality Factors
I	Policy Management Budget Allocation	Agreements & Differences Meeting Fin. Obligations
II	Training Logistics IEC	Improved Service Awareness of issues
III	Consultations Levels of Workload	
IV	Acceptors Abandons Other Achievements	Cost Per Unit " "
V	Fertility Rates Morbidity/Mortality Health Status Family Size	Public Social Costs Availability for Work

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ANNEX M

List of Contacts

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INDIVIDUALS CONTACTED

FAMILY HEALTH AND POPULATION PROJECT PERSONNEL

Marieme Diop, Director
Laty N'Doye, Deputy Director
Victoria Albis, Clinical Coordinator
Sidy Fall, Logistician
Caroline Mane, IEC National Coordinator
Aissatoy Samb, IEC National Coordinator

MINISTRY OF PUBLIC HEALTH AND SOCIAL ACTION

Bandougou Sylla, Director of Cabinet
Lamine Cisse Sarr, Director, Public Health
Issakha Diallo, Chief, Primary Health Care
El Hadji Malick Diame, Chief, Division of Statistics, DSP
Oury Kane Ba, Coordinator, National MCH/FP
Sega Gningue, Logistician, MCH/FP
Mme. Mane, Director, Division of Human Resources
Alassane Nakoulima, Director, MCH/FA Division
Maty Cisse Samb, AID Liasion Officer, Cabinet Management Unit
Yacine Seck, Coordinator, National MCH/FP

MINISTRY OF FINANCE, DIRECTION DE LA PREVISION ET DE LA STATISTIQUE

Awa Thiongane, Director
Ibrahima Sarr, Chief, Bureau of Research Studies
Cheihk Gueye, Demographer
Momodou Ndiaye, Demographer
Edmond Rodriguez, Chief, Statistics Bureau
Issa Ndiaye, Computer Specialist
Salif Ndiaye, Demographer, Bureau d'Etudes

MINISTRY OF FINANCE, DIRECTION OF DEBT AND INVESTMENT
Mme Ndeye Coumba Drame Guisse, Contact

MINISTRY ON THE CONDITION OF WOMEN AND CHILDREN
Ndjoro Ndiaye, Minister
Khardiata Lo Ndiaye, Technical Advisor

MPHSA/DAKAR REGION
Nafissakou Correa, Regional Nutrition Supervisor
Virginie Diouf, Regional Technical Advisor, PF
Marietou Diop Mane, Sage-Femme, Director Thiaraye/Mer PF
Toure Fatou, Regional Supervisor, SMI/PF
Cisse Aissaton Kebe, Responsible Officer, Medina PF Center
Ndoye Khar Camara, Principal Sage-Femme, Dantec PF
Clara Cisse, Social Assistant, Dantec PF

KAOLACK REGION
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Bocar Diallo, Governer
Lamine Diop, Regional Medical Director
Ousmane Fall, Director, S.S.P. Training Center, Kaolack

THIES REGION
Camera, Regional Medical Officer
N. Ngone Toure, Medical Officer, SN/SMI
Dado Ndiaye, Sage-femme, Randoulene FP Clinic
Ami Diam, Sage-femme, Randoulene FP Clinic
Ada Ndiaye, Regional Coordinator

NGOUNDIANE VILLAGE
Village Chief
Head of Women's Group
Nanma Konate, Government Nurse

VSPP PRIVATE SECTOR and PARA-PUBLIC CLIENTS
Yacine Camara, Sage-Femme d'Etat, Directrice, Port of Dakar PF
Tabara Sarr, Nurse, Port of Dakar
Justin Ndiaye, Medical Director, SOS/Kaolack
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WORLD BANK/DAKAR
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ANNEX N

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ANNEX O

Comments on the Draft Evaluation Report

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ANNEX O-1

Letter of Transmittal to USAID of Draft Report

MEMORANDUM

DATE: May 10, 1991

TO: Mary Ann Micka, HPN, USAID/Dakar

FROM: Irving Rosenthal, Team Leader
FHPP Final Evaluation

RE: Submission of Draft Report

In accordance with the original scope for the evaluation of the FHPP, I am pleased to submit the draft English language report. In accordance with agreement between you and me, and with the concurrence of DEVRES, I also agreed to arrange for and submit an French version of the report, which is also herewith attached.

As you are well aware, it became a logistic headache to arrange for the translations and, indeed, some of these have not yet been completed.
I met with Linda Lankeneau and Tim Rosche this afternoon, and have worked out a way for the translation to be completed. I gave Tim Rosche $1,500 which is all I have left in my budget for translations. Linda is attempting to work something out for the $500-$1,000 additionaL which may be needed.

Because of the delay resulting from the translations and late receipt of sections from local team members, some of the finaL material has not been seen by me and will need significant additional work in Washington. Because of other difficulties resulting from the size and nature of the evaluation, a number of other Chapters also need additional work. I have requested, and DEVRES concurs, that 5 additionaL days should be added to the contract so I can complete this work in Washington.

The tentative schedule is, as follows:

May 21--All translation into French and English in Dakar will be completed and the draft report will be submitted for review to USAID and GOS.

May 26--I will complete a chapters in Washington on Infrastructure and I will strengthen the Chapter on VSPP and Fax it to you.

June 10--USAID will forward to DEVRES written comments, in English, from the GOS and USAID on the draft report.

June 28--DEVRES will complete the final English version and pouch 5 copies to Dakar.

The key dates are the time the GOS/USAID will have for review and this has been agreed to be 10 days after receipt of my additional material. The other key dates are the time for DEVRES preparation of the final report and this is counted as 15 work days from the time DEVRES receives USAID/GOS comments.

This letter was typed with 15 minutes left before the car was to take me to the airport. I apologize for its brevity and for the fact that I did not have the opportunity to say goodbye to you. I will communicate more fully as soon as I get to Washington.

ANNEX O-2

Marieme Diop, FHPP

PROJET SANTE FAMILIALE
SENEGAL

RÉPUBLIQUE DU SÉNÉGAL
UN PEUPLE - UN BUT - UNE FOI

PROJET SANTE FAMILIALE ET POPULATION
N° 685.0248 - Téléphone : 22-72-13
Rte du Front de Terre - B.P. 49

N° 0229 MSPAS/DA/PSFP

DAKAR, le 12 AOUT 1991 198

Le Directeur

REMARQUES ET OBSERVATIONS PORTANT SUR LE PRE-RAPPORT D'EVALUATION DU PSFP

L'étude du pré-rapport d'évaluation du Projet Santé Familiale et Population (PSFP), suscite un certain nombre de remarques et d'observations que nous avons choisies de vous livrer selon le plan ci-après :

Tout d'abord, nous présenterons les considérations d'ordre général, portant sur le rapport global aussi bien dans sa forme que dans son fond. Ensuite, les différents chapîtres seront tour à tour abordés en indiquant les observations et remarques spécifiques qu'ils suggèrent. Toutefois, il convient de signaler que nous n'insisterons pas outre mesure sur les parties BNR, VSPP, MST; les responsables de ces volets ayant déjà fait une analyse approfondie de leurs parties respectives.

I. Considérations d'ordre général-

A) - Sur le plan de la forme du document

Le document s'avère être d'une grande maniabilité malgré son volume. Cependant, la maniabilité pourrait être améliorée si la numérotation des pages était faite.

.../...

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La numérotation à laquelle on se refère a été effectuée par nous-mêmes suivant les chapîtres.

B) - Concernant le fond du document

Quelques remarques générales peuvent être dégagées :

- De façon générale, l'on peut regretter que la période d'évaluation n'ait pas été propice à un constat effectif des activités du Projet. Ces activités ont connu un ralentissement certain, si elles n'avaient pas tout simplement cessé d'être à l'exemple des activités IEC. Il a été par conséquent difficile dans le cadre de cette évaluation de juger d'une situation normale;

- Dans sa globalité, le rapport d'évaluation ne reflète pas suffisamment les acquis du Projet de même que le niveau actuel de réalisation.

- La mesure des efforts deployés par rapport aux objectifs initiaux n'est pas évidente. Par exemple en ce qui concerne les objectifs quantitatifs liés à la formation (Auxiliaires, sages-femmes, médecins, personnel IEC.); il importe de signaler qu'ils ont été largement dépassés.

- Le rapport d'évaluation gagnerait en fournissant les proportions précises pour remédier aux lacunes du Projet. Cela éviterait certaines généralisations dommageables. Par exemple dans la partie "Services cliniques", tout semble à refaire dans le domaine de la formation du personnel prestataire de services malgré les importants efforts accomplis depuis plusieurs années et la faiblesse probable du taux d'echec de contraception chez les acceptrices.

.../...

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II. Observations et remarques spécifiques-

A) - Méthodologie d'évaluation

Dans cette partie nous intégrons les observations relatives aux questionnaires joints en annexe du document. En effet, l'on peut regretter qu'une exploitation systèmatique des questionnaires n'ait pas été réalisée alors qu'ils comportent des questions d'une grande pertinence. (Par exemple : Clients et Contraceptifs).

- Concernant les clientes et leaders, quelle est leur opinion sur la séparation des services de PF et SMI? Sur la qualité des services?

- Quant aux questionnaires IEC, leurs destinataires ne sont pas précisés.

- L'on peut également s'interroger sur l'utilisation du questionnaire axé sur le VSPP. A-t-il été utilisé?

Par ailleurs, l'on peut se demander si les centres de PF choisis sont réellement représentatifs de l'ensemble des centres de PF. Si l'équipe d'évaluation avait retenu de visiter des structures considérées comme "bonnes, moyennes ou mauvaises", ce choix ne transparaît pas suffisamment au niveau des résultats de l'évaluation.

B) - Services cliniques en matière de PF

- Le taux d'échec des méthodes contraceptives n'est pas déterminé. Cela permettrait cependant d'apprécier si les sages-femmes donnent convenablement les services.

- Certains constats relatifs aux prestations de services par les sages-femmes et consistant à dire que l'examen clinique général et gynécologique, l'interrogatoire des clientes, la stérilisation et la désinfection du matériel révèlent des lacunes dans le programme de formation en PF, renvoient plus à la

la formation de base, à l'organisation des services, à la gestion des ressources humaines qu'à la formation sur les méthodes contraceptives. Est-ce qu'un tel constat concerne l'ensemble des sages-femmes? La proportion serait à préciser.

- La mauvaise qualité de la communication interpersonnelle n'est pas à lier au seul défaut de la formation des sages-femmes dans ce domaine. Il faut également considérer la charge importante de travail, l'exiguîté des locaux etc.

- Par rapport à la recommandation n°10, il serait intéressant de savoir pourquoi le manuel de supervision n'a pas été utilisé. Est-ce dû à la lourdeur par exemple? Parmi les recommandations, il convient d'ajouter l'évaluation périodique des formations, si l'on sait que le curriculum a été élaboré depuis 82 et n'a jamais été évalué et révisé.

- Réctificatif : Le Curriculum de formation utilisé dans le cadre du projet a été élaboré depuis le 1er Projet PSF avant 1985.
Une recommandation importante serait de former des agents qui soient en mesure d'assurer une évaluation et une révision périodique des programmes.

- Avant de procèder au recyclage il convient de voir précisément les domaines dans lesquels les lacunes sont effectives et les sages-femmes concernées.

- A réctifier : - P 11 les Aide-Infirmiers ne sont pas pris en compte dans les formations cliniques. Ils le sont en IEC plutôt.

- Ne convient-il pas de nuancer certains propos. Le fonctionnement des poupinelles serait-il inconnu de la totalité des sages-femmes? Y'aurait-il des problèmes liés à l'inadéquation du matériel?

.../...

- P23 - Si les données établies par les Sages-femmes des centres de PF ne sont pas parfois fiables, celles relevées annuellement par l'équipe nationale sont relativement fiables. Les tournées annuelles de l'équipe nationale sont l'occasion d'une remise en ordre dans les classements des fichiers et un décompte rigoureux des clientes en respectant la terminologie adoptée par le PSFP.

C) - Recherches biomédicales et psychosociales

La remarque fondamentale qu'il importe de faire par rapport à la partie recherche, c'est l'exclusivisme dans les conclusions. S'il importe de capitaliser et de mettre à profit l'ensemble des recherches réalisées, l'arrêt de toute activité de recherche serait préjudiciable aux programmes. Ces conclusions s'avèrent contradictoires avec les propositions de recherches formulées notamment dans la partie IEC-BNR et même Clinique.

D) - Gestion de la logistique contraceptive - Création d'un système de Gestion des informations PF

1. Achat des Produits Contraceptifs-

Avant d'en arriver à ce stade, il y a tout d'abord l'EXPRESSION DES BESOINS. Le document est muet là-dessus alors que cette étape semble fondamentale. En effet, l'on ne sait pas par quels critères ISTI exprime la quantité des besoins. En tout état de cause, les commandes sont le plus souvent très en dessus des besoins, du moins en ce qui concerne les préservatifs surtout. La commande d'un container d'abaisse-langue est illustrative à ce propos.

- Achat proprement dit :

.../...

Si cette étape est l'exclusivité de l'AID, il serait cependant intéressant que le Projet soit informé de la procèdure des commandes.

2. Expédition et Réception

a) - Expédition

Le Projet devrait être informé des différentes étapes de l'expédition. Ceci permettrait de prendre les dispositions pour informer à temps les différents membres de la commission de réception.

b) - Réception

La commission de réception est composée de ISTI, l'AID et du Projet contrairement à ce qui est dit dans le rapport.

Il y a lieu de bien clarifier la situation. Car au moment de la livraison, c'est l'agent de ISTI qui reçoit et signe les documents alors que c'est le Logisticien du Projet qui en est responsable. La commission est également amputée de l'IOF alors que la présence de ce dernier est obligatoire selon la règlementation du Ministère de la Santé Publique et de l'Action Sociale.

3. Système d'information sur la gestion des stocks

Il ne peut pas y avoir un système d'information fonctionnel si les agents chargés d'utiliser ces informations ne sont pas formés à cet effet et si également les moyens nécessaires au bon fonctionnement de leur travail quotidien ne sont pas mis à leur disposition.

Il faudrait également ajouter que pour une bonne circulation de l'information, le rôle des différents volets doit être clairement défini de manière à éviter les blocages et les empiètements.

.../...

- Statistiques :

- Veiller à la formation des agents chargés de la collecte des données statistiques afin d'éviter les multiples contradictions notées jusque là au niveau des cliniques après le passage des équipes chargées de la supervision.

D) - L'information, l'Education et la-Communication (IEC)

P.9 - L'évaluateur parle d'un taux relativement faible de volontaires formés. A ce propos, il importe de préciser que la formation des auxiliaires a réellement démarré en fin 1987 et s'est arrêtée debut 1990 du fait de la crise qui a traversé le Projet. Dans ce court laps de temps un nombre d'auxiliaires supérieurs aux objectifs initiaux ont été formés. Il ne faut également pas perdre de vue que l'objectif était de les former et de les rendre toutes opérationnelles avant d'en former d'autres.

- Dans tout le rapport, l'évaluation parle d'assistants sociaux quand il s'agit d'agents IEC. Une telle appellation peut prêter à confusion. Il y a lieu de rectifier P.11- 3è paragraphe à la fin, l'évaluateur parle du rôle d'intermédiaire que le Coordinateur Régional EPS peut jouer. En quoi cela consiste-t-il? Qui va concevoir, élaborer, mettre en oeuvre, évaluer, réajuster les programmes IEC? Avec quels moyens humains et matériels?

- P.16 - 2è paragraphe : il y a lieu de rappeler que la formation des formateurs a eu lieu à Rufisque et elle regroupait des responsables venus des régions parmi lesquels des Inspecteurs d'Animation, des Maîtresses d'Economie Familiale, des Sages-femmes, des Assistants Sociaux, des Monitrices.

- P.17 - 2è paragraphe : En réalité la pré-campagne a duré 45 J au lieu de 15 et il n'y a pas eu de diffusion à la télévision.

- P.21 - 3è paragraphe : FAgaru et Dundu Jaboot n'ont pas été rediffusés.

- P.31 -2è paragraphe : Cette suggestion de l'évaluateur pourrait aider le Projet à contourner les difficultés liées à l'insuffisance du personnel IEC. L'appui sur les auxiliaires nous serait d'une grande utilité.

- P.32 - 2è paragraphe : Parler de rémunération quand il s'agit de volontaire est inapproprié. Peut-être faudrait-il parler de motivation.

- P.34 - 2è paragraphe : quand l'évaluateur dit que le personnel IEC pense que les volontaires sont mal répartis, il y a lieu de préciser que toutes les formations ont été munitieusement planifiées. Des objectifs ont été fixés compte tenu de plusieurs critères et les formations se sont tenues en fonction de ces objectifs.

- P.38 : M. Parlato réprend à son compte les affirmations contradictoires de M. Delanoé qui dit que d'une part les acteurs ont été laissés à eux-mêmes et d'autre part que les programmes médiats étaient excellents et gagneraient à être diffusés.

- P.40 : Ce n'est pas indiqué dans le document du Projet qu'il devrait y avoir une collaboration avec l'URTNA. C'est dans le cadre du développement des programmes que cette collaboration a été amorcée.

- P.45 : Concernant les affiches, leur utilité a été démontrée dans le cadre du Projet. Des demandes nombreuses parviennent au Projet du SENEGAL et de l'Etranger. Le matériel publicitaire en général, vise d'abord à susciter l'intérêt.
Est-il prouvé que le matériel publicitaire et les affiches soient d'une faible rentabilité coût/efficacité? De plus, comme M. Delanoé a eu à le remarquer, les auxiliaires utilisent les affiches de manière créative pour la communication

interpersonnelle lors des causeries. Par rapport aux boîtes à images et autres flanellographes, les affiches présentent l'avantage d'être légères à transporter et aussi de coûter moins chères.

- P.48 : En réalité les volontaires non-rémunérés, pour la plupart analphabètes n'ont pas de fiches à remplir.

- P.48 : Pour le moment, les volontaires au niveau de la communauté ne distribuent, ni ne vendent les produits contraceptifs.

- P.49 : Les propos selon lesquels, il y eu très peu de recherche opérationnelle dans le Projet sont en contradiction avec les conclusions de la partie recherche. Cependant, l'idée d'une étude sur le système de volontariat est excellente.

- P.50 : L'UNICOM est chargé de coordonner l'ensemble des activités IEC/Population et non pas l'ensemble des activités IEC/PF. Il demeure que l'intégration des deux domaines pose encore problème .

E) - Projets d'Accompagnement (WID)

Nous regrettons que l'équipe d'évaluation ne se soit pas adressée directement aux personnes chargées des activités WID.
C'est peut-être ce qui explique que Raditz soit mis au premier plan et l'absence de recommandations particulières dans le sens d'aider au développement du volet WID. Raditz dans ses termes de référence avait-il les mêmes objectifs que l'équipe d'évaluation?
Compte tenu de la place du volet WID dans la stratégie de développement et de pérennisation des actions PF, il s'avère nécessaire de redonner à ce volet toute son importance que ne semble pas refléter l'Annexe V classant les volets prioritaires pour le nouveau Projet. Il conviendrait en outre de mettre en exergue les différentes contraintes qui ont gêné son développement, partant, faire les recommandations y relatives.

F) - Administration et Gestion du Projet
Assistance Technique

Cette partie du travail de l'Equipe d'évaluation portant sur 2 chapîtres : l'Administration et la Gestion du Projet de même que l'assistance technique est d'une grande importance parce que conditionnant pour une très large part l'efficacité de l'action et le bon déroulement des programmes. La lecture du texte suscite un certain nombre de remarques ou observations générales et spécifiques nécessitant parfois quelques commentaires pour confirmer ou infirmer certains propos de l'auteur.

Observations Générales-

1) - Au plan de la forme, le texte axé sur l'Administration et la Gestion du Projet articulé autour de (5) principaux axes (Buts, Description, Analyse et Evaluation,Constations, Recommandations) paraît bien long dans sa partie descriptive. Mais peut-être, cela était-il nécessaire afin de mieux appréhender le Projet dans son fonctionnement en tant qu'entité et dans ses interelations avec l'environnement global. En tout état de cause, certains développements (par ex : P.23 cadre juridique de la contrepartie sénégalaise, description résumée du système de gestion) malgré le souci pédagogique certain auraient pu allèger le texte.

2) - Plus généralement, l'on peut noter un déséquilibre frappant entre les multiples constats du chapître "Administration et Gestion du Projet" et les recommandations qui en découlent. D'importants constats sont faits relatifs à la coordination du Projet, au recours par le bailleur à des structures de décisions parallèles,à l'accaparement par ISTI des tâches de détermination des priorités et planification des activités, de gestion financière etc. De tels constats devraient se traduire en recommandations spécifiques. Au demeurant, ces recommandations paraissent inachevées. la dernière ligne de la dernière page (... s'assurer que les procèdures internes de mobilisation et...) reste sans suite et cède la place au chapître K contenant 5 recommandations.

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3) - A l'inverse, le chapître relatif à l'assistance technique, malgré son développement relativement faible,formule de multiples recommandations dont certaines pourraient être reliées au chapître portant sur l'Administration et la Gestion.
En conséquence, la fusion des 2 chapîtres en un seul, et le regroupement des recommandations résorberaient en partie le déséquilibre constaté.

4) - La recommandation à l'adresse du GDS visant à augmenter le soutien fourni par les bénéficiaires et la contribution du secteur privé pour allèger au maximum le secteur public, s'avère opportune. Cependant, elle est sans lien avec les développements ou constats antérieurs.

5) - Certains problèmes de coordination du reste réels, internes au MSPAS et qui font l'objet du point 1 "Analyse des aspects administratifs (P.27 - 30)" devrait suggérer une recommandation à l'adresse du MSPAS.
La définition d'un organigramme qui clarifierait les attributions des uns et autres. Il va sans dire que cet organigramme devra être élaboré dans la perspective de la mise en place du PNPF.

6) - Les appréciations concernant l'assistance technique méritent que l'on s'y attarde. En effet, selon l'évaluateur 35 % de la Subvention est consacrée à l'assistance technique. A travers le compte ISTI (au lieu du compte local) qui regroupe l'assistance technique, la formation extérieure, les achats extérieurs, elle représente plus de 50 %. Cela s'avère énorme et renforce sa proposition quant à la définition d'un plan de relève de l'assistance technique. Des indications sur la démarche à entreprendre sont énoncées dans la recommandation relative au transfert des compétences. En tout état de cause, les appréciations sur l'assistance technique devraient aider dans la définition du nouveau Projet d'autant plus que malgré son coût élevé, l'efficacité de l'Assistance Technique du Projet est plus que douteuse.

.../...

7) - Globalement, les recommandations appelent les observations ci-après :

- Les rapports issus de séjours de consultants devront obligatoirement être transmis non seulement au Directeur Technique du Projet et au DSP mais également au Directeur du Projet.

- Le manuel de procèdures dont il est proposé la ré-écriture a été déjà signé.

- La recommandation selon laquelle "les procèdures de préparation des budgets et de définition des responsabilités devraient être plus spécifiques" mérite d'être clarifiée.

. Observations spécifiques-

- P.1. : Organisation administrative du Projet. L'arrêté portant création du Projet annoncé en annexe n'y figure pas.

- P.2. : Personnel composant la Direction du Projet.
Préciser un Directeur Adjoint également chargé de la supervision du Bureau Administratif et Financier (BAF) qui est Inspecteur de l'Animation.

- P.2. : Environnement du Projet : les partenaires. Parmi les partenaires il convient d'ajouter le Ministère de l'Urbanisme et de l'Habitat. Les divisions régionales de l'Urbanisme et de l'Habitat ont grandement contribué à la bonne exécution du programme de construction et rénovation.

- P.8. : Le BNR n'est pas une direction mais une division (Division des Statistiques Démographiques) de la Direction de la Prévision et de la Statistique.

- P.11 : La SMI/PF

Le rôle du Directeur Technique du Projet a fait l'objet d'une description précise des tâches dans le cadre du PSFP.

.../...

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- P.11 : La Coordination au sein du Projet.
Les tâches du Directeur Technique sont également bien définies.

- P.14 : Coordination avec le niveau central.
Le Projet a bien requis l'appui des DAGE (ex-MDS et MSPAS) pour la mobilisation des fonds de contrepartie.

La Coordination avec les bailleurs.

Au moment de la signature de l'accord de subvention; il existait bien un cadre institutionnel malgré les inconhérences.
La mise en oeuvre du Programme National de PF devrait permettre la définition d'un cadre institutionnel cohérent.

- P.15 : Le processus de planification décrit et basé sur la concertation des acteurs mériterait d'être traduit en recommandations. Cette concertation s'avère capitale dans les relations entre ISTI et le PSFP.

- P.22 : Les dernières dispositions du manuel de procèdures prévoient que le Projet soit membre de la commission de dépouillement.

- P.26 : Est-il nécessaire d'indiquer que la restructuration bancaire s'est faite sous la pression du FMI?

- P.33 : 1er paragraphe : Il n'est pas prévu l'achat de voitures par le Gouvernement du SENEGAL. En outre le déclin du Projet comme l'affirme l'auteur n'est pas dû au manque de ressources du G.D.S. Il y a lieu de nuancer une telle affirmation.

- La liste annoncée concernant les ressources humaines ne figure pas en annexe.

- P.3 Chap- Assistance technique : Il n'y a jamais eu de vacance du poste de Directeur du PSFP.

.../...

I) - Volets Secteur Privé et Para-Public-

- L'évaluateur IEC n'a pas eu le temps de se pencher réellement sur ce volet.

- Cependant, le volet Clinique souligne ici encore hormis l'opérationnalité des locaux les mêmes problèmes que dans le secteur public.

- L'expérience VSPP s'est avéré intéressante, mais il reste à voir comment amener progressivement, le secteur privé à se prendre en charge et participer aussi plus activement encore au développement de la PF au Sénégal.

G) - Bureau National du Recensement-

L'objectif assigné à ce volet est d'améliorer la base de données démographiques pour faciliter l'intégration de la variable démographique dans la planification du développement. Des acquis certains existent dans ce domaine.

En ce qui concerne l'articulation avec le volet Planification Familiale, elle aurait pu se faire à travers la recherche opérationnelle, la rationalisation du recueil de données dans les cliniques, la saisie informatique et l'exploitation des statistiques. Malheureusement, il n'y a pas eu de communication entre les différents volets du PSFP,ISTI étant leur seul interlocuteur qui se contentait de centraliser l'information sans la faire circuler. Ceci a certes renforcé le pouvoir de ISTI, mais au détriment de l'efficacité du programme. Il faut aussi dire qu'apparement les différents partenaires sénégalais n'ont pas cherché à établir le contact entre eux. La structure proposée par l'évaluateur pour aider à une meilleure

.../...

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gestion de l'information du Projet est bonne. La SMI étant un secteur prioritaire de la santé, l'existence d'une unité propre n'est pas un luxe mais une nécessité, étant bien entendu qu'il s'agira d'un sous système du système global d'information sanitaire du MSPAS.

Mme Marième DIOP

ANNEX O-3

Dr. Ibra N'Doye, Director, MPHSA, STD/AIDS

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REPUBLIQUE DU SENEGAL

MINISTERE DE LA SANTE PUBLIQUE
ET DE L'ACTION SOCIALE

COMITE NATIONAL
PLURIDISCIPLINAIRE DE PREVENTION
DU SIDA

N° 001451

Dakar, le 22 AOUT 1991

Le Secrétaire Général
Coordonnateur du Programme Sida

à

Date Rec'd 22 AOUT 1991
MRN 3165
Action Taken .....
Date .....
Signature .....

Linda

Madame,

Vous trouverez ci-joint une copie de nos commentaires sur le Rapport de la Mission d'Evaluation du Projet Santé Familiale et Population, en attendant que le Directeur de la Santé vous transmette l'original.

Salutations.

Docteur Ibra NDOYE

COMITE NATIONAL
PLURIDISCIPLINAIRE DE
PREVENTION DU SIDA
Le Secrétaire Général

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SYST
ASU
MP
RIG
EMB
CHRON

Mme Mary Ann Micka
Chef du Bureau Santé
USAID
D A K A R

COMMENTAIRES SUR LES RECOMMANDATIONS DU RAPPORT DE LA MISSION D'EVALUATION DU PROJET SANTE FAMILIALE ET POPULATION

*****

I. D'ORDRE GENERAL,

Dans un souci de coordination et d'efficacité, il est souhaitable que les activités de lutte contre les MST dans les centres de planning familial "Formation, Services cliniques, laboratoires, etc... se conforment aux objectifs définis dans le Programme National de Lutte contre les MST et le SIDA et ne devront plus être exécutées dans le futur de manière verticale à l'intérieur du Programme de planification familiale.

A CE PROPOS

1. La lutte contre les MST et la stérilité doit rester un sous objectif intégré dans toutes les structures de planning familiale telle qu'il est défini dans la politique gouvernementale de planification familiale.

2. Les activités de lutte contre les MST dans les centres de planning familial "Système d'information - Formation - IEC - prestations cliniques et de laboratoire" devront dépendre du même système de coordination et de supervision nationale, régionale, départementale défini dans le Programme National de Lutte contre les MST et le SIDA.

AID-

II. D'ORDRE SPECIFIQUE

Sur le Plan de l'IEC

l'IEC sur le SIDA devra être intégrée dans l'IEC (PF/MST) car les programmes nationaux de planification familiale et MST/SIDA ont
la même cible : la population en âge sexuelle active d'où une harmonisation des activités IEC et de prévention (préservatifs) entre ces 2 programmes.

Sur le Plan de la Gestion

Il serait important avant de faire les commandes sur les matériels cliniques, de laboratoire et les médicaments que les responsables des programmes de planification familiale fassent appel à des compétences techniques dont bénéficie le Programme MST/SIDA concernant les services en MST.

Ceci éviterait l'automatisme gestionnaire et des erreurs dans les commandes des produits MST.

Le Coordonnateur du
Programme MST/SIDA

Docteur Ibra NDOYE

ANNEX O-4

Vivian Toro, U.S. Bureau of the Census

7/16/91

COMMENTS ON DRAFT OF EVALUATION REPORT ON THE SENEGAL FAMILY HEALTH AND POPULATION PROJECT (Chapter VII.)

by
Vivian Toro
U.S. Bureau of the Census

GENERAL COMMENTS

Senegal was one of the first African countries to use microcomputers to successfully process their census. This was due to the great commitment of the Senegalese working at the Bureau Informatique and the support received by the BNR staff. However, the Senegalese would not have been able to do this without the financial support provided by USAID through the Family Health and Population project in the form of resources, training and technical assistance. This included the participation of the U.S. Bureau of the Census.

In spite of the many difficulties that have been and are still being encountered, the Senegalese have already improved their performance as compared to their 1976 census. It was not until 1981, 5 years after the data were collected, that the tabulations were made available. (This did not include demographic analysis which was done in subsequent years). For the current census, the BI tabulated the data based on a 10 percent sample by the Summer of 1989. The BNR published the report based on these data in November of 1990. The BI started to make available in the Summer of 1989 the tabulated data based on the 100 percent data by region. The BNR staff is still reviewing the tabulations and indicating desired changes. The BNR demographers are using these regional tabulations for demographic analysis. A census data dissemination seminar is scheduled for the Winter of 1991, 3 1/2 years after the data were collected. Additionally, the BNR conducted a Post-Enumeration Survey to measure census content and coverage. Most of the analysis of this analysis has been completed. The Post-Enumeration Survey conducted during the 1976 census was never processed or analysed.

The U.S. Bureau of the Census found the BNR and BI staff to be well intentioned, taking professional pride in their work, and having a good overall level of expertise. (It should be pointed out that the BI is a separate entity from the BNR. The BI is at the same administrative level as the BNR under the direction of the Direction de la Prevision et de la Statistique. The BI was responsible for receiving, coding, keying and processing the census data).

However, the BNR and, to a lesser extent, the BI staff were handicapped by poor organizational habits, unavailability of clearly defined priorities, lack of effective coordination, and low motivation due to low salaries and/or limited career advancement possibilities. This had a direct impact on the processing, analysis, and the dissemination of the census data. The generally accepted practice of doing other paying jobs during work hours such as teaching, consultancies, and assistance to researchers had a direct effect on the delays in obtaining census results.

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The Senegalese statistical office is often considered one of the more mature statistical offices in West Africa. Nevertheless, other West African countries have been able to conduct successful and more timely censuses with more limited resources and expertise. This might be an appropriate time for the Senegalese statistical office to reflect on how to maximize some of the resources that they already have such as higher levels of education, more practical experience, a more stable staff, and a longer history of statistical gathering and analysis.

Additionally, the current administrative structure is not conducive to producing the most effective or efficient results. The responsibilities of the Director of the Direction de la Prevision et de la Statistique (DPS) are so many that they preclude a more active management of the BNR and BI activities. Additionally, the physical distance of the DPS, BNR, and BI buildings (coupled with unreliable, limited, or non-existent telephone lines) makes the coordination of day-to-day activities difficult. It had a direct effect on the coordination of the population census activities.

The support given to the U.S. Bureau of the Census by the International Science and Technology Institute (ISTI) both in Dakar and Washington, has been excellent throughout the duration of the project.

SPECIFIC COMMENTS

Chapter VII.

p.2 B. Description of Component Activities

In the introductory chapter that follows this title and throughout the document there is no reference to the Bureau Informatique (BI) and its key role in the processing of the census data. The BI is at the same administrative level as the BNR. They are both under the direction of the DPS (formerly Direction de la Statistique (DS)). The BI was responsible for the data entry and processing activities as well as the production of the data base that contains the geographic codes, names and housing and population counts for the census. It was in the BI building were the questionnaires were received and coded. They are still stored there.

Senegal was one of the first African countries to use microcomputers to successfully process their census. The BI tabulated the data based on a 10 percent sample by the Summer of 1989. The BNR published the report based on these data in November 1990. The BI started to make available in the Summer of 1989 the tabulated results based on the 100 percent data by region. Unfortunately, these tabulations were not reviewed by the BNR staff until June 1990. The specified changes were incorporated into the tabulation programs. The BNR demographers are using these regional tabulations for demographic analysis. A census data dissemination seminar is scheduled for the Winter of 1991. If this schedule is retained, this will be a significant improvement over the availability of the 1976 census tabulations in 1981, 5 years after the data were collected. This did not include demographic analysis which was done in subsequent years.

The coordination of technical assistance trips by the U.S. Bureau of the Census to assist the BI were well coordinated and timely.

p.3 B.3.a. It would be useful to define what in the context of this report is considered a demographic data base (line 8). Does an actual data base using database software packages such as dBASE exist? If so in which office? Are you just referring to compiling related information and having access to it? Are there explicit plans to arrive at this stage?

p.4 B.4. Technical Assistance

technical assistance to the BNR provided - add "BNR and BI"

p.5 B.4 1986 (see attached sheets summarizing USBUCEN TA)

Two planning TA ..... (USBUCEN) - change to "One planning trip to Dakar ..."

Add "On-the-job training at the U.S. Bureau of the Census in Washington, D.C. for 2 BI data processors."

1987

Two Technical Assistance ..... (USBUCEN) - change two to four

1989

Five Technical ..... : data processing, PES, master frame sample design - change five to four technical assistance and eliminate "master frame sample design".

Principal Results of the 1988 census ... - should read "Preliminary Results based on manual counts of the 1988 .....".

1990

Four Technical Assistance trips ... (USBUCEN); introduction ... and CENTS 4. - replace four with six and replace "introduction ..." with "data processing, thematic mapping, PES, master sample design."

Birane Ndao of BNR/BI/DPS ..... - should read "Birane Ndao and Thiecouta Ndiaye...".

Add "Work-study visit of a statistician from the BNR to prepare to co-teach with a statistician from the U.S. Bureau of the Census a seminar in Data Presentation Techniques."

In-country seminar .... from DPS. - add "It was co-taught by the U.S. Bureau of the Census and a statistician from the BNR".

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1991

"Three Technical Assistance trips ...." - should read "Three technical assistance trips to Dakar for the 1988 Census of Senegal (USBUCEN). Two of them from a data processing advisor in January and June and one form a Mathematical Statistician. The purposes of these trips were to obtain final census tabulations, to assist in implementing the master sample design and the final coverage and content PES tabulations, and to assist with the IMPS (software) applications for ESAM."

FYI: IMPS stands for Integrated Microcomputer Processing System.

Eliminate "Work study visit to BUCEN by Bureau Informatique ..... (ESAM). This was financed by the World Bank.

All activities beginning and following "Work study visits to BUCEN by two DED staff members for demographic analysis...." are planned; they have not taken place.

BUCEN statistician and data processing ... 1. Data users .... 2. IMPS ... 3. statistical ... - should read "BUCEN statisticians to prsent three workshops at DPS: 1. Data users and producers workshop (concerning census data dissemination); and 2. statistical analysis workshop with emphasis on the 1988 census data.

Add "U.S. Bureau of the Census Statistician/Demographer to provide technical assistance to the DPS in establishing a database on women's statistics using the census data."

Eliminate "Two staff are scheduled for short-term training at the U.S. BUCEN in 1991"

p.9 B.6.a.

16 census reports - Which ones? It is somewhat misleading to say there are 16 census reports. The two that are published and available to the public at large are: "Resultats Preliminaires" (September 1988) and "Le principaux resultats provisoires" (Decembre 1989). If anything else is available please specify how the census data were used. If only the total number of households and persons for a particular region or village was used, those reports should be classified as something other than census reports.

B.6.b. Training

reference to BNR/DPS - should read BNR/BI/DPS.

BNR Training - should read BNR/BI training.

p.10 B.6.c.

1. "U.S. Burea of the Census ..." - "21 missions to BNR/Dakar" should be replaced with "31 missions (including TA trips, on-the-job-training and formal training)...."

"Techical Assistance Activities provided ...." - "to BNR by the U.S..." should read "to BNR and BI by the U.S...". For the actual list of activities refer to the attached summary list of TA provided by the U.S. Bureau of the Census. Otherwise, the existing list would require the following modifications:

3. Edit and tabulation specifications

4. Data Processing Systems Design, Training, and Programming Support (in-country and in Washington, D.C.)

7. Revise Computer Programs and Present CONCOR work-study.

11. Assistance with the Planning, Data Processing and Evaluation of the Post-Enumeration Survey Results.

13. Thematic Mapping Training

Note: Technical assistance was provided by the U.S. Bureau of the Census in cartography. This assistance was funded by USAID/Dakar under a separate project.

p. 16

"There appeared to be some overlap in the tasks performed by the U.S. BUCEN staff and the demographic consultant (i.e., the demographic consultant contributed a good deal to the design of the census tabulation plan although not originally included in his scope of work)."

A few facts to clarify the issue related to Charbit's occasional census tasks which were complementary to the assistance provided by the U.S. Bureau of the Census. As a matter of fact, he was conscientious enough to do the work that the BNR was supposed to accomplish because he understood that not accomplishing them would seriously delay the data processing activities. This task was the development of detailed tabulation specifications. The U.S. Bureau of the Census staff, in consultation with the BNR staff, developed a tabulation plan on December 1985. This consisted of a basic list of table titles. In order to write the table programs, the BNR staff had to develop more detailed table specifications. In spite of repeated requests, the BNR had not developed these specifications, therefore, Charbit, volunteered to develop these specifications for the BNR. The specifications were clear and timely, and allowed the BI staff to start developing the computer programs. However, the design of the tabulation plan had already been done by the U.S. Bureau of the Census in consultation with the BNR in December 1985. Charbit also participated in the final discussions related to the census questionnaire

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in January 1986. The bulk of the questionnaire had been developed during a Bureau of the Census visit in December 1985. In conclusion, Mr. Charbit's input was welcomed, timely and complementary to the tasks performed by the U.S. Bureau of the Census. In some instances, he did the work that otherwise the BNR should have accomplished.

).16 "BNR and U.S. BUCEN planning and preparation for the TA visits of U.S. BUCEN consultants to BNR were often insufficient, leading to inefficient use of TA's time during BNR visits."

The phrasing of this sentence is somewhat confusing. It is not clear who's planning and preparation for TA's was insufficient, the BNR or the U.S. Bureau of the Census, or both?. From the discussion with Irving Rosenthal, the sentence is meant to indicate that the BNR was responsible for the lack of preparation. As a matter of fact, the U.S. Bureau of the Census staff grew impatient with the cycle of verifying the status of the activities the BNR was supposed to have accomplished before the proposed trip, the BNR assuring the U.S. Bureau of the Census that they had been accomplished, and then finding out upon arrival to Dakar that they had not been accomplished. This was particularly true for the development of edit and tabulation specifications, the review of table outputs, and the Post-Enumeration Survey.

However, this was not the case with the trips from the U.S. Bureau of the Census to assist the BI. As a matter of fact, the BI was able to enter, edit and tabulate the census data for the 10 percent by Summer 1989 and the 100 percent in early 1990.

p.16 "Data is not exchanged among project components."

The U.S. Bureau of the Census is in total agreement with this statement. Not only are data not exchanged among project components but with other data users. Like many other African statistical offices, the DPS/BNR/BI have concentrated their efforts in collecting and processing data. Sometimes the tabulation of these data would take years to obtain; sometimes never. Technological developments have allowed the tabulated data to be available much faster. Statistical offices are getting used to their new roles as data disseminators. The DPS/BNR/BI is no exception. They need to establish a unit or group of persons that can take care of disseminating data on a full time basis. This includes presenting these data so that it is easily understood by persons of different backgrounds, particularly, policy makers. Additionally, this includes informing the user's about the availability of these data.

p. 23 # 6. See previous comment on this sentence.

p. 23 # 7. "During the Project period the BNR had four (4) different Directors and undergone a number of reorganizations which has disrupted the continuity and coherence of the BNR volet of the Project."

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This is indeed the case and it raises an even larger issue relating to the organizational structure of the DPS/BNR/BI. First, although the chief of the BNR and the BI both report to the Director of the DPS, the Director is occupied with many other responsibilities, limiting the amount of time dedicated to the closer coordination and guidance of the BNR and BI activities. Furthermore, the three organizations are physically in separate buildings that are miles apart. This makes the coordination of day-to-day activities hard and time-consuming, particularly between the BNR and the BI.

p. 25 #2. "We recommend that adequate funds be allocated for the full exploitation and analysis of the ....."

The U.S. Bureau of the Census recommends the inclusion of dissemination in addition to the exploitation and analysis of data.

p. 26 #5. "The team recommends that the BNR director and Division Heads at the BNR receive training in management procedures ..."

The U.S. Bureau of the Census fully agrees with this recommendation. The BI staff should also be included.

p. 27 #7. "We recommend that training in ..."

The U.S. Bureau of the Census also recommends training in data use and dissemination.

p. 27 #8 "We recommend a reduction in the proportion of Project financial support for the technical assistance for the 1998 Census of Senegal during the 1992-1997 period (assuming that TA needs for 1998 census will not be as great until the census year 1998 and that funds ....)

The U.S. Bureau of the Census disagrees with the assumption that TA needs will not be great until the census year 1998. Based on our experience, planning for a national census should start at least 2 1/2 years before the actual enumeration. This includes planning and preparation, consultation with data users, questionnaire design and table outlines, the development of computer programs and, especially, mapping. Substantial funds are needed for training, staff, computers, etc. before 1998.

"Better planning is needed ..."

See comments on similar sentence above.

CLARIFICATION OF COMMENT BY YVES CHARBIT

On the annex to Charbit's trip report dated June 17, 1991, a remark made in section 3.1 needs clarification. The example Charbit uses to underline his remark about long-term training and its impact on project was not appropriate. In French it reads: "Un exemple precis est fourni par l'envoi en formation longue duree ses deux responsable du Bureau Informatique. Leurs remplacants sont incapables de repondre aux demandes de tableaux du recensement faites par le BNR, d'ou des retards dans l'analyse des donnees du recensement." In English it reads: "A specific example is the sending of 2 staff members of the Bureau Informatique for long-term training. Their replacements are incapable of responding to the requests for tabulations made by the BNR, which has caused delays in the analysis of the census data."

It is necessary to clarify the issue regarding delays in the analysis of the census data. These delays were NOT caused by the current staff at the Bureau Informatique being incapable of producing the tabulations requested by the BNR. The tabulations based on the 100 percent census data were made available by region starting in the Summer of 1989. The BNR staff was asked to review these tables for inconsistencies, elimination or addition of tables, and cosmetic changes. This is a standard cycle of the verification of table outputs. It is desirable to do it as soon as the tables for the first region appear so that resources are not wasted in processing the other regions. The national level tables are not necessary at this stage. The BNR staff was repeatedly asked to review these tables by the BI staff and the U.S. Bureau of the Census. It was not until June 1990, a year later, that the BNR indicated the changes to the tabulations, at the insistance of a U.S. Bureau of the Census staff member on mission to Dakar. In the meantime, the BI staff continued to produce the tables by region.

By early 1990, when the 2 data processors were scheduled to leave to receive long-term training, the tabulations for 6 regions were available. One of the data processors has been working for the BI for 20 years and had been responsible for the data entry activities of two censuses and numerous surveys. The other has been working for the BI since graduating from college. For this person, one of the main motivations for receiving additional training is to formally receive a higher classification for the supervisory work performed for at least 4 years without formal classification and corresponding salary increase. Out of the 5 data processors that started with the census activities in 1985, only these two stayed until the tabulations were made available in 1990; that is, 5 years of commitment to the census processing activities. Before their departure, they trained staff to finish the remaining work. This included the person in charge of the tabulations. Additionally, the replacement has since then worked with staff from the U.S. Bureau of the Census and received additional training in the use of the software. The U.S. Bureau of the Census finds that person to be very capable of producing the tabulations and has shown his capability by actually producing them. On the other hand, this person has been working on the census tabulations only on a part-time basis because of conflicting priorities with other surveys. Additionally, the processing has been hampered by computer failures and repairs. It was not until April 1991 that the comments on the re-executed tabulation outputs were received from the BNR.

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In conclusion, the above facts show that the example used by Charbit is not accurate or representative of the point he is trying to make. The U.S. Bureau of the Census does agree with the point being made by Charbit but strongly disagrees with the example.

ANNEX O-5

Yves Charbit, Principal Consultant

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Tim ROSCHE et Linda LANKENAU m'ont transmis certains chapitres du Rapport de la mission d'évaluation du PSPF, dont celui sur la démographie. A la demande de Mary-Ann MICKA, j'ai rédigé les commentaires suivants et j'ai fait des propositions sur le Programme de travail du BNR jusqu'en septembre 1992 et sur les besoins en jours de consultation jusqu'en septembre 1992 (voir annexe).

Par ailleurs, j'ai rencontré Julius COLES, Directeur de l'USAID, pour lui expliquer l'ensemble des activités en démographie dans le cadre du PSPF. Il m'a demandé de faire des propostions sur ce que l'USAID pourrait appuyer comme activités dans le domaine de la démographie dans les années à venir.

IX- DIVERS

Au cours de ma mission, j'ai eu diverses réunions de travail:

- avec Mari CLARK, consultante de passage à Dakar, à qui j'ai transmis le texte sur la condition féminine réalisé à partir des données du recensement.
- avec Charles BECKER et Valérie DELAUNAY (programme Niakhar de l'ORSTOM).
- avec Michelle LEWIS (FHI) qui va peut-être faire une étude sur le SIDA à Kaolack. Je vais mettre Michelle LEWIS en contact avec Myriam de LOENZIEN, car les thèmes sont proches.

ANNEXE:
COMMENTAIRES SUR LE CHAPITRE VII DE LA MISSION D'EVALUATION DU PSPF

DAKAR, LE 17 JUIN 1991

AUTEUR: YVES CHARBIT
DESTINATAIRES : M.A. MICKA, L. LANKENAU
COPIES: M . DIOP, T. ROSCHE, I. SARR

NOTE POUR L'USAID
SUR LES ACTIVITES DU BNR DANS LE CADRE DU PSPF

Cette note comprend trois parties:
1/ Commentaires sur le chapitre 7 de la mission d'évaluation du PSFP
2/ Programme de travail du BNR jusqu'en septembre 1992
3/ Evaluation des besoins en jours de consultation jusqu'en septembre 1992

I/ COMMENTAIRES SUR LE CHAPITRE VII (RELATIF AU BNR) DE LA MISSION D'EVALUATION DU PSFP

Le chapitre VII du rapport d'évaluation du volet BNR présente assez fidèlement les activités du BNR du point de vue de sa contribution au Projet Santé Familiale et Population, mais il sous-estime un objectif important de ce volet BNR, à savoir le renforcement institutionnel du BNR. Je ne traiterai pas ici des activités de valorisation et de dissémination (voir p. 3: Training of Development Planners and Policy Makers), qui n'entraient pas dans mes responsabilités de consultant.

1/ La stratégie du volet BNR: soutien au PSFP et amélioration de la base de données

1.1/ Le rapport ne donne pas assez d'importance à un objectif essentiel du volet BNR: "The data base improvement". Il se situe trop strictement dans une évaluation de la contribution du BNR à la mesure des progrès de la PF au Sénégal. En tant que démographe, Tom KANE sait parfaitement qu'une institution comme le BNR a d'abord comme fonction de collecter et d'analyser des données afin de fournir les bases pour les programmes d'action futurs. Si le BNR avait eu pour seule mission de servir de soutien au PSFP, alors pourquoi avoir financé le recensement?

1.2/ L'utilité d'une approche large, en termes de "data base improvement" est certaine.

1.2.1/ Par exemple, sur le conseil de Mary Ann MICKA, j'ai rencontré le 14 juin Mary CLARK, en mission de l'USAID à Dakar. J'ai pu lui remettre toute une étude sur la condition des femmes réalisée avec les données du recensement, grâce à l'appui du FNUAP et de l'USAID. Cette étude est la seule disponible pour le programme de l'USAID sur la condition des femmes. Or cette étude résulte d'une initiative personnelle: susciter des analyses et des travaux de recherche sur les données des enquêtes et du recensement. Ces travaux de recherche sont réalisés par les chercheurs sénégalais du BNR mais aussi par des chercheurs appartenant à d'autres structures. C'est aussi une façon de valoriser les Ph.D faits aux USA et financés par le PSFP. Il en résultera un livre de synthèse sur l'ensemble de ces travaux (parution prévue en 1992), qui sera très utile au moment où tout le monde parle de la nécessité d'une approche large des questions démographiques, en termes de "population et développement". *C'est pour cela que je suis d'accord avec la recommandation n° 2 (p. 25) de donner une priorité à l'analyse des données existantes.* Je répète ceci dans tous mes rapports de mission et j'ai signalé dès 1988 à Dennis BAKER que l'USAID aurait du prévoir des fonds pour l'analyse des données.

1.2.2/ Dans cette perspective, j'ai dès 1986 obtenu de la Fondation Ford des fonds pour l'analyse. Ensuite, j'ai progressivement impliqué le FNUAP, l'OMS et la France. J'ai d'ailleurs préparé en 1990 une note dite 'leverage' pour Mary Ann MICKA, que j'ai donnée à Tom KANE. Le rapport ne parle pas de cette contribution.

2/ Mon rôle de consultant

Ceci conduit le rapport à sous-estimer le rôle que j'ai joué comme consultant. Rappelons d'abord les termes de référence de mon contrat:

"Compte tenu du nombre, de la qualification et de l'expérience des cadres sénégalais chargés de la conduite des travaux d'exécution du "Volet BNR", il n'est pas prévu de recruter un expert-résident. Toutefois, un coordonnateur désigné par l'USAID, avec l'accord du BNR, sera chargé d'assurer le suivi de l'exécution des travaux sur les plans scientifique et technique. Les principales tâches du coordonnateur seront :- aider le responsable du "Volet BNR" à l'élaboration du programme scientifique et au suivi de son exécution ;- assister les cadres nationaux au moment de la conception, de la préparation technique de leurs recherches et de la rédaction de leurs rapports d'analyse; - procéder tous les ans, pour le compte de l'USAID, à l'évaluation de l'état d'avancement des travaux d'exécution du "Volet BNR" et formuler des recommandations quant à la poursuite des activités qui ont été programmées."

La note dite 'Institutional building of the BNR', que j'ai également préparée en 1990 pour Mary Ann MICKA, et qui a été transmise à Tom KANE, fait le point sur ce rôle que j'ai joué. Le rapport ne parle pas de cette note et n'en a visiblement pas tenu compte.

Parmi les points importants, il faut signaler l'organisation de voyages d'études à l'Institut National d'Etudes Démographiques (à Paris) de brève durée (3 mois), pour que les cadres du BNR puissent se consacrer de manière intensive à l'atravail liée aux départs.

Depuis 1990, il en résulte pour moi une charge supplémentaire de travail de follow-up à Paris entre les missions à Dakar.

Compte tenu de tous ces éléments, les recommandations faites concernant le profil du 'demographic technical consultant' sont contradictoires avec la recommandation n°2 (voir p. 28). Il faut au contraire quelqu'un capable de valoriser des données très diverses dans des domaines d'analyse démographique très variés, sauf si l'on considère que le BNR doit seulement être utilisé pour aider le PSFP.

Il s'agit d'un choix stratégique. Mais si cette deuxième option est retenue, alors il est contradictoire de proposer (p. 26) en même temps de créer une "Statistical Research and Evaluation Unit", qui ferait exactement le même travail au PSPF ou au Ministère dela Santé.

3/ Le fonctionnement du BNR

3.1/ La difficulté à laquelle j'ai été confronté, comme le BUCENS d'ailleurs, est la surcharge de travail du BNR et la mobilité très élevée de ses cadres. *Tom KANE a raison de souligner la tendance du BNR à accepter plus de responsabilités qu'il ne peut réellement en assumer, et par conséquent à être toujours en retard par rapport au planning prévu.*

Mais il faut faire la part de deux facteurs dont le BNR n'est pas directement responsable:

a) l'existence de trois systèmes de régles de fonctionnement administratif (ISTI, USAID, Administration sénégalaise) a beaucoup compliqué les choses.

b) il y a une contradiction fondamentale dans le volet BNR du projet PSFP. La charge de travail initialement prévue correspondait à un effectif d'une dizaine de

démographes. En même temps, le PSPF avait généreusement prévu des formations de longue durée à l'étranger (Ph D notamment). Il en est résulté une diminution du nombre des cadres disponibles, et ce qui est plus grave, des départs pour d'autres postes mieux payés. Un exemple précis est fourni par l'envoi en formation longue durée des deux responsables du Bureau Informatique. Leurs remplaçants sont incapables de répondre aux demandes de tableaux du recensement faites par le BNR, d'où des retards dans l'analyse des données du recensement.

Cependant ce problème de la surcharge de travail du BNR et des retards dans le planning a plus gêné les missions du BUCENS que les miennes dans la mesure où je venais plus souvent et où la diversité de mes tâches me permettait de toujours remplir à 100% mon temps de travail. Deux observations à ce sujet:

a) il est rapidement apparu nécessaire de faire plus de missions chaque année, mais de plus courte durée: actuellement une tous les deux mois environ, d'une durée de 6 à 10 jours de travail chacune. Mais comme l'INED paye les billets d'avion, cela n'implique pas un coût supplémentaire pour l'USAID.

b) il est inexact d'écrire en p.11:
"TA provided by Yves CHARBIT included:
1 general technical assistance in the coordination of research and secondary analysis of the 1986 DHS and the 1988 national census
2 TA for the Village Monograph studies, etc."
La coordination de la recherche n'était pas limitée à la DHS et au Census, et c'est ce qui m'a permis d'avoir toujours quelque chose à faire pendant les missions.

3.2/ En ce qui concerne l'assistance donnée par le BNR au PSFP, que le rapport considère comme insuffisante (voir p. 24), je peux témoigner que des efforts réels et constants ont été faits dans ce sens par le BNR. Par exemple, il n'a jamais été possible d'obtenir des commentaires du Directeur du PSPF (M. Samb) sur le questionnaire de l'EPF, que le BNR lui a communiqué 3 fois.

4/ Les Enquêtes Démographiques Régionales

Tom KANE recommande de ne pas réaliser les EDR pour quatre raisons (voir p. 13, p. 25):
1/ *Il n'est pas réaliste de les prévoir d'ici à la fin du PSPF.* Cette position est raisonnable si la DHS II est faite en 1992. En sens inverse, les questionnaires sont prêts ainsi que les échantillons.
2/ *Financièrement cela permettrait un économie substantielle sur le budget (280,000 US $).* C'est le meilleur argument.
3/ *Ces enquêtes n'apporteraient rien de plus que la DHS II si on augmente la taille de l'échantillon de celle-ci .*
Cet argument n'est pas valide si l'on considère que les EDR ont pour but de fournir des indicateurs démographiques régionaux. Il faut alors fournir des données au niveau régional, voire départemental, pour les plans régionaux de développement intégrés. On retrouve la question de ce que doit être le rôle du BNR (data base improvement) au niveau national et régional.

4/ *Le contenu de ces enquêtes n'est que partiellement pertinent par rapport au PSPF.* Ici encore tout dépend du rôle que doit avoir le BNR: uniquement centré sur la PF ou renforcement des données démographiques et statistiques dans l'intérêt de l' ensemble des administrations et aussi des bailleurs de fonds puisqu'ils disposeront de meilleures statistiques démographiques.

II/ PROGRAMME DE TRAVAIL DU BNR JUSQU'EN SEPTEMBRE 1992

Après consultation de Ibrahima SARR, il parait raisonnable de prévoir pour la période qui va jusqu'en septembre 1992 les taches suivantes:
- Analyse des données de l'EPF 1990
- Réalisation de la DHS II
- Réalisation de monographies de villages dans la région du Fleuve (Décembre 1991) et dans la région de Louga (Décembre 1992).Ces monographies ne ne mobilisent pas beaucoup de ressources du BNR. Par contre, elles vont beaucoup impliquer Salif NDIAYE qui va s'en servir pour sa thèse de doctorat.
- Valorisation des données du recensement par un programme d'analyses plus approfondies que celles actuellement prévues et qui doivent être achevées en septembre 1991. Ces analyses seront réalisées avec l'appui de l'INED et du CERPA (accueil à Paris pour des séjours d'étude courts).

III/ EVALUATION DES BESOINS EN JOURS DE CONSULTATION JUSQU'EN SEPTEMBRE 1992

La note d'Ibrahima Sarr du 26 février 1990 décrivait la charge de travail prévisible. Si l'USAID décide de préserver le rôle institutionnel du BNR (data base improvement), alors la charge de valorisation et d'analyse des données va être importante jusqu'en septembre 1992. Il faudra prévoir 6 missions de 8 jours chacune par an et un travail de follow-up à Paris. Voici une estimation des coûts annuels:

6 missions de 8 jours x 300 US$ =	14,400
per diem: 6 x10 jours x 100 US$ =	6,000
Follow-up à Paris: 70 jours x 300US$=	21,000
TOTAL ANNUEL:	41,400

Y Charbit

Yves CHARBIT. Paris, le 23 Juin 1991

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ANNEX O-6

Ibrahima Sarr, Bureau of National Census

Note sur le Rapport d'évaluation final du Projet Santé familial et Population

Dans l'ensemble, nous sommes d'accord avec les conclusions quant à la participation du BNR à la mise en place d'une base de données démographiques utilisables pour l'évaluation et la formulation d'objectifs pour le projet.

Nous acceptons aussi un certain nombre d'insuffisances constatées à notre niveau cependant certaines conclusions méritent explication.

- La dissemination de l'EDS. Un séminaire de vulgarisation des résultats de l'EDS où tous les volets du projet ont été invités s'est déroulé du 6 au 8 Mars. Il se trouve malheureusement qu'il y a des volets qui pensent pouvoir se passer des données démographiques dans leur travail et n'ont pas jugé utile d'envoyer des représentants.

D'autre part, une soixantaine de Rapports du l'EDS ont été envoyés au Projet pour distribution aux différents volets.

- Pour le recensement, l'évaluation parle de retards. Pourtant dans toutes les communications qui ont été faites sur le recensement, dans tous les documents élaborés, il est mentionné que les résultats définitifs ne pouvaient être disponibles que 3 ans après le recensement. Il se trouve que pour pallier à la demande pressante en données nouvelles, un échantillon au 1/10 a été tiré exploité et analysé. La plublication de la plaquette qui a été élaborée à cet effet en Décembre 1989 a été retardée par des problèmes financiers au niveau d'ISTI. La plaquette a été enfin de compte publiée par le FNUAP en 1990.

Les répertoires des villages qui sont des instruments indispensables pour toute planification à la base, en particulier pour les PRDS, sont disponibles depuis Septembre 1989. Ces répertoires devaient être publiés par ISTI, mais à cause des problèmes financiers que nous connaissons, un seul répertoire a été publié par ISTI. Nous nous sommes encore tournés vers le FNUAP pour publier 5 autres répertoires.

Quatre répertoires attendent encore que les fonds d'ISTI soient disponibles. Les analyses régionales sont en cours, certaines régions (Thiès, Fatick, Diourbel, Ziguinchor) sont disponibles

pour la publication. Mais il faudra encore attendre que les fonds d'ISTI soeient disponibles. On dit dans l'évaluation que le Gouvernement du Sénégal s'est engagé a publié les résultats. En fait dans la demande de financement du Recensement des frais de publications ont été demandés aux bailleurs de fonds dont l'USAID dans le cadre du Projet.

Actuellement toutes les données sont disponibles au niveau régional et départemental depuis Juin 1990. Je ne connais pas de pays africain qui a fait mieux que nous.

Il est certain que sans un certain nombre de petits problèmes internes que nous avons eu surmonter nous aurions pu mieux faire.

Pour les analyses, elles se feront toutes au courant de l'année 1991.

- <u>Les missions</u>. Toutes les missions qui se sont déroulés au BNR. cartographie, élaboration des questionnaires, échantillon ont toujours été bien préparées et n'ont connu aucun impair. Nous reconnaissons quelques problèmes au niveau de l'enquête post-censitaire car les visites de contrôles que nous croyions déjà saisies ne l'ont pas été.

Pour les missions futures, il est sûr que l'on aura pas besoin de beaucoup de missions pour le recensement par contre des missions d'assistance pour les analyses resteront sûrement nécessaires.

<u>- Pour le programme de travail futur</u>.

A cause des différents départs volontaires, des personnes actuellement en formation, le BNR ne dispose plus du personnel nécessaire à l'exécution de plusieurs tâches à la fois. Voilà pourquoi, bien que nous pensions que les enquêtes régionales soient nécessaires, la charge de travail supplémentaire que cela nécessité n'est plus supportable par le BNR. Cependant, il faudra au cours de l'EDS II surpondéré certains groupes pour avoir des données valables jusqu'au niveau régional. Le coût additionnel de cette surpondération ne figure pas sur le budget de l'EDS II et doit être pris en charge par l'USAID.

Les fonds qui étaient destinés aux enquêtes régionales pourraient alors servir à :

- Achat de deux micro-ordinateurs grande capacité pour le stockage des données du rensecment et pour accueillir le logiciel **REDATAM** devant servir à sortir des tableaux au niveau des petites unités (villages, quartiers, hameaux etc)
- Achat de deux imprimantes
- Participation au séminaire de finalisation des analyses du RGPH/88
- Publication des résultats du RGPH/88
- Analyse de l'enquête EPF.
- <u>Pour la création d'un service de gestion des informations PF</u>, l'idée est en elle-même bonne. Un systeme plus souple serait que le projet recrute un certain nombre de spécialiste chargés de collecter et d'analyser les données statistiques du projet en rapport avec les autres structures qui interviennent dans ce domaine au niveau du projet. Cela éviterait les telescopages possibles, car dès que l'on met en place une unité de recherche, on ne peut plus limiter ses domaines d'intervention. On risque de se retrouver au niveau de la recherche dans les mêmes incertudes que l'administration.
- <u>Au niveau administratif</u>.

Il faut qu'on ramène le rôle de ISTI à ce qu'il devrait être. Le rôle de coordination, d'élaboration du budget, d'approbation des dépenses devrait revenir au PSF, ISTI gardant seulement sa tâche première de contrôle et de conseiller. Les achats devraient revenir au défférents volets.

En effet des retards énormes sont constatés sur les commandes effectuées par ISTI, ainsi que des livraisons non conformes.

Ibrahima SARR
Chef DSD

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ANNEX O-7

Comments by Alpha Dieng, Director, Private and Para-Public Component

[redacted]

Par votre lettre n° 3965/MSPAS/DA/PSFP du 17 Juin 1991, vous avez bien voulu requérir mes pensées sur le rapport préliminaire d'évaluation du Projet Santé Familiale et Population.

Après l'avoir lu, ce document appelle de ma part les observations suivantes :

1) Données de l'évaluation : l'évaluation s'est fondée, à mon avis, sur des données fiables, nombreuses et diverses. Elle m'a paru avoir eu à sa disposition toutes informations (rapports, notes, textes juridiques, entrevues avec personnes clés, etc...) utiles à son élaboration.

[redacted]

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MINISTERE DE LA SANTE PUBLIQUE
ET DE L'ACTION SOCIALE
COURRIER CONFIDENTIEL
enregistré à l'arrivée sous
le N° 148 le 26-06-91

Comments from VSPP /

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J'ai été personnellement impressionné par les nombreuses références à des études, recherches et autres activités dont certaines n'avaient jamais été portées à ma connaissance, alors que j'étais responsable de l'un des volets du Projet (résultats de la recherche sur le Norplant, étude sur les statistiques et les actives, différents amendements, possibilités d'exploitation de certains travaux du B.N.R.).

2) Qualité de l'évaluation

A deux exceptions près (évaluation du VSPP d'une part, Assistance technique et financière, j'estime que le rapport dans son ensemble, est satisfaisant.

En particulier, toutes les analyses concernant les activités de clinique PF, d'IEC, de MST, de recherche, d'études et de population donnent un enseignement exhaustif et précieux de la situation actuelle.

Ceci atteste d'une bonne maîtrise par les membres du groupe d'évaluation chargés d'étudier ces différents domaines, des missions qui leur étaient dévolues.
Par exemple, tous les problèmes posés par la supervision, la qualité des prestations de services, l'exploitation des résultats des recherches, la coordination entre les volets ont été bien cernés et ont donné lieu à des recommandations qui, dans leur ensemble, ne souffrent d'aucune contestation.

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Toutefois, il faut regretter que le VSPP n'ait pas donné lieu à une évaluation aussi fouillée et aussi approfondie. Au reste, le groupe d'évaluation le reconnaît.

S'agissant des chapitres XII et XIII consacrés d'une part à l'administration et à la gestion du Projet, d'autre part à l'assistance technique, il convient, à la décharge des évaluateurs auxquels il incombaient, d'admettre qu'il s'agit de sujets tellement complexes dans le cas du Projet, qu'il n'était guère facile de les traiter avec autant d'aisance que pour les sujets tels la clinique PF ou encore les MST et autres recherches.

Toutefois, le mérite de l'évaluation a été de faire ressortir le malaise que l'assistance technique et financière d'ISTI a engendré dans le Projet. Malaise dû, à mon avis, non pas à la formule d'une agence d'exécution comme ISTI mais plutôt aux 4 facteurs suivants :

- [redacted]

- les rapports conflictuels entre ISTI et les volets du Projet, alors que ces rapports devraient être plutôt complémentaires ;

[redacted];

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- les manquements à la gestion financière et comptable qui ont fait réagir le bailleur de fonds qui, depuis 1989, s'est montré plus soucieux de protéger les fonds du Projet que d'en simplifier les modalités d'utilisation.

4) Précision dans les recommandations

Les recommandations qui figurent dans le rapport sont toutes claires, nettes et précises. La question est plutôt de savoir si elles sont toutes pertinentes et opportunes.

- S'agissant des recommandations relatives aux activités de clinique de PF, elles me paraissent tout à fait fondées sauf pour ce qui concerne le transfert du volet MST au programme national de SIDA/MST. A mon humble avis, ce transfert risque de créer des difficultés supplémentaires, notamment de soumettre au programme de PF des exigences dont il n'a pas besoin en matière de MST.

- S'agissant de l'incoordination des organes chargés, au plan administratif et technique, de l'exécution du programme de PF, il me semble nécessaire que des instructions précises venant du Ministre insistent sur la nécessité :

  * de développer et d'améliorer la coordination des activités de PF ;

  * d'amener les agents techniques (médecins, sages-femmes, infirmiers et agents sociaux) à accorder davantage d'importance et à consacrer davantage leur temps de travail au PF, particulièrement en ce qui concerne la prestation de service, le suivi des statistiques et les activités d'IEC.

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- S'agissant des études et recherches, j'adhère aux recommandations du rapport, mais il aurait été souhaitable d'une part qu'il fût plus explicite sur le mode d'exploitation des résultats desdites études et recherches (tournées régionales ou départementales d'information, contrôles périodiques de l'application, séminaires, stages de recyclage, instructions ministérielles) ; d'autre part que le programme de recherche ne s'arrêtât pas notamment dans des domaines où aucun retard ne doit plus être permis (études et enquêtes sur le sevrage des entreprises, sur la distribution à l'échelon communautaire, sur le marketing social, etc...).

- S'agissant de l'IEC/PF, les recommandations devraient tenir compte de la nécessité de changer d'orientation dans le programme national d'IEC et de mener une activité qui désormais pousse plutôt les Sénégalais vers la contraception que de se contenter simplement de changer favorablement leur attitude vis-à-vis de cette dernière.

- S'agissant du Volet Secteurs Privé et Para-public, il me paraît plus judicieux de reprendre purement et simplement la partie qui lui est consacrée dans le document afin de faire ressortir davantage les points suivants :

  * nécessité d'aider à l'auto-suffisance des entreprises recevant l'assistance du Projet en PF ;

  * nécessité de renforcer l'encadrement des sociétés bénéficiant de l'assistance du VSPP (qualité des prestations de services, application des nouvelles règles en matière d'examens para-cliniques, tenue des statistiques, coordination de l'activité de plusieurs cliniques appartenant à une même entreprise, etc...) ;

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* nécessité d'assister de nouvelles sociétés ;

* nécessité d'obtenir auprès des pouvoirs publics un soutien sans faille ;

* nécessité de rendre complémentaires les activités des secteurs privé et para-public ainsi que celles du secteur public ;

* nécessité de transférer la gestion du programme du secteur privé à des O.N.G. nationales ;

* nécessité d'encourager le secteur privé à aider à l'élaboration d'un programme de marketing social adapté au Sénégal et bénéficiant du soutien sans embage du Gouvernement du Sénégal. A signaler à cet effet que contrairement à ce qu'affirme le rapport, SANFAM est parfaitement habilitée à s'y impliquer ;

* nécessité de permettre au secteur privé de concourir sous le contrôle des pouvoirs publics à la conception et au développement d'un programme de distribution à l'échelon communautaire adapté aux réalités socio-culturelles du pays ;

* nécessité de faire respecter les accords de subvention passés entre le VSPP et les sociétés auxquelles il apporte son assistance. A ce titre, il faut signaler que plusieurs engagements pris par le VSPP vis-à-vis de ces sociétés ne sont toujours pas respectés, notamment en ce qui concerne le matériel IEC, le matériel de laboratoire, la formation en MST et la formation en IEC/PF ;

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* nécessité de restituer au VSPP le reliquat de l'enveloppe financière dont il est allocataire (soit près d'un million de dollars) pour lui permettre de continuer à développer et à diversifier ses activités ;

* nécessité d'accorder une place de premier choix au Volet Secteurs Privé et Para-public dans le nouveau projet et surtout de lui accorder une plus grande autonomie et une plus grande souplesse dans son fonctionnement et dans ses opérations d'assistance.

- S'agissant de l'assistance technique et financière, il paraît évident que le moment est venu pour qu'une large concertation s'établisse entre le Gouvernement du Sénégal, la bailleur de fonds (USAID), ISTI, la Direction du PSFP, pour revoir la formule d'une telle assistance. Plusieurs options peuvent s'offrir à cet effet :

* soit l'intégration pure et simple d'une équipe de 2 ou 3 assistants techniques dans la Direction du Projet (ou du Service National de PF), équipe qui serait fournie par l'agence d'exécution ;

* soit la redéfinition du rôle d'ISTI et la reprécision de ses rapports avec l'USAID et avec les différents volets du Projet ;

* soit le recrutement direct d'assistants techniques et financiers à titre individuel, placé sous l'autorité directe de la Direction du Projet ;

[redacted]

.../...

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4) Organisation de l'évaluation

Vu le temps très court qui lui était imparti et le volume de travail fourni, il est manifeste que l'évaluation était bien organisée. Il faut surtout admettre qu'elle comportait parmi ses membres des agents assez compétents.

Ce qu'en revanche il faut regretter c'est :

- l'absence d'un spécialiste en matière de gestion des programmes privés de PF. Je suis persuadé que MSH ou John Snow Inc. (Enterprise Program) aurait pu le fournir facilement ;

- le caractère tardif de l'évaluation. Car il a fallu la 5ème année de l'existence du Projet pour en entreprendre la première évaluation. Alors que si le plan d'évaluation tel que précisé dans le "Grant Agreement" avait été exécuté normalement, la qualité du travail de l'équipe actuelle aurait été beaucoup plus performante.

Telles sont essentiellement mes appréciations du volumineux rapport préliminaire d'évaluation du PSFP que vous avez bien voulu me soumettre.

Il s'agit d'un document fouillé, sérieux, qui gagnerait certes à être complété et amélioré. Mais tout document d'évaluation s'apprécie par rapport aux préoccupations de son utilisateur. C'est pourquoi toutes critiques, toutes suggestions et toutes recommandations qui y sont contenues ne doivent pas être perçues comme d'inexorables recettes mais plutôt comme des idées pouvant ouvrir à d'éventuelles corrections, améliorations ou restructurations.

.../...

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Dans le cas du présent rapport, les idées forces qui paraissent devoir être retenues sont les suivantes :

1) Le PSFP a été d'un apport incontestablement positif au Sénégal : c'est grâce, en très grande partie, à ce Projet que :

* le planning familial est devenu une réalité vivante au Sénégal et qu'il s'est propagé aussi rapidement à travers tout le pays ;

* le Sénégal possède à présent une politique de population et un programme national de PF ;

* le secteur privé a pris rapidement un essor beaucoup plus important que par le passé ;

* l'attitude des Sénégalais à l'égard du planning familial a notablement évolué ;

* l'on a acquis une plus grande expérience des programmes de PF et une meilleure approche des problèmes qu'ils posent ;

* l'on a une meilleure connaissance de la composition et des structures de notre population ainsi qu'une plus grande maîtrise des politiques à mener ou des moyens à mettre en oeuvre pour lui imprimer les orientations les plus appropriées.

.../...

2) Comme toute activité nouvelle, et surtout très controversée à sa naissance, le Projet a dû souffrir bien évidemment de nombreuses insuffisances que l'on pourrait qualifier de "maladies infantiles", pour reprendre l'expression célèbre d'un grand penseur contemporain : ce sont notamment toutes ces imperfections et toutes ces défectuosités signalées par les évaluateurs pour tout ce qui concerne l'incoordination, le défaut de supervision, la qualité moyenne des services de PF, les lacunes de l'assistance technique et financière, sans oublier l'excès d'optimisme dont on avait fait preuve au début du Projet en matière d'objectifs chiffrés en PF.

Mais ces maladies infantiles étaient bien nécessaires pour servir d'éclairage aux développements futurs du Projet et notamment pour éviter au prochain programme national de PF de s'empêtrer dans des difficultés déjà connues et désormais plus facilement maîtrisables.

3) Le Projet a compté, dans ses principales composantes, le Volet Secteurs Privé et Semi-public qui, malheureusement n'a pas eu, dans le rapport, le traitement qu'il méritait.

Cette insuffisance reconnue, au reste, par les évaluateurs eux-mêmes, devrait être réparée. Et cette réparation s'avère d'autant plus justifiée et pressante que les pouvoirs publics et le bailleur de fonds ont besoin d'avoir l'information la plus fiable concernant le secteur privé, en vue de décider ensemble de la manière de le renforcer et d'améliorer son action dans l'avenir./.

ANNEX O-8

Comments by Linda Lankenau, USAID/Senegal/HPNO

UNCLASSIFIED
AID 7/12/91
DIR:JECOLES
HPNO:LLANKENAU:PB
1.HPNO:MAMICKA, 2.PRM:SCISSE, 3.PRM:RGILSON
AID AMB DCM, CHRON

INITIALS:
AUTH JEC
DRAFTER LL
1.CLEAR MAM
2. SC
3. RG
4. LF
5. (1071H)

AMEMBASSY DAKAR
SECSTATE WASHDC

AIDAC

FOR MS/OP/OS/AFR, J. HACKEN
INFO: AFR/SWA/SMNC, J. ROYER; AFR/TR/HPN, H. SUKIN;

E.O. 12356: N/A
SUBJECT: FAMILY HEALTH AND POPULATION PROJECT EVALUATION

REFS: A) CONTRACT NO. PDC-0085-I-9089-00,
- DELIVERY ORDER NO. 16
- B) FAX LANKENAU/DEVRES 6/20/91

TO: DEVRES, INC.
7201 WISCONSIN AVENUE, SUITE 500
BETHESDA, MD 20814
TEL. NO. (301) 951-5546

SUBJECT: FAMILY HEALTH AND POPULATION PROJECT EVALUATION

REFS: A) CONTRACT NO. PDC-0085-I-9089-00,
- DELIVERY ORDER NO. 16
- B) FAX LANKENAU/DEVRES 6/20/91

1. AS THE COMPLETED DRAFT EVALUATION IN ENGLISH WAS READY, USAID DISTRIBUTED IT FOR REVIEW BEFORE TRANSLATION AND DISTRIBUTION OF THE FRENCH VERSION.

4.PDO:LFRANCHETT

THE GOS COMMENTS WILL FOLLOW IN SEPTEL AS PER SCHEDULE SET FOR IN REF (B). BOTH SETS OF COMMENTS WILL HAVE TO BE TAKEN INTO CONSIDERATION IN THE FINALIZATION OF THE REPORT.

2. USAID COMMENTS ARE DIVIDED INTO TWO MAJOR SECTIONS. THE FIRST SECTION WILL ADDRESS THE REPORT AS A WHOLE: SCOPE, RESPONSIVENESS TO TERMS OF REFERENCE (TOR), COMPLETENESS, ORGANIZATION, ETC. THE SECOND SECTION WILL COMMENT CHAPTER BY CHAPTER CORRECTING INFORMATION, POSING SPECIFIC QUESTIONS AND CONCERNS, ETC.

3. PLEASE NOTE THAT MANY PEOPLE FROM USAID, ISTI, GOS, AND OTHER DONORS PROVIDED EXHAUSTIVE COMMENTS ON DRAFT CHAPTERS PRIOR TO PRODUCTION OF THE FINAL DRAFT LEFT WITH USAID. NONE OF THESE COMMENTS AND SUGGESTIONS WERE INCORPORATED INTO THE DOCUMENT LEFT FOR REVIEW. WE CANNOT REPRODUCE ALL THOSE COMMENTS HERE - SOME WERE WRITTEN ON DRAFT CHAPTERS RETURNED TO THE DRAFTERS OR TO ROSENTHAL; OTHERS WERE GIVEN ORALLY IN HOURS OF DEBRIEFINGS AND MEETINGS. HOWEVER, WE EXPECT THAT ALL THESE COMMENTS WILL BE INCLUDED IN THE FINALIZATION OF THE DOCUMENT.

4. IN ADDITION, A COPY OF THE EVALUATION IN ENGLISH WITH MARGINAL NOTES WILL BE DHLED TO WASHINGTON ASAP.

5. USAID/SENEGAL MUST NOTE THAT THE DRAFT LEFT WITH US COULD IN NO WAY BE CONSIDERED AS A FINAL DRAFT. WITH TWO MAJOR EXCEPTIONS, (EVALUATION OF VSPP AND FINANCIAL/TECHNICAL ASSISTANCE SECTIONS) THE INFORMATION NEEDED FOR A COMPREHENSIVE EVALUATION REPORT IS PRESENT. IN GENERAL, THE EVALUATION IDENTIFIES KEY PROBLEMS SUCH AS LACK OF SUPERVISION, QUALITY OF SERVICES, USE AND DIFFUSION OF DATA, COORDINATION, ETC. HOWEVER, THERE ARE

SOME SECTIONS WHERE THE LINK BETWEEN FINDINGS, PROBLEMS, AND RECOMMEDATIONS IS NOT CLEAR. IN ADDITION, EXTENSIVE EDITORIAL CHANGES ARE NEEDED: VARIOUS CHAPTERS AND SECTIONS OF CHAPTERS CONTRADICT ONE ANOTHER; THERE ARE SECTIONS THAT ARE INCOMPREHENSIBLE; THE TRANSLATED CHAPTERS NEED ALOT OF EDITING; AND, THERE ARE GRAMMATICAL, SYNTAX AND SPELLING ERRORS TOO NUMEROUS TO NOTE. WE ARE CONCERNED THAT DEVRES MIGHT NOT BE ABLE TO PRODUCE A FINAL REPORT ACCEPTABLE TO USAID, GIVEN THE EXTENSIVE CHANGES NEEDED. THEREFORE, IF THE QUALITY OF THE QUOTE FINAL REPORT UNQUOTE IS NOT ACCEPTABLE, USAID RESERVES THE RIGHT TO FURTHER COMMENT AND DEVRES WILL THEN REVISE THAT DOCUMENT UNTIL DEEMED ACCEPTABLE BY USAID AS A FINAL EVALUATION REPORT.

6. GENERAL COMMENTS:

(A) THE DRAFT IS LARGELY DESCRIPTIVE AND INCONCLUSIVE. THE REPORT DESCRIBES WHAT HAS HAPPENED AND SUGGESTS NEW THINGS FOR THE FUTURE RATHER THAN REACHING FUNDAMENTAL CONCLUSIONS. THE FOCUS IS ON THE MINUTIA OF DETAILS RATHER THAN THE BIG PICTURE. THESE RAMBLING NEED TO BE SYNTHESIZED AND PULLED TOGETHER INTO A COHERENT DOCUMENT WHICH HAS BEEN WELL EDITED.

ALL ASPECTS/COMPONENTS OF THE PROJECT ARE ASSESSED. BUT THE DRAFT DOES NOT PROVIDE AN OVERALL ANALYSIS OF THE PROJECT, INCLUDING ANSWERS TO THE FOLLOWING QUESTIONS:

- ARE KEY ASSUMPTIONS MADE IN PROJECT DESIGN STILL VALID?
- IS THE PROJECT PURPOSE REALISTIC?
- WHAT ARE THE MAJOR ACCOMPLISHMENTS/SHORTFALLS OF THE PROJECT?
- WHAT ARE THE MAJOR PROBLEMS THE PROJECT HAD TO SOLVE? HOW WERE THOSE PROBLEMS SOLVED?

- WERE PROJECT INPUTS DELIVERED IN A TIMELY MANNER? IF NOT, WHAT WAS THE IMPACT ON OUTPUTS? ON IMPLEMENTATION? WERE THERE ANY DELAYS IN PROJECT IMPLEMENTATION AS A RESULT OF LATE DELIVERY OF INPUTS?

SUCH AN OVERALL ANALYSIS STARTING FROM FINDINGS WOULD LEAD TO CONCLUSIONS ON OVERALL SUCCESS OR LACK THEREOF OF THE PROJECT AND WOULD PROVIDE THE BASIS FOR RECOMMENDATIONS. SUCH AN ANALYSIS WOULD ALSO PERMIT US TO KNOW WHETHER THE PROJECT IS MEETING ITS OBJECTIVES OR NOT, AND IF NOT, WHY? WITHOUT ANSWERS TO THESE QUESTIONS USAID CANNOT COMPLETE THE PROJECT EVALUATION SUMMARY.

(B) THE EVALUATION AVOIDS MAKING JUDGEMENTS IN SEVERAL PLACES - PARTICULARLY THE PROJECT'S CONTRIBUTION TO EXPANDED CONTRACEPTIVE USE. IT LAYS OUT THE FACTS WITHOUT MAKING A JUDGEMENT WHETHER THEY ARE GOOD OR BAD, I.E. 70,000 ACCEPTORS AND AN INCREASE OF 20-40 PERCENT PER ANNUM WOULD APPEAR SIGNIFICANT YET THE REPORT SIMPLY STATES THAT THIS IS INSUFFICIENT TO MEET THE 200,000 GOAL. MAYBE THE GOAL WAS UNREASONABLE?

THE EVALUATION DESCRIBES THE ACTIVITIES AND THEN JUMPS TO RECOMMENDATIONS. THE QUOTE EVALUATIVE UNQUOTE ELEMENT MUST BE ADDED - WERE THE ACTIVITIES GOOD, BAD OR INDIFFERENT.

(C) THE SUMMARY DOES NOT HAVE ANY REAL DESCRIPTION OF ACCOMPLISHMENTS; IT IS RATHER, A LITANY OF PROBLEMS. NO MENTION IS MADE OF THE GENERAL ENVIRONMENT OF ACCEPTABILITY FOR FAMILY PLANNING NOW COMPARED WITH 1985. HOWEVER, BURIED AT THE END OF CHAPTER 7, THE EVALUATION PRESENTS EVIDENCE OF SOME SUCCESS IN FAMILY PLANNING. THE SUMMARY, IN FACT, SHOULD PRESENT AN OVERVIEW OF BOTH SIDES: PROGRESS/ACCOMPLISHMENTS AND PROBLEMS.

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(D) A NUMBER OF POSITIVE BENEFITS ARE DIRECTLY LINKED TO THE PROJECT NOTABLY:

- FAMILY PLANNING HAS BECOME A REALITY IN SENEGAL AND SERVICES ARE NOW AVAILABLE THROUGHOUT THE COUNTRY;

- SENEGAL HAS PRODUCED A POPULATION POLICY AND A NATIONAL FAMILY PLANNING PROGRAM, ENDORSED BY THE PRESIDENT AND PROMOTED AS A GOVERNMENT PRIORITY IN 1991;

- THE PRIVATE SECTOR HAS RAPIDLY TAKEN ON AN IMPORTANT NICHE IN THE NATIONAL FAMILY PLANNING PROGRAM;

- THE ATTITUDE OF SENEGALESE REGARDING FAMILY PLANNING HAS RAPIDLY EVOLVED TO A POINT WHERE IT CAN BE DISCUSSED RELATIVELY OPENLY;

- THE PROJECT HAS GIVEN THE NECESSARY EXPERIENCE TO FAMILY PLANNING IMPLEMENTORS IN ORDER TO PROGRESS TO NEWER AND MORE EFFICIENT PROGRAMS; AND

- THERE EXISTS A MUCH BETTER UNDERSTANDING OF POPULATION DYNAMICS AND CHARACTERISTICS IN SENEGAL WHICH HAVE LED TO BETTER DEVELOPMENT PLANNING.

(E) RECOMMENDATIONS:

(1) WE COUNTED 131 RECOMMENDATIONS, NOT 97 AS STATED. WITH SO MANY RECOMMENDATIONS THEY SHOULD BE CLEARLY SPLIT INTO TWO CATEGORIES:

- RECOMMENDATIONS PERTAINING TO THE ON-GOING PROJECT INCLUDING WHAT ADJUSTMENTS, IF ANY, ARE NECESSARY FOR THE REMAINING LIFE OF THE PROJECT?

- RECOMMENDATIONS PERTAINING TO THE PROSPECTIVE POPULATION AND CHILD SURVIVAL PROJECT (OR ACTIONS TO BE TAKEN IN THE FUTURE.)

(2) THE ATTEMPT MADE BY THE TEAM TO PROVIDE SOME ACTION ORIENTED RECOMMENDATIONS IDENTIFYING WHICH ENTITY (USAID, GOS, TA CONTRACTOR) SHOULD BE RESPONSIBLE FOR IMPLEMENTATION IS FULLY APPRECIATED.

(3) SUGGESTIONS FOR THE DESIGN OF THE NEW PROJECT DO NOT CLEARLY IDENTIFY OPTIONS FOR THE MOST APPROPRIATE/ MANAGEABLE PACKAGE OF POPULATION ACTIVITIES TO BE IMPLEMENTED.

(F) THE CONCEPT OF A TIGHTER FOCUS IS MENTIONED SEVERAL TIMES BUT THE TEAM MADE NO CONCRETE SUGGESTIONS. WHAT IS THIS TIGHTER FOCUS? DESCRIBE ELEMENTS THAT SHOULD RECEIVE THE MOST ATTENTION IN THE REMAINING TIMEFRAME. SEVERAL SECTIONS RECOMMEND USING 5 TO 12 COOPERATING AGENCIES TO SUPPORT VARIOUS COMPONENTS. IS THE EVALUATION TEAM SAYING THAT USE OF THE CENTRALLY-FUNDED COOPERATING AGENCIES IS A PREFERRED ROUTE? HOW DO COOPERATING AGENCIES EFFECT A TIGHTER FOCUS?

(G) IT IS APPARENT THAT THERE ARE MULTIPLE PHASES OF THE PROJECT - BOTH IN TERMS OF MANAGEMENT STRUCTURE AND IN THE PROGRESS OF THE PROJECTS ACCOMPLISHMENTS: THE AUDIT OF 1989 LEADING TO A QUOTE CRISIS UNQUOTE; THE MINISTERIAL CHANGE IN 1990 FROM THE MINISTRY OF SOCIAL ACTION TO THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ACTION (MPHSA); AND SUBSEQUENT REORGANIZATIONAL CHANGES IN THE MPHSA. NONE OF THESE CHANGES ARE CLEARLY DESCRIBED; THEY ARE ONLY REFERRED TO AS PRESENTING PROBLEMS. THIS RESULTS IN A VERY CONFUSING KALEIDOSCOPE. A DESCRIPTION OF THESE EVENTS NEEDS TO BE PRESENTED EARLY IN THE

EVALUATION. IN EACH SECTION THEN REFERENCE TO THESE CHANGES (GOOD OR BAD) AND SUBSEQUENT PROJECT PERFORMANCE NEEDS TO BE SHOWN.

(H) THE CHAPTERS ARE NOT CONSISTENT IN DISCUSSING INPUTS. FOR EXAMPLE THE CHAPTERS ON BNR AND IEC DESCRIBE BOTH THE LONG AND SHORT-TERM TECHNICAL ASSISTANCE PROVIDED AND GIVE SOME IDEA OF THE QUALITY OF THOSE INPUTS. HOWEVER, THE CHAPTERS ON CLINICAL, STD, RESEARCH AND LOGISTICS DO NOT DESCRIBE THESE ASPECTS AT ALL. CHAPTER 13 ONLY DESCRIBES ISTI'S OVERALL ROLE AND DOES NOT FILL IN THE GAPS NOR GIVE APPROPRIATE SUMMARIES OF BOTH LONG AND SHORT-TERM TA PROVIDED (EXAMPLE: LAURA EVISON (NURSE/MIDWIFE), AL BARON (TEAM LEADER), MOHAMED IBRAHIM (LOGISTICIAN), ETC).

THE SAME INCONSISTENCIES APPEAR IN THE DISCUSSIONS OF TRAINING - BOTH LONG AND SHORT-TERM. CERTAIN CHAPTERS ADDRESS THE APPROPRIATENESS OF TRAINING PROVIDED AND OTHERS DO NOT. THERE IS NO SUMMARY OF THIS ISSUE WITHIN THE DOCUMENT.

(I) THE EVALUATION GIVES CONFLICTING DATA THROUGHOUT THE REPORT. MARGINAL COMMENTS ON THE DRAFT TO BE DHLED WILL PROVIDE DETAILS BUT TO NOTE JUST A FEW OF THE KEY ONES:

- PAGE 5 CHAPTER 3 STATES THERE ARE 27 PRIVATE AND PARASTATAL ORGANIZATIONS WITH 40 CLINICS, WHEREAS PAGE 35 CHAPTER 7 STATES THERE ARE 32 (OR IS IT 31?)

- PAGES 8 AND 9 OF CHAPTER 3 STATE THERE ARE 29,890 (PUBLIC) PLUS 9,111 (PRIVATE) PLUS 19,300 (COMMERCIAL) USERS FOR A TOTAL OF 58,301; PAGE 35 OF CHAPTER 7 STATES 61,376; THE SUMMARY OF FINDINGS STATES 70,107; AND, CHAPTER 6 PAGE 15 STATES THERE ARE 56,949 ACCEPTORS. PLEASE CLARIFY.

- PAGE 9 OF CHAPTER 3 STATES THERE ARE 29 UNFPA CLINICS BUT PAGE 35 CHAPTER 7 STATES THERE ARE 34 CENTERS.

- PAGE 38 CHAPTER 7 SHOWS 96,000 COUPLE YEAR PROTECTION (CYP) FOR ALL SECTORS AND TABLE 1 CHAPTER 6 SHOWS 136,218 CYP.

ALL THESE AND MANY MORE INCONSISTENCIES MUST BE REVIEWED. IF DIFFERENT METHODS ARE USED TO CALCULATE THESE NUMBERS, THE METHODOLOGIES MUST BE DESCRIBED AND THE IMPLICATIONS NOTED. THE RAW DATA USED FOR CALCULATING CYP'S MUST BE PRESENTED IN AN ANNEX TO SUBSTANTIATE THE CALCULATIONS.

(J) LESSONS LEARNED: WE APPRECIATE THE SUGGESTIONS REGARDING THE MANAGEMENT OF THIS EVALUATION AND OF THE A.I.D. EVALUATION PROCESS IN GENERAL. HOWEVER, AN ADDITIONAL EFFORT IS NEEDED TO PULL OUT LESSONS THAT COULD BE HELPFUL FOR THE DESIGN AND IMPLEMENTATION OF SIMILAR PROJECTS IN THE FUTURE.

(K) THE MANAGEMENT SECTION DEALS WITH THE MANAGEMENT OF THE EVALUATION RATHER THAN THE MANAGEMENT OF THE PROJECT. THE VERY CONTROVERSIAL CHAPTER 13 ON TA IS THE ONLY PLACE WHERE THE MANAGEMENT ISSUES BEGIN TO SURFACE. THE QUOTE CRISIS UNQUOTE IS REFERRED TO ONLY IN THE LATER CHAPTERS, YET IT WAS A MAJOR FACTOR IN THE PROJECT'S PROGRESS AS NOTED IN (B) ABOVE. AID MANAGEMENT IS NOT REALLY DISCUSSED EXCEPT IN THE CONTRACEPTIVE PROCUREMENT PORTION.

THIS SECTION SHOULD BE COMPLETELY REWRITTEN (SEE NOTES ON SPECIFIC CHAPTERS - CHAPTER 12 BELOW.)

(L) THROUGHOUT THE TEXT MOST CHAPTERS BEGIN WITH GOALS AND OBJECTIVES FOLLOWED BY DISCUSSION. HOWEVER, PRESENTATION OF RESULTS DO NOT CLEARLY SHOW THE RELATIONSHIP BETWEEN THE LOGFRAME AND PROJECT COMPONENTS. THIS SHOULD BE DESCRIBED.

(M) IN GENERAL, THE EVALUATION DOCUMENT CONSISTS OF INDIVIDUAL REPORTS WITH LITTLE COHERENCE AND MAJOR GAPS. THIS MUST BE PULLED TOGETHER TO PRESENT A TEAM EVALUATION REPORT.

7. SEPCIFIC COMMENTS BY CHAPTERS:

A. INTRODUCTION, ETC - DETAILED MARGINAL NOTES WILL BE SENT TO CORRECT ACRONYMS, ETC.

B. EXECUTIVE SUMMARY

- IMPACT STATEMENTS NEED TO BE INCLUDED HERE AS WELL AS DESCRIPTIVE PASSAGES ABOUT ACTIVITIES (INPUTS/OUTPUTS LEVEL.) FOR EXAMPLE PAGE 2 STATES THAT THE PROJECT PRECEEDED THE NATIONAL POPULATION POLICY AND THE NATIONAL FAMILY PLANNING PROGRAM BUT FAILS TO NOTE THAT THESE KEY DOCUMENTS WERE PRODUCED DUE TO DIRECT INPUTS PROVIDED BY THE FAMILY HEALTH AND POPULATION PROJECT (FHPP).

- THERE ARE NUMEROUS PARAGRAPHS AND SENTENCES THAT DO NOT MAKE SENSE SUCH AS PAGE 2 CLINICAL SERVICES SENTENCES 1 AND 3; PAGE 3 CONTRACEPTIVE LOGISTICS LAST SENTENCE; PAGE 3 DATA BASE IMPROVEMENT FIRST SENTENCE, ETC, ETC, ETC.

- PLEASE NOTE PAGE 2, PARA 3 THAT USAID FULLY INTENDS TO DESIGN THE NEW PROJECT IN SUCH A COLLABORATIVE MODE. WE REQUESTED THE EVALUATION TO PRESENT TO BOTH USAID AND THE

GOS RECOMMENDATIONS OF THE MOST EFFECTIVE INTERVENTIONS TO BE CONSIDERED IN THE NEW DESIGN, BASED ON PAST EXPERIENCE; THE EVALUATION TEAM WAS NOT ASKED TO DESIGN THE NEW PROJECT.

- PAGE 4 RESEARCH - PLEASE NOTE RESEARCH WAS TO BE DEVELOPED, APPROVED, REVIEWED, ETC. FOR EACH COMPONENT. IF THIS WAS NOT ACCOMPLISHED EFFECTIVELY IT SHOULD BE SO NOTED; HOWEVER, THIS PARAGRAPH SUGGESTS THAT THERE WAS NO PLAN TO CARRY OUT RESEARCH WHICH WAS NOT THE CASE.

- PAGE 4 SMALL SCALE ECONOMIC ACTIVITIES FOR WOMEN. IN THE RECOMMENDATIONS YOU STATE THAT NO FURTHER ACTIVITIES SHOULD BE SUPPORTED BY THE PROJECT. THIS RECOMMENDATION SHOULD APPEAR IN THE SUMMARY.

C. SUMMARY: FINDINGS AND RECOMMENDATIONS

- IN ALL SECTIONS FINDINGS SOULD SHOW DATA ON WHICH THE CONCLUSION IS BASED. EXAMPLE 80 PERCENT OF THE X NUMBER OF CENTERS VISITED SHOWED...

- PAGE 4.C.2. - THE PROJECT IS SUPPOSED TO SUPPORT THE NATIONAL STD (INCLUDING AIDS) PROGRAM, NOT SET UP A SEPARATE PROGRAM.

- PAGES 4 AND 5 SECTION C - WE GET NO FEELING OF THE ROLE AND ADEQUATENESS OF PRE-SERVICE (BASIC CURRICULUM) OR IN-SERVICE TRAINING EVEN THOUGH THE CORRESPONDING RECOMMENDATION SECTION STATES STD TRAINING SHOULD BE INCREASED. CLARIFY.

- PAGE 5 SECTION D.2. - UNFPA WILL SUPPLY INJECTABLES, NOT NORPLANT.

- PAGE 6 SECTION D.5. - THE EXPLANATION GIVEN IS NOT LOGICAL IN VIEW OF THE DATA PRESENTED.

- PAGE 6 SECTION D.4. - ISTI, MPHSA AND PROJECT STAFF COLLECT THE DATA.

- PAGE 12 SECTION J.3. - NOT TRUE, USAID HAS NOT AGREED TO SUBSTITUTE U.S. FUNDS FOR THE LOCAL CONTRIBUTION. HOWEVER, BECAUSE OF DELAYS IN RELEASING LOCAL CONTRIBUTIONS, U.S. FUNDS HAVE BEEN DRAWN DOWN FASTER THAN ANTICIPATED.

- FINDINGS SHOWN ON PAGES 11-13 ON ADMINISTRATION, MANAGEMENT AND BUDGET (J) AND TECHNICAL ASSISTANCE ARE NOT THE SAME AS THOSE FOUND AT THE END OF CHAPTERS 12 AND 13.

- PAGE 14 SECTION A.1. - HOW CAN THE PROJECT BE HELD RESPONSIBLE FOR ALL GOVERNMENT MINISTERS TAKING OR NOT TAKING INITIATIVES TO SUPPORT THE FAMILY PLANNING POLICY AND PROGRAM? VERY UNREALISTIC.

- SOME SECTIONS DIVIDE RECOMMENATIONS INTO SHORT-TERM VS LONG-TERM. OTHER SECTIONS DO NOT. BE CONSISTENT.

- PAGE 28 SECTION I - DOES NOT REFLECT THE RECCOMMENDATION THAT THE PROJECT SHOULD NOT CONTINUE SUPPORT TO WID PROJECTS.

- PAGES 28-29 - YOU SHOULD DIVIDE RECOMMENDATIONS ON VSPP, CSM AND CBD. THEY ARE SEPARATE ACTIVITIES AND NOT NECESSARILY IMPLEMENTED NOR MANAGED IN THE SAME WAY.

- RECOMMENDATIONS FOR ADMINISTRATION, MANAGEMENT AND BUDGET (K) AND TECHNICAL ASSISTANCE (L) ARE NOT THE SAME AS THOSE THAT APPEAR AT THE END OF CHAPTERS 12 AND 13.

D. CHAPTER 2 PROJECT BACKGROUND AND EVALUATION METHODOLOGY

- PERHAPS THIS IS WHERE A FULL DESCRIPTION OF QUOTE THE CRISIS UNQUOTE AND THE MINISTERIAL CHANGES NEEDS TO BE PRESENTED AS INDICATED IN PARA 6.G. ABOVE.

- CHECK FINANCIAL FIGURES ON PAGE 5 WITH THOSE FIGURES PRESENTED IN CHAPTER 12. THEY ARE NOT CONSISTENT.

- SECTION C, PAGES 6-12 DESCRIBES THE MANAGEMENT AND IMPLEMENTATION OF THE EVALUATION NOT THE PROJECT. MOVE THE DISCUSSION OF THE EVALUATION PROCESS TO AN ANNEX.

- HOWEVER, SECTION G, PAGE 11 DESCRIBING HOW THE SITES TO BE VISITED WERE SELECTED SHOULD STAY IN THE MAIN DOCUMENT, RATHER THAN BE IN AN ANNEX. IN ADDITION, YOU SHOULD NOTE SITES WERE SUGGESTED THAT WERE QUOTE GOOD EXAMPLES UNQUOTE - HIGH NUMBER OF ACCEPTORS, INCREASING GROWTH RATE OR QUOTE BAD UNQUOTE - LOW NUMBER OF ACCEPTORS OR A FALL-OFF IN THE RATE OF ACCEPTANCE OR IN ABSOLUTE NUMBERS. IT WAS HYPOTHESIZED THAT THIS ANALYSIS WOULD LEAD TO LESSONS LEARNED ABOUT ACTIVITIES OR FACTORS THAT WORK AND THOSE THAT DO NOT.

E. CHAPTER 3: FAMILY PLANNING CLINICAL SERVICES

- GOOD MATERIAL PRESENTED BUT NEEDS LOTS OF EDITING AND PROOFING. READS LIKE A TRANSLATION.

- PAGE 1 - EVALUATION METHODOLOGY PRESENTED HERE IS REPETITIVE OF THE PREVIOUS CHAPTER, THOUGH THIS DESCRIPTION IS A BIT MORE COMPELTE. THE EVALUATION METHODOLOGY SHOULD BE PRESENTED BRIEFLY IN ONLY ONE PLACE; EXTENSIVE DETAILS SHOULD BE IN AN ANNEX.

- LIST OF SITES SHOULD BE IN AN ANNEX.

- THE CHAPTER DOES NOT DEFINE THE MANAGEMENT RESPONSIBILITIES OF THE FORMER MINISTRY OF SOCIAL DEVELOPMENT AND THE MPHSA. BE CLEAR WHEN THE DISCUSSION IS TALKING ABOUT PAST MANAGEMENT OR CURRENT MANAGEMENT.

- PAGE 7 - WHERE IS TABLE?

- PAGE 8 - SPLIT ASBEF VS VSPP CLIENTS AND SHOW THE TWO DIFFERENT RATES OF INCREASE.

- PAGE 10 SECTION 2 - SPECIFY THAT THERE WERE 11 PUBLIC SECTOR CLINICS OF THE TOTAL 15 SITES VISITED.

- CORRECT ALL ACRONYMS AND SPELLINGS: EXAMPLE, FEMENAL, TUBA/LIGATURE, DIRE.

- PAGES 11 AND 12 - THERE ARE NUMEROUS WORDS THAT ARE NOT ENGLISH NOR CORRECT TERMINOLOGY EXAMPLE PARA - CLINICAL CHECK-UP, RECEPTION OF CLIENTS, ETC.

- PAGE 12 - THERE ARE SEVERAL DESCRIPTIONS OF PROBLEMS DUE TO LACK OF FUEL FOR SUPERVISION AND RESUPPLY OF CONTRACEPTIVES. HERE YOU NOTE A VERY IMPORTANT FACT: FUNDS ARE GENERATED AT THE CLINICS. COULD THESE FUNDS BE USED TO FUND SUPERVISION AND RESUPPLY OF CONTRACEPTIVES.

ARE THE PRICES CHARGED PROHIBITIVE FOR CLIENTS? DOES THE ACCEPTOR RATE CHANGE IF 100 OR 1,000 FCFA IS CHARGED? WHO HAS OR SHOULD HAVE CONTROL OF THESE FUNDS? IF YOU DO NOT HAVE ENOUGH DATA TO ANSWER THESE QUESTIONS, IT MAY BE A PRIME OPERATIONAL RESEARCH QUESTION TO BE ANSWERED BEFORE THE END OF THE PROJECT.

- THE NEW CHAPTER ON INFRASTRUCTURE SHOULD BE ADDED AS A SECTION TO CHAPTER 3. CURRENTLY THERE EXIST THREE DIFFERENT VERSIONS OF THE INFRASTRUCTURE SECTION: PAGES 16 AND 17 TITLED QUOTE NEW CHAPTER INFRASTRUCTURE UNQUOTE; DR. THIAM HAS GIVEN USAID A NEW VERSION; AND ROSENTHAL FAXED A COMPLETELY DIFFERENT VERSION OF THE NEW CHAPTER. PLEASE CONSOLIDATE AND EDIT.

- ROSENTHAL'S FAXED INFRASTRUCTURE CHAPTER PRESENTS ONLY DATA ON INSUFFICIENT EQUIPMENT AND CONSTRUCTION. IT DOESN'T PRESENT INFORMATION NEEDED TO ANSWER WHETHER THE PROJECT PROVIDED THE CORRECT EQUIPMENT, THE NEEDED MAINTENANCE, REPAIR, AND REPLACEMENT OF EQUIPMENT AND WHETHER PROJECTED LEVELS OF CONSTRUCTION (NUMBER OF CENTERS) WERE SUFFICIENT TO REACH THE GOAL OF CYP/ACCEPTORS.

- PAGE 20 MOTHERS DID NOT PARTICIPATE IN STUDY TOURS.

- YOUR NUMBERS ARE NOT CONSISTENT: PAGE 22 SHOWS 303 MIDWIVES AND PAGE 19 SHOWS 300 TRAINED. PAGE 19 SHOWS NO NURSE ASSISTANTS BUT PAGE 22 SHOWS 306.

F. CHAPTER 4: CONDUCT OF BIO-MEDICAL AND PSYCHO- SOCIAL RESEARCH

- THIS CHAPTER IS CONFUSING. THERE IS NO SYNTHESIS NOR SUMMARY OF ALL THE RESEARCH REVIEWED AND EVALUATED. THERE SHOULD ALSO BE AN OVERALL SYNTHESIS OF THE PROJECT'S RESEARCH ACTIVITIES.

- PAGES 2-14 PRESENT VERY DETAILED DESCRIPTIONS OF ONLY A FEW STUDIES. THESE WOULD BE BEST SHOWN IN AN ANNEX WITH ONLY REFERENCE TO THEIR IMPACT, APPROPRIATENESS, IN THE TEXT. ALL BUT ONE DETAILED ACTIVITY IS BIO-MEDICAL RESEARCH. NO REAL ANALYSIS OF THE PSYCHO-SOCIAL RESEARCH IS GIVEN.

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- PAGE 4 - MISSING.

- AFTER PRESENTING DETAILED STUDIES, PAGE 14 REFERS TO OTHER STUDIES NOT PRESENTED IN DETAIL. WERE THESE EVALUATED OR NOT?

- NOWHERE DOES THE REPORT PRESENT WHAT THE RESEARCH STUDIES REVEALED; WERE THEY WELL DONE, WERE THE RESULTS USED, ETC. THE FHPP DIRECTOR'S KNOWLEDGE ABOUT THE STUDIES IS ONLY ONE FACTOR.

- IT IS NOT CLEAR WHAT THE ADDENDUM IS SUPPOSED DEMONSTRATE.

- PAGE 17 ENDS IN THE MIDDLE OF A SENTENCE. WHAT IS THE RELATION OF THESE PROBLEMS TO THE FINDINGS?

G. CHAPTER 5: STD AND FERTILITY

- PAGE 7 WHAT IS MEANT BY 58.55 PERCENT PREVALENCE.

- IT IS NOT CLEAR WHAT THE TABLES ON PAGES 8 AND 10 ARE SUPPOSED TO SHOW. THE TABLES ARE NOT LINKED TO THE NARRATIVE.

- NUMEROUS PAGES ARE BLANK 9, 11, 15, 17. ARE WE MISSING SOMETHING?

- THERE IS NO CLEAR LINKAGE BETWEEN PROBLEMS (PAGES 8, 16 AND 18) AND FINDINGS.

H. CHAPTER 6: CONTRACEPTIVE LOGISTICS MANAGEMENT

- PAGE 6 SECTION C.3. - SMO HAS NEVER RECEIVED THE MONTHLY SHIPPING CHART, SO HOW COULD THEY USE IT? HOWEVER, THE FACT COULD BE NOTED THAT SMO SHOULD RECEIVE THE REPORT. THEN THE SECTION COULD DESCRIBE HOW THE REPORT CAN BE USED TO IMPROVE COMMODITY TRACKING.

- PAGE 19 - PLEASE NOTE THAT TO DATE NO PROJECT COMMODITIES HAVE EXPIRED. THOSE REFERRED TO ARE ALL CONTRACEPTIVES LEFT FROM THE FIRST FAMILY PLANNING PROJECT THAT ENDED IN 1985.

- SOME OF THESE TABLES ARE ANNEX MATERIAL. PLEASE REVIEW EXISTING LOGISTIC ANNEXES FOR THEIR RELEVANCE; DO THEY ADD ANYTHING TO THE EVALUATION?

- THE NARRATIVE DOES NOT LINK THE EXISTING ANNEXES TO THE DATA PRESENTED IN THE CHAPTER.

- PAGE 7 - THERE USED TO BE 5 WAREHOUSES NOT 3 AS NOTED. ALSO, THE EVALUATION SHOULD NOTE THAT THOUGH THE NATIONAL PHARMACY HAS ALLOCATED SPACE TO THE PROJECT, NO PROTOCOLS EXIST. THEREFORE, PROBLEMS ARRISE AS TO WHO HAS RESPONSIBILITY AND CONTROL OF THE KEYS, STOCK, ETC.

I. CHAPTER 7: BUREAU NATIONAL DE RECENSEMENT (BNR)

- THE CHAPTER IS GENERALLY WELL WRITTEN AND PRESENTED. IT REALLY GIVES A FEEL FOR WHAT THE PROJECT DID OR DIDN'T DO AND HOW WELL IT WAS DONE.

- PAGES 12-17 PRESENT THE TIMEFRAME AND ACTIVITIES AND PAGES 17-20 PRESENT THE QUANTITATIVE SUMMARY. THESE SECTIONS ARE LITTLE MORE THAN A LISTING WITH NO REAL EVALUATIVE COMMENT. THEY MIGHT BEST BE SHOWN IN AN ANNEXES.

- THE KEY POINT UNDERLYING THIS COMPONENT IS THAT THE GOAL OF THE PROJECT WAS QUOTE THE DATA BASE IMPROVEMENT UNQUOTE. THIS IS NOT THE SAME AS DEVELOPING A DATA COLLECTION AND ANALYSIS SECTION FOR MONITORING AND EVALUATING A FAMILY PLANNING PROGRAM. THE BNR COMPONENT WAS TO ASSIST THE COUNTRY IN DEVELOPING THE INSTITUTION OF BNR WITH AN ABILITY TO CARRY OUT NEEDED FUNCTIONS. THIS OBJECTIVE WAS NOT EVALUATED. RATHER, THE USE AND THE RELATIONSHIP OF THE RESULTS OF BNR'S REASEARCH TO THE FAMILY PLANNING PROGRAM WAS. THE EVALUATION MIGHT CONCLUDE THAT THE GOAL OF THIS ELEMENT WAS NOT APPROPRIATE; RATHER, BNR RESEARCH SHOULD HAVE BEEN DIRECTLY LINKED TO THE FAMILY PLANNING PROJECT'S NEEDS. BUT DO NOT EVALUATE BNR ON AN OUTPUT THAT WAS NOT DEFINED IN THE LOGFRAME.

- A RELATED ASPECT IS THE ROLE OF THE CONSULTANT YVES CHARBIT. HIS WORK OBJECTIVE WAS TO ASSIST IN THE OVERALL INSTITUTIONAL DEVELOPMENT OF BNR AND SHOULD BE EVALUATED AS SUCH. IT WAS NOT TO WORK SPECIFICALLY ON ONE STUDY OR ANOTHER. THE FACT THAT OTHER CONSULTANTS WERE USED FOR SPECIFIC RESEARCH ANALYSIS IS AN IMPORTANT FINDING. THE EVALUATION TEAM MAY WISH TO JUSTIFY ONE APPROACH IN PREFERENCE TO ANOTHER BUT DO NOT EVALUATE CHARBIT'S WORK ON OBJECTIVES HE DID NOT HAVE.

- GIVEN THE TWO PRECEEDING STATEMENTS THE RECOMMENDATION MADE CONCERNING DEMOGRAPHIC CONSULTANTS ON PAGE 28/29 NO. 10 IS CONTRADICTORY TO THE STATED OBJECTIVES OF THE PROJECT.

- THE EVALUATION SHOULD REVIEW THE EFFECTIVENESS OF THE LONG-TERM TRAINING PROVIDED FOR STAFF OF THE DIRECTION DE LA PREVISION ET DE LA STATISTIQUE AND PROVIDE SUGGESTIONS FOR IMPROVING THE PROBLEMS IDENTIFIED.

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- PAGE 28 - YOU STATE THAT NOT ENOUGH ANALYSIS IS DONE. BUT NO EXPLANATION GIVEN AS TO WHY? WHAT CAN BE DONE ABOUT IT?

- ADDENDUM TO CHAPTER 7 - MEASURING IMPACT. PRESENTS QUITE A NUMBER OF INTERESTING ANALYSES. IT SEEMS THAT A NUMBER OF THEM (NOS. 1, 5, 6, 7, 13, 17, 19, 22) COULD BE MOVED TO SECTIONS TO SHOW CHANGES THAT HAVE TAKEN PLACE ASSOCIATED WITH PROJECT ACTIVITIES. FOR EXAMPLE, PLEASE REFER TO THE GRAPH SENT TO DEVRES FROM MARY ANN MICKA IN THE LETTER COLES/MILLER-WOOD DATED MAY 23, 1991 TO SHOW POTENTIAL PROJECT IMPACT.

J. CHAPTER 8: ESTABLISHING A FAMILY PLANNING MANAGEMENT UNIT - NO COMMENT EXCEPT THAT A SYNTHESIS OF ALL SECTIONS ON RESEARCH AND THE USE OF RESEARCH RESULTS MIGHT BE PRESENTED HERE.

K. CHAPTER 9: INFORMATION, EDUCATION AND COMMUNICATION (IEC)

- THE CHAPTER IS CLEAR, TO THE POINT. IT PRESENTS THE POSITIVE AND NEGATIVE ASPECTS OF THE PROJECT. NO MAJOR CONCERNS.

L. CHAPTER 10: WOMEN IN DEVELOPMENT

- THE MISSION APPRECIATES YOUR EFFORT IN LOOKING AT THIS ELEMENT. THE STUDY QUOTED BY C. RADITZ WAS FOCUSED ON CHANGING THE WID PROJECTS TO A CREDIT PROGRAM. OTHER POSSIBILITIES WERE NOT EXPLORED; THEREFORE, THE RECOMMENDATIONS MAY NOT NOW BE APPROPRIATE.

- SECTION F: OVERALL GENDER CONSIDERATIONS - NO HARD DATA WAS GIVEN; IS THIS BECAUSE IT DOES NOT EXIST? SHOULD DISAGGREGATED DATA EXIST?

M. CHAPTER 11: CONTRACEPTIVE SOCIAL MARKETING (CSM)

- IT IS REGRETTABLE THAT THE VSPP ELEMENT COULD NOT HAVE BEEN REVIEWED IN THE SAME DETAIL AS OTHER COMPONENTS.

- FIRST OF ALL IT MUST BE NOTED THAT THROUGHOUT THIS CHAPTER CSM, VSPP AND CBD ARE MIXED. THE OBJECTIVES, ACTIVITIES, ETC. ARE NOT CLEAR. WE SUPPOSE THIS WAS DONE AS SANFAM, A NEW NGO HAS TAKEN THE LEAD IN DESIGNING AND IMPLEMENTING THESE ACTIVITIES. YOU NEED TO SEPARATE OUT THE ISSUE OF SANFAM FROM THE ACTIVITIES UNDERTAKEN OR PLANNED.

- SUGGEST YOU RENAME THE CHAPTER PARA-PUBLIC AND PRIVATE SECTOR FAMILY PLANNING ACTIVITIES WITH THREE SUB-SECTIONS 1) ON VSPP (SUPPLY OF FAMILY PLANNING SERVICES FROM PARA-PUBLIC AND PRIVATE CLINICS) WHICH IS BEING IMPLEMENTED; 2) CSM; AND 3) CBD. BOTH ITEMS 2 AND 3 ARE PLANNED ACTIVITIES BUT HAVE NOT YET BEEN IMPLEMENTED.

- VSPP HAS BEEN QUITE ACTIVE AND HAS EXPANDED SERVICE DELIVERY TO THE PRIVATE SECTOR. REFER TO THE CLINICAL/IEC CHAPTERS TO GIVE A FULL DESCRIPTION OF THE ACTIVITY. PAGES 6-10 JUST DESCRIBE AN INPUT (MONEY) FLOW. WHAT IS MISSING IS ANY COMMENT ON WHETHER THIS ELEMENT IS NEEDED? DID IT REACH A PORTION OF THE POPULATION THAT WOULD NOT HAVE BEEN REACHED BY THE PUBLIC SECTOR ALONE? DOES IT SERVE TO LEVERAGE OTHER RESOURCES FROM THE PRIVATE SECTOR WHERE THESE WOULD NOT EXIST EXCEPT FOR THE PROJECT? ETC.

- THOUGH NOTED IN THE INTRODUCTION THAT NO PRIVATE SECTOR SPECIALIST WAS IN THE TEAM, THE EVALUATION TEAM DID HAVE ENOUGH EXPERTS TO EVALUATE THE PUBLIC SECTOR ASPECT OF FAMILY PLANNING SERVICES. YOU HAVE THE SAME INFORMATION TO DO SO FOR THE PRIVATE SECTOR. PERHAPS YOU CANNOT SHOW THE COST-EFFECTIVENESS OF USING THE PRIVATE VS PUBLIC SECTOR DELIVERY SYSTEM BUT YOU CAN DESCRIBE THE SAME PARAMETERS OF APPROPRIATE OR INAPPROPRIATE SERVICE DELIVERY, MANAGEMENT, SUPERVISION AND COMPARE IT TO THE PUBLIC SECTOR, AT LEAST FOR THE FOUR CLINICS VISITED. AFTER ALL THE SAME PERCENTAGE OF CLINICS WAS VISITED FOR THE PUBLIC (12 PERCENT) AND PRIVATE (13 PERCENT) SECTORS.

- THE EVALUATION SHOULD REVIEW THE FOLLOWING POINTS:
-- THE VALUE OF EXPANDING FAMILY PLANNING SERVICES VIA THE PRIVATE SECTOR TO COMPLEMENT THE PUBLIC SECTOR;
-- THE NECESSITY OF VSPP ASSISTING THE COMPANIES TO SUSTAIN THEIR ACTIVITIES;
-- THE IMPORTANCE OF ADDING NEW ORGANIZATION OR STRENGTHENING EXISTING SITES;

- THE FOLLOWING QUESTIONS SHOULD ALSO BE ADDRESSED:
-- WHAT SHOULD BE THE RELATIONSHIP BETWEEN THE PUBLIC AND PRIVATE SECTORS?
-- WHAT KINDS OF TECHNICAL ASSISTANCE SHOULD THE PRIVATE SECTOR RECEIVE (CLINICAL, MANAGERIAL, ETC.)?
-- HOW SHOULD MANAGEMENT OF THIS SECTOR BE SENEGALIZED E.G. SHOULD MANAGEMENT OF VSPP BE MOVED FROM ISTI TO ANOTHER INSTITUTION? IF SO WHICH ONE?
-- IS THERE OR SHOULD THERE BE A RELATIONSHIP BETWEEN THE VSPP SECTOR AND THE DEVELOPMENT OF A CSM PROGRAM?
-- WHAT SHOULD THE OVERALL COORDINTION BE BETWEEN VSPP, GOS AND DONORS?

- PAGE 6 - WE DOUBT THE STATEMENT QUOTE BECAUSE THE GOVERNMENT DOES NOT YET FULLY SUPPORT THESE ACTIVITIES, ONLY ABOUT ONE THIRD OF THE PLANNED BUDGET HAS BEEN EXPENDED UNQUOTE. RATHER, THE QUOTE CRISIS UNQUOTE AFFECTED EXPENDITURE RATES FOR VSPP AS WELL AS FOR THE PUBLIC SECTOR. IN ADDITION, APPROXIMATELY TWO THIRDS OF THE PLANNED BUDGET HAS BEEN EXPENDED WHEN SALARIES AND OPERATING COSTS ARE CONSIDERED.

- TABLES PAGES 9 AND 10 MIGHT BE BETTER IN AN ANNEX.

- FOLLOW THE SECTION ON VSPP WITH A DISCUSSION OF CSM AND HOW THIS ACTIVITY CAN COMPLEMENT OR HAVE A SYNERGETIC EFFECT WITH THE VSPP ACTIVITY.

- SECTION C.4. CBD - ONLY ONE TYPE OF TWO PROPOSED CBD ACTIVITIES IS DESCRIBED. A SECOND PROPOSED CBD ACTIVITY FOLLOWS THE GAMBIA MODEL. THIS PROPOSAL SHOULD ALSO BE DESCRIBED.

- THE PROJECT HAS SUPPORTED A NUMBER OF STUDY TOURS TO OTHER PRIVATE SECTOR PROJECTS AS WELL AS TO REVIEW CBD, AND CSM. WERE THEY EFFECTIVE? SHOULD MORE BE DONE? IN ADDITION, WORKSHOPS WITH PHARMACISTS HAVE TAKEN PLACE TO LOOK AT SUPPORT FOR A CSM PROGRAM. WHAT IS YOUR EVALUATION OF THIS INTERVENTION?

N. CHAPTER 12: PROJECT ADMINISTRATION AND MANAGEMENT

- THIS TOTAL CHAPTER IS PROBLEMATIC BECAUSE IT NEEDS EXTENSIVE EDITING AND IS VERY UNCLEAR. WE SUGGEST A COMPLETE REWRITE TO BE PRESENTED TO USAID FOR REVIEW BEFORE GOING INTO FINAL. HOWEVER, PLEASE NOTE THE FOLLOWING CLARIFICATIONS OF FACT IN YOUR REWRITE.

- PLEASE NOTE PARA 6 (G) ABOVE. IT IS NOT CLEAR WHAT TIMING AND MANAGEMENT STYLE IS BEING PRESENTED DURING THE NARRATIVE. IF IT WERE CLARIFIED, THE WHOLE CHAPTER MIGHT MAKE MORE SENSE.

- PAGE 40 - THE CHAPTER SHOULD DESCRIBE THE VARIOUS MPHSA UNITS (NOW SHOWN ON PAGES 8-12) AND HOW THEY RELATE TO THE ACTIVITIES OF THE PROJECT; EXAMPLE HEALTH EDUCATION.

- PAGES 19-21 AND ANNEXES - THE FIGURES ARE INCONSISTENTLY INCORRECT. PLEASE REFER TO BUDGET TABLES PROVIDED TO THE EVALUATION TEAM BY MARY ANN MICKA. VIA THE HAND-CARRY WE WILL TRY TO PROVIDE OUR UNDERSTANDING OF THE FIGURES.

- PAGE 23 B - THE FIGURES LISTED ARE WRONG. THE LOCAL ACCOUNT TOTAL PROJECTED EXPENDITURES ARE U.S. DOLS. 6,190,782 COMPARED TO 10,672,000 WITH THE LATTER NUMBER BEING 1.7 TIMES THE LOCAL ACCOUNT (NOT 457 TIMES HIGHER). FYI AUDITORS RULED THAT NO TECHNICAL ASSISTANCE WAS TO BE PROCURED FROM THE LOCAL ACCOUNT FOLLOWING THE GUIDELINES ESTABLISHED IN THE PROJECT IMPLEMENTATION LETTER THAT ESTABLISHED THE LOCAL ACCOUNT. CONSEQUENTLY, ONLY U.S. DOLS. 14,531 WAS SPENT FOR THIS LINE ITEM BEFORE IT WAS ALL SHIEFTED TO THE ISTI CONTRACT.

- PAGE 24 - PLEASE NOTE THAT NO EXPENDITURE CAN TAKE WITHOUT A DAP. THE DAP IS SIGNED BY THE PROJECT DIRECTOR. THEREFORE, EVERY EXPENDITURE MUST IN PRACTICE BE APPROVED BY THE DIRECTOR. IT IS NOT ACCURATE TO SAY THAT THE PROEJCT DIRECTOR IN UNAWARE OF AND HAS NO CONTROL OVER EXPENDITURES.

- PAGE 25 - EXTERNAL PURCHASES: THE IMPLICATION IS THAT ISTI MAKES PURCHASES WITH NO GOS APPROVAL. PURCHASES MUST HAVE A GOS SIGNED PIO/T OR PIO/C BY THE PROJECT DIRECTOR, DIRECTEUR DE CABINET OR MINISTER. THEREFORE, THE GOS DOES APPROVE PURCHASES. THE SAME SYSTEM EXISTS FOR PAGE 26: PURCHASES MADE BY AID.

- PAGE 31 - 6: WHERE IS THE CHART REFERRED TO?

- SEVERAL STATEMENTS ARE MADE INSINUATING CERTAIN MOTIVATIONAL REASONS BEHIND ACTIONS. PLEASE PRESENT FACTS. (SEE PAGE 35 FINANCIAL ASPECTS AND APGE 36 LAST PARAGRAPH).

-ONCE AGAIN, FINDINGS AND RECOMMENDATIONS ARE NOT CONSISTENT WITH ONES PRESENTED IN THE SUMMARY SECTION.

- THE PROJECT LEVERAGED (HPNO ESTIMATES) U.S. DOLS. 5 MILLION TO U.S. DOLS. 7 MILLION OF AID/W FUNDS VIA PARTICIPATION OF CENTRALLY FUNDED PROJECTS SUCH AS JHPIEGO, AVSC, FPMD, ETC. WHAT EFFECTS DID THESE INPUTS HAVE? E.G. WERE THESE CENTRALLY FUNDED PROJECT INPUTS NEEDED?

- THIS CHAPTER DOES NOT ADDRESS THE MANAGEMENT TRAINING NEEDS ADDRESSED BY THE PROJECT. FOR EXAMPLE, THE PROJECT HAS SENT OVER 20 SHORT-TERM PARTICIPANTS TO SANTA CRUZ FOR A THREE MONTH COURSE ON FAMILY PLANNING MANAGEMENT. WAS IT WORTH IT? SHOULD WE HAVE DONE MORE OR LESS MANAGEMENT TRAINING?

- COULD THE EVALUATION TEAM RECOMMEND CERTAIN ROLES AND RESPONSIBILITIES OF THE VARIOUS PLAYERS GIVEN THE FINDINGS NOTED?

N. CHAPTER 13: TECHNICAL ASSISTANCE

- AS WITH CAHPTER 12, WE SUGGEST A COMPLETE REWRITE TO BE PRESENTED TO USAID BEFORE GOING TO FINAL. HOWEVER, FOLLOWING YOU WILL FIND SOME QUESTIONS TO CLARIFY.

- THE CHAPTER RAISES SOME FUNDAMENTAL ISSUES OF THE ROLE OF TA. HOWEVER, IT DISCUSSES ISSUES AT A BROADER LEVEL THAN IN PREVIOUS CHAPTERS. IT DOES NOT PRESENT HARD DATA ON THE EFFECTIVENESS OF TA PROVIDED AS OTHER CHAPTERS DID.

TWO THEMES EMERGE:

1) AN EVALUATION OF CONTRACTOR ON PERFORMANCE OF THE CONTRACTOR AND OF OTHER TA; 2) GENERIC ISSUES OF THE ROLE OF TA IN DEVELOPMENT PROJECTS. IS THE CONTRACTOR JUDGED BY GLOBAL PARAMETERS, RATHER THAN BY WHAT THEY DID OR DID NOT DO? THERE ARE MANY INFLAMJATORY, UNSUBSTANTIATED REMARKS THAT DO NOT BELONG IN AN OBJECTIVE EVALUATION DOCUMENT. FACTS MUST BE PRESENTED.

- PLEASE NOTE THAT PARA 6.G. SHOULD BE REVIEWED HERE. WE NEED A CONSISTENT REVIEW OF THE APPROPRIATENESS OF OVERALL LONG-TERM AND SHORT-TERM TA PROVIDED.

- PAGE 1 - DOES THE 50 PERCENT CITED REPRESENT THE AMOUNT IN THE ISTI CONTRACT OR AMOUNTS CALCULATED FROM THE TOTAL COST OF LONG-TERM AND SHORT-TERM CONSULTANTS PROVIDED TO THE PROJECT?

- PAGE 4 - YOU STATE THAT ISTI'S ROLE WAS ONLY PAYING THE BILLS. THAT IS NOT CORRECT - LONG-TERM TA WAS IN PLACE; SHORT-TERM TA WAS BEING PROVIDED; ISTI WAS ARRANGING TRAINING; BUYING COMMODITIES, ETC., ETC., ETC.

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- PAGE 3 - PLEASE CLARIFY STATEMENT MADE ON PAGE 3 ABOUT STOPPING FUNDING FOR CERTAIN ACTIVITIES. FOR EXAMPLE, GAS AT THE LOCAL LEVEL. IN THE PROJECT AGREEMENT WITH THE GOS, THE GOS WAS TO TAKE OVER CERTAIN LOCAL EXPENDITURES. WHEN THEY DID NOT, USAID DID NOT SUBSTITUTE. AS FUNDS FOR GOS FUNDS; THEREFORE, CERTAIN ACTIVITIES CAME TO A HALT.

- ONCE AGAIN FINDINGS AND RECOMMENDATIONS ARE NOT CONSISTENT WITH THE SUMMARY. THERE ARE NO FINDINGS SHOWN AT THE END OF CHAPTER 13 AND THE RECOMMENDATIONS PRESENTED ARE DIFFERENT FROM THOSE SHOWN IN THE SUMMARY.

8. WE HOPE YOUR FIND THESE COMMENTS HELPFUL AND AWAIT THE FINAL DRAFT OF CHAPTERS 12 AND 13 TO MAKE MORE DETAILED COMMENTS.

FROM: HEALTH, POPULATION AND NUTRITION OFFICE
DAKAR - ID
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20531-2130
SHIRLEY##

ANNEX O-9

Comments on Draft Report by Professor Fadel Diadhiou
Gynecology and Obstetrics Clinics, Faculty of Medicine
Universite Cheikh Anta Diop de Dakar

UNIVERSITE CHEIKH ANTA DIOP DE DAKAR

FACULTE DE MEDECINE
ET DE PHARMACIE

CLINIQUE GYNECOLOGIQUE
ET OBSTETRICALE

Professeur Fadel DIADHIOU

N° 253

Dakar, le 23 août 1991

Date Rec'd 29 AOUT 1991
MRN No. 3283
Action Taken .....
Date .....
Signature .....

Madame Mary Ann MICKA

Chef
du Bureau Santé
B.P. 49
DAKAR (SENEGAL)

Vos références : votre lettre du 14 août 1991 AID/HPNO/91-0250.
Objet : commentaires relatifs au rapport d'évaluation du Projet Santé Familiale et Population (685-0248).

Madame,

A la suite de votre lettre citée en référence relative au rapport d'évaluation du Projet Santé Familiale et Population, je dois mentionner tout d'abord que ce rapport m'est parvenu le 27 juin 1991, de la part du Docteur THIAM CT8 sans notification de date de remise de commentaires. Par la suite, j'ai été informé verbalement en fin juillet que ces commentaires étaient sans objet parce que le rapport final était déjà achevé.

Au nom de la Clinique Gynécologique et Obstétricale, nous pouvons avancer que : le rapport est complet et les observations faites comme les conclusions proposées sont pertinentes et objectives. Nous nous appesantissons sur les chapitres des Services Cliniques, de la Formation, de la Recherche, de la Stérilité, et de l'I.E.C.
Nos commentaires vont se faire autour de 3 axes du fait de la nature et de la spécificité du CHU au sein de la pyramide sanitaire du SENEGAL.

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DUE 09/12
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I - SERVICES CLINIQUES, STERILITE, I.E.C.

1°) Services cliniques

La quantité ou le nombre a jusqu'ici été privilégiée par rapport à la qualité, c'est une erreur ! Cela a entrainé la non intégration de la planification familiale au sein de la promotion de la santé maternelle et infantile, et, même dans ce cadre là, le volet maternel est traité de façon marginale : tout ceci relevant de la nécessité imposée d'accroître les performances par le nombre de clientes.

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La planification familiale était juxtaposée et constituait une entité à part avec des moyens rendant jaloux les autres secteurs d'activités : d'où les horaires réduits 8H/12H et partant l'affluence des clientes telle qu'elle exclut la qualité (accueil, animation-conseil, collecte de données, suivi, etc...).
En résumé :

- la planification familiale doit être intégrée dans la promotion de la santé maternelle et infantile.

- La qualité de services doit primer à tous points de vue (cliniques et I.E.C.).

- Le choix contraceptif doit être une réalité.

2°) Stérilité

Ce volet n'a jamais été pris en compte sérieusement. Il faudrait le promouvoir et faire en sorte que le petit nombre de sujets vivant ce drame soit pris en compte de façon correcte. Ainsi par ce biais les candidates à des grossesses planifiées seront rassurées et verront leur nombre s'accroître.
La Clinique Gynécologique et Obstétricale se propose de mettre en circulation très prochainement un guide de prise en charge des couples stériles.

3°) I.E.C. (information, éducation, conseils)

Cette rubrique n'a pas été suffisamment promue en qualité et en profondeur avant les prestations de services. Elle a été bâclée sinon inexistante, or elle est la pièce angulaire de toute politique de promotion de la santé maternelle et infantile.
En effet si du côté Personnel, le "médical" est plus ou moins initié aux techniques d'animation-conseil, il doit sur le terrain être couplé avec un "social" rompu à cette technique. Le couple "médical et social", dans cette entité I.E.C., doit être déséquilibré en volume et en préséance en faveur de l'élément social.
Une I.E.C. bien faite combat les fausses rumeurs, fait une bonne publicité contraceptive et entraine une adhésion et une participation communautaire plus forte.

II - FORMATION

Le constat est accablant : 2/3 de médecins, 1/3 de sages-femmes, 0 infirmiers/infirmières.
La formation au niveau des Ecoles et de la Faculté doit être révisée. Il ne s'agit pas d'une révision théorique mais d'une révision découlant d'une évaluation sur le terrain : les formateurs doivent être sur le terrain, y faire des constats et adapter la formation en conséquence. Les constats sur le terrain doivent servir également à la nécessité et à l'ampleur des recyclages.
La non application des conclusions du Symposium sur le Bilan Paraclinique en est une preuve.

.../...

S'agissant de formation, à côté de la théorie, la pratique sous forme de gestes techniques contrôlés, maitrisés doit être un objectif fondamental, et cette pratique doit être échelonnée de façon réaliste dans le temps.
La précipitation ne peut pas aller de paire avec la qualité de la formation.
Les programmes de formation doivent être réadaptés après évaluation périodique, quinquennale par exemple.
La formation et le recyclage doivent reposer sur du matériel didactique en nombre suffisant. Le recyclage doit être décentralisé et régionalisé, exemple : LOUGA regroupant SAINT-LOUIS et THIES, par exemple par groupe de 03 régions.

III - RECHERCHE

Elle doit comporter plusieurs aspects :

1 - socio-culturel,

2 - médical (nouvelles méthodes, abandons, etc...), et

3 - statistique.

Ces aspects qui ne peuvent être confondus.

S'agissant de l'aspect médical, le CHU doit être associé.

Cette recherche s'impose pour un programme de cette dimension : elle doit être organisée.

La Clinique Gynécologique et Obstétricale et le Centre Hospitalier et Universitaire sont disposés à prêter leurs concours dans ses différents domaines, parce que partie intégrante du système de santé et pour un mieux-être des populations.

Ampliation :

Médecin Commandant Lamine
CISSE SARR
Directeur de la Santé Publique,
pour diffusion.

Faculté de Médecine et de Pharmacie
Le Professeur
Clinique Gynécologique et Obstétricale

Professeur Fadel DIADHIOU

ANNEX O-10

Comments by SMI

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REPUBLIQUE DU SENEGAL
UN PEUPLE - UN BUT - UNE FOI

MINISTERE DE LA SANTE PUBLIQUE
ET DE L'ACTION SOCIALE

DIRECTION DE LA SANTE PUBLIQUE

SERVICE NATIONAL SMI

N° ..... MSPAS/DSP

Dakar, le .....

OBSERVATIONS ET COMMENTAIRES RELATIFS AU
RAPPORT PRELIMINAIRE D'EVALUATION DU PSFP

REMARQUES GENERALES

L'étude du document de rapport préliminaire d'évaluation du PSFP a été rendu très difficile du fait :

- du volume excessif du document ;
- du mauvais agencement des pages : le manque de numérotation n'a pas facilité la correction du texte ;
- de l'incohérence et même la contradiction de certaines affirmations, d'un chapitre à l'autre.

LES DONNEES DE L'EVALUATION

1. Si la fiabilité des données, surtout démographiques, est incontestable parce que tirées du dernier recensement national de la population ou de l'EDS, leur utilisation pour tirer des conclusions sur l'impact du PSFP ne semble pas évidente.

   En effet, le PSFP ne couvre que six (6) régions sur les 10 que compte le Sénégal ; l'impact des activités réalisées dans le cadre de ce programme ne peut donc , pour être fiable, avoir comme dénominateur que la population cible couverte et non la population totale des dix régions.

2. Certains documents utilisés pour appuyer des conclusions ont été réalisés sur la base de projection et non sur des données réelles.

LA QUALITE DE L'EVALUATION

Après ces points soulevés dans la fiabilité des données, nous ne pouvons pas juger l'évaluation de bonne qualité. Cependant, elle a permis de détecter plusieurs contraintes dans la mise en oeuvre des activités et d'apporter des suggestions pertinentes pour la poursuite des interventions.

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ORGANISATION DE L'EVALUATION

La planification des activités de l'évaluation n'a pas permis aux évaluateurs de cerner tous les problèmes soulevés.

Certains responsables n'ont pas été interviewés correctement afin de leur permettre d'apporter des éclaircissements sur certains points qui reviennent dans le document sans que la raison fondamentale ne soit recherchée. Comme exemple, nous citerons :

* L'inexistence de la lettre circulaire sur le bilan paraclinique au niveau des centres. Ceci ne signifie pas la méconnaissance des directives de cette circulaire, la lettre ayant été envoyée par le Ministère à tous les Médecin-Chefs de Région. A ce niveau, toutes les directives émanant du niveau central sont diffusées lors des réunions de coordination et répercutées au niveau des services impliqués.

* Le remplissage incomplet de la Fiche de PF. Cette fiche est trop fastidieuse à remplir à cause de renseignements superflus jamais utilisés qui y figurent. Sa revue, pour la rendre plus simple, a été décidée depuis longtemps par le niveau national.

* L'"Organisme Belge" dont l'évaluateur de la logistique a fait mention n'a jamais mis en place une méthodologie pour la mise en place des contraceptifs injectables au niveau des centres du PSFP.
  L'inexistence des injectables dans les 6 régions d'intervention du PSFP est exclusivement liée au manque de compétences techniques de certaines prestataires, concernant cette méthode contraceptive qui n'était pas très développée dans leur curriculum de formation parce que ne faisant pas partie des contraceptifs utilisés dans le programme USAID.

* Concernant la supervision, le SNSMT est tributaire de ISTI qui gère tous les moyens destinés à cette importante activité (entretien des véhicules, dotation en carburant, paiement des frais de déplacement).
  Les contraintes que cet organisme impose notamment l'obligation de passer la nuit dans un hôtel pour justifier les frais de prise en charge, étaient la plupart du temps incompatibles avec une bonne supervision.
  Les trois quarts du temps prévu pour la supervision étant consacrés à faire la navette entre le seul hôtel de la région et les points de service distants parfois d'une centaine de kilomètres.

PRECISION DANS LES RECOMMANDATIONS

Les recommandations ont été précises et pertinentes ; cependant des problèmes soulevés n'ont pas trouvé de proposition de solution.

ANNEX O-11

Comments by Betsy Stevens, ISTI Project Manager

#71

International Science and Technology Institute, Inc.

Headquarters: 1129 20th Street, N.W., Washington, D.C. 20036
202/785-0831 • Telex: 272785 ISTI UR • FAX: 202/223-3865

MEMORANDUM

TO: Irving Rosenthal
Team leader
Senegal Family Health & Population Project Evaluation

FROM: Betsy Stephens
ISTI Project Manager
Senegal Family Health & Population Project

DATE: August 13, 1991

SUBJECT: Senegal Family Health & Population Project Evaluation
ISTI response to draft report

ISTI was asked by USAID/Dakar to comment on the draft evaluation report and to submit our comments directly to you, copied to USAID/Dakar.

As you know, we received a disk and an annotated Index that enabled us to put together a copy of the draft. Our copy includes Chapters I - XII and Chapter XIV in English and chapter XIII in French.

All of our specific comments refer to Chapter XII and by implication to the relevant sections of Chapter I, the summary. This is the section of the report in which there were a number of statements that required clarification by ISTI.

ISTI's overall reaction to the report was that there is a fair amount of information but that nowhere is there a cohesive description of the significant achievements that can be attributed to the Project. We believe, as you have indicated in various parts of the evaluation, that a great deal has been accomplished and that these achievements should be summarized and acknowledged at the outset of the report.

USAID, the Government of Senegal and the several organizations and individuals, including ISTI, that have provided technical assistance, put a great deal of effort into the Project. There certainly have been serious constraints and problems involved in the implementation -- many of which the evaluation has cited. However, the family planning environment in Senegal has, since the beginning of the Project, changed dramatically and we believe that this is in large part attributable to the important contributions made by USAID and the Government of Senegal in the context of this Project.

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The knowledge and practice of family planning has grown significantly, a national family planning policy was established, family planning services have been introduced into clinics in many parts of the country, many practitioners, social services workers and managers have been trained in clinical services, communications and family planning management, effective IEC activities have been implemented, relevant regulatory and clinical policies have been modified, and an important program has been implemented in the non-governmental sector.

Following, are our comments on Chapter XII that relate to specific statements in the draft report (the quotations indicate wording from the draft report):

p. 4 (sec. 3b) ISTI "...provides the Project with technical assistance..."

It should be clarified that technical assistance includes both short-term TA and the TA provided by long-term advisors. At present the ISTI Liaison Officer spends a major portion of his time acting as a motivating force or catalyst to help the Project Director expeditiously program, coordinate and execute Project activities.

p. 11 (sec. 5b) ISTI budget

Attached is a copy of our budget as it appeared in the most recent contract modification.

p.11 (sec. 6a) "...Before the 'crisis' of 1989/90 when it was necessary to change Project Directors..."

Since the 'crisis' had such an important effect on the operation of the Project, it should be described somewhere, and the implications discussed.

Suspicions of mismanagement, long brewing, got to the point where finally both A.I.D. (through the R.I.G.) and the GOS (through the I.G.E. - Inspection Generale de l'Etat) found it necessary to investigate formally. Both found considerable evidence of malfeasance, which led not only to the "change of Project Directors" but also to replacing the Project accountant and logistician. These were the three central figures who had been controlling Project planning and management, all of whom had had major implementing roles from the beginning of the Project and had received training, on-the-job and off-the-job, at the Project's expense. This was a major loss in terms of experience, operational knowledge and institutional memory.

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From the time the Director was removed (o/a July 1, 1990) until he was replaced (October 1, 1990) there was no direction. Moreover, during the final stages of the investigation, the Director's authority was so weakened, his credibility so diminished, and his energies so absorbed in self-defence and counterattack, that the lack of effective leadership started long before his actual removal. A.I.D.'s reaction was necessarily one of increased control, and ISTI, reacting to the need for increased vigilance, had to take a more active role to fill the vacuum.

One must consider the added burdens resulting from the investigations -- the time and effort spent by A.I.D., ISTI and the GOS responding to the investigations and the increased necessity to document every action, combined with the lack of a local currency budget due to the fact that the Procedures Manual had not been signed off on by the GOS. This caused a suspension of most Project activities, although most operating costs continued, resulting in a dramatic reduction of productivity and serious loss of Project momentum. Thus the amount of money lost through embezzlement or mismanagement only represents part of the problems that "the crisis" left in its wake. This needs to be made clear rather than just vaguely referring to "the crisis".

p. 11 (sec. 6a) "Since 1989, the planning process...."

It is accurate to say that ISTI's role in the planning process increased, for reasons stated above. However, this was transitory, a filling of the vacuum. Although it took a long time to reestablish the role of the Project leadership, things are back on track now as witnessed by the planning workshop (held July 2- 4, 1991) and the two weeks of programming and budgeting that followed -- in which PSFP, Bien-etre Familial, MSPAS, A.I.D., the World Bank, FNUAP and ISTI all participated.

p. 16 [sec. 7,c(6)] "Financing activities...."

This is not an accurate description of the process. It leaves the Project Director completely out of the loop, which is not the case. ISTI did indeed work directly with the component directors to elaborate the 1990-91 Budget, which later became the '90-day Interim Budget', due to the lack of Project Director at the time it was being prepared. However, by the time that it was submitted to A.I.D. for approval, and an advance request was prepared, the new Director was on board, and, although new, was directly and extensively involved, in collaboration with ISTI, with the numerous revisions and modifications that the budget underwent before approval.

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The 1991 Budget, which covered the remainder of the year's activities following the Interim Budget, was in fact submitted to A.I.D. by the Project Director. ISTI's role is to provide assistance to the Project Director, to strengthen her skills in project planning and management. So it is the Project Director, not ISTI (although with ISTI's assistance) who centralizes the budgets from the different components, and is involved in and responsible for the revisions and modifications.

The same concept applies to advance requests which are jointly prepared by PSFP and ISTI (although here PSFP basically decides activities in the annual budget will be carried out in the following 90 days, and ISTI prepares the budget, broken down by line items.) PSFP obtains the signature of the MSPAS Director de Cabinet, returns the advance request to ISTI, who in turn submits it to A.I.D. The check issued by A.I.D. is in the name of the Project, not ISTI, and is released to ISTI to be deposited in the Project's account, not ISTI's.

The implication in this section is that ISTI goes about its business, working directly with the various component directors, thus bypassing the Project Director and robbing him/her of the ability and authority to manage. While ISTI, necessarily, did step in temporarily, this was only during the period of the vacuum in Project leadership. Both the Project Director and ISTI have now resumed their roles.

It should be noted here that of the four components, three (PSFP, SN/SMI, and BNR) are all branches of the same government (GOS) and two (PSFP and SN/SMI) are part of the same Ministry (MSPAS). If there is a lack of communication between PSFP and the other components, it is not the role of ISTI, an outside agency, to take responsibility for the communication among different sections of a host country entity. This is a very important leitmotif that comes up again and again, not only in the evaluation but in day to day Project implementation.

p. 19 (sec. 7a) "Local purchases by ISTI"

Again, in this section the implication is that the Project has little management control. While the process described is basically accurate, there is an important lacuna: The DAPs are not transmitted directly to ISTI by the components; they are first signed by the Project Director (or the Directeur de Cabinet of MSPAS during the period when there was no director) and transmitted to ISTI by the PSFP.

The issue that is raised "ISTI makes procurement decisions on its own, without Project personnel involvement" stems from the bitterness that responsibility for the procurement (contacts with suppliers, etc.) was taken away from the Project by A.I.D. after

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the audits. Since the "crisis" ISTI has made procurement decisions, ensuring that procurement follows appropriate procedures and that the Project gets the best buy possible. Thus the Project might argue that ISTI is more concerned with price than quality. However, when decisions of a technical nature need to be made, there is communication between ISTI and the Project and the Project's views are taken into consideration. There are no historical examples of ISTI having procured commodities for the Project that were found to be unacceptable.

It should be noted that some of the commodities (bureaux, chaises, etc.) purchased when the PSFP was responsible are still in the warehouse because the centers refused to accept them due to their inappropriateness and poor quality.

p. 23 (sec. 2) "Financial Aspects..... do not understand why more than 35%%.....spent by ISTI.....36%....used to cover foreign technical assistance....."

It is not clear to what the 35% of the grant refers; nor is it clear what is meant by 36% of the funds deposited in the local account. No funds from the Project's local account are used for foreign TA. The ISTI local currency account is used to support foreign TA (housing, utilities, etc.) but not to pay foreign TA salaries or to finance foreign consultants.

p. 23 (sec. 2) "....PHPP can not monitor the Project and the GOS can not control the use of funds..."

As noted before, all expenditures of local funds require DAPs signed by the PSFP Director. Moreover, ISTI now provides the monthly local account reports to the Project.

p. 23 (sec. 2) "....if more effort and resources had been provided to train Project staff in U.S. management practices and procedures."

Over 20 people were trained in family planning management at Santa Cruz, another 12 or so through Columbia University and CAFS. The Director, accountant and logistician who were removed following the investigations had training in management and computerized inventory control in Rabat and Boston.

Together with the long-term TA there was a continual involvement of Project staff in A.I.D. management practices and procedures and an attempt to transfer to them the capability to take over these responsibilities. Unfortunately, the principle beneficiaries of this training are no longer with the Project.

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p. 25 (sec. 9) " procedure used by ISTI for bidding on contracts ....did not insure ...open competition...insufficiently involved GOS ..."

It is not clear which contracts were referred to here. If it refers to technical assistance consultants, all were approved by the PSFP. In the case of the three consultants who helped to develop the Population Policy, they were chosen by the Ministere du Plan (GOS) and contracts signed by the PSFP Director.

In the case of construction contracts, there was full and open competition and all contracts were signed by the PSFP.

cc: Linda Lankenau, HPNO, USAID/Dakar
Tim Rosche, Liaison Officer, ISTI/Dakar

Attachment

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I. SECTION B, ARTICLE 2 - ESTIMATED CONTRACT COST AND FINANCING

Delete paragraph 2 in its entirety and substitute the following in lieu thereof:

"2. ESTIMATED CONTRACT COST AND FINANCING

(a) The total estimated cost for performance of the work specified in Section C of this contract is $8,335,164. The fixed fee is $322,613. The total estimated cost plus fixed fee is $8,657,777.

(b) The amount of funds currently obligated to this contract for performance hereunder is $8,657,777. This amount fully funds the contract. The contractor shall not exceed this amount unless authorized by the Contracting Officer pursuant to the clause of this contract entitled "Limitation of Cost" (FAR 52.232-20) or "Limitation of Funds" (FAR 52.232-22), as applicable (see Section I of this contract)."

II. SECTION B, ARTICLE 3 - BUDGET

Delete "Itemized Budget" under paragraph 3(b) and substitute the following revised budget:

"ITEMIZED BUDGET

Categories	Budget Amount
Salaries and Wages	$2,150,088
Fringe Benefits	84,125
Overhead	901,017
Consultants	222,277
Travel	201,607
Allowances	1,024,985
Subcontracts	451,533
Other Direct Costs	1,085,287
Project Training	1,272,508
Sub-Total	$7,398,427
Less Disallowances	(41,477)
Sub-Total	$7,356,950
G & A	876,037
Fixed Fee	322,613
Commodity Fixed Fee	102,177
GRAND TOTAL	$8,657,777"

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ANNEX O-12

Comments from the Office of Health Education
(Ministry of Public Health)

REPUBLIQUE DU SENEGAL

MINISTERE DE LA SANTE PUBLIQUE
ET DE L'ACTION SOCIALE

DIRECTION DE LA SANTE PUBLIQUE

SERVICE DE L'EDUCATION POUR LA SANTE

N° ..... MPS/DSP/SEPS

Dakar, le ..... 19.....

OBSERVATIONS ET COMMENTAIRES

RELATIFS AU RAPPORT PRELIMINAIRE D'EVALUATION

DU P.S.F.P

-=-=-=-=-=-=-

L'équipe d'évaluation a fourni des efforts considérables pour aboutir à des résultats très utiles à la relance des activités de P.F. A cet effet, nous leur renouvelons toutes nos félicitations.

Au point de vue des données, l'équipe a su exploiter la quasi totalité des études réalisées dans le cadre de la P.F., ceci est une très bonne chose, car tout est lié.

Cependant, le choix des sîtes pouvait prendre en compte des sîtes au niveau des autres régions couvertes par le PSFP, compte tenu des spécifités régionales (exemple de Ziguinchor). Ceci permettrait de renforcer les résultats obtenus.

Au niveau de la communication interpersonnelle, l'accent a été surtout mis sur l'utilisation des monitrices et des volontaires, alors que nous avons peu d'informations sur les résultats obtenus par ces deux groupes cibles. En effet, dans la mouvance de l'intégration il est souhaitable de s'appuyer en plus sur les autres ressources humaines locales disponibles (ASC, comités de santé, comité des mamans, ICP, enseignants...) à l'image du P.E.V.

.../...

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Au niveau des Recommandations :

- Concernant la collecte et l'analyse des données (R.4-5-6-7), il serait souhaitable de s'appuyer d'avantage sur les compétences existantes au niveau de la Division des Statistiques du MSPAS pour éviter les problèmes de disponibilité ou de formation posés au niveau du B.N.R,

- Concernant l'I.E.C :

◊ La distribution communautaire (R.3-4) doit être bien étudiée mais surtout avec un accent particulier sur son aspect motivation des revendeurs pour lequel il a été proposé une rémunération selon le bénéfice obtenu.

◊ R.6 - Si la communication interpersonnelle est privilégiée, il faudrait nécessairement produire un matériel léger adapté pour supporter les activités d'éducation de groupe : exemple une boîte à images ou un flanellographe serait tout à fait indiqué.

Par ailleurs l'évaluation déplore la non utilisation des productions audio-visuelles sur le terrain (cassettes vidéo, audio et diapositives).
Il serait souhaitable de démultiplier ce matériel pour son utilisation effective au niveau région et district, étant donné que le matériel de projection existe sans qu'on puisse avoir des précisions sur sa sous utilisation (manipulation, disponibilité des films, etc..).

◊ R.8 : la collaboration avec l'UNICOM est nécessaire, mais pas spécifiquement en ce qui concerne la stratégie à adopter pour toucher les autorités nationales, religieuses et traditionnelles.

#81

DATE: JULY 16, 1991

USAID/Senegal
FAX Transmission

Fax Number 23-29-65
Senegal IDD code 221

TO:

FAX# (301) 652-5934

Address DEVRES, Inc. - 7201 Wisconsin Avenue
Suite 500 - Bethesda, MD 20814

Attn.

From:

Person: Linda Lankenau

Office: Health, Population § Nutrition

This message is 13 pages not counting this cover sheet.

Subject: Family Health and Population Project Evaluation (685-0248)

Refs: A) Contract No. PDC-0085-I-9089-00, Delivery Order No. 16
B) Fax Lankenau/Devres 6/20/91

1. Please find attached the Mission's comments re subject evaluation report.

[redacted]

Approved for transmission at USAID: Julius E. Coles, DIR

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1. AS DEVRES IS AWARE THE COMPLETED DRAFT EVALUATION IN ENGLISH WAS DISTRIBUTED FOR REVIEW AS COMPLETED BEFORE THE TRANSLATION AND DISTRIBUTION OF THE FRENCH VERSION.
THE GOS COMMENTS WILL FOLLOW IN SEPTEL AS PER SCHEDULE SET FOR IN REF (B). BOTH SETS OF COMMENTS WILL HAVE TO BE TAKEN INTO CONSIDERATION IN THE FINALIZATION OF THE REPORT.

2. USAID COMMENTS ARE DIVIDED INTO TWO MAJOR SECTIONS. THE FIRST SECTION WILL ADDRESS THE REPORT AS A WHOLE: SCOPE, RESPONSIVENESS TO TERMS OF REFERENCE (TOR), COMPLETENESS, ORGANIZATION, ETC. THE SECOND SECTION WILL COMMENT CHAPTER BY CHAPTER CORRECTING INFORMATION, POSING SPECIFIC QUESTIONS AND CONCERNS, ETC.

3. PLEASE NOTE THAT MANY PEOPLE FROM USAID, ISTI, GOS, AND OTHER DONORS PROVIDED EXHAUSTIVE COMMENTS ON DRAFT CHAPTERS PRIOR TO PRODUCTION OF THE FINAL DRAFT LEFT WITH USAID. NONE OF THESE COMMENTS AND SUGGESTIONS WERE INCORPORATED INTO THE DOCUMENT LEFT FOR REVIEW. WE CANNOT REPRODUCE ALL THOSE COMMENTS HERE - SOME WERE WRITTEN ON DRAFT CHAPTERS RETURNED TO THE DRAFTERS OR TO ROSENTHAL; OTHERS WERE GIVEN ORALLY IN HOURS OF DEBRIEFINGS AND MEETINGS. HOWEVER, WE EXPECT THAT MOST COMMENTS WILL BE INCLUDED IN THE FINAL DOCUMENT.

4. IN ADDITION, A COPY OF THE EVALUATION IN ENGLISH WITH MARGINAL NOTES WILL BE DHLED TO WASHINGTON ASAP.

5. USAID/SENEGAL MUST NOTE THAT THE DRAFT LEFT WITH US COULD IN NO WAY BE CONSIDERED AS A FINAL DRAFT. WITH TWO MAJOR EXCEPTIONS, (EVALUATION OF VSPP AND FINANCIAL/TECHNICAL ASSISTANCE SECTIONS) THE INFORMATION NEEDED FOR A COMPREHENSIVE EVALUATION REPORT IS PRESENT. IN GENERAL, THE EVALUATION IDENTIFIES KEY PROBLEMS SUCH AS LACK OF SUPERVISION, QUALITY OF SERVICES, USE AND DIFFUSION OF DATA, COORDINATION, ETC. HOWEVER, THERE ARE SOME SECTIONS WHERE THE LINK BETWEEN FINDINGS, PROBLEMS, AND RECOMMEDATIONS IS NOT CLEAR. IN ADDITION, EXTENSIVE EDITORIAL CHANGES ARE NEEDED: VARIOUS CHAPTERS AND SECTIONS OF CHAPTERS CONTRADICT ONE ANOTHER; THERE ARE SECTIONS THAT ARE INCOMPREHENSIBLE; THE TRANSLATED CHAPTERS NEED ALOT OF EDITING; AND, THERE ARE GRAMMATICAL, SYNTAX AND SPELLING ERRORS TOO NUMEROUS TO NOTE. IF THE QUALITY OF THE QUOTE FINAL REPORT UNQUOTE IS NOT ACCEPTABLE, USAID RESERVES THE RIGHT TO MAKE FURTHER COMMENTS. DEVRES WILL HAVE TO REVISE THE DOCUMENT UNTIL IS ACCEPTABLE.

6. GENERAL COMMENTS:

(A) THE DRAFT IS LARGELY DESCRIPTIVE AND INCONCLUSIVE. THE REPORT DESCRIBES WHAT HAS HAPPENED AND SUGGESTS NEW THINGS FOR THE FUTURE RATHER THAN REACHING FUNDAMENTAL CONCLUSIONS. THE FOCUS IS ON TOO MUCH DETAIL RATHER THAN THE BIG PICTURE. THE COMMENTARY TENDS TO RAMBLE AND WILL NEED TO BE SYNTHESIZED AND PULLED TOGETHER INTO A COHERENT DOCUMENT WHICH HAS BEEN WELL EDITED.

ALL ASPECTS/COMPONENTS OF THE PROJECT ARE ASSESSED. BUT THE DRAFT DOES NOT PROVIDE AN OVERALL ANALYSIS OF THE PROJECT, INCLUDING ANSWERS TO THE FOLLOWING

QUESTIONS CONTAINED IN THE TERMS OF REFERENCE AND PRESENTED IN THE USAID/SENEGAL BRIEFING OF THE EVALUATION TEAM:

- ARE KEY ASSUMPTIONS MADE IN PROJECT DESIGN STILL VALID?
- IS THE PROJECT PURPOSE REALISTIC?
- WHAT ARE THE MAJOR ACCOMPLISHMENTS/SHORTFALLS OF THE PROJECT?
- WHAT ARE THE MAJOR PROBLEMS THE PROJECT HAD TO SOLVE? HOW WERE THOSE PROBLEMS SOLVED?
- WERE PROJECT INPUTS DELIVERED IN A TIMELY MANNER? IF NOT, WHAT WAS THE IMPACT ON OUTPUTS? ON IMPLEMENTATION? WERE THERE ANY DELAYS IN PROJECT IMPLEMENTATION AS A RESULT OF LATE DELIVERY OF INPUTS?

SUCH AN OVERALL ANALYSIS OF THE PROJECT STARTING FROM FINDINGS WOULD HELP LEAD TO CONCLUSIONS ON OVERALL SUCCESS OR LACK THEREOF OF THE PROJECT AND WOULD PROVIDE THE BASIS FOR RECOMMENDATIONS. SUCH AN ANALYSIS WOULD ALSO PERMIT US TO KNOW WHETHER THE PROJECT IS MEETING ITS OBJECTIVES OR NOT, AND IF NOT, WHY?

(B) THE EVALUATION AVOIDS MAKING JUDGEMENTS IN SEVERAL PLACES - PARTICULARLY THE PROJECT'S CONTRIBUTION TO EXPANDED CONTRACEPTIVE USE. IT LAYS OUT THE FACTS WITHOUT MAKING A JUDGEMENT WHETHER THEY ARE GOOD OR BAD, I.E. 70,000 ACCEPTORS AND AN INCREASE OF 20-40 PERCENT PER ANNUM WOULD APPEAR SIGNIFICANT YET THE REPORT SIMPLY STATES THAT THIS IS INSUFFICIENT TO MEET THE 200,000 GOAL.

THE EVALUATION DESCRIBES THE ACTIVITIES AND THEN JUMPS TO RECOMMENDATIONS. THE QUOTE EVALUATIVE UNQUOTE ELEMENT MUST BE ADDED - WERE THE ACTIVITIES GOOD, BAD OR INDIFFERENT.

(C) THE SUMMARY DOES NOT PROVIDE A DESCRIPTION OF THE PROJECT'S ACCOMPLISHMENTS; IT IS RATHER, A LITANY OF PROBLEMS. NO MENTION IS MADE OF THE GENERAL ENVIRONMENT OF ACCEPTABILITY FOR FAMILY PLANNING NOW COMPARED WITH 1985. HOWEVER, BURIED AT THE END OF CHAPTER 7, THE EVALUATION PRESENTS EVIDENCE OF SOME SUCCESS IN FAMILY PLANNING. THE SUMMARY, IN FACT, SHOULD PRESENT AN OVERVIEW OF BOTH SIDES: PROGRESS/ACCOMPLISHMENTS AND PROBLEMS.

(D) SOME OF THE PROJECT'S ACCOMPLISHMENTS USAID/SENEGAL BELIEVES SHOULD BE NOTED:

- FAMILY PLANNING HAS BECOME A REALITY IN SENEGAL AND SERVICES ARE NOW AVAILABLE THROUGHOUT THE COUNTRY;

- SENEGAL HAS PRODUCED A POPULATION POLICY AND A NATIONAL FAMILY PLANNING PROGRAM, ENDORSED BY THE PRESIDENT AND PROMOTED AS A GOVERNMENT PRIORITY IN 1991;

- THE PRIVATE SECTOR HAS RAPIDLY TAKEN ON AN IMPORTANT NICHE IN THE NATIONAL FAMILY PLANNING PROGRAM;

- THE ATTITUDE OF SENEGALESE REGARDING FAMILY PLANNING HAS RAPIDLY EVOLVED TO A POINT WHERE IT CAN BE DISCUSSED RELATIVELY OPENLY;

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- THE PROJECT HAS GIVEN THE NECESSARY EXPERIENCE TO FAMILY PLANNING IMPLEMENTORS TO ENABLE THEN TO DEVELOP MORE EFFICIENT PROGRAMS; AND

- THERE EXISTS A MUCH BETTER UNDERSTANDING OF POPULATION DYNAMICS AND CHARACTERISTICS IN SENEGAL WHICH HAVE LED TO BETTER DEVELOPMENT PLANNING.

(E) RECOMMENDATIONS:

(1) WE COUNTED 131 RECOMMENDATIONS, NOT 97 AS STATED. WITH SO MANY RECOMMENDATIONS THEY SHOULD BE CLEARLY SPLIT INTO TWO CATEGORIES:

- RECOMMENDATIONS PERTAINING TO THE ON-GOING PROJECT INCLUDING WHAT ADJUSTMENTS, IF ANY, ARE NECESSARY FOR THE REMAINING LIFE OF THE PROJECT?

- RECOMMENDATIONS PERTAINING TO THE PROPOSED POPULATION AND CHILD SURVIVAL PROJECT (OR ACTIONS TO BE TAKEN IN THE FUTURE.)

(2) THE ATTEMPT MADE BY THE TEAM TO PROVIDE SOME ACTION ORIENTED RECOMMENDATIONS IDENTIFYING WHICH ENTITY (USAID, GOS, TA CONTRACTOR) SHOULD BE RESPONSIBLE FOR IMPLEMENTATION IS APPRECIATED.

(3) SUGGESTIONS FOR THE DESIGN OF THE NEW PROJECT DO NOT CLEARLY IDENTIFY OPTIONS FOR THE MOST APPROPRIATE/MANAGEABLE PACKAGE OF POPULATION ACTIVITIES TO BE IMPLEMENTED.

(F) THE CONCEPT OF A TIGHTER FOCUS IS MENTIONED SEVERAL TIMES BUT THE TEAM MADE NO CONCRETE SUGGESTIONS AS TO HOW THIS MIGHT BE DONE. THE REPORT SHOULD DESCRIBE ELEMENTS THAT SHOULD RECEIVE THE MOST ATTENTION IN THE REMAINING TIMEFRAME. SEVERAL SECTIONS RECOMMEND USING 5 TO 12 COOPERATING AGENCIES TO SUPPORT VARIOUS COMPONENTS. IS THE REPORT RECOMMENDING A REDUCED NUMBER CENTRALLY-FUNDED COOPERATING AGENCIES OR WHAT?

(G) IT IS APPARENT THAT THERE ARE MULTIPLE PHASES OF THE PROJECT - BOTH IN TERMS OF MANAGEMENT STRUCTURE AND IN THE PROGRESS OF THE PROJECTS ACCOMPLISHMENTS: THE AUDIT OF 1989 LEADING TO A QUOTE CRISIS UNQUOTE; THE MINISTERIAL CHANGE IN 1990 FROM THE MINISTRY OF SOCIAL ACTION TO THE MINISTRY OF PUBLIC HEALTH AND SOCIAL ACTION (MPHSA); AND SUBSEQUENT REORGANIZATIONAL CHANGES IN THE MPHSA. NONE OF THESE CHANGES ARE CLEARLY DESCRIBED; THEY ARE ONLY REFERRED TO AS PRESENTING PROBLEMS. A DESCRIPTION OF THESE EVENTS NEEDS TO BE PRESENTED EARLY IN THE EVALUATION. IN EACH SECTION THEN REFERENCE TO THESE CHANGES (GOOD OR BAD) AND SUBSEQUENT PROJECT PERFORMANCE NEEDS TO BE SHOWN.

(H) THE CHAPTERS ARE NOT CONSISTENT IN DISCUSSING INPUTS. FOR EXAMPLE THE CHAPTERS ON BNR AND IEC DESCRIBE BOTH THE LONG AND SHORT-TERM TECHNICAL ASSISTANCE PROVIDED AND GIVE SOME IDEA OF THE QUALITY OF THOSE INPUTS. HOWEVER, THE CHAPTERS ON CLINICAL, STD, RESEARCH AND LOGISTICS DO NOT DESCRIBE THESE ASPECTS AT ALL. CHAPTER 13 ONLY DESCRIBES ISTI'S OVERALL ROLE AND DOES NOT FILL IN THE GAPS NOR GIVE APPROPRIATE SUMMARIES OF BOTH LONG AND SHORT-TERM TA PROVIDED (EXAMPLE: LAURA EVISON (NURSE/MIDWIFE), AL BARON (TEAM LEADER), MOHAMED IBRAHIM (LOGISTICIAN), ETC).

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THE SAME INCONSISTENCIES APPEAR IN THE DISCUSSIONS OF TRAINING - BOTH LONG AND SHORT-TERM. CERTAIN CHAPTERS ADDRESS THE APPROPRIATENESS OF TRAINING PROVIDED AND OTHERS DO NOT. THERE IS NO SUMMARY OF THIS ISSUE WITHIN THE DOCUMENT.

(I) THE EVALUATION GIVES CONFLICTING DATA THROUGHOUT THE REPORT. MARGINAL COMMENTS ON THE DRAFT TO BE DHLED WILL PROVIDE DETAILS BUT TO NOTE JUST A FEW OF THE KEY ONES:

- PAGE 5 CHAPTER 3 STATES THERE ARE 27 PRIVATE AND PARASTATAL ORGANIZATIONS WITH 40 CLINICS, WHEREAS PAGE 35 CHAPTER 7 STATES THERE ARE 32 (OR IS IT 31?)

- PAGES 8 AND 9 OF CHAPTER 3 STATE THERE ARE 29,890 (PUBLIC) PLUS 9,111 (PRIVATE) PLUS 19,300 (COMMERCIAL) USERS FOR A TOTAL OF 58,301; PAGE 35 OF CHAPTER 7 STATES 61,376; THE SUMMARY OF FINDINGS STATES 70,107; AND, CHAPTER 6 PAGE 15 STATES THERE ARE 56,949 ACCEPTORS. PLEASE CLARIFY.

- PAGE 9 OF CHAPTER 3 STATES THERE ARE 29 UNFPA CLINICS BUT PAGE 35 CHAPTER 7 STATES THERE ARE 34 CENTERS.

- PAGE 38 CHAPTER 7 SHOWS 96,000 COUPLE YEAR PROTECTION (CYP) FOR ALL SECTORS AND TABLE 1 CHAPTER 6 SHOWS 136,218 CYP.

ALL THESE AND MANY MORE INCONSISTENCIES SHOULD BE REVIEWED AND RECONCILED. IF DIFFERENT METHODS ARE USED TO CALCULATE THESE NUMBERS, THE METHODOLOGIES MUST BE DESCRIBED AND THE IMPLICATIONS NOTED. THE RAW DATA USED FOR CALCULATING CYP'S MUST BE PRESENTED IN AN ANNEX TO SUBSTANTIATE THE CALCULATIONS.

(J) LESSONS LEARNED: WE APPRECIATE THE SUGGESTIONS REGARDING THE MANAGEMENT OF THIS EVALUATION AND OF THE A.I.D. EVALUATION PROCESS IN GENERAL. HOWEVER, AN ADDITIONAL EFFORT IS NEEDED TO PULL OUT LESSONS THAT COULD BE HELPFUL FOR THE DESIGN AND IMPLEMENTATION OF SIMILAR PROJECTS IN THE FUTURE.

(K) THE MANAGEMENT SECTION DEALS WITH THE MANAGEMENT OF THE EVALUATION RATHER THAN THE MANAGEMENT OF THE PROJECT. THE VERY CONTROVERSIAL CHAPTER 13 ON TA IS THE ONLY PLACE WHERE THE MANAGEMENT ISSUES BEGIN TO SURFACE. THE QUOTE CRISIS UNQUOTE IS REFERRED TO ONLY IN THE LATER CHAPTERS, YET IT WAS A MAJOR FACTOR IN THE PROJECT'S PROGRESS AS NOTED IN (B) ABOVE. AID MANAGEMENT IS NOT REALLY DISCUSSED EXCEPT IN THE CONTRACEPTIVE PROCUREMENT PORTION.

THIS SECTION SHOULD BE COMPLETELY REWRITTEN (SEE NOTES ON SPECIFIC CHAPTERS - CHAPTER 12 BELOW.)

(L) THROUGHOUT THE TEXT MOST CHAPTERS BEGIN WITH GOALS AND OBJECTIVES FOLLOWED BY DISCUSSION. HOWEVER, PRESENTATION OF RESULTS DO NOT CLEARLY SHOW THE RELATIONSHIP BETWEEN THE LOGFRAME AND PROJECT COMPONENTS. THIS SHOULD BE DESCRIBED.

(M) IN GENERAL, THE EVALUATION DOCUMENT CONSISTS OF INDIVIDUAL REPORTS WITH LITTLE COHERENCE AND MAJOR GAPS. THIS MUST BE PULLED TOGETHER TO PRESENT A TEAM EVALUATION REPORT.

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7. SPECIFIC COMMENTS BY CHAPTERS:

A. INTRODUCTION, ETC - DETAILED MARGINAL NOTES WILL BE SENT TO CORRECT ACRONYMS, ETC.

B. EXECUTIVE SUMMARY

- IMPACT STATEMENTS NEED TO BE INCLUDED HERE AS WELL AS DESCRIPTIVE PASSAGES ABOUT ACTIVITIES (INPUTS/OUTPUTS LEVEL.) FOR EXAMPLE PAGE 2 STATES THAT THE PROJECT PRECEEDED THE NATIONAL POPULATION POLICY AND THE NATIONAL FAMILY PLANNING PROGRAM BUT FAILS TO NOTE THAT THESE KEY DOCUMENTS WERE PRODUCED DUE TO DIRECT INPUTS PROVIDED BY THE FAMILY HEALTH AND POPULATION PROJECT (FHPP).

- THERE ARE NUMEROUS PARAGRAPHS AND SENTENCES THAT DO NOT MAKE SENSE SUCH AS PAGE 2 CLINICAL SERVICES SENTENCES 1 AND 3; PAGE 3 CONTRACEPTIVE LOGISTICS LAST SENTENCE; PAGE 3 DATA BASE IMPROVEMENT FIRST SENTENCE, ETC, ETC, ETC.

- PLEASE NOTE PAGE 2, PARA 3 THAT USAID FULLY INTENDS TO DESIGN THE NEW PROJECT IN SUCH A COLLABORATIVE MODE. WE REQUESTED THE EVALUATION TO PRESENT TO BOTH USAID AND THE GOS RECOMMENDATIONS OF THE MOST EFFECTIVE INTERVENTIONS TO BE CONSIDERED IN THE NEW DESIGN, BASED ON PAST EXPERIENCE.

- PAGE 4 RESEARCH - PLEASE NOTE RESEARCH WAS TO BE DEVELOPED, APPROVED, REVIEWED, ETC. FOR EACH COMPONENT. IF THIS WAS NOT ACCOMPLISHED EFFECTIVELY IT SHOULD BE SO NOTED; HOWEVER, THIS PARAGRAPH SUGGESTS THAT THERE WAS NO PLAN TO CARRY OUT RESEARCH WHICH WAS NOT THE CASE.

C. SUMMARY: FINDINGS AND RECOMMENDATIONS

- IN ALL SECTIONS FINDINGS SOULD SHOW DATA ON WHICH THE CONCLUSION IS BASED. EXAMPLE 80 PERCENT OF THE X NUMBER OF CENTERS VISITED SHOWED...

- PAGE 4.C.2. - THE PROJECT IS SUPPOSED TO SUPPORT THE NATIONAL STD (INCLUDING AIDS) PROGRAM, NOT SET UP A SEPARATE PROGRAM.

- PAGES 4 AND 5 SECTION C - WE GET NO FEELING OF THE ROLE AND ADEQUATENESS OF PRE-SERVICE (BASIC CURRICULUM) OR IN-SERVICE TRAINING EVEN THOUGH THE CORRESPONDING RECOMMENDATION SECTION STATES STD TRAINING SHOULD BE INCREASED. CLARIFY.

- PAGE 5 SECTION D.2. - UNFPA WILL SUPPLY INJECTABLES, NOT NORPLANT.

- PAGE 6 SECTION D.5. - THE EXPLANATION GIVEN IS NOT LOGICAL IN VIEW OF THE DATA PRESENTED.

- PAGE 6 SECTION D.4. - ISTI, MPHSA AND PROJECT STAFF COLLECT THE DATA.

- PAGE 12 SECTION J.3. - NOT TRUE, USAID HAS NOT AGREED TO SUBSTITUTE U.S. FUNDS FOR THE LOCAL CONTRIBUTION. HOWEVER, BECAUSE OF DELAYS IN RELEASING LOCAL CONTRIBUTIONS, U.S. FUNDS HAVE BEEN DRAWN DOWN FASTER THAN ANTICIPATED.

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- FINDINGS SHOWN ON PAGES 11-13 ON ADMINISTRATION, MANAGEMENT AND BUDGET (J) AND TECHNICAL ASSISTANCE ARE NOT THE SAME AS THOSE FOUND AT THE END OF CHAPTERS 12 AND 13.

- PAGE 14 SECTION A.1. - HOW CAN THE PROJECT BE HELD RESPONSIBLE FOR ALL GOVERNMENT MINISTERS TAKING OR NOT TAKING INITIATIVES TO SUPPORT THE FAMILY PLANNING POLICY AND PROGRAM?

- SOME SECTIONS DIVIDE RECOMMENATIONS INTO SHORT-TERM VS LONG-TERM. OTHER SECTIONS DO NOT.

- PAGE 28 SECTION 1 - DOES NOT REFLECT THE RECOMMENDATION THAT THE PROJECT SHOULD NOT CONTINUE SUPPORT TO WID PROJECTS.

- PAGES 28-29 - YOU SHOULD DIVIDE RECOMMENDATIONS ON VSPP, CSM AND CBD. THEY ARE SEPARATE ACTIVITIES AND NOT NECESSARILY IMPLEMENTED NOR MANAGED IN THE SAME WAY.

- RECOMMENDATIONS FOR ADMINISTRATION, MANAGEMENT AND BUDGET (K) AND TECHNICAL ASSISTANCE (L) ARE NOT THE SAME AS THOSE THAT APPEAR AT THE END OF CHAPTERS 12 AND 13.

D. CHAPTER 2 PROJECT BACKGROUND AND EVALUATION METHODOLOGY

- PERHAPS THIS IS WHERE A FULL DESCRIPTION OF QUOTE THE CRISIS UNQUOTE AND THE MINISTERIAL CHANGES NEEDS TO BE PRESENTED AS INDICATED IN PARA 6.G. ABOVE.

- CHECK FINANCIAL FIGURES ON PAGE 5 WITH THOSE FIGURES PRESENTED IN CHAPTER 12. THEY ARE NOT CONSISTENT.

- SECTION C, PAGES 6-12 DESCRIBES THE MANAGEMENT AND IMPLEMENTATION OF THE EVALUATION NOT THE PROJECT. MOVE THE DISCUSSION OF THE EVALUATION PROCESS TO AN ANNEX.

- HOWEVER, SECTION G, PAGE 11 DESCRIBING HOW THE SITES TO BE VISITED WERE SELECTED SHOULD STAY IN THE MAIN DOCUMENT, RATHER THAN BE IN AN ANNEX. IN ADDITION, YOU SHOULD NOTE SITES WERE SUGGESTED THAT WERE QUOTE GOOD EXAMPLES UNQUOTE - HIGH NUMBER OF ACCEPTORS, INCREASING GROWTH RATE OR QUOTE BAD UNQUOTE - LOW NUMBER OF ACCEPTORS OR A FALL-OFF IN THE RATE OF ACCEPTANCE OR IN ABSOLUTE NUMBERS.

E. CHAPTER 3: FAMILY PLANNING CLINICAL SERVICES

- GOOD MATERIAL PRESENTED BUT NEEDS LOTS OF EDITING AND PROOFING. READS LIKE A TRANSLATION.

- PAGE 1 - EVALUATION METHODOLOGY PRESENTED HERE IS REPETITIVE OF THE PREVIOUS CHAPTER, THOUGH THIS DESCRIPTION IS A BIT MORE COMPLETE. THE EVALUATION METHODOLOGY SHOULD BE PRESENTED BRIEFLY IN ONLY ONE PLACE; EXTENSIVE DETAILS SHOULD BE IN AN ANNEX.

- LIST OF SITES SHOULD BE IN AN ANNEX.

- THE CHAPTER DOES NOT DEFINE THE MANAGEMENT RESPONSIBILITIES OF THE FORMER MINISTRY OF SOCIAL DEVELOPMENT AND THE MPHSA. BE CLEAR WHEN THE DISCUSSION IS TALKING ABOUT PAST MANAGEMENT OR CURRENT MANAGEMENT.

- PAGE 7 - WHERE IS TABLE?

- PAGE 8 - SPLIT ASBEF VS VSPP CLIENTS AND SHOW THE TWO DIFFERENT RATES OF INCREASE.

- PAGE 10 SECTION 2 - SPECIFY THAT THERE WERE 11 PUBLIC SECTOR CLINICS OF THE TOTAL 15 SITES VISITED.

- CORRECT ALL ACRONYMS AND SPELLINGS: EXAMPLE, FEMENAL, TUBA/LIGATURE, DIRE.

- PAGES 11 AND 12 - THERE ARE NUMEROUS WORDS THAT ARE NOT ENGLISH NOR CORRECT TECHNICAL TERMINOLOGY EXAMPLE PARA - CLINICAL CHECK-UP, RECEPTION OF CLIENTS, ETC.

- PAGE 12 - THERE ARE SEVERAL DESCRIPTIONS OF PROBLEMS DUE TO LACK OF FUEL FOR SUPERVISION AND RESUPPLY OF CONTRACEPTIVES. HERE YOU NOTE A VERY IMPORTANT FACT: FUNDS ARE GENERATED AT THE CLINICS. COULD THESE FUNDS BE USED TO FUND SUPERVISION AND RESUPPLY OF CONTRACEPTIVES?

ARE THE PRICES CHARGED PROHIBITIVE FOR CLIENTS? DOES THE ACCEPTOR RATE CHANGE IF 100 OR 1,000 FCFA IS CHARGED? WHO HAS OR SHOULD HAVE CONTROL OF THESE FUNDS? IF YOU DO NOT HAVE ENOUGH DATA TO ANSWER THESE QUESTIONS, IT MAY BE A PRIME OPERATIONAL RESEARCH QUESTION TO BE ANSWERED BEFORE THE END OF THE PROJECT.

- THE NEW CHAPTER ON INFRASTRUCTURE SHOULD BE ADDED AS A SECTION TO CHAPTER 3. CURRENTLY THERE EXIST THREE DIFFERENT VERSIONS OF THE INFRASTRUCTURE SECTION: PAGES 16 AND 17 TITLED QUOTE NEW CHAPTER INFRASTRUCTURE UNQUOTE; DR. THIAM HAS GIVEN USAID A NEW VERSION; AND ROSENTHAL FAXED A COMPLETELY DIFFERENT VERSION OF THE NEW CHAPTER. PLEASE CONSOLIDATE AND EDIT.

- ROSENTHAL'S FAXED INFRASTRUCTURE CHAPTER PRESENTS ONLY DATA ON INSUFFICIENT EQUIPMENT AND CONSTRUCTION. IT DOESN'T PRESENT INFORMATION NEEDED TO ANSWER WHETHER THE PROJECT PROVIDED THE CORRECT EQUIPMENT, THE NEEDED MAINTENANCE, REPAIR, AND REPLACEMENT OF EQUIPMENT AND WHETHER PROJECTED LEVELS OF CONSTRUCTION (NUMBER OF CENTERS) WERE SUFFICIENT TO REACH THE GOAL OF CYP/ACCEPTORS.

- PAGE 20 MOTHERS DID NOT PARTICIPATE IN STUDY TOURS.

- YOUR NUMBERS ARE NOT CONSISTENT: PAGE 22 SHOWS 303 MIDWIVES AND PAGE 19 SHOWS 300 TRAINED. PAGE 19 SHOWS NO NURSE ASSISTANTS BUT PAGE 22 SHOWS 306.

F. CHAPTER 4: CONDUCT OF BIO-MEDICAL AND PSYCHO- SOCIAL RESEARCH

- THERE IS NO SYNTHESIS NOR SUMMARY OF ALL THE RESEARCH REVIEWED AND EVALUATED. THERE SHOULD ALSO BE AN OVERALL SYNTHESIS OF THE PROJECT'S RESEARCH ACTIVITIES.

- PAGES 2-14 PRESENT VERY DETAILED DESCRIPTIONS OF ONLY A FEW STUDIES. THESE WOULD BE BEST SHOWN IN AN ANNEX WITH ONLY REFERENCE TO THEIR IMPACT, APPROPRIATENESS, IN THE TEXT. ALL BUT ONE DETAILED ACTIVITY IS BIO-MEDICAL RESEARCH. NO REAL ANALYSIS OF THE PSYCHO-SOCIAL RESEARCH IS GIVEN.

- PAGE 4 - MISSING.

- AFTER PRESENTING DETAILED STUDIES, PAGE 14 REFERS TO OTHER STUDIES NOT PRESENTED IN DETAIL. WERE THESE EVALUATED OR NOT?

- NOWHERE DOES THE REPORT PRESENT WHAT THE RESEARCH STUDIES REVEALED; WERE THEY WELL DONE, WERE THE RESULTS USED, ETC. THE FHPP DIRECTOR'S KNOWLEDGE ABOUT THE STUDIES IS ONLY ONE FACTOR.

- IT IS NOT CLEAR WHAT THE ADDENDUM IS SUPPOSED DEMONSTRATE.

- PAGE 17 ENDS IN THE MIDDLE OF A SENTENCE. WHAT IS THE RELATION OF THESE PROBLEMS TO THE FINDINGS?

G. CHAPTER 5: STD AND FERTILITY

- PAGE 7 WHAT IS MEANT BY 58.55 PERCENT PREVALENCE.

- IT IS NOT CLEAR WHAT THE TABLES ON PAGES 8 AND 10 ARE SUPPOSED TO SHOW. THE TABLES ARE NOT LINKED TO THE NARRATIVE.

- NUMEROUS PAGES ARE BLANK 9, 11, 15, 17. ARE WE MISSING SOMETHING?

- THERE IS NO CLEAR LINKAGE BETWEEN PROBLEMS (PAGES 8, 16 AND 18) AND FINDINGS.

H. CHAPTER 6: CONTRACEPTIVE LOGISTICS MANAGEMENT

- PAGE 6 SECTION C.3. - SMO HAS NEVER RECEIVED THE MONTHLY SHIPPING CHART, SO HOW COULD THEY USE IT? HOWEVER, THE FACT COULD BE NOTED THAT SMO SHOULD RECEIVE THE REPORT. THEN THE SECTION COULD DESCRIBE HOW THE REPORT CAN BE USED TO IMPROVE COMMODITY TRACKING.

- PAGE 19 - PLEASE NOTE THAT TO DATE NO PROJECT COMMODITIES HAVE EXPIRED. THOSE REFERRED TO ARE ALL CONTRACEPTIVES LEFT FROM THE FIRST FAMILY PLANNING PROJECT THAT ENDED IN 1985.

- SOME OF THESE TABLES ARE ANNEX MATERIAL. PLEASE REVIEW EXISTING LOGISTIC ANNEXES FOR THEIR RELEVANCE; DO THEY ADD ANYTHING TO THE EVALUATION?

- THE NARRATIVE DOES NOT LINK THE EXISTING ANNEXES TO THE DATA PRESENTED IN THE CHAPTER.

- PAGE 7 - THERE USED TO BE 5 WAREHOUSES NOT 3 AS NOTED. ALSO, THE EVALUATION SHOULD NOTE THAT THOUGH THE NATIONAL PHARMACY HAS ALLOCATED SPACE TO THE PROJECT, NO PROTOCOLS EXIST. THEREFORE, PROBLEMS ARRISE AS TO WHO HAS RESPONSIBILITY AND CONTROL OF THE KEYS, STOCK, ETC.

I. CHAPTER 7: BUREAU NATIONAL DE RECENSEMENT (BNR)

- THE CHAPTER IS GENERALLY WELL WRITTEN AND PRESENTED. IT REALLY GIVES A FEEL FOR WHAT THE PROJECT DID OR DIDN'T DO AND HOW WELL IT WAS DONE.

- PAGES 12-17 PRESENT THE TIMEFRAME AND ACTIVITIES AND PAGES 17-20 PRESENT THE QUANTITATIVE SUMMARY. THESE SECTIONS ARE LITTLE MORE THAN A LISTING WITH NO REAL EVALUATIVE COMMENT. THEY MIGHT BEST BE SHOWN IN AN ANNEX.

- THE KEY POINT UNDERLYING THIS COMPONENT IS THAT THE GOAL OF THE PROJECT WAS QUOTE THE DATA BASE IMPROVEMENT UNQUOTE. THIS IS NOT THE SAME AS DEVELOPING A DATA COLLECTION AND ANALYSIS SECTION FOR MONITORING AND EVALUATING A FAMILY PLANNING PROGRAM. THE BNR COMPONENT WAS TO ASSIST THE COUNTRY IN DEVELOPING THE INSTITUTION OF BNR WITH AN ABILITY TO CARRY OUT NEEDED FUNCTIONS. THIS OBJECTIVE WAS NOT EVALUATED. RATHER, THE USE AND THE RELATIONSHIP OF THE RESULTS OF BNR'S REASEARCH TO THE FAMILY PLANNING PROGRAM WAS. THE EVALUATION MIGHT CONCLUDE THAT THE GOAL OF THIS ELEMENT WAS NOT APPROPRIATE; RATHER, BNR RESEARCH SHOULD HAVE BEEN DIRECTLY LINKED TO THE FAMILY PLANNING PROJECT'S NEEDS. BUT DO NOT EVALUATE BNR ON AN OUTPUT THAT WAS NOT DEFINED IN THE LOGFRAME.

- A RELATED ASPECT IS THE ROLE OF THE CONSULTANT YVES CHARBIT. HIS WORK OBJECTIVE WAS TO ASSIST IN THE OVERALL INSTITUTIONAL DEVELOPMENT OF BNR AND SHOULD BE EVALUATED AS SUCH. IT WAS NOT TO WORK SPECIFICALLY ON ONE STUDY OR ANOTHER. THE FACT THAT OTHER CONSULTANTS WERE USED FOR SPECIFIC RESEARCH ANALYSIS IS AN IMPORTANT FINDING. THE EVALUATION TEAM MAY WISH TO JUSTIFY ONE APPROACH IN PREFERENCE TO ANOTHER BUT DO NOT EVALUATE CHARBIT'S WORK ON OBJECTIVES HE DID NOT HAVE.

- GIVEN THE TWO PRECEEDING STATEMENTS THE RECOMMENDATION MADE CONCERNING DEMOGRAPHIC CONSULTANTS ON PAGE 28/29 NO. 10 IS CONTRADICTORY TO THE STATED OBJECTIVES OF THE PROJECT.

- THE EVALUATION SHOULD REVIEW THE EFFECTIVENESS OF THE LONG-TERM TRAINING PROVIDED FOR STAFF OF THE DIRECTION DE LA PREVISION ET DE LA STATISTIQUE AND PROVIDE SUGGESTIONS FOR IMPROVING THE PROBLEMS IDENTIFIED.

- PAGE 28 - YOU STATE THAT NOT ENOUGH ANALYSIS IS DONE. BUT NO EXPLANATION GIVEN AS TO WHY? WHAT CAN BE DONE ABOUT IT?

- ADDENDUM TO CHAPTER 7 - MEASURING IMPACT. PRESENTS QUITE A NUMBER OF INTERESTING ANALYSES. IT SEEMS THAT A NUMBER OF THEM (NOS. 1, 5, 6, 7, 13, 17, 19, 22) COULD BE MOVED TO SECTIONS TO SHOW CHANGES THAT HAVE TAKEN PLACE ASSOCIATED WITH PROJECT ACTIVITIES. FOR EXAMPLE, PLEASE REFER TO THE GRAPH SENT TO DEVRES FROM MARY ANN MICKA IN THE LETTER COLES/MILLER-WOOD DATED MAY 23, 1991 TO SHOW POTENTIAL PROJECT IMPACT.

J. CHAPTER 8: ESTABLISHING A FAMILY PLANNING MANAGEMENT UNIT - NO COMMENT EXCEPT THAT A SYNTHESIS OF ALL SECTIONS ON RESEARCH AND THE USE OF RESEARCH RESULTS MIGHT BE PRESENTED HERE.

K. CHAPTER 9: INFORMATION, EDUCATION AND COMMUNICATION (IEC)

- THE CHAPTER IS CLEAR, TO THE POINT. IT PRESENTS THE POSITIVE AND NEGATIVE ASPECTS OF THE PROJECT. NO MAJOR CONCERNS.

L. CHAPTER 10: WOMEN IN DEVELOPMENT

- THE MISSION APPRECIATES YOUR EFFORT IN LOOKING AT THIS ELEMENT. THE STUDY QUOTED BY C. RADITZ WAS FOCUSED ON CHANGING THE WID PROJECTS TO A CREDIT PROGRAM. OTHER POSSIBILITIES WERE NOT EXPLORED; THEREFORE, THE RECOMMENDATIONS MAY NOT NOW BE APPROPRIATE.

- SECTION F: OVERALL GENDER CONSIDERATIONS - NO HARD DATA WAS GIVEN; IS THIS BECAUSE IT DOES NOT EXIST?

M. CHAPTER 11: CONTRACEPTIVE SOCIAL MARKETING (CSM)

- IT IS REGRETTABLE THAT THE VSPP ELEMENT COULD NOT HAVE BEEN REVIEWED IN THE SAME DETAIL AS OTHER COMPONENTS.

- FIRST OF ALL IT MUST BE NOTED THAT THROUGHOUT THIS CHAPTER CSM, VSPP AND CBD ARE MIXED. THE OBJECTIVES, ACTIVITIES, ETC. ARE NOT CLEAR. WE SUPPOSE THIS WAS DONE AS SANFAM, A NEW NGO HAS TAKEN THE LEAD IN DESIGNING AND IMPLEMENTING THESE ACTIVITIES. YOU NEED TO SEPARATE OUT THE ISSUE OF SANFAM FROM THE ACTIVITIES UNDERTAKEN OR PLANNED.

- SUGGEST YOU RENAME THE CHAPTER PARA-PUBLIC AND PRIVATE SECTOR FAMILY PLANNING ACTIVITIES WITH THREE SUB-SECTIONS 1) ON VSPP (SUPPLY OF FAMILY PLANNING SERVICES FROM PARA-PUBLIC AND PRIVATE CLINICS) WHICH IS BEING IMPLEMENTED; 2) CSM; AND 3) CBD. BOTH ITEMS 2 AND 3 ARE PLANNED ACTIVITIES BUT HAVE NOT YET BEEN IMPLEMENTED.

- VSPP HAS BEEN QUITE ACTIVE AND HAS EXPANDED SERVICE DELIVERY TO THE PRIVATE SECTOR. REFER TO THE CLINICAL/IEC CHAPTERS TO GIVE A FULL DESCRIPTION OF THE ACTIVITY. PAGES 6-10 JUST DESCRIBE AN INPUT (MONEY) FLOW. WHAT IS MISSING IS ANY COMMENT ON WHETHER THIS ELEMENT IS NEEDED? DID IT REACH A PORTION OF THE POPULATION THAT WOULD NOT HAVE BEEN REACHED BY THE PUBLIC SECTOR ALONE? DOES IT SERVE TO LEVERAGE OTHER RESOURCES FROM THE PRIVATE SECTOR WHERE THESE WOULD NOT EXIST EXCEPT FOR THE PROJECT? ETC.

- THOUGH NOTED IN THE INTRODUCTION THAT NO PRIVATE SECTOR SPECIALIST WAS IN THE TEAM, THE EVALUATION TEAM DID HAVE ENOUGH EXPERTS TO EVALUATE THE PUBLIC SECTOR ASPECT OF FAMILY PLANNING SERVICES. YOU HAVE THE SAME INFORMATION TO DO SO FOR THE PRIVATE SECTOR. PERHAPS YOU CANNOT SHOW THE COST-EFFECTIVENESS OF USING THE PRIVATE VS PUBLIC SECTOR DELIVERY SYSTEM BUT YOU CAN DESCRIBE THE SAME PARAMETERS OF APPROPRIATE OR INAPPROPRIATE SERVICE DELIVERY, MANAGEMENT,

SUPERVISION AND COMPARE IT TO THE PUBLIC SECTOR, AT LEAST FOR THE FOUR CLINICS VISITED. AFTER ALL THE SAME PERCENTAGE OF CLINICS WAS VISITED FOR THE PUBLIC (12 PERCENT) AND PRIVATE (13 PERCENT) SECTORS.

- THE EVALUATION SHOULD REVIEW THE FOLLOWING POINTS:
-- THE VALUE OF EXPANDING FAMILY PLANNING SERVICES VIA THE PRIVATE SECTOR TO COMPLEMENT THE PUBLIC SECTOR;
-- THE NECESSITY OF VSPP ASSISTING THE COMPANIES TO SUSTAIN THEIR ACTIVITIES;
-- THE IMPORTANCE OF ADDING NEW ORGANIZATION OR STRENGTHENING EXISTING SITES;

- THE FOLLOWING QUESTIONS SHOULD ALSO BE ADDRESSED:
-- WHAT SHOULD BE THE RELATIONSHIP BETWEEN THE PUBLIC AND PRIVATE SECTORS?
-- WHAT KINDS OF TECHNICAL ASSISTANCE SHOULD THE PRIVATE SECTOR RECEIVE (CLINICAL, MANAGERIAL, ETC.)?
-- HOW SHOULD MANAGEMENT OF THIS SECTOR BE SENEGALIZED E.G. SHOULD MANAGEMENT OF VSPP BE MOVED FROM ISTI TO ANOTHER INSTITUTION? IF SO WHICH ONE?
-- IS THERE OR SHOULD THERE BE A RELATIONSHIP BETWEEN THE VSPP SECTOR AND THE DEVELOPMENT OF A CSM PROGRAM?
-- WHAT SHOULD THE OVERALL COORDINTION BE BETWEEN VSPP, GOS AND DONORS?

- PAGE 6 - WE DOUBT THE STATEMENT QUOTE BECAUSE THE GOVERNMENT DOES NOT YET FULLY SUPPORT THESE ACTIVITIES, ONLY ABOUT ONE THIRD OF THE PLANNED BUDGET HAS BEEN EXPENDED UNQUOTE. RATHER, THE QUOTE CRISIS UNQUOTE AFFECTED EXPENDITURE RATES FOR VSPP AS WELL AS FOR THE PUBLIC SECTOR. IN ADDITION, APPROXIMATELY TWO THIRDS OF THE PLANNED BUDGET HAS BEEN EXPENDED WHEN SALARIES AND OPERATING COSTS ARE CONSIDERED.

- TABLES PAGES 9 AND 10 MIGHT BE BETTER IN AN ANNEX.

- FOLLOW THE SECTION ON VSPP WITH A DISCUSSION OF CSM AND HOW THIS ACTIVITY CAN COMPLEMENT OR HAVE A SYNERGETIC EFFECT WITH THE VSPP ACTIVITY.

- SECTION C.4. CBD - ONLY ONE TYPE OF TWO PROPOSED CBD ACTIVITIES IS DESCRIBED. A SECOND PROPOSED CBD ACTIVITY FOLLOWS THE GAMBIA MODEL. THIS PROPOSAL SHOULD ALSO BE DESCRIBED.

- THE PROJECT HAS SUPPORTED A NUMBER OF STUDY TOURS TO OTHER PRIVATE SECTOR PROJECTS AS WELL AS TO REVIEW CBD, AND CSM. WERE THEY EFFECTIVE? SHOULD MORE BE DONE? IN ADDITION, WORKSHOPS WITH PHARMACISTS HAVE TAKEN PLACE TO LOOK AT SUPPORT FOR A CSM PROGRAM. WHAT IS YOUR EVALUATION OF THIS INTERVENTION?

N. CHAPTER 12: PROJECT ADMINISTRATION AND MANAGEMENT

- THIS TOTAL CHAPTER IS PROBLEMATIC BECAUSE IT NEEDS EXTENSIVE EDITING AND IS VERY UNCLEAR. HOWEVER, PLEASE NOTE THE FOLLOWING CLARIFICATIONS OF FACT IN YOUR REWRITE.

- PAGE 40 - THE CHAPTER SHOULD DESCRIBE THE VARIOUS MPHSA UNITS (NOW SHOWN ON PAGES 8-12) AND HOW THEY RELATE TO THE ACTIVITIES OF THE PROJECT; EXAMPLE HEALTH EDUCATION.

- PAGES 19-21 AND ANNEXES - THE FIGURES ARE INCONSISTENTLY INCORRECT. PLEASE REFER TO BUDGET TABLES AND COMMENTARY PROVIDED TO THE EVALUATION TEAM BY MARY ANN MICKA.

- PAGE 23 B - THE FIGURES LISTED ARE WRONG. THE LOCAL ACCOUNT TOTAL PROJECTED EXPENDITURES ARE U.S. DOLS. 6,190,782 COMPARED TO 10,672,000 WITH THE LATTER NUMBER BEING 1.7 TIMES THE LOCAL ACCOUNT (NOT 457 TIMES HIGHER). FYI AUDITORS RULED THAT NO TECHNICAL ASSISTANCE WAS TO BE PROCURED FROM THE LOCAL ACCOUNT FOLLOWING THE GUIDELINES ESTABLISHED IN THE PROJECT IMPLEMENTATION LETTER THAT ESTABLISHED THE LOCAL ACCOUNT. CONSEQUENTLY, ONLY U.S. DOLS. 14,531 WAS SPENT FOR THIS LINE ITEM BEFORE IT WAS ALL SHIEFTED TO THE ISTI CONTRACT.

- PAGE 24 - PLEASE NOTE THAT NO EXPENDITURE CAN TAKE WITHOUT A DAP. THE DAP IS SIGNED BY THE PROJECT DIRECTOR. THEREFORE, EVERY EXPENDITURE MUST IN PRACTICE BE APPROVED BY THE DIRECTOR. IT IS NOT ACCURATE TO SAY THAT THE PROJECT DIRECTOR IN UNAWARE OF AND HAS NO CONTROL OVER EXPENDITURES.

- PAGE 25 - EXTERNAL PURCHASES: THE IMPLICATION IS THAT ISTI MAKES PURCHASES WITH NO GOS APPROVAL. PURCHASES MUST HAVE A GOS SIGNED PIO/T OR PIO/C BY THE PROJECT DIRECTOR, DIRECTEUR DE CABINET OR MINISTER. THEREFORE, THE GOS DOES APPROVE PURCHASES. THE SAME SYSTEM EXISTS FOR PAGE 26: PURCHASES MADE BY AID.

- PAGE 31 - 6: WHERE IS THE CHART REFERRED TO?

- SEVERAL STATEMENTS ARE MADE INFERRING CERTAIN MOTIVATIONAL REASONS BEHIND ACTIONS. PLEASE PRESENT FACTS. (SEE PAGE 35 FINANCIAL ASPECTS AND APGE 36 LAST PARAGRAPH).

- ONCE AGAIN, FINDINGS AND RECOMMENDATIONS ARE NOT CONSISTENT WITH ONES PRESENTED IN THE SUMMARY SECTION.

- THE PROJECT LEVERAGED (HPNO ESTIMATES) U.S. DOLS. 5 MILLION TO U.S. DOLS. 7 MILLION OF AID/W FUNDS VIA PARTICIPATION OF CENTRALLY FUNDED PROJECTS SUCH AS JHPIEGO, AVSC, FPMD, ETC. WHAT EFFECTS DID THESE INPUTS HAVE? E.G. WERE THESE CENTRALLY FUNDED PROJECT INPUTS NEEDED?

- THIS CHAPTER DOES NOT ADDRESS THE MANAGEMENT TRAINING NEEDS ADDRESSED BY THE PROJECT. FOR EXAMPLE, THE PROJECT HAS SENT OVER 20 SHORT-TERM PARTICIPANTS TO SANTA CRUZ FOR A THREE MONTH COURSE ON FAMILY PLANNING MANAGEMENT. WAS IT WORTH IT? SHOULD WE HAVE DONE MORE OR LESS MANAGEMENT TRAINING?

- COULD THE EVALUATION TEAM RECOMMEND CERTAIN ROLES AND RESPONSIBILITIES OF THE VARIOUS PLAYERS GIVEN THE FINDINGS NOTED?

N. CHAPTER 13: TECHNICAL ASSISTANCE

- AS WITH CAHPTER 12, WE SUGGEST A COMPLETE REWRITE. SOME OF THE QUESTIONS THAT SHOULD BE CLARIFIED ARE:

- THE CHAPTER RAISES SOME FUNDAMENTAL ISSUES OF THE ROLE OF TA. HOWEVER, IT DISCUSSES ISSUES AT A BROADER LEVEL THAN IN PREVIOUS CHAPTERS. IT DOES NOT PRESENT HARD DATA ON THE EFFECTIVENESS OF TA PROVIDED AS OTHER CHAPTERS DID.

TWO THEMES EMERGE:

1) AN EVALUATION OF CONTRACTOR ON PERFORMANCE OF THE CONTRACTOR AND OF OTHER TA; 2) GENERIC ISSUES OF THE ROLE OF TA IN DEVELOPMENT PROJECTS. IS THE CONTRACTOR JUDGED BY GLOBAL PARAMETERS, RATHER THAN BY WHAT THEY DID OR DID NOT DO? FACTS SHOULD BE PRESENTED.

- PLEASE NOTE THAT PARA 6.G. SHOULD BE REVIEWED HERE. WE NEED A CONSISTENT REVIEW OF THE APPROPRIATENESS OF OVERALL LONG-TERM AND SHORT-TERM TA PROVIDED.

- PAGE 1 - DOES THE 50 PERCENT CITED REPRESENT THE AMOUNT IN THE ISTI CONTRACT OR AMOUNTS CALCULATED FROM THE TOTAL COST OF LONG-TERM AND SHORT-TERM CONSULTANTS PROVIDED TO THE PROJECT?

- PAGE 4 - YOU STATE THAT ISTI'S ROLE WAS ONLY PAYING THE BILLS. THAT IS NOT CORRECT - LONG-TERM TA WAS IN PLACE; SHORT-TERM TA WAS BEING PROVIDED; ISTI WAS ARRANGING TRAINING; BUYING COMMODITIES, ETC., ETC., ETC.

- PAGE 3 - PLEASE CLARIFY STATEMENT MADE ON PAGE 3 ABOUT STOPPING FUNDING FOR CERTAIN ACTIVITIES. FOR EXAMPLE, GAS AT THE LOCAL LEVEL. IN THE PROJECT AGREEMENT WITH THE GOS, THE GOS WAS TO TAKE OVER CERTAIN LOCAL EXPENDITURES. WHEN THEY DID NOT, USAID DID NOT SUBSTITUTE. AS FUNDS FOR GOS FUNDS; THEREFORE, CERTAIN ACTIVITIES CAME TO A HALT.

- ONCE AGAIN FINDINGS AND RECOMMENDATIONS ARE NOT CONSISTENT WITH THE SUMMARY. THERE ARE NO FINDINGS SHOWN AT THE END OF CHAPTER 13 AND THE RECOMMENDATIONS PRESENTED ARE DIFFERENT FROM THOSE SHOWN IN THE SUMMARY.

8. WE HOPE YOUR FIND THESE COMMENTS HELPFUL AND AWAIT THE FINAL DRAFT OF CHAPTERS 12 AND 13 TO MAKE MORE DETAILED COMMENTS.