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USAID/SENEGAL HEALTHCARE FINANCING & POLICY PROJECT

MIDTERM EVALUATION

DECEMBER 2009
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ACRONYMS

List of Acronyms

ADEMAS Development and Social Marketing Agency [Agence pour le Développement et le Marketing Social]

ANS Senegalese Standardization Association [Association Sénégalaise de Normalisation]

APROFES Senegalese Association for the Promotion of Women [Association pour la Promotion de la Femme Sénégalaise]

ARD Regional Development Agency [Agence Régionale de Développement]

ARI Acute Respiratory Infections

BCC Behavior Change Communication

BOD Board of Directors

BRAN Regional Food and Nutrition Office [Bureau Régional de l'Alimentation et de la Nutrition]

BRISE Regional Immunization and Epidemiological Surveillance Office [Bureau Régional de l'Immunisation et de la Surveillance Epidémiologique]

CA Cooperation Agency

CAF/SP Health Financing and Partnership Support Unit [Cellule d'Appui au Financement de la Santé et au Partenariat]

CAS/PNDS National Health Development Program Support and Monitoring Unit [Cellule d'Appui et de Suivi/Programme National de Développement Sanitaire]

CBO Community-based Organization

CCF Christian Children's Fund

CDD Departmental Development Committee [Comité départemental de développement]

CGO OBGYN Clinic

CHA Community Health Agent

CLD Local Development Committee [Comité local de développement]

CLNS National AIDS Council [Conseil National de Lutte contre le Sida]

CNCA Caisse Nationale du Crédit Agriole

COP Chief Of Party

COSFAM Senegalese Food Fortification Alliance [Comité Sénégalais pour la Fortification des Aliments en Micronutriments]

CPS Planning and Monitoring Committee [Comité de planning et de suivi]

CRD Regional Development Committee [Comité régional de développement]

CRF Regional Training Center [Centre régional de formation]

CS Civil Society

CTO Cognizant Technical Officer

CTR Select Technical Committee

DAGE General Administration and Equipment Department [Direction de l'Administration Générale and de l'Equipement]

DANSE Division of Food and Nutrition for Child Survival [Division de l'Alimentation,de la Nutrition et de la Survie de l'Enfant]

DCL Local Government Directorate [Direction des collectivités locales]

DES Hospitals Directorate [Direction des Etablissements de Santé]

DGL Decentralization/Local Governance

DISC Decentralization and Community Health Initiatives [Initiatives de Santé Communautaire]

DLSI AIDS Division [Division de Lutte contre le Sida]

DQA Data Quality Audit

DS Health Directorate [Direction de la Santé]

DSR Reproductive Health Division [Direction de la Santé reproductive]

ECS Community Health Educator [Educateur communautaire de santé]

ENDSS National Social and Health Development School [Ecole Nationale de Développement Sanitaire et Social]

EIPS Health Policy Initiatives Team [Equipe d'Initiative de Politiques de Santé]

EPS Education for Health

FAO Food and Agriculture Organization

FHI Family Health International

GRAIM MHO Initiative Research and Support Group [Groupe de Recherche et d'Appui aux initiatives mutualistes]

HC Health Committee

HD Health District

HKI Helen Keller International

ICP Head Post Nurse

IDE Registered Nurse

ILO International Labor Organization

INTRAH IntraHealth

ISSA [Innovation of Health Systems in Africa] Innovation des Systèmes de Santé en Afrique

ITA Food Technology Institute [Institut de Technologie Alimentaire]

LG Local Government

MC	Management Committee
MHO	Mutual Health Organizations
MI	Micronutrients Initiative
MNCH/FP	Maternal Neonatal and Child Health/Family Planning
MOH	Ministry of Health
MR	Regional Health Directorial
MTSEF	Medium-Term Sectoral Expenditure Framework
NGO	Non-governmental Organization
NHA	National Health Accounts
NO	National Office
OI	Opportunistic Infections
OP	Operating Plan
OVI	Objectively Verifiable Indicator
PAA	Annual Action Plans
PCR	President, Rural Council
PH	Public Health
PLWHIV	Person Living With HIV/AIDS
PMI	President, Malaria Initiative
PNA	National Pharmacy
PNT	Tuberculosis Program
PO	Operating Plan
POCL	Community Health Plan [Plan d'Opérations de collectivité locale]
PRSP	Poverty Reduction Strategy Paper
PSSC	Health Program-Community Health
PTA	Annual Work Plan [Plan de Travail Annuel]
RC	Rural Community
RH	Reproductive Health
RO	Regional Office
SEF	Sectoral Expenditure Framework
SFE	Registered Midwife [Sage Femme d'Etat]
SNEIPS	National Education and Information for Health Service [Service National de l'Education et l'Information pour la Santé]
SPS	Strengthening Pharmaceutical Systems
STI	Sexually Transmissible Infections

TB	Tuberculosis
TOR	Terms of Reference
UAEL	Union of Associations of Local Elected Officials
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

In late summer 2009 USAID issued a scope of work for a mid-term evaluation of the Health Policy and Financing component of its USAID/Santé Program with the objective of determining the extent to which the expected results have been achieved and to identify areas for improvements that will facilitate the attainment of the planned results. A team consisting of one expatriate and two Senegalese experts carried out the evaluation during late November and early December, performing document reviews, key informant interviews, site visits, and focus group studies. Meetings were held with all major stakeholders in Dakar and field visits were conducted to Regional offices in Louga, Thies, and Kolda.

The team noted that the overall design of the project was sound, with the balance between centralized and decentralized activities a particular strength. The designation of a single organization to be the coordinator of the entire USAID/Santé program has also been a key to the success of the project in the regions. However, the full benefits of the coordination have been limited because there was confusion between the four organizations about the definition of coordination and the expectations of each group.

The overall performance of the project has been mixed. Real strengths have been demonstrated in the areas of policy dialogue and social financing where targets have been met or exceeded. Performance has been weaker for the development of capacity in the MOH where there have been acknowledged improvements in the ability to plan, and report but no impact on the amount of funding allocated by the Government to the health sector; nor has there been a change in the perception that the health sector is “over-financed”. On the other hand, the Project has facilitated a redistribution of funds through its support to the National Health Accounts that has been used to develop the national health development plan II (PNDS II). Decentralized institutions have received considerable assistance, but these same institutions have shown little in the way of lasting capacity improvement with only one third of health committees meeting the requirements to be “functional” and in the third year of the project no local collectivity produced the required work-plan (POCL). There has been some innovative activity around the public display of consumer prices and financial accounts at health facilities as a step towards greater transparency and good governance. However, the project’s anticipated activities to engage civil society as an advocate for increased financing and as a “watch dog” for better governance have not yet begun which calls into question whether many of the activities begun at the community level will be sustainable.

The Project has faced an interesting set of external challenges such as having seven ministers of health in three years, frequent requests to take on additional activities, and the devaluation of the dollar. Each challenge has been met effectively, and USAID is currently negotiating with the project to adjust the budget to take into account the devaluation of the dollar.

The project’s approach to technical assistance has been sound, working through the Ministry of Health at all times and not pushing an external agenda. However this strength has also been a weakness in some quarters where the Project has been perceived to be an “appendage of the government”, and not a technical assistance agency providing outside push and support. This is particularly true of the Project’s partners in the USAID/Santé

program who feel the Project has been passive in the face of much needed policy challenges in the reproductive health, HIV/AIDS and quality of care technical areas.

The individual technical staff members recruited for the project are all excellent professionals with many years of experience and highly respected by their counterparts. This has facilitated the ability of the project to work effectively and to maintain its focus despite the frequent changes of ministers. The collaboration between the four remaining three technical partners in the consortium is also excellent and quite seamless. However, there is a concern that Abt is not following USAID branding policy in its representation of the project and in addition has effectively subsumed all its sub-grantees under its own logo rather than having a Project identity, which gives a false impression of Abt's achievements and has negative results on the morale of partners.

The technical approaches that the project has selected for implementation of the four priority areas are all sound but with varied results (as noted above).

The management procedures within the project are all effectively designed to assure accountability and transparency. There are clear manuals, procedures are documented, and the oversight of subcontracts is good with problems rapidly identified and rectified. However, procedures are unnecessarily centralized to Bethesda with insufficient decision-making delegated to the field which results in slowness of responses, failure to develop local capacity, and is an inefficient use of highly skilled personnel. In addition, there has been a lack of technical input from the home office during the first three years of implementation which has deprived the project of Abt's world-wide experience and capacity

In addition, the Health Care Financing and Policy Project suffered severe budgetary constraints as a result of a combination of overall underfunding of the project and serious errors in budgeting on the part of the Prime Grantee. These problems have significantly affected the ability of the Project to meet its full potential.

Policy Dialogue and Coordination has been the strongest element of the Project and the Project's work has placed USAID in a central role for policy development.

The project has successfully supported 15 policies and decrees, worked with the Ministry of Health to create the Health Policy Initiative Team, which now has full ownership by the government and has already successfully addressed six priority policy areas. The team has now begun to address five new priority areas which include performance based financing and health systems strengthening. The strength of the relationships built with the Ministry of Health and the Ministry of Finance are very strong and are based on the technical excellence of the work the project has performed. This work has included building the capacity to use tools such as the National Health Accounts and the CDS-MT; provision of technical assistance to develop the PNDS; revision of the POCL approach; elaboration of CDS-MT performance reports; and, conducting studies on behalf of the MOH.

Despite all these successes, there are three areas of concern. Firstly, the Project is seen as not taking policy development far enough and needs to go beyond simply supporting the publication of policy to create an implementation framework for policy. Secondly, local

government and civil society do not have sufficient engagement with the policy process – the biggest omission being the lack of engagement of civil society at either the central or peripheral levels. Finally, the project needs to narrow its focus in support of new policy and research. The project must look towards sustainability, advocating with other donors or development agencies to support the Ministry in its policy efforts. The project should be limiting its own policy support to the area of performance-based financing.

Capacity Strengthening of the Ministry of Health is the weakest of the Projects technical areas.

The Project has expanded the role of civil society from its original role as an advocate for increased funds to being a watch-dog for good governance. It is therefore truly unfortunate that there is no visible evidence that civil society is currently playing either of these roles. The project's decision not to begin work with civil society until year three, and then the failure to perform by the sub-grantee means that with less than two years remaining, civil society has not been significantly engaged.

Most importantly, the original design of the Project stressed the opportunity for the Project to alter the perception of Politicians and Government leaders about the health budget and to allocate significant external resources to health. This has not happened. The best that can be said is that the project has supported the successful reallocation of internal Ministry of Health funds to reproductive health, and some redistribution of funds to the districts.

There have been some positive outcomes. The National Health Accounts and the CDS-MT have been effective tools that the project has been able to bring to bear. The National Health Accounts have demonstrated to Government where funding priority areas should lie, while the CDS-MT process has developed increased capacity in the Ministry of Health to Plan and has created a degree of transparency that led the Ministry of Finance to observe that "for the first time they clearly understand the budgetary and planning priorities of the Ministry of Health".

Social Financing is an area where the Project has met its targets with the creation of 40 new Mutuelles and 5 URMS, reaching 98,000+ beneficiaries, and over 5,000 vulnerable and handicapped people.

The Project has shown flexibility to support Mutuelles at varying stages of development – from the embryonic in Kolda to the mature in Louga, and the Project's approach is perceived to be collaborative, capacity building, empowering, and effective. Most importantly, engagement of other NGOs and civil society in the Mutuelle process has been key a element in the success.

Regional Unions are generally new creations but are already engaged in the process of creating and supporting Mutuelles, and the Unions recognize the importance of becoming sustainable and are willing to take the steps necessary to do this.

The main areas of concern for social financing are around sustainability of the Mutuelles and Regional Unions (especially the newer ones). Specific challenges are how to grow the existing Mutuelles to cover larger populations than those currently served (both expanding the geographic area and the percentage penetration in existing areas); how to address the continuing demand to support the development of new Mutuelles (which makes even more demands on already overburdened staff within the project and redirects focus from consolidation of the gains in the existing Mutuelles); how to engage other donors in scaling up of Mutuelles now that the Government has stated its policy for 50% of the population to have coverage by 2010; and, how to professionalize Mutuelles while at the same time retaining the key elements of social solidarity that is key to their existence.

Institutions of Decentralization is the most complex of the technical areas and the one with the most varied and mixed results.

In many ways, there have been two quite distinct projects. In the North the Project has been a follow-up to the DISC project and is providing technical assistance and training in planning to decentralized institutions – health committees, local collectivities, and management committees. In the South the Project has introduced matching grants and thus has had the means to provide incentives for change.

At the central level the Project advocated for, and supported, the development of a decree for the creation of a new Health Development Committee (CDS) which would merge the functions of the health committee and management committee and clearly define new roles and responsibilities. Unfortunately this committee is not yet legally formed while the decree is pending. While waiting for the decree the project has not focused on institution building with the result that health committees perform very poorly (only 10% developed action plans in 2009 and only 32% met the criteria for functionality). At the same time, the local collectivities did not produce any POCLs in 2009.

The decisions not to use matching grants in the North and to limit their use in the South has had very negative effects in terms of capacity development and raises many questions about the purpose of matching grants and the evolution of their value over time. It is clear from the work of the Project in Kolda and Ziguinchor that the true value of the matching grants is providing incentives for capacity building, institutional reform, quality improvement, community ownership, good governance, and transparency. This is a process that takes years, not months to develop. It is therefore vital that the Project work with the Mission to examine the lessons learned from the matching grant program in the North (where no new POCL has been produced since the phase out of the DISC program) and re-examine the approach as a possible element within a larger performance-incentive program.

The project has done effective work in identifying proxy indicators of good governance and in making improvements through observational studies, and the relationships established with local authorities (especially the ARD) have been very important for building stronger linkages with local collectivities.

The Project has not yet begun to engage health committees or local collectivities in improving quality of care, nor has the project found the necessary synergies in the quality of care policy debate with the reproductive health and HIV/AIDS components of the program.

The project has met the majority of its goals and objectives, but these achievements are tenuous at this point and it is important for the project to focus on maintaining those achievements and transferring capacity. To this end, the project should not take on significant new activities and should dedicate all its technical efforts towards identifying those institutions or individuals to whom long-term capacity will be transferred, and to then work through those individuals and institutions to build that capacity in a formative fashion. In order to accomplish this, the Project should develop a detailed sustainability plan to supplement the year 4 workplan, which will identify key partners to transfer capacity to, and also include capacity assessments, gap analyses, and specific activities to be conducted in the remaining two years

INTRODUCTION

While Senegal has improved on its social indicators and more than one-third of its population has seen improvements in community health care and infrastructure over the past five years, the country still falls short of achieving the Millennium Development Goals (MDGs) in health. For many Senegalese, getting basic health care is costly and time-consuming because either they have no health clinics near their homes or the clinics themselves lack equipment, medicine, and supplies. In many parts of the country, people walk long distances or pay for transportation by horse cart to reach a health facility. Consequently, women often skip pre-natal consultations and give birth at home, contributing to high maternal mortality. Children are not regularly immunized, and malaria (Senegal's number one killer) goes untreated until it is too late. In addition, less than 65 percent of persons living in rural areas have access to potable water, which greatly contributes to the persistent problems of child and maternal mortality.

Thus, despite considerable progress, there are serious needs for improvements in the quality and use of health services, products, and information in the areas of maternal, newborn, and child health; family planning and reproductive health; and the prevention and control of malaria, HIV/AIDS and tuberculosis.

In response to this analysis, USAID (in 2006) issued Annual Program Statement no. 685-06-005 for FY 2006 – 2011, entitled "Capacity Strengthening for Resource Use in the Ministry of Health, Policy Dialogue Coordination, Social Financing Mechanisms and Institutions of Decentralization." This APS resulted in the award of four Cooperative Agreements: Maternal and Reproductive Health – managed by IntraHealth; HIV/AIDS and Tuberculosis – managed by Family Health International; Child and Neonatal Health – managed by The Child Fund; and, Health Care and Financing and Policy – managed by Abt Associates. Together these four Cooperative Agreements are known as the USAID/Santé Program.

In 2009 USAID issued a scope of work for a mid-term evaluation of the Health Policy and Financing component of the Program with the objective of determining the extent to which the expected results have been achieved and to identify areas for improvements that will facilitate the attainment of the planned results. Specific questions were posed to fully understand:

a. The adequacy of the program's activities
b. The soundness of the approaches
c. The quality of overall program management
d. The appropriateness of the technical assistance to achieve desired outcomes and impacts, and
e. The potential of sustaining aspects of the program

Ultimately USAID asked for general and specific conclusions and recommendations on ways to:

a. Maintain and continue program progress
b. Expand the program, and/or
c. Make the most appropriate modifications in the program

BACKGROUND

The current Health Care Financing and Policy Project (HCFPP) is a follow-on to USAID/Senegal's eight-year strategy (1998-2006) that supported integrated and decentralized health service delivery in Senegal. Analysts had found that the decades-long practices of centrally allocated health budgets to the health district level, based on a top down approach to budgeting and planning, had left civil society and elected leaders with little insight, experience and expertise in the management and operation of local health services. The introduction of cost recovery approaches based on the Bamako Initiative in the late 1980s had helped create some limited understanding of the financial implications of providing health care on the peripheries of society, but perceptions of the real costs of health care were elusive.

Following a health related decentralization study toward the end of the1990s, Senegal introduced decentralized health service management and pilot-tested decentralized maternal/health care in the regions of Fatick, Kaolack, and Louga with mixed results. Frequently mayors who were ignorant of health priorities redirected money to non-health related activities. USAID/Senegal supported decentralization of health services through its existing maternal and child health (MCH) activities through their bilateral and the BASICS projects, and PHR began serious analyses of how to make things work to rescue the community-based financing that no-longer functioned. In addition, the Mission developed alternative mechanisms for financing health services through community-based health insurance schemes and established a matching grant program to encourage local government participation in health financing.

In essence, USAID's strategic approach sought to strengthen the quality and sustainability of activities at the peripheral level, where the majority of Senegalese seek health care services. Following the close of the two-year pilot project, USAID supported a three prong strategy designed to strengthen MCH and HIV/AIDS services and to support decentralization through the Decentralization and Community Health Initiative Project (DISC), which began in mid-2000 and ended in 2006. DISC had as its objective to introduce, build, and assist institutions in support of decentralized community health care planning and financing based on the principles of "good local governance" in USAID target areas.

HCFPP builds on the successful experiences of PHR and DISC and was designed to work with the Ministry of Health (MOH) to take the process of health system reform to the next step. USAID/Senegal awarded Abt Associates Inc. the five year HCFPP Cooperative Agreement in June 2006 with the objective to "(i) make the health environment conducive to transparency and accountability, and (ii) mobilize more and more public and private resources for health." The focus of HCFPP is to promote efficient use of health sector resources; help communities gain an increased share of resources; build within the MOH a link for technical support to local communities; and increase involvement of private providers. The overarching goal is increased use and improved quality of priority services, particularly for the poor and disadvantaged.

The program interventions fall under four key components:

- Policy dialogue and coordination – coordinating policy efforts of USAID MCH and HIV/AIDS programs and improving the development and policy implementation environment within the MOH so policies are adopted and implemented more quickly and effectively

- Strengthening MOH capacities – providing an evidence base to enable the Senegalese government to allocate additional resources to deal with public health problems and ensure that these resources are used in an effective, transparent, and participatory manner.

- Social financing mechanisms – expanding coverage, particularly among economically vulnerable populations, and improving sustainability of social financing mechanisms, such as mutual health organizations

- Decentralized institutions – identifying problems and solutions to ensure that decentralized institutions in the health sector, management committees, and health committees function appropriately and that mobilized resources are used effectively.

Working with Abt on HCFPP are three partner organizations: Africare, Groupe Issa, and Helen Keller International (HKI). Africare works on decentralization issues while Groupe Issa deals with policy dialogue and capacity building, and HKI deals with nutritional fortification and public-private partnerships.

Specific capacity strengthening, social financing, and decentralization activities take place in the regions of Thiès, Louga, Kaolack, Kaffrine, Kolda, Sédhiou, and Ziguinchor. In these regions, HCFPP plays the coordinating role for USAID/Senegal's health interventions by establishing and managing regional offices in Thiès and Kolda.

Quarterly and Annual Reports from HCFPP show considerable progress towards achieving the original goals of the program, nevertheless, there are obstacles remaining. These include: (a) insufficient transparency and accountability; (b) insufficient coordination with communities, civil society and private sector; (c) inadequate sector financing and budgetary procedures; and (d) high financial barriers to access and utilization of health services.

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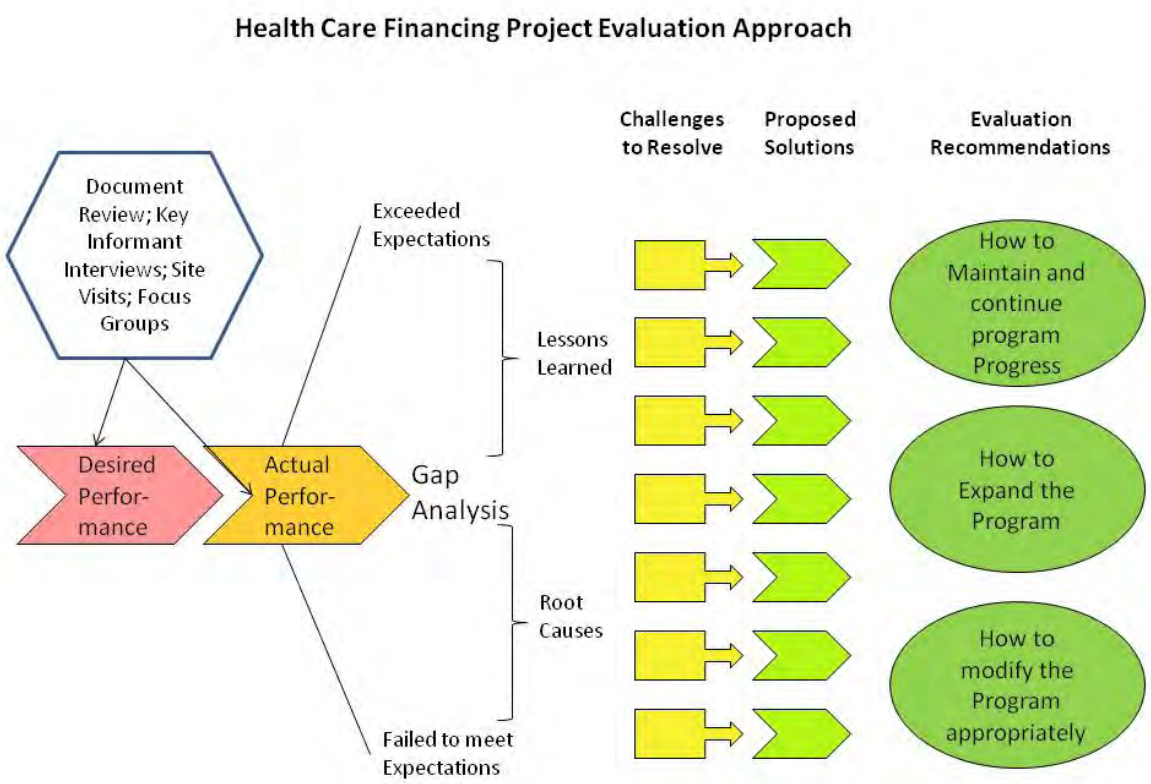
PURPOSE AND METHODOLOGY OF THE ASSESSMENT

The evaluation was conducted by a team of expatriate and local senior experts who bring a long and deep knowledge of health system improvement activities in Senegal and elsewhere in the world. The detailed evaluation framework and questionnaires are contained in Annex 2. A summary of the overall methodology is represented in Figure 1. The formulation of questions was done through a detailed analysis of the original Annual Program Statement, the Scope of Work of the Cooperative Agreement between Abt Associates and USAID, and the 29 questions posed by USAID in the Scope of Work for this evaluation.

The team began with reviews of existing documents, including project reports, reports documenting changes in the health system in Senegal by Government of Senegal and international agencies, and health system performance and financial data. The reviews were followed by a week of key informant interviews of USAID and Abt's team and within Senegal's MOH central offices in Dakar. There were also interviews with GoS Ministry of Finance and elected members of local and central government and civil society leaders working in the areas of health policy, financing and delivery.

Figure 1 Health Care Financing Project Evaluation Approach



During the second week the team split into two and visited Kolda, Louga, and Thies. These visits included meeting with Regional and District health authorities, local government authorities, locally elected officials, health committees, management committees, Mutuelles, Regional Unions, and various civil society groups. Interview methods included one-on-one, group discussion, and focus groups.

The final week involved further meetings with key informants in Dakar, formulating and testing hypotheses with key stakeholders, and sharing preliminary findings with the Project team and with USAID/Dakar.

FINDINGS OF THE EVALUATION

This section lays out the detailed findings of the evaluation team organized first according to the five general questions posed by USAID (with their 29 sub-questions). This is followed by

a detailed analysis of each of the four technical areas of the project with specific recommendations included.

GENERAL FINDINGS

1.1.1 Adequacy of Activities

USAID Question: Did the original design of the project include an appropriate combination of the activities to achieve the program goals?

Findings: The overall design of the project is sound and there are three strong points that that the team wishes to underline:

- *The importance of having a balanced approach to central level support and decentralized technical assistance.*

In the past, USAID has cycled between a heavily decentralized approach and a strongly centralized approach. The design of this project has provided an excellent balance between the need to conduct implementation activities in the field, and the need to provide policy and budgetary support at the central level

- *The use of the four technical activity areas are well balanced between the need to strengthen policy and to implement policy*

The emphasis on developing policy, developing the technical capacity to budget and manage activities related to the policy, engage civil society and other actors, and the focus on implementation of policy at the periphery was realistic and has allowed for great flexibility in USAID's support to the Ministry of Health and the Ministry of Finance.

- *The identification of a single contractor to be the coordinator of the entire USAID/Santé program was an important step towards creating a single USAID health program.*

However, the design left several gaps. Firstly, there was significant overlap between the technical areas of Capacity Building and Decentralized Institutions which has caused confusion because of the need to build capacity in multiple institutions and not simply within the Ministry of Health. The Project has been able to address this satisfactorily, but more clarity in the design would have facilitated the start-up of the project.

Secondly, while the addition of a formal coordination role is noted to have been important, the definition of coordination is unclear. It has been interpreted by each agency differently, and has also been interpreted differently at the central versus the peripheral levels. This has in turn resulted in confusion and inefficiencies while USAID/Santé program members have tried to work this out with insufficient guidance.

Thirdly, the mechanism of coordination was not built into the original APS with the result that no individual organization built it into their proposal and the mechanism had to be worked out after award – with considerable difficulty.

Fourthly, the concept of matching grants was not adequately thought out for this project with the result that their true value as incentives for performance and change has not been realized.

Recommendations:

The mission continue to emphasize the need for projects to have a strong central coordinating and standard setting role to support an equally strong decentralized focus on implementation.

The mission clearly identify what it means by coordination in any future program design and build the role into the solicitation for proposals.

USAID Question: To what extent is the range of activities sufficiently broad for achieving the program goals?

Findings: The original APS was very broad and allowed for covering all possible activities. The design of the APS was very clever with its balance of issue and challenge statements, followed by pointed questions. This design forced the respondents to be creative in their responses, taking into account the realities of Senegal. The net result was an excellent proposal.

Unfortunately, the breadth of the design also left the door open for the respondent to over commit to activities without adequate attention to the availability of resources. As noted later, this over commitment was not identified by a cost-realism analysis and has resulted in financial short-falls for the project.

Recommendations:

An open APS format is extremely effective in stimulating innovation and creativity in proposals, but any proposal must receive a very thorough cost-realism analysis to prevent over commitment of the final project's resources

USAID Question: Was the project financing adequate for successfully implementing the range of project activities?

Findings: The financing was inadequate for the breadth of the technical scope at the decentralized level and having to support activities in five (later seven) regions. The breadth of the technical scope has meant that technical experts have to be duplicated in each regional office and the lack of financing has severely limited the ability of the limited number of technical experts to work with counterparts to develop capacity and sustainability. In addition, the costs of coordination were not taken into account in the original budget which has placed a heavy burden on the project's resources and reduced the ability to achieve technical activities. Finally, the limitations in financing meant that there were only two regional offices. The Project's objectives would have been more easily reached with additional Regional offices – preferably one in each Region.

The budget has suffered dramatically because of the devaluation of the US dollar. The mission has responded to this with a proposed amendment to increase the budget appropriately. Overall the evaluation team estimates that the project would have benefited from approximately $2m additional funding at the outset.

There is considerable fault to be found with both the contractor and the mission contracting office which allowed a budget to be finalized that did not meet a cost-realism analysis. Abt made serious errors by under-budgeting the cost of doing business in Senegal and by failing to budget for the Matching Funds.

An additional budgetary challenge is the fact that Abt has been unable to bring the $2m in cost-share that was committed to the Project. While Abt explains this as a result of their nature as a for-profit organization with no external sources of financing, the net result is that they made a commitment to a cost share which has not been brought to bear and the technical activities of the project have been affected proportionately. USAID has agreed to reduce the level of cost-share which further reduces the funding available.

At present, the budget that remains would be inadequate if the project were to continue to roll-out significant technical activities. Abt has already taken measures to address the shortfall by changes in staffing and scopes of work of subcontractors. However, the evaluation team recommends that the project focus extensively on sustainability and transfer of capacity in the remaining two years, which should significantly alleviate the budgetary challenges.

Recommendations:

Future programs should budget adequately for the geographic and technical scope

USAID Question: If there are additional areas USAID/Senegal should be addressing what are they and what are the cost implications of expanding the activity array to incorporate these activities?

Findings: Because of the budgetary constraints, and the imperative for the gains of the Project to be consolidated, the evaluation team believes that the Project must narrow its focus as much as possible. During our discussions it was clear that the most important element in the health system at present is the lack of accountability and a performance management system. In the light of the recent study tour to Rwanda (in which the Project participated), there is significant momentum to pursue performance-based financing (PBF). However, the actions in this area should not cost additional resources for the Project.

Recommendations

The Project limit any additional areas that are taken on to that of supporting the MOH in its policy agenda in relation to performance based financing. Most importantly, the Project should provide assistance in helping the MOH

understand PBF as an approach to strengthening health systems with a focus on:

- Human resource planning and evaluation
- Information management
- Good governance and transparency
- Quality management
- Essential drug supply

The mission should seriously consider the role of PBF in the design of any future health financing and policy program as both an approach to strengthening health systems and in creating good governance. Such a program would require both technical assistance and financing for performance incentives. Based on project designs with a similar theme, the budgetary amount would be in the region of $30m to $50m.

1.1.2 Appropriateness of the technical assistance

USAID Question: Has the program been able to complete the planned activities within the stipulated times?

Findings: Detailed findings are listed in the sections that follow. The evaluation team would make the following overall observations:

- Policy Dialogue and Coordination – The project exceeded expectations and its targets
- Capacity Development to Plan for and Mobilize Resources – The project has failed in its primary objectives of mobilizing external resources to increase the MOH budget and to shift funds from the central level to the regions. The project has facilitated shifts in budgetary allocations within the health sector to increase funding of maternal and reproductive health.
- Mobilizing civil society – the project has failed its objectives to-date at both central and decentralized levels
- Social Financing – the project has met all its targets
- Decentralized Institutions – The project has failed to build significant capacity in the health and management committees as evidenced by only 32% of health committees meeting the project's definition of being functional, and zero local collectivities have preparrd POCLs in the third year of the project
- Good governance – the project has been innovative and effective in addressing this area

USAID Question: What are the key contributions to the health care policy and financing programming in Senegal?

Findings: Detailed findings are listed in the sections that follow, however the key contributions include: Finalization and publication of the National Health Accounts;

institutionalization of the CDS-MT; development of the PNDS II and it's-M&E plan; policy guide for government contracting with private sector; framework for scaling up successful community based initiatives; reform of financing through universal health insurance; development of a policy to reform health and management committees; establishment of the HPIT; and, contribution as a partner in the multi-sectoral effort on food fortification.

USAID Question: Are the planned (output, outcome and impact-level) results achievable with all those hindering factors such as exchange rate fluctuation, low internal resource mobilization, possible "délégations spéciales", newly elected officials, delay in reforming the health committees, etc.

Findings: The short answer is yes! The Project has faced a wide range of constraints such as those identified above; in addition there has been considerable instability in the Ministry of Health, with seven ministers being appointed during the life of the project. However, none of these constraints are unusual in a five-year project and the Project has been able to overcome these challenges very effectively with strong political skills, technical competence, flexibility, and with good prioritization. The only constraint that has been beyond the ability of the Project to respond to has been the devaluation of the dollar, which the mission is overcoming an amendment to add supplemental financing.

USAID Question: How can be minimized dependency on allotted devolution fund mobilization so that the planned technical assistance is provided as scheduled?

Findings: The evaluation team feels that this is not the correct question. It should be rephrased to "How has the Project responded to problems with devolution of funds?"

The Project appears to have taken a passive position in which it bemoans the fact that the "State" has not allotted devolved funds. The initial work done by the Project and the Mission to induce the Ministry of Health to add a line item for 2b FCFA is commendable, but the fact that the Ministry of Finance will not allow these funds to be released is predictable. A large, well resourced technical assistance project such at the HCFPP should be taking an active problem solving approach to mobilize these resources. A detailed approach that the Project could take is outlined in section 4.c.

USAID Question: How effective/efficient have been the Health Policy Initiative Team and Steering Committee to speed-up issuance of reform texts?

Findings: The Health Policy Initiative Team has been both effective and efficient. It has full ownership by the Ministry of Health, has expanded to include membership beyond USAID, and will almost certainly be a legacy that lasts long after the end of the Project.

The Steering Committee has been an effective tool in bringing specific concerns from USAID/Santé program elements onto the policy agenda. It has been perceived by the other members of the program as being a less effective forum for resolution of program challenges however.

1.1.3 Soundness of the approaches

USAID Question: How well have the four components of the USAID health program been coordinated?

Findings: As noted above, coordination faced the challenge that there was lack of definition of what coordination actually means. Coordination became a mandate without the power of a contractual obligation; and, it was inadequately budgeted.

Despite these constraints, all members of the USAID/Santé program are in agreement that coordination in the Regions has been effective in presenting a single face to partners. This was confirmed by the evaluation team in discussion with partners. It is also clear that the sharing of offices and materials is a significant savings in resources. Abt worked extremely hard to meet its obligations, played a strong leadership role, created a procedure manual that was finally agreed to by all parties, and absorbed many costs themselves in the initial phases.

The Child Fund maintains a separate office in the regions, and organizations such as RTI and ADEMAS, who do not have regional staff, still operate in the regions without their work being integrated through the regional office. Unfortunately, this creates a "double standard" in the regions and maintains the reality of multiple vertical USAID programs.

At the central level it appears that coordination has not worked well. Monthly meetings take place, but do not address synergy, true coordination, or learning between USAID/Santé members. It was universally stated by Abt's program partners that the meetings were poorly managed, stifled open sharing and debate, and were "A complete waste of time". Further discussion led to suggestions for how this might be addressed during the life of this project – by sharing the role of chairing coordination meetings, introducing a set of learning objectives, defining the role of coordination, and establishing formal mechanisms for drawing on the resources of each partner to achieve overall program goals. In addition, each partner recommended that while USAID should develop the concept of coordination further in future projects, the fact that partners are also competitors presents a specific challenge that USAID should attempt to overcome.

Recommendations:

Coordination at both central and decentralized levels be built into all future USAID projects

Future projects mandate that all USAID health projects be housed within the same offices in the periphery with no exceptions.

For the remaining two years of the project the central level of coordination be shared by the four program partners. Each will host three meetings per year at which the agenda will cover the specific programmatic challenges and advances of the

host project, learning objectives concerning the technical domain of the host project, problem solving, and an opportunity to seek synergy. Each meeting will result in a defined set of actions and the host project will be responsible for follow-up on those actions.

In future USAID should consider a mechanism to overcome the innate inability of competitive organizations to be full and open collaborators at the central level. This could take the form of recruiting an uninterested party as coordinator at the central level, or USAID itself taking on this role.

USAID Question: How effective has collaboration been with sub-grantees and other donors intervening in health care policy and financing?

Findings: The collaboration between sub-grantees has been exceptionally strong. Group ISSA, Africare and HKI have all performed excellently and are largely responsible for the majority of technical achievements in the Project.

Two subgrantees did not perform adequately. This was rapidly identified by the Prime and addressed. DGL Afrique was removed because of financial irregularities, and RADI removed because of technical non-performance.

Branding of the project is a particular concern to the evaluation team. The project is branded exclusively under the Abt logo (with only the Project Director's business cards acknowledging USAID or the Project). This means that not only are USAID's branding requirements not being met, but the staff of sub-grantees are being falsely represented as Abt staff with no credit being given to their parent institutions. In addition to being misrepresentative, it also undermines the concept of local capacity building.

Collaboration with other donors has been effective on a policy level and has also brought interesting collaboration at the local level with NGOs such as World Vision. However, the evaluation team was deeply concerned with the Project's lack of vision of how to engage other donors as an element of cost-sharing. In discussion with Abt it appeared that the cost-share issue is seen more as an accounting problem than as a technical challenge to engage other donors and use the project's leverage to bring additional resources to bear to improve the health of the Senegalese population. The Project Director has shown significant initiative in finding sources of support that can be counted towards cost share, but there has been little support from the home office.

The issue of using cost-share as a means of leverage is of particular importance given the concerns about the need to rapidly expand Mutuelle health organizations, and the fact that USAID remains the major supporter of Mutuelles.

Recommendations:

Abt actively rebrand the way in which the partnership is represented under the Project Logo, recognizing USAID, and also recognizing the institutions for which individuals work.

Abt actively re-think its approach to cost-share to move away from an accounting approach to simply count the amount of other's contributions, to one of actively working to use the project's work to leverage the input and support of other donors.

USAID Question: How successful has been the approach to increasing participation of collectivities, civil society, private sector, and (central and local) governments?

Findings: Detailed discussion of these areas is conducted in sections that follow. In summary the evaluation team observes:

- Collectivities – Very effective in the South where matching grants have been available as an incentive. Relatively ineffective in the North where the activities were mostly re-training. Ineffective at the central level.
- Civil Society – Ineffective to-date
- Private sector – Ineffective to-date
- Government – Very effective at the central level, moderately effective at the Regional level

USAID Question: Were any formal or informal mechanisms established for involving key stakeholders?

Findings: Effective mechanisms were developed at both central and peripheral levels. At the central level informal relationships were established with key leaders of all partner offices, while there were formal relationships through the HPIT, Steering Committee, various task forces, and with the Ministry of Finance. At the peripheral level formal relationships were established with the Regional and District offices, all existing and new Mutuelles, many NGOs, and more informally through participation in national days, political events.

USAID Question: Did the program managers establish necessary linkages with governmental agencies, and civil society and private organizations?

Findings: The necessary linkages were formed with governmental agencies at all levels both within the Ministry of Health, Ministry of Finance, and the PNDL. Similarly at the peripheral level, linkages were created with the governor's office, ARD, communes, and local collectivities.

Civil society linkages were not created at the central level, while at the peripheral level those linkages that were created focused on the development of Mutuelles.

Private sector linkages were very weak. The relationship with World Vision and PACT were excellent innovations but not replicated adequately elsewhere. Other private linkages were lacking.

USAID Question: Has the approach for accomplishing policy reform been effective?

Findings: The approach has been extremely effective. However, the Ministry of Health would like the assistance to extend beyond the existing level to produce an implementation framework when a policy is developed (see details in section 4 b).

USAID Question: What constraints or challenges have hindered successful implementation of project approaches?

Findings: As noted earlier, there have been many constraints. Some of the most important have been: taking on the role of coordinator for the USAID/Santé program; mis-budgeting; loss of the matching grants as an incentive for change; devaluation of the dollar; political instability with many ministers; creation of new administrative boundaries and two new regions.

USAID Question: How has the project dealt with or adapted to those challenges?

Findings: Details of how effective these responses have been are found in the specific technical sections. In summary the evaluation team would note the following:

- Coordination – The project took immediate responsibility for the role despite the challenges, hired two excellent regional coordinators and added them to the payroll, developed an administrative procedures manual which met the satisfaction of all partners, and revised the manual after a one-year evaluation. The Project also re-budgeted to assume the responsibility of being coordinator at the regional levels.
- Misbudgeting – The project lobbied hard to remove the matching grants so that money was freed up to finance other activities. Equipment and vehicles from old projects was recycled into the new Project. Technical assistance was cut and staff who left were not replaced. Home office technical support was cut to virtually zero, cost share was cut from 17% to 7.2%, and the project lobbied hard to have additional funds added to the budget (in addition to the adjustment for devaluation of the dollar).
- Lack of matching grants as an incentive change – The Project lobbied and succeeded in getting the Ministry of Health to add a substantial line item to its budget to cover these costs. Unfortunately the Project did not take the next step in facilitating the release of these funds.
- Devaluation of the dollar – the Project is in the process of negotiating with USAID for an increase in the budget to off-set the devaluation.
- Political changes – the Project has been particularly effective in maintaining a stable relationship with the Secretary General and in providing outstanding

technical assistance which is seen as benefiting the GOS regardless of who the minister is.
- Creation of new boundaries – the Project is planning to address this challenge in the coming year.

USAID Question: Are the intervention approaches still valid in light of 36 months of implementation?

Findings: The approaches are appropriate BUT the project must change its focus from implementation to sustainability at this point.

All activities must be through local partners and not done directly by the project. Specific partners include:

The Regional Unions to support Mutuelles

The ARD to support planning at the local collectivity

The district offices to support the health committee and the new CDS

Selected "favored" civil society partners to support the rest of civil society organizations

The Association of Elected Officials, civil society, and the district offices to support all good governance activities.

The Project's assistance should focus on:

- Skill building
- Capacity building
- Providing essential resources
- Facilitation of implementation plan development
- Facilitation of communication plan development
- Assistance in development of business plans or in resource generation plans

USAID Question: What needs to be changed to speed-up or expand the interventions?

Findings: Specific recommendations for each of the technical areas are to be found in the relevant sections. Beyond that, the recommendations to the previous question are appropriate as the priority of the project must be to retain progress and assure continuance of activities after the project ends.

1.1.4 Soundness of the overall management

USAID Question: What are the most important management features staffing: materials, activities, sub-grants, administrative and financial arrangements)?

Findings: Overall the project has an extremely well documented set of management and administrative approaches which have been used by Abt in many settings to manage USAID funds. The following points were raised concerning the management procedures:

- Staffing – The project under-budgeted the cost of staff in its design which has resulted in a chronic shortage of staff for all tasks. Hiring of staff is a two-stage process in which the local office conducts interviews and the Bethesda office makes the hiring decision. Consultants are hired in the same fashion as long-term staff. Unlike the performance of long-term staff, there have been complaints by counterparts and partners about slow performance of consultants and long delays in the production of reports and recommendations
- Materials – The project produces work plans and reports through a sound, collaborative, internal process. Both are produced in a timely fashion, as are M&E reports and data. An excellent procedure manual exists at the central level modeled on Abt world-wide procedures, and at the regional level after negotiation with local partners.
- Equipment – is purchased according to USAID and Abt procedures. The elderly nature of the vehicles keeps maintenance costs high.
- Activities – The Project created a "Guide Indicatif" early on, followed by a M&E plan and an M&E guide. Quarterly reports are timely and follow the guidelines of the annual workplan as do the annual reports. All reports are joint efforts produced by the staff at all levels.
- Sub-grants – Abt has managed the sub-grants very effectively. Both performance against the scope of work and financial performance are routinely monitored and problems have been rapidly identified. As an example of the effectiveness of Abt's processes: Financial concerns with DGL and Group ISSA led to financial audits. As a result DGL was let go from the project, while Group ISSA received additional technical assistance to improve their accounting procedures. Similarly, RADI was rapidly diagnosed as being non-performing and let go.
- Administration and Finance – The process is highly centralized to Bethesda with most accounting seeming to be mostly pass-through with little actual decision-making allowed in the Dakar office. The same is true of Abt's regional office, however, for dealings with other partners the procedures manual has proven to provide sufficient flexibility and comfort for partners to be able to work effectively.

USAID Questions: Are those features contributing to the attainment of the objectives within the specified timeframe?

How do the features contribute to achievement of desired outcomes/impacts?

How do the features contribute to not achieving the desired outcomes/impacts? If so, how?

Findings: The evaluation team felt that while the management and administrative procedures are designed to minimize financial risk to the Prime Grantee there are significant consequences:

- The Procedures are cumbersome and cause the project to be slow to respond to needs. An example was given of peripheral partners having to wait for

extended periods of time for funds to be made available even though work plans were approved. The net result is slowing of project activities, frustration, and a loss of good will.

- The centralized approach to Bethesda slows down response times – both for financial management and for hiring. The centralization also goes against the principles of developing local capacity, does not use the highly competent staff that the project has recruited to the best of their ability, and has a de-motivating effect on staff.

- The lack of direct home office support to the Project Director has slowed the project implementation. The Project Director has excellent qualifications and skills but as this was his first assignment in this role, he needed support in "learning the ropes". The lack of direct support has resulted in slower than necessary start-up and action in many areas of the project.

- The lack of home office technical support to the project in the first three years has deprived the project of Abt's world-wide experience and capacity and impaired the Project's ability to learn from global lessons.

USAID Question: What adjustments will be needed to achieve desired outcomes/impacts?

Findings: The necessary steps involve:

Decentralization of financial and administrative decision-making to the field to allow more rapid response times;

Directing more technical support from Abt's global work force to Senegal (it should be noted that this could be done as part of Abt's cost share);

Stop the imminent purchase of new vehicles and other capital projects and invest the funds in technical activities related to sustainability. While it is expensive to maintain old vehicles, the cost of replacing the vehicles for two years will be many times greater than the maintenance of the old vehicles.

USAID Question: How feasible is it to make those adjustments?

Findings: Making changes in Abt's administrative and technical programs will require institutional changes that may not be practical. However, the use of the funds programmed for vehicles can easily be managed.

1.1.5 Sustainability

USAID Question: What legal, regulatory, or administrative barriers to achieving desired outcomes/impacts need to be addressed or mitigated?

Findings: Two legal barriers need to be addressed: Firstly (as noted elsewhere), the Project must facilitate the response to the concerns of the Ministry of Finance that will enable the release of the 2b FCFA for planning and implementation of the POCL.

Secondly, the Project needs to continue its support to the Secretary General in pushing for passage of the decree for the creation of the CDS. However, this should not delay immediate provision of assistance to build the capacity of health committees to plan and manage.

USAID Question: Are the intervention approaches conducive to sustainability?

Findings: Yes they are, but the project needs to change its focus to be almost entirely on sustainability at this time if the gains are not to be lost.

USAID Question: How can activities and capacities be transferred and sustained after the program ends?

Findings: Reference should be made to the response to the validity of the approaches and the need to focus on sustainability. To this effect, the project should develop a specific sustainability plan in addition to its regular workplan. This sustainability plan will identify key institutions that will be partners (as noted above), and for each individual or institution the following should be conducted:

- A Capacity Assessment
- A gap analysis
- A specific set of activities to respond to the gap
    - Skill building
    - Capacity building
    - Capital resources needed
    - Planning requirements

Most importantly the Project must take an approach that is capacity building, and not simply carry out training. This approach will contain the following elements:

- Group teaching/training
- Individual mentoring
- Accompanying individuals and groups in their work
- Formative supervision

USAID Question: What institutional reforms will help sustain the momentum?

Findings: The major institutional reform that is necessary is to make accountability for performance as the key attribute of individuals and institutions. To this end the Project must support the Ministry of Health in its efforts to introduce a framework for performance based financing.

USAID Question: How can involvement of the local collectivities in the development committees at various levels be institutionalized?

Findings: All the necessary elements for the local collectivities are already in place. The collectivities are already members of every local institution required including the CLD, CRD, ARD, CDD, PRDL, and PNDL. Therefore what is required is to identify where the collectivities are not engaged or making their presence felt and use the relevant committee to engage them. The evaluation team believes that the most appropriate agency for this would be the ARD.

POLITICAL DIALOGUE COORDINATION

In the original APS, USAID posed the following:

Issue: *USAID's effectiveness at facilitating policy change and implementation at the MOH is weakened by the dispersed manner by which each CA pursues its policy agenda vis-à-vis its interlocutor independently. Further, however long the process between policy dialogue and decision takes, once a policy is adopted its implementation is generally weak.*

Challenge: *To coordinate the policy efforts of all USAID project components and to improve the policy development and implementation environment in the Ministry of Health so that policies are more quickly and effectively implemented.*

1.1.6 General observations by the evaluation team

The team had the opportunity to review a wide range of policy and related documents that the project has supported, as well as meeting with senior counterparts at the Ministry of Health and the Ministry of Finance. In addition the team attended a meeting of the Health Policy Initiative Team. In discussion with USAID, meetings with other donors and development partners were felt to not be necessary as they would not add to the findings.

This is the strongest of the projects technical areas with significant successes and the anticipated scope of work has been exceeded. As a result of the project's approach and success using the national health reform process, USAID has now been placed in a central role for advising on and supporting policy development. The response to the challenge has resulted in the improved development and implementation environment in the Ministry of Health, and it is clear that policies are more quickly and effectively implemented. However, the coordination of the policy efforts of all USAID project components has been less effectively carried out, and there is room for improvement in this area.

It should be pointed out that this work has been done in an exceptionally volatile and unstable leadership environment. In the three years of the Project's life there have been seven ministers of health, with the latest turn-over happening during our visit. Clearly, changes in senior leadership have the potential to disrupt progress in policy reform and development. However, the Project has been able to use the stability proffered through the continuing presence of the Secretary General for Health to steer through the reforms and keep focused. Accomplishments include:

- A total of 15 policies and decrees have been developed with the project's technical support;
- The Health Policy Implementation Team was created early in the life of the project, and at this point in time, the GOS has assumed full ownership of the Team, expanding its membership beyond the original limits to include representatives of all the donor and development partners in health;
- The HPIT has effectively taken on six major policy reform areas in its first three years of operation and with the Project's assistance has successfully brought these to a conclusion.
    1. The completion of the National Health Accounts for 2005, publication and distribution of the documentation, and commencement on the reproductive health sub-account;
    2. Support in making the CDS-MT process at the central level into a practical policy in collaboration with the MOH and MOF;
    3. Support to the MOH in developing a major policy reform to address the issue of the conflicting roles of the Health Committee and the Management Committee. This has taken the form of a presidential decree which will merge the two into a single Committee de Development de Santé and clearly define the role of the committee. This decree, while delayed, is expected to be signed by March 2010 at the latest;
    4. Planning and financing policy through the POCL. The project's support has enabled the redefinition of the POCL process to align it with the new PNDS. A new manual has been created to support this (and is awaiting reproduction and distribution), and regulations have been appropriately modified to require the inclusion of the POCL in district health plans;
    5. Health Insurance policy reform has become a high priority as a result of the findings of the NHA that 37% of health sector income comes directly from households and that only 12% of households have any form of health insurance. The project has supported both the research required to develop appropriate insurance policy and participated in the final decree signed.
    6. Putting together a way to share experiences and lessons learned from Community Health care. This has not been a major focus of the Project's work.
- The HPIT has now identified five new challenge areas for the coming year:
    1. Good Governance
    2. Budget Monitoring
    3. Health System Strengthening
    4. Performance-Based Financing
    5. Disaster Response

- The project has established very strong relationships with the MOH and MOF at all levels.
- The Project has provided technical assistance in many extremely important areas. A full catalogue of activities is represented in the quarterly reports, but it the most significant areas have been:
    1. The facilitation of the development of the PNDS
    2. The development of the first ever PNDS Monitoring and Evaluation plan
    3. The elaboration of the CDS-MT reports in such a format that they have proven useful to both the MOH and the MOF
    4. The Revision of the POCL process and documentation
    5. Conducting studies on behalf of the MOP

1.1.7 Project Strengths

As identified above, this technical area is in itself one of the Project's greatest strengths. This has come about through four exceptionally strong elements of the Project.

Firstly, the technical experts that the project has fielded in policy and finance have been exceptional. Their level of competence and experience has enabled them to work with counterparts easily and to command great respect from those counterparts

Secondly, the approach to technical assistance that the Project has taken at the central level has been extremely effective at placing Project counterparts in the leadership role, with the Project staff taking a "rear seat". In this way, there is no sense that policies that have been developed have been anything other than those desired by the GOS. This was echoed at the Regional level who identified the approach taken by the USAID/Santé Program as being one of supporting the GOS and not coming in with their own agenda.

Thirdly, the flexibility that the Project has been able to show in responding to changing demands and requests from the MOH has built enormous good will and increased the willingness of counterparts to listen to, and draw upon Project resources. Examples include the ability to respond to the elaboration of the NHA, and the current work on female genital mutilation. It is important to stress the positive aspect of this flexibility because responding to these requests pose significant logistical, technical, and financial challenges for the Project, and are often seen as a negative aspect by Project managers.

Fourthly, the Project's ability to seize new opportunities for partnerships has proven to be very valuable for the building of capacity of the MOH and for the MOF. Specific examples include the partnership developed between the Project and the MSP to develop a proposal for the establishment of the ILM, and the ability to seize the chance to work with the PNDL to supplement health plans being developed through the POCL process.

1.1.8 Areas of Concern

The Project's approach to partnership with the MOH, identified as a strength above, has led to several key partners having the perception that the Project is more "an extension of the

MOH" than an external technical agency. This is particularly the case for other partners in the USAID/Santé health program who have urgent needs for health policy reform in the areas of reproductive health, HIV, TB, and Child Health. These reforms require senior level policy support beyond the technical units responsible. The Project's inability (or failure) to generate this high-level support contributes to this perception and weakens the Project's effectiveness with both USAID partners and with the technical units of the MOH.

The Secretary General expressed his concern that the Project's policy support frequently ended with the publication of a policy, which left the MSP unprepared for implementation of the policy. He would like to see the Project taking a more pro-active role in developing an implementation framework for policies that are developed with the Project's assistance.

Locally elected government and civil society are not substantially engaged in the policy process. While local government has a stronger role, often being included in technical working groups of the HPIT, they are not directly engaged in the HPIT itself. Civil Society is not formally engaged in the process at all.

1.1.9 Recommendations

1. *The Project should advocate for the inclusion of local government and civil society representatives in the HPIT*.
   This will broaden the input into the HPIT and more actively engage key stakeholders in a positive way. Civil society engagement is particularly important given the potential for two-way exchange and dialogue; the value of having key civil society partners understand the policy process; the importance of creating ownership of policies by civil society leadership; and, the benefit of creating powerful advocates within society for implementation of the policies.

2. *Every policy developed with the Project's assistance must accompanied by an implementation framework and plan*.
   The Implementation framework and plan should contain the following elements:
   a. Situational analysis
   b. Strategy for implementation
   c. Strategy for dissemination
   d. Specific Activities
   e. Tools to be developed
   f. Human Resources required
   g. Financial Resources required
   h. Monitoring and evaluation
   i. Operations research

3. *The project should limit itself to a more narrow focus for new policy initiatives.*
   The HPIT has just identified five new policy directions, and there will be evolution of new policy initiatives during the next two years. It is important that the Project limit its adoption of new initiatives at this time to both conserve the technical capacities and focus on sustainability.

Of the various policy priorities identified, the evaluation team recommends that the Project place its primary policy support in the area of Performance Based Financing. The MOH is strongly committed to exploring adapting PBF to the Senegalese setting. There is growing experience with the approach around the world, and especially in collaborative efforts by USAID and the World Bank. This therefore represents both a significant area of reform for the MSP and a direction that the evaluation team believes should be considered as a focus that USAID should explore for expanding in its future implementation support in Senegal after the current project.

4. *The Project should focus its policy efforts on sustainability and capacity building.* Up until now, much of the Project's work has been directly in support of the MOH using Project resources. As the last half of the Project is implemented, it is increasingly important that the Project change its focus to identify key development partners who can assume this role for specific requests for policy support, policy-related studies, and technical assistance.

   The capacity that the Project has been able to develop with counterparts in the MSP makes it well placed to advocate for support from the wide range of development partners who participate in the HPIT to take on support of policy development and share in the provision of resources to maintain the policy agenda. It should be a priority of the Project to broker relationships with other development partners while at the same time narrowing the Project focus as recommended in #3.

5. *Capacity building activities should focus on assuring sustainability and ownership of key gains already achieved by the projects*:
   These should be limited to finalizing the NHA and the Reproductive Health Sub-Account, and developing the capacity to use the CDS-MT at both central and decentralized levels.

6. *Continue to provide technical assistance to implement policies already in place:*
   The specific areas are: The PNDS; The PNDS – M&E; the government contracting process; and, the Food supplementation policy.

CAPACITY STRENGTHENING FOR RESOURCE USE IN THE MINISTRY OF HEALTH

In the original APS, USAID posed the following:

Issue: *The MOH has limited ability to plan, budget, monitor, and evaluate program results in such a way as to convince the MOF to provide additional funds and the health sector is perceived as adequately funded already*

Challenge: *To persuade the Government of Senegal to provide additional resources to address public health issues, and to ensure that these resources are used in an effective, transparent and participatory fashion, in other words, to hold the MOH accountable for its health outcomes according to its policies, planning and budget*

1.1.10 General Observations by the evaluation team

The evaluation team reviewed appropriate project documents, training reports, and budget reports and projections. In addition, interviews were conducted with staff at all levels of the Ministry of Health at the central level, departmental level, district level, and with individual health workers in facilities. Focus groups were also conducted at the community level with civil society groups such as youth, special interest, and women's groups.

Overall this has been an area with mixed success for the project. There is no doubt that the Ministry of Health's capacity to plan, budget and monitor the implementation of the budget has been increased as a direct result of the project's interventions. This was attested to by both central and decentralized staff of the MOH, and confirmed by senior staff in the Ministry of Finance. The Project has also been able to make excellent steps in raising the awareness of the Ministry of Finance about the health priorities of the country through its support to the CDS-MT.

The Project has also played an important role in advocating for and implementing changes that have increased the transparency of the planning process and in a more effective, transparent and participatory use of funds as a result of the limited experience with the matching grants, and the innovations in posting prices and financial accounts in facilities.

Unfortunately, the project has not been successful in persuading the Government of Senegal to transfer new funds to the health sector as was envisioned in the APS, nor has it been effective in convincing the Ministry of Finance to provide additional funds. In addition, the Project is not perceived as having had any success in shifting resources from the central level of the MOH to decentralized levels. On a more positive note, the Project has contributed to the reallocation of existing funds within the budget to provide additional funding for Family Planning, Reproductive, and Maternal Health (in partnership with the rest of USAID/Santé's implementing partners).

The project has also introduced some interesting innovations in transparency at the health facility level through posting financial accounts at health facilities. While limited in its effectiveness because of the reluctance of facilities to post accounts publicly (instead simply making them available on request), and the low level of literacy making the documents inaccessible to the majority of the population, these have been important first steps in the larger move to good governance.

The work with civil society has been expanded from its original vision of simply being advocates for increased allocation of funds to the health sector, to one of being a "watch dog" for good governance, which is a very positive development. Unfortunately, the extensive delays in engaging with civil society have meant that there has been little (if any) engagement of civil society beyond their role in stimulating the start-up of Mutuelles.

1.1.11 Project Strengths

The work with the CDS-MT has had very significant results for both capacity development and for transparency. It is possible that the Project has laid the ground-work that may result in new allocations of funds to the health sector in the future, but that is still not on the immediate horizon.

In discussions with the Ministry of Finance, the impact of the work with the CDS-MT is apparent. The key counterpart at MOF stated that "For the first time ever, we are able to clearly understand the budgetary and planning priories of the Ministry of Health and measure their performance". While it is true that this is the object of the CDS-MT, and that the CDS-MT was a process adopted by the MOH prior to the Project's involvement, it is the quality of technical assistance and capacity building brought by the project that is almost wholly responsible for these remarkable advances. In addition, the CDS-MT process is now being rolled out to the regional and district levels and will have similar effects there. Ultimately, it is entirely possible that the process will result in significant shifts of budget to the peripheral level as capacity, transparency and accountability is developed.

Finally, the project has successfully advocated with the Ministry of Health to add a budget line-item of 2b FCFA for planning and implementation in relation to the POCL process.

1.1.12 Areas of Concern

The failure to mobilize additional resources for health from external sources such HIPC represents a significant failure of the project to achieve one of its major objectives. The small gains in understanding by the Ministry of Finance about health priorities have not met the expectation of changing the perception that the health sector is over-financed. In fact the Ministry of Finance is currently focusing on reforming health insurance to deal with the disproportionate contributions from the household rather than working to bring significantly increased resources to bear through the government contributions.

The lack of engagement of civil society is a serious setback for the project and is a recurring theme that runs throughout the findings of this evaluation. The role of civil society at all levels of the health and political pyramid is key in advocating for change, promoting responsibility, and ensuring accountability. The fact that there are few channels for civil society engagement in the health policy process at any level is something that needs to be changed urgently.

The project's decision to delay significant engagement with civil society until the third year of the project was a mistake, easily seen in hindsight. Work with civil society organizations should have begun immediately when project implementation began so that capacity could be developed over an extended time period and sustainability of involvement ensured through partnering through the full range of policy and implementation issues. The choice of a local NGO (RADI) to undertake this work in the third year of the project has made the situation worse because RADI proved to be incompetent to carry out their scope of work. While RADI has now been removed and the Project is undertaking the activities to support

civil society themselves, it is questionable whether with the time remaining, and the resources available, that the project will be able to achieve the desired results.

It should be noted that this challenge is made even more difficult by the doubling of the scope of work for civil society by adding the “watch-dog” role to their originally envisioned advocacy role.

1.1.13 Recommendations

1. *The Project must make an immediate priority to engage civil society at the local level for advocacy and good governance;*
   A very tenuous base has been developed following the regional trainings conducted by RADI. The regional staff of the project must now rapidly finalize the communication plans that are still in draft form, select key civil society partners, and rapidly roll-out the program.

2. *Identify central level civil society partners who can focus on resource mobilization and governance*
   The Project has ignored the key civil society actors at the central level which needs to be reversed. Civil society actors such as Unions and the Media represent extremely powerful advocates on behalf of the health sector. The Project should be engaging these groups, educating them on the key issues in relation to health policy, and empowering them to become significant actors in advocating for resource allocation and good governance.

3. *The Project should engage existing consumer advocacy groups to advocate for resource mobilization and good governance*
   There are already consumer advocacy groups who advocate on behalf of special needs groups or for the general population. These groups need to be engaged by the Project at all levels to represent the needs for resource allocation to these groups health needs.

4. *The Project must develop an internal advocacy strategy for the MOH and MEF to free up the 2 billion FCFA in the MOH budget*
   The Project has failed in its role of mobilizing resources generally, but a particularly significant failing has been the lack of follow-through in mobilizing the resources committed for planning and implementation of the POCL. The Project did not conduct a detailed problem solving/performance improvement analysis to understand how to deal with the challenge. The Project needs to diagnose the concerns of the MOF, layout the legislative steps required, support passing of the legislation, and provide technical assistance to manage the funds through the new mechanism.

   In future the Project needs to take a problem solving/Performance Improvement approach to all challenges. A simple PI approach includes the following steps:

   A clear stakeholder analysis

   An identification of the desired outcomes

A statement of the current situation

A gap analysis

A root cause analysis

A challenge process

A simple implementation and activity plan

A monitoring and evaluation plan

These steps can be carried out rapidly based on the existing knowledge and the use of a simple Plan, Study, Do, Act approach will result in continued monitoring and improvement of the approach.

5. *Continue the focus on building the capacity of regions and districts to use the CDS-MT process*
   The process begun at the central level needs to be reinforced and the active training and support of Regions and Districts that has already begun needs to be scaled up to develop capacity at every level.

6. *Actively engage local government (through the Association des Elus Locale) as advocates for increased funding and good governance*
   Engagement with local politicians has largely focused on the development of local plans and (in the South where matching grants were used) in mobilizing their own resources. The Project should be developing the capacity of locally elected officials and their communities to advocate for changes in the allocation of budgets to the health sector and for good governance.

7. *Actively work with the health and population group of parliament as advocates for increased funding*
   The health and population group of parliament has been actively engaged in the past as advocates on behalf of USAID project for policy change. They have proven to be powerful advocates and very effective. The Project should seek this group out immediately and work with them to make them aware of health financing challenges and the issues that surround good governance so that they can take on these challenges in Parliament.

8. *Continue the role-out of the NHA as a tool for a more appropriate allocation of funds*
   The work with the NHA has only just begun and the project has already identified the need to support the continued roll out of the document and the use of the NHA as a tool to support the allocation of funds. This work needs to continue.

SOCIAL FINANCING MECHANISMS

In the original APS, USAID posed the following:

Issue: *A relatively small percentage of the population is enrolled in a Mutual Health Organization and this mechanism, because it requires the payment in cash of a monthly*

premium, is not easily accessed by the poor or epidemiologically vulnerable, such as persons living with HIV/AIDS.

***Challenge**: To expand the coverage, particularly toward economically vulnerable populations, and sustainability of social financing mechanisms such as Mutual Health Organizations*

1.1.14 General observations by the evaluation team

The project has met its specific targets and has created 40 new Mutuelles, 5 Regional Unions, recruited and supported 98,043 beneficiaries, and supported 5,450 vulnerable or disadvantaged people.

In an environment where the need for local health insurance in increasingly recognized, and the government has established a policy objective of having 50% of the Senegalese population insured through Mutuelles or other mechanisms, the advances of the Project are very important. The process that the Project has put in place builds on the work of previous projects and is described as being collaborative, builds capacity, empowering, and effective. All this has been done with very limited resources, and only one staff member in each regional office to do the work.

The fact that Mutuelles are in a very varied stage of development has posed significant challenges for the project. In Kolda and Ziguinchor the Mutuelle process is generally new and most Mutuelles are one-year old or less. In Louga, Thies, and Kaolack the process has been going on for several years and many Mutuelles can be described as mature. The project has been able to adapt well to the differing needs at different stages and has a clearly defined set of steps to support and develop individual Mutuelles and their capacity.

The great success in the South with starting up new Mutuelles in such a short period of time is the result of both the Project's high quality support and the fact that each Mutuelle has been started by a civil society group who already had the vision to address inequitable financial access through establishing a Mutuelle, excellent community leadership, and a high level of commitment to put in the volunteer labor required to start up the Mutuelle.

The Regional Unions are a much newer concept than the Mutuelles with the oldest being just five years and the newest only a few months. Even after such a short period of time, all are actively engaged in the process of starting up and supporting Mutuelles. What is more important however, is the fact that the Regional Unions themselves are very clear about what their role should be, the need for them to become self-sustaining, and each seems willing to take the steps necessary to achieve sustainability.

1.1.15 Project Strengths

In addition to the routine of establishing new Mutuelles, the project has introduced some extremely effective innovations in partnering for the creation and support of Mutuelles with

local NGOs. In the South the growing partnership with World Vision and the on-going relationship with PACT have led to the creation of 5 Mutuelles, while a new partnership is new underway in the North. Such partnerships are a vital step if the goal of reaching 50% of the population by 2015 is to be reached.

1.1.16 Areas of Concern

The overriding concern for both Mutuelles and for the Regional Unions is the sustainability of the effort. Even the oldest of Mutuelles have very little capital and are limited in the services that they can offer without risking going bankrupt. The newer Mutuelles are very small and revenues are so low that services are very limited indeed. At present, for the newer Mutuelles, the fact that any service is offered represents an improvement from the status quo, but without improvements in quality of service it is likely that adherents will drop.

The primary challenge therefore is to increase the revenue of the Mutuelles. This can be done in two ways:

- Increase the number of adherents
  - expand to a wider geographic area
  - Increase the percentage of the population within the existing target area who are members of the Mutuelle
- Develop additional methods of revenue generation:
  - Use of microfinance as a means to generate funds from the general population
  - Use of favorable microfinance rates to encourage membership
  - Increased partnership with special interest groups (following the model used with World Vision in Kolda).

The sustainability of the Regional Unions is critical to the sustainability of the entire Mutuelle process as these groups will ultimately be the bodies that support the development of new Mutuelles, provide technical assistance to existing Mutuelles, establish a forum for sharing of experiences, and hold individual Mutuelles accountable. At present the existing Regional Unions do not have this capacity, nor do they have the material resources necessary to do their jobs. In addition, with the administrative changes that have resulted in the creation of two new Regions in the Project areas, two new Unions will be created next year, which will pose further challenges.

The project's limited capacity presents a particular challenge as increasing numbers of communities make requests for support in creating new Mutuelles. These demands overburden the staff and take efforts away from the consolidation of gains made with existing Mutuelles.

The evaluation team noted a particular area of concern that despite the fact that Mutuelles have been demonstrated to be successful in Senegal for more than a decade and that government policy now encourages Mutuelle formation, USAID is still the only donor that is significantly engaged in supporting the development of Mutuelles. While there is recent engagement by the Belgian Technical Cooperation, if the National goals are to be met, the

next two years needs to see **all** development partners becoming actively engaged in supporting the Mutuelle process.

Finally, it was observed that while the Regional Unions provide a forum for sharing of experiences, there is no national forum for sharing experiences and lessons learned. Such a forum is important because of the wide variation in the development to of Mutuelles around the country and the very varied experiences.

1.1.17 Recommendations

1. *The Project must direct the majority of its efforts to establishing sustainability of existing Mutuelles and Regional Unions*
   In order to do this the following steps are necessary:
   - The Project should stop directly supporting the development of new Mutuelles
   - The Project's direct focus must be on capacity of the URMS
   - The approach to capacity building of the URMS should be through teaching, mentoring, and on-the-job training
   - All new Mutuelles will be supported by the URMS with support and supervision to the URMS being provided from the Project
   - Two resource people from every Mutuelle in the URMS should be trained as resources/specialists to establish sufficient capacity and redundancy
   - Essential logistics, office equipment, IT equipment, and capital outlays for the URMS should be provided by the Project

2. *The Project should develop a revised set of indicators of Mutuelle performance to include financial stability and sustainability measures*
   At present the indicators of success of a Mutuelle relate to long established factors such as size, type of service offered, number of members, etc. In order to more accurately establish indicators of success and sustainability the Project should explore establishing a new set of indicators such as: degree of capitalization; percentage of target population who are adherents; percentage of adherents who drop out; percentage of revenue obtained from sources other than fees; ratio of chronically ill to young and health; etc.

3. *The Project should work with the URMS to develop a business planning approach for the Mutuelles*
   The Mutuelle is currently seen much more as a social institution than as a business. The social aspects are extremely important and have been critical to the success of the approach in its early stages. However, with time, volunteerism becomes less tenable and a measure of professionalism needs to take over. In order to do this, the individual Mutuelle should develop a business plan that will follow the standard elements of a business planning approach. The Project can play a significant role in modifying an approach to the specific circumstances of Mutuelles in Senegal.

4. *Identify and create linkages between URMS and microfinance organizations (or other resource generating sources)*
   With a business plan and the development of capacity to manage Mutuelles, the Regional Unions will need to play a key role in identifying potential sources of external

finance for individual Mutuelles and making the links between those sources and the Mutuelles.

5. *Support the development by Regions of an education program for health providers*
   Despite the fact that Mutuelles are not part of GOS policy, there remains considerable ignorance among health care providers about their importance and how they operate to the benefit of the community. Anecdotally there are stories of individual health providers who have actively discouraged the formation of Mutuelles because of their misunderstanding.

   It is vital that the departments and districts take on the responsibility to educate and inform their staff on the value of Mutuelles so that they can both advocate for, and support the development of, Mutuelles.

6. *Advocate at the central level for a National Campaign to promote Mutuelles*
   As noted above, it is extremely unlikely that the national goals of 50% of the Senegalese population being covered by Mutuelles by 2015 will be reached unless major changes occur to accelerate the rate of development. This cannot be done by small scale efforts at the local level by a single partner. Therefore the Project should strongly advocate at the central level for the establishment of a nation-wide, long-term campaign to promote Mutuelles using every form of communication available, and to engage all development partners in the effort.

7. *Facilitate the development of a communication plan at regional and district levels to increase awareness of Mutuelles and dispel rumors or negative information*
   Rumors and misconceptions about Mutuelles are not confined to health care providers. During the evaluation the team became aware of a strong rumor in Louga that Mutuelles were “contra to the teachings of Islam”. Clearly a spurious rumor, the potential effect is very damaging and the Project should work with the regions to establish a specific communication plan to identify rumors as they arise and take actions to dispel them.

8. *Explore the possibility of using the purchasing power of Mutuelles to negotiate preferential terms with private pharmacies for use if drugs are not available in health facilities*
   With the very limited purchasing power of the majority of existing Mutuelles, heavy reliance is placed on obtaining drugs supplied through the public health system and the Bamako Initiative. However, those drugs are frequently out-of-stock because of breakdowns in the drug management system at Regional and National levels. Such stock-outs severely affect the quality of care offered by the Mutuelle and lead to the risk of loss of membership.

   While it is unreasonable to have Mutuelles pay commercial prices for medications (which are overinflated and the quality of the drugs often questionable), it would be valuable for the project to explore using the purchasing power of several thousand individuals to negotiate appropriate rates and quality of care from a single local pharmacy in the event that the drugs are not available through the health post or health center.

9. *Facilitate the development of a regular form for sharing Mutuelle experiences and lessons learned around the country*
   Having an annual meeting of Regional Unions would provide a national exchange of experience and enable newer regions to learn from those with more experience.

   Creating a quarterly or semi-annual newsletter of lessons learned would enable individual Mutuelles to show-case innovations and lessons learned.

INSTITUTIONS OF DECENTRALIZATION

In the original APS, USAID posed the following:

Issue: *The legislation that established the policy of decentralization of the sector foresaw the functioning of key structures that are not in practice operational, and these results in a lack of transparency and efficiency.*

Challenge: *To identify problems and solutions that will ensure that the institutions of decentralization, particularly Health and Management Committees, function appropriately and that resources generated are used effectively.*

1.1.18 General observations by the evaluation team

This is by far the most difficult area of implementation for the Project. In most respects there have been two quite distinct projects. In the North the Project has followed the prior DISC project which provided matching grants to local collectivities to implement specifically developed health implementation plans (POCL). These funds ended at the end of the DISC project and have not been continued. The project's interventions have thus largely been to reinforce the skills developed during the DISC project to create POCL and seek funding of the plans from local authorities.

In the South it was decided to introduce the matching grants for a very limited period of time. Originally it was envisioned that the grants would run for two years (with a limited number of collectivities involved in the first year, and a much larger number in the second year). However, because of a variety of factors (including the mis-budgeting at the out-set of the Project, and confusion created with the introduction of the PNDL), an extremely small amount of funding was made available ($75,000 instead of the anticipated $1,000,000), and only a very small number of grants were given.

The project rapidly identified that the existence of two committees with overlapping responsibilities represented a degree of dysfunctionality that was not conducive to good management and stewardship at the community level. Thus significant effort and support was given at the central level to develop a new policy that decrees the combining of the two committees into a single Health Development Committee (CDS), with a clearly defined role and which will remove the previously identified problems.

It has been unfortunate that the passage of the legislation has proven to be extremely slow (and is not expected until the end of the first quarter of 2010). The early decision of the Project (on USAID's recommendation) to wait for the legislation to pass before entering into capacity building activities has been reversed at this point because it is now clear that no-matter what the structure looks like, the capacities in management, planning, accountability, and good governance will be the same.

Because of the decision to not actively engage in capacity development in the early part of the project, the results are very disappointing. Only 10% of health committees have action plans and 32% of health committees meet the Project's definition of "functional". At the same time, while early results showed gradual improvements in the development of POCL, the third year of the Project resulted in zero POCLs being developed – which raises serious questions about the entire process.

1.1.19 Project Strengths

The Project has developed excellent relationships with the local authorities, and particularly with the ARD in all the regions. This establishes an important base for establishing sustainability of interventions and addressing some of the concerns addressed in the next section.

The Project has also conducted work at the local level in advocating for the introduction of important innovations in transparency and good governance. This encompasses those activities already discussed under Capacity Building, but they also include some remarkable successes in Kolda through the use of the matching grants. Using matching grants, individual communities have learned the value of issuing RFPs, obtaining multiple proposals, and making choices to ensure both high quality and accountability. In addition to this, communities have also developed new skills in planning and accounting that they have been able to carry over into other areas of development.

Finally, while not an objective measurement, two of the communities visited during the field visits identified that the matching grant process resulted in observable changes in health status in their community. One focused on Malaria prevention through the distribution of bednets and claimed that malaria incidence was reduced by more than a half (this was confirmed verbally by the ICP). The second focused on diarrheal disease in children and claims that children no-longer suffer from such frequent and prolonged bouts of diarrhea. While anecdotal evidence, it would be important for the Project to build in specific health status measurements into any future POCL so that impact on health can be measured and not simply inputs, outputs and outcomes.

1.1.20 Areas of Concern

The essential focus of this element of the project using the POCL as the means to develop capacity brings to light two significant problems.

1. The concept of matching grants was not well thought out in the original design of the project and not well understood during implementation. In the previous DISC project, matching grants were seen as "seed" money that would introduce communities to the concept of paying for health interventions in the community and to stimulate them to make ever-growing amounts of the community's money available in the future.

   The failure of communities in the North to significantly engage in the process in the absence of matching grants, and the complete failure of any communities to produce a POCL in year three when matching grants were not available at all has been interpreted as a "lack of commitment" by communities. However, if examined in more detail, this failure suggests that the underlying concept behind the matching grants was flawed.

   In observing the project's remarkable successes in the South with extremely small matching grants, the evaluation team noted that the real purpose of the matching grants was as an incentive mechanism to:

   - Build health committee capacity
   - Undertake institutional reform in the community
   - Bring about quality improvement
   - Establish stronger community ownership of the health process; and
   - Create good governance and transparency

   Each of these were clearly documented in the 12 communities that received matching grants and represent the first steps of a dramatic process of improved governance. However, such a process is a multi-year process, not a one-year process. Thus if matching grants are looked upon as incentives for system change around good governance, the decision to eliminate them in the North, and cut them short in the South was incorrect.

   The evaluation team believes that with an increasing focus on performance-based financing, and the use of performance incentives, it is essential that an incentive mechanism be established, and that in any future USAID program, matching grants should be considered as a serious incentive to promote change.

2. There is a significant question as to whether the project has developed the capacity to plan in the local collectivities that was desired. The Project has conducted a large number of training activities with the transfer of skills to individuals. However, when external incentives were withdrawn, no-one developed a plan. This leads us to the conclusion that:
   - The collectivities do not see the inherent value of planning
   - There is no vision within the community for what plans could be used for
   - There is no leadership or ownership of the planning process within the community.

Thus we are led to the conclusion that without the extensive use of approaches beyond training (such as regular in-situ follow up, mentoring, and, formative supervision), there has been little or no actual capacity built at the collectivity level.

The decentralization expert in Kolda was able to lay out an approach that he felt would address this, which included the design of post training materials for use by district supervisors. This should be addressed with some urgency and such materials included in the design of all future training activities.

Another significant concern is the lack of any project actions to improve quality of care. This is true at the community level, where it was originally expected that the project would work with the health committees to achieve this. It is also true at the national level where the HIV and Reproductive Health elements of the USAID/Santé program have introduced extensive clinical quality of care activities, but without the support of the Project to address the GOS quality program (which has been stuck for four years), the entire USAID assistance in quality of care has been held back.

Finally, the fact that the recent elections resulted in a very significant turn-over in elected officials has meant that the Project has needed to develop a contingency plan to identify the newly elected and undertake to train them, thus losing momentum in the community and wasting project resources through duplicating an effort that has already been conducted.

1.1.21 Recommendations

1. *The Project should rapidly expand the capacity development of health committees in management, planning, quality management, accountability, transparency, and good governance*
   The decision to reverse the delay in addressing these issues while waiting for the legislation creating the CDS has been taken, but the Project needs to make the development of the capacity of the health committees an immediate priority regardless of the policy decisions at central level. It is sufficiently clear at this point what the tasks and roles will be of the committees that capacity building can easily take place.

2. *The Project needs to adopt a capacity building approach rather than a training approach*
   As discussed above, the project needs to develop tools for follow-up activities following Project sponsored training. These activities will both develop the capacity of supervisors to become increasingly familiar with the topics, and also reinforce the lessons of the training, facilitate problem solving, establish mentoring relationships, and set the stage for further skill development.

3. *Advocate at central and local levels to integrate the planning process into a single, integrated ARD/POCL process*
   The relationships that the project has been able to establish with the ARD has created enormous potential for synergy in the Regions to transfer the planning process to the ARD and negotiate an appropriate role for their support of the POCL. While not

straightforward, there is political will and technical competence for this to happen at all levels.

4. *Rapidly expand the engagement and use of civil society in the area of good governance and advocacy for funding of key activities*
   As previously identified, the complete lack of engagement of civil society has greatly impaired the Project's ability to address good governance and needs to be a major priority for the coming two years.

5. *Provide advocacy and technical assistance to the ARD to develop the means to assure long term capacity in planning when elected officials change*
   The large turn-over of locally elected officials is not an isolated event, and can be anticipated to occur again. In discussion with the ARD, civil society representatives, and PCRs it is clear that all are open to establishing a mechanism within the community where individuals in civil society and amongst ex-officials in the community retain the institutional memory of the planning, governance, and transparency process. These individuals would then represent a permanent skill set in the community who would be responsible for maintain capacity for these tasks and thus obviating the need for external resources such as the Project.

6. *Study should be made to analyze matching grants and other incentive payments as a capacity building and performance improvement tool, not simply as a supplement of substitute for the local budget*
   The project should document the experiences of the matching grant program (limited as it was), with as much data as possible focused on the value of the grant as a means to incite performance and behavior change. This will be of value in making a more accurate assessment of the grant program's effectiveness and enable more effective decision-making in the future about the value of matching grants

7. *Matching grants should be considered within the wider policy and approach to system-wide performance-based financing*
   If USAID is to further explore the concept of using performance-based financing as part of a system-wide approach, then the place of matching grants should be considered very strongly. In other settings where performance incentives are offered the financing has not required a contribution from the community. However, in Senegal, the precedent is already set for communities to expect to contribute, which means that there are novel options for the introduction of PBF at the community and health facility level. In addition, if community funds are involved, the capacity to use them as leverage for good governance is greatly improved.

SUMMARY OF RECOMMENDATIONS AND STRATEGIC OPTIONS

Individual recommendations have been made in the relevant sections with detailed descriptions of what these recommendations require. This section draws all the recommendations together under a single set of headings.

General recommendations

1. As noted throughout the evaluation, the project's priority for the final two years must be to ensure that the gains are sustainable. In order to assure sustainability the following steps are necessary:
    a. Development of a detailed sustainability plan for the final two years of the Project
    b. Identification of appropriate institutions to transfer capacity at each level of the health pyramid and in each technical area of the project
    c. Use of a systematic capacity building approach:
        i. Group teaching/training
        ii. Individual mentoring
        iii. Accompanying individuals and groups in their work
        iv. Formative supervision
    d. Application of a standard set of activities for partner institutions
        i. A Capacity Assessment
        ii. A gap analysis
        iii. A specific set of activities to respond to the gap
        iv. Skill building
        v. Capacity building
        vi. Capital resources needed
        vii. Planning requirements

2. The Project limit its expansion in the Policy agenda to that of supporting the definition of Performance-Based Financing and its impact on systems strengthening. In addition, USAID should explore the possibilities of building its future activities around PBF.

3. Coordination at both central and decentralized levels be built into all future USAID projects.

4. Future projects mandate that all USAID health projects be housed within the same offices in the periphery with no exceptions.

5. For the remaining two years of the project the central level of coordination be shared by the four program partners. Each will host three meetings per year at which the agenda will cover the specific programmatic challenges and advances of the host project, learning objectives concerning the technical domain of the host project, problem solving, and an opportunity to seek synergy. Each meeting will result in a defined set of actions and the host project will be responsible for follow-up on those actions.

6. In the future USAID should consider a mechanism to overcome the innate inability of competitive organizations to be full and open collaborators at the central level. This could take the form of recruiting an uninterested party as coordinator at the central level, or USAID itself taking on this role.

7. Abt actively rebrand the way in which the partnership is represented under the Project Logo, recognizing USAID, and also recognizing the institutions for which individuals work.

8. Abt actively re-think its approach to cost-share to move away from an accounting approach of simply counting the amount of other's contributions, to one of actively working to use the project's work to leverage the input and support of other donors.

9. Decentralization of financial and administrative decion-making to the field to allow more rapid response times;.

10. Directing more technical support from Abt's global work force to Senegal (it should be noted that this could be done as part of Abt's cost share);.

11. Stop the imminent purchase of new vehicles and other capital projects and invest the funds in technical activities related to sustainability. While it is expensive to maintain old vehicles, the cost of replacing the vehicles for two years will be many times greater than the maintenance of the old vehicles.

Policy Dialogue and Coordination

1. The Project should advocate for the inclusion of local government and civil society representatives in the HPIT.

2. Every policy developed with the Project's assistance must **be** accompanied by an implementation framework and plan.

3. The project should limit itself to a more narrow focus for new policy initiatives.

4. The Project should focus its policy efforts on sustainability and capacity building.

5. Capacity building activities should focus on assuring sustainability and ownership of key gain already achieved by the projects.

6. Continue to provide technical assistance to implement policies already in place.

Capacity Strengthening for resource use in the Ministry of Health

1. The Project must make an immediate priority to engage civil society at the local level for advocacy and good governance.

2. Identify central level civil society partners who can focus on resource mobilization and governance.

3. The Project should engage existing consumer advocacy groups to advocate for resource mobilization and good governance.

4. The Project must develop an internal advocacy strategy for the MOH and MEF to free up the 2 billion FCFA in the MOH budget.

5. Continue the focus on building the capacity of regions and districts to use the CDS-MT process.

6. Actively engage local government (through the Association des Elus Locale) as advocates for increased funding and good governance.

7. Actively seek out the health and population group of parliament as advocates for increased funding.

8. Continue the role-out of the NHA as a tool for a more appropriate allocation of funds.

Social Financing

1. The Project must place the majority of efforts to establishing sustainability of existing Mutuelles and Regional Unions.

2. The Project should develop a revised set of indicators of Mutuelle performance to include financial stability and sustainability measures.

3. The Project should work with the URMS to develop a business planning approach for the Mutuelles.

4. Identify and create linkages between URMS and microfinance organizations (or other resource generating sources).

5. Support the development by Regions of an education program for health providers.

6. Advocate at the central level for a National Campaign to promote Mutuelles.

7. Facilitate the development of a communication plan at regional and district levels to increase awareness of Mutuelles and dispel rumors or negative information.

8. Explore the possibility of using the purchasing power of Mutuelles to negotiate preferential terms with private pharmacies for use if drugs are not available in health facilities.

9. Facilitate the development of a regular form for sharing Mutuelle experiences and lessons learned around the country.

Institutions of Decentralization

1. The Project should rapidly expand the capacity development of health committees in management, planning, quality management, accountability, transparency, and good governance.

2. The Project needs to adopt a capacity building approach rather than a training approach.

3. Advocate at central and local levels to integrate the planning process into a single, integrated ARD/POCL process.

4. Rapidly expand the engagement and use of civil society in the area of good governance and advocacy for funding of key activities.

5. Advocacy and technical assistance to the ARD to develop the means to assure long term capacity in planning when elected officials change.

6. Study should be made to analyze matching grants and other incentive payments as a capacity building and performance improvement tool, not simply as a supplement of substitute for the local budget.

7. Matching grants should be considered within the wider policy and approach to system-wide performance-based financing.

CONCLUSIONS

The evaluation team concludes that the HCFPP project has achieved mixed results. It has had with an overall positive effect on the policy agenda of the country, made some significant inroads into improved planning and transparency at the central level of the Ministry of Health, facilitated new and stronger relationships between the Ministry of Health and the Ministry of Finance, and been a vital resource in the production of key resources such as the national health accounts, PNDS, and CDS-MT.

The Project has also played a strong role in coordinating the USAID/Santé program at the regional level, ensuring that counterparts view the program as a single entity. Decentralized activities in the creation and support of Mutuelle Health Organizations have been very successful, with the meeting or exceeding of targets and very important lessons and innovations taking place through new partnerships.

Capacity building to be able to plan within the Ministry of Health has been effective, but without any measurable impact in the reallocation of funds to the health sector, nor has there been any change in the perception that the health sector is over-financed. There have been some shifts in funds to the Districts (although these are not recognized by the districts), and there has been a redistribution of funds to reproductive health which is significant.

Capacity building of decentralized institutions has been very weak, but this is at least in-part a design flaw in the thinking around the value and utility of performance incentives and the role that matching funds can play. The project is aware of the steps necessary to move beyond training to capacity building, but needs to take these steps in the next year if the work of the first three years is to be capitalized and converted into real capacity.

Civil society engagement is completely lacking at present, but is a high priority for the project and will contribute to both the advocacy and good governance agendas.

The management of the Project at the local level is excellent with strong administrative and financial management, and effective leadership from the Project Director. The backstopping and support from the home office has been either weak or nonexistent (from the technical perspective), or overly controlling and restrictive with negative effects on the running of the project (from the administrative perspective). These problems could be easily reversed with more devolution of decision-making to the field and stronger institutional technical engagement.

The quality of technical assistance provided by the Project has been excellent with an all Senegalese staff who have commanded the highest respect from their counterparts and who have the skills to use this respect to bring about effective change.

The project has achieved many (though not all) of its goals. At this time the project needs to switch its priority to maintaining the gains made in the first three years, transferring capacity to local institutions, and ensuring the sustainability of local level institutions.

ANNEX 1 BIBLIOGRAPHY

Annual Program Statement No. 685-06-005. Usaid/Senegal Fy 2006 – 2011 Capacity Strengthening For Resource Use In The Ministry OfHealth, Policy Dialogue Coordination, Social Financing Mechanisms And Institutions Decentralization.

Atelier De Validation Du Plan Stratégique Pour La Fortification Des Aliments En Micronutriments Au Sénégal (2007 – 2012) (17 Novembre 2006) Comite Senegalais Pour La Fortification Des Aliments En Micronutriments(COSFAM)

Carte Sanitaire du Sénégal. 2008. Gouvernement du Sénégal

Composante Financement et Politiques de Santé – Powerpoint présentation. Equipe Abt12 novembre 2009 Dakar

Comptes Nationaux De La Sante. Année 2005 Rapport provisoire. Government of Senegal

Document de Stratégie pour la Croissance et la Réduction de la Pauvreté 2006 – 2010. Gouvernement du Sénégal

Final Abt Senegal Associated Agreement. Abt/USAID, 2006

Guide de Suivi – Evaluation. Composante Financement et Politiques de Santé

Manuel Des Procedures De Gestion Des Fonds De Cofinancement (Matching June 2007

Module De Formation En Gouvernance Locale. USAID, Abt, AED, IRG. July 2009

Module De Formation En Gouvernance Sanitaire Locale. Septembre 2008

Plan D'action Annuel (Octobre 2006-Septembre 2007). Abt and Team

Plan D'action Annuel (Octobre 2007 - Septembre 2008). Abt and Team

Plan D'action Annuel (Octobre 2008 - Septembre 2009). Abt and Team

Plan de Suivi des Performances de la Composante 2007 – 2011. Programme Santé Financement et Politiques de Santé

Plan de Suivi et Evaluation du PNDS 2009 – 2018 Gouvernement du Sénégal

Plan National de Développement Sanitaire 2009 – 2018 Gouvernement du Sénégal

POCL dans le cycle de planification _Edition 2 juin2009 Gouvernement du Sénégal

Programme Indicatif 2006 – 2011. Composante Financement et Politiques de Santé

Quarterly Report Y1 Q1 Oct-Dec 2006 [French]. Abt and Team

Quarterly Report Y1 Q2 Jan-Mar 2007 [French]. Abt and Team

Quarterly Report Y1 Q3 Apr-Jun 2007 [French]. Abt and Team

Quarterly Report Y1 Q4 -July-Sept 07 [French]. Abt and Team

Quarterly Report Y2 Q1 Oct-Dec 07 [English]. Abt and Team

Quarterly Report Y2 Q2 Jan-Mar 2008 [French] Abt and Team

Quarterly Report Y2 Q3 Apr-Jun 08 [French] Abt and Team

Quarterly Report Y2 Q4 Jul-Sept 08 [French] Abt and Team

Quarterly Report Y3 Q1 Oct-Dec 2008 [French] Abt and Team

Quarterly Report Y3 Q2 Jan-March 20009 French Abt and Team

Quarterly Report Y3 Q3 April-June 2009 French Abt and Team

Quarterly Report Y3 Q4 July-Sept 2009 Abt and Team

Rapport Annuel De La Composante Financement Et Politiques De Santé. Octobre 2007

Rapport Annuel De La Composante Financement Et Politiques De Santé. Octobre 2008

Rapport Annuel De La Composante Financement Et Politiques De Santé. Octobre 2009

Rapport performance CDSMT 2007. Gouvernement de Sénégal

Rapport performance CDSMT 2008. Gouvernement de Sénégal

Technical Application - Health Care Financing and Policy Project Annual Program Statement Solicitation # 685-06-005. Abt Associates, April 17, 2006

ANNEX 2 EVALUATION METHODOLOGY AND QUESTIONAIRES

OVERVIEW OF QUESTIONS BY SECTION AND TECHNICAL AREA

GENERAL QUESTIONS

To be addressed to all informants either as formal questions, or as questions that are woven through the conversation. Specific questions may or may not be relevant depending on the informant and may be omitted.

1. Are you familiar with the HCFP?

2. Do you know the overall purpose of the project?
    a. If not then the interviewer should describe a very quick summary of the project.

3. How long have you been involved with the project?

4. What has been the nature of your involvement with the project?

5. Do you have any general observations about the project?
    a. Are you aware of any positive successes that the project has brought?
    b. Are you aware of any problems that the project has caused or run into?
    c. Do you know if the project had any challenges with the start-up?
    d. Do you know if there have been any staffing challenges?
    e. Do you know if there have been any management or administrative problems?

6. Can you comment on three things that the project is doing best?

7. Can you comment on three major challenges that the project faces in the remaining two years?

8. Do you have any other observations?

QUESTIONS SPECIFIC TO PROJECT MANAGEMENT

For key informants inside the Project, within USAID, in other USAID-funded projects, and senior level counterparts in the central MOH

For Abt and USAID informants

1. Please describe the management approach to staffing
    a. Have there been any specific challenges with staffing?
    b. If there have been, how have you dealt with them?
    c. Are the challenges satisfactorily resolved now?
    d. Have staffing challenges affected the ability of the project to achieve its goals in any way?

2. Describe the management approach to procurement and materials
    a. Have there been any specific challenges with procurement?
    b. If there have been, how have you dealt with them?
    c. Are the challenges satisfactorily resolved now?
    d. Have challenges with procurement affected the ability of the project to achieve its goals in any way?

3. Describe the management approach to planning and monitoring of program activities
    a. Have there been any specific challenges with planning, and monitoring?
    b. If there have been, how have you dealt with them?
    c. Are the challenges satisfactorily resolved now?
    d. Have these challenges affected the ability of the project to achieve its goals in any way?

4. Describe the management approach to sub-grants in the target regions
    a. Have there been any specific challenges with sub-grants?
    b. If there have been, how have you dealt with them?
    c. Are the challenges satisfactorily resolved now?
    d. Have challenges affected the ability of the project to achieve its goals in any way?

5. Describe the overall administrative and financial arrangements of the project
    a. Have there been any specific challenges with administrative and financial management?
    b. If there have been, how have you dealt with them?
    c. Are the challenges satisfactorily resolved now?
    d. Have challenges affected the ability of the project to achieve its goals in any way?

For all informants

6. Are you familiar with the way in which the project is managed?
    a. Can you describe how the project's management is specifically tailored to strengthen the technical success of the project?
    b. Can you provide any examples of this?

7. Are you aware of any specific problems with the overall management of the project
    a. If so, could you describe what you have seen?
    b. Do you know the cause of the problems?
    c. How have any problems been resolved?
    d. Has the project's ability to achieve its goals been affected at all by these problems?

8. Do you think that the Project is managed as efficiently and effectively as possible?
    a. If not what could be done to improve the management of the project?
    b. Is it feasible to improve the management of the project in the specific setting?

QUESTIONS SPECIFIQUE AU DIALOGUE POLITIQUES ET COORDINATION

Issue*:* USAID's effectiveness at facilitating policy change and implementation at the MOH is weakened by the dispersed manner by which each CA pursues its policy agenda vis-à-vis its interlocutor independently. Further, however long the process between policy dialogue and decision takes, once a policy is adopted its implementation is generally weak.

Challenge*:* To coordinate the policy efforts of all USAID project components and to improve the policy development and implementation environment in the Ministry of Health so that policies are more quickly and effectively implemented.

(Acteurs clés : Autres composantes programme USAID, MoH-CAS/PNDS-DAGE, Régions médicales, WHO, UNICEF, PRN, Banque Mondiale, Union Européenne, AFD, CONGAD, M. finances, association des médecins et pharmaciens privés… ?)

1. Quelle appréciation sur les changements sur l'environnement politique régulièrement entrepris (Création de nouvelle régions et de nouveaux districts ...) ?

2. Appréciation du niveau et de qualité de mise en œuvre du Cadre de dépense sectoriel à moyen terme ? (Ministere de l'economie et des finances, USAID, UNICEF, WHO, Banque Mondiale)

3. Quels sont les mécanismes de suivi et d'évaluation du CDS-MT et résultats ou changements pouvant être attribues a l'adoption du CD-SMT ?

4. Quelles ont été les changements apportés suite conclusions et recommandations issues du rapport sur les performances du CDS-MT ? (Document rapport CDS-MT à consulter)

5. Rôles et réalisations de l'équipe d'initiatives et de Politiques (EIPS) ? (MoH, Abts, Child's Fund, FHI, Intrah-Health…)

6. Quelles sont les relations entre l'association des élus locaux et le ministère de la santé et comment ces relations sont appréciées si elles existent ? (AEO, MoH…)

7. Quelles sont les relations entre les organisations de la société civile et le ministère de la santé et comment ces relations sont appréciées si elles existent ? (Société civile, MoH…)

8. Quelle est la stratégie de communication des élus et des groupes de la société civile pour les engager dans les questions de financement et de politique de la santé ? (Abts staff)

9. Base de données des organisations de la société civile impliquées dans le secteur de la santé (Abts staff…)

10. Quelles actions spécifiques de plaidoyer entreprises par les organisations de la société civile pour l'adoption de reformes politiques ou promouvoir la mise en œuvre de politiques adoptées ?

11. Quels changement apportés dans la motivation basée sur la performance des personnels de santé ?

12. Quels sont les changements apportés dans les relations entre le secteur privé et les districts de santé et les collectivités locales ?

13. Niveau de réalisation des activités prévues (mapping des pratiques dans le secteur privé, atelier de consensus dans l'implication du secteur privé dans la planification et la mise en oeuvre de la politique de santé…réf. Page 4 proposition de Abts)

14. Quelles sont les actions conduites par le programme pour faire l'appréciation des initiatives de subvention existant(accouchements, Plan SESAM, ARV…?

15. Quel est le système de monitoring de la politique des prix et des subventions ? Contraintes dans la mise en œuvre de ce système s'il existe ?

16. Facteurs de succes dans l'adoption de la politique de fortification en micronutriments des aliments largement consommés

17. Changements initiés dans la formation des IDE et SFE ?

18. Qu'est ce qui a été fait pour promouvoir la nutrition en dehors de la fortification sur la nutrition ?

QUESTIONS SPECIFIC TO STRENGTHENING THE CAPACITY OF THE MOH

Issue: The MOH has limited ability to plan, budget, monitor, and evaluate program results in such a way as to convince the MOF to provide additional funds and the health sector is perceived as adequately funded already.

Challenge: To persuade the Government of Senegal to provide additional resources to address public health issues, and to ensure that these resources are used in an effective, transparent and participatory fashion, in other words, to hold the MOH accountable for its health outcomes according to its policies, planning and budget

For key informants engaged with the planning and budgetary process in the MOH at central or decentralized level; local government; and, collectivité.

For Central Level and Regional Level Informants

1. There used to be the perception that the health sector had too much funding compared to other sectors. Do you think that perception is still present?

2. Can you describe the MOH planning and budgeting process?

3. Are you familiar with the National Health Accounts?
    a. Are these used in the planning and budgeting process?
    b. How are they used and what has been the outcome of their use?

4. Do you think that the MOH planning capacity has improved since 2006?

5. Do you think that the MOH ability to monitor program impact has improved since 2006?

6. Do you know if there has been any increase in funding for the health sector since 2006?
    a. If so, do you know the source of the funding?
    b. Has the Project had any role in that?

7. Are you aware of any changes in budgetary allocation to specific initiatives such as EPI, IMCI, EOC, or FP?

8. Are you familiar with the PRSP?
    a. If so, do you think that the current MOH budget will address the health challenges of the plan? How?

For all informants

9. Do you believe that there is a role for civil society in advocating for changes in the budget and planning process?
    a. If yes, what is that role?
    b. If no, how should the needs of the community be represented in the process?

For Abt project staff and other USAID project staff

10. What activities have you undertaken to actively promote the engagement of civil society in advocating for improvements in resource allocation?

For all informants

11. Has civil society been more actively engaged in advocacy for budget and planning since 2006?
    a. If yes, has this resulted in specific changes in the allocation of resources to maternal, child and neonatal health?
    b. Where have the additional resources come from?

12. Have you personally been involved in any form of consensus building or study about setting priorities for the funding of reproductive and child health?
    a. If so, could you describe what was involved?
    b. What were the outcomes of your involvement?

For decentralized informants at regional, district and collectivité level

13. Could you describe the local health planning process at the district and the collectivité?
    a. Do you think that the ability to produce health plans at the local level has improved at all in the last 3 years?
    b. If so, what have been the contributing factors to this improvement?

14. Have local governments increased their funding or contributions to local health plans in the last 3 years?

15. Has the MOH increased its financing of local health plans during the last 3 years?

16. Can you describe how the local plans are monitored?
    a. How are planned activities monitored – for successful completion?
    b. How is the budget monitored?
    c. How is financial accountability ensured?

SOCIAL FINANCING MECHANISMS

Issue: A relatively small percentage of the population is enrolled in a Mutual Health Organization and this mechanism, because it requires the payment in cash of a monthly premium, is not easily accessed by the poor or epidemiologically vulnerable, such as persons living with HIV/AIDS.

Challenge: To expand the coverage, particularly toward economically vulnerable populations, and sustainability of social financing mechanisms such as Mutual Health Organizations

Informants include Abt staff, USAID staff, central level MOH staff, MEF staff, URMS members, individual MHO managers and volunteers, members of MHOs, community members, and health facility staff.

For Informants at the central level

1. How many Mutuelles are there in the country?
    a. Do you know how many people receive services from Mutuelles?

2. Do you have a direct role in the support, management, or policy development around Mutuelles?
    a. If so, could you describe your role and how long you have been engaged with them?

3. In your opinion have Mutuelles been successful in Senegal?
    a. Can you describe examples of how they have been successful?
    b. Can you describe any problems that have arisen?

4. Please describe the policy that is in place to support Mutuelles.
    a. Is the existing policy adequate to the success and expansion of Mutuelles
    b. If changes are needed what are these changes?
    c. How easy is it to make the needed changes?

5. What is the current role of the MOH in supporting Mutuelles?
    a. Has the MOH become stronger in supporting Mutuelles in the last three years?

6. How effective are URMS in playing a coordinating role?
    a. Do the URMS function as a focal point to share experiences?
    b. Do the URMS function as a source of technical assistance to individual Mutuelles?

7. What role do Mutuelles play in monitoring and assuring quality of services?
    a. If they play a role, is it strong enough or should it be improved
    b. If they do not play a role, what should be done to engage them more actively?

For informants in the URMS and within the management of individual Mutuelles

8. Please describe how the URMS is organized and structured
    a. How many members?
    b. What fees does the URMS charge?
    c. Is the administration fully funded by fees from Mutuelles?

9. Please describe the URMS approach to sharing experiences between Mutuelles?

10. Please describe how the URMS provides technical assistance to Mutuelles?

11. Please describe how the URMS uses its position to negotiate reduced prices for Mutuelles?

12. Please describe how the URMS starts up new Mutuelles?

For Mutuelle managers/volunteers

13. How is your Mutuelle structured?
    a. How did you come into existence?
    b. How long have you been in existence?
    c. Number of members
    d. How do you recruit new members
    e. Type of services covered
    f. Management and administration, including financial accounting
    g. How high is the capitalization of the Mutuelle?

14. How do you deal with financial risk?
    a. Do you actively recruit people who are healthy to offset adverse selection?
    b. Do you provide incentives to join the Mutuelle?
    c. Do you offer any form of microfinance?

15. What percentage of the population you serve are members of the Mutuelle?
    a. Do you have suggestions for how this could be increased?

16. How is the Mutuelle managed?
    a. Who receives a salary and who is a volunteer?
    b. Is the situation sustainable?

17. How does the Mutuelle deal with indigents and people who cannot pay?

For members of the Mutuelle

18. How much do you contribute as a family each year to the Mutuelle?
    a. Annual fee?
    b. Cotisation at the health center when you receive services?

19. Do you feel that you get adequate value from the Mutuelle?
    a. How could the services you receive be improved?

20. Do you have suggestions for how the Mutuelle program could be made more effective or efficient?
    a. To benefit you personally?
    b. To benefit your family and friends?
    c. To benefit the community in general?
    d. To benefit indigent and vulnerable people?

QUESTIONS SPECIFIQUE AUX INSTITUTIONS DE LA DECENTRALISATION

Issue: The legislation that established the policy of decentralization of the sector foresaw the functioning of key structures that are not in practice operational, and these results in a lack of transparency and efficiency.

Challenge: To identify problems and solutions that will ensure that the institutions of decentralization, particularly Health and Management Committees, function appropriately and that resources generated are used effectively.

(Acteurs clé: ARD, PNDL, Centre d'appui au développement local, association des élus, MoH, organisation de la société civile, associations de femmes…)

1. Voir la situation des comités de gestion dans la zone couverte (Centre de sante et poste de sante) par le programme (#/# structures de santé)

2. Place des comités de gestion dans l'agenda de l'association des élus (Plan d'action, actions concretes,resultats obtenus…)

3. Activités entreprises, succès et contraintes pour renforcer l'efficacité des comités de gestion des centres de santé et postes de sante dans les zones couvertes par le programme

4. Place des interventions de santé dans les POCL ? Quelles sont les principales activités de santé prises en charge dans les POCL ? % apports par rapport aux autres efforts de développement ?...)

5. Est-ce que les organisations de la société civile ont un agenda pour amener les comités de santé à aller au dela de l'achat des ME pour une utilisation des ressources collectées dans des activités visant l'amélioration de la qualité des soins ? (membres des organisations de la société civile comme les ASC, association de quartier/ville/village…)

6. Contraintes et facteurs favorisant pour amener les comités de santé à aller au delà de l'achat des ME pour une utilisation des ressources collectées dans des activités visant l'amélioration de la qualité des soins ?

7. Rôle des femmes dans la gestion des comités de santé ? Ratio homme/femme dans les bureaux des comités de santé ?

8. Quels sont les mécanismes mis en place pour permettre aux organisations de la société civile et communauté d'apporter leur contributions et feedbacks par rapport a une meilleure utilisation des ressources pour améliorer la qualité des services ?

9. Quels sont les indicateurs pour mesurer les progrès dans l'allocation des ressources pour une amélioration de la qualité des services ?

10. Actions entreprises par le programme pour un renforcement des capacités et compétences des organisations de société civile en matière de leadership, communication et plaidoyer ? (desk review)

11. Quelles les actions entreprises par l'association des élus pour mobiliser les organisations de la société civile dans un plaidoyer pour une plus grande allocation de ressources nationales pour le financement des POCL ?

12. Qu'est ce qui a été fait par les organisations de la société civile pour faire porter leur voix pour une plus grande allocation de ressources pour le financement des POCL, aux autorités centrales ?

13. # de forum régional, de district et communautaire rassemblant les élus locaux, professionnels de la santé, membres des comités de santé, leaders communautaires, représentant des organisations de femmes et de jeunes et les autorités administratives (Desk Review)

14. # réunions des comités de planification locaux

15. Quels sont les mécanismes en place et les indicateurs pour le monitoring de la transparence et le devoir de rendre compte ? (Abts staff, District health team, comité de gestion)

16. Quelles sont les contraintes dans la mobilisation des ressources (Locales, fond de dotation, comités de santé…) devant servir de levier pour recevoir le matching de l'USAID ?

EVALUATION QUESTION PLANNING MATRIX

EVALUATION QUESTIONS		DATA SOURCES	TYPE OF DATA COLLECTION INSTRUMENTS
1	**ADEQUACY OF ACTIVITIES**		
1. a	Did the original design of the project include an appropriate combination of the activities to achieve the program goals?	• USAID & Abt Cooperative Agreement, including any modifications and progress reports • Interviews with USAID, Abt and MOH personnel	• Document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents.
1. b	To what extent is the range of activities sufficiently broad for achieving the program goals?	• USAID APS, Abt Proposal, Modifications, quarterly and annual reports	• Document review • Interview guides that include common open-end items asked of all identified respondents.
1. c	Was the project financing adequate for successfully implementing the range of project activities?	• Original budget, annual expenditure reports, revised budget requests and modifications	• Document review • Specific questions directed to USAID and Abt staff
1. d	If there are additional areas USAID/Senegal should be addressing what are they and what are the cost implications of expanding the activity array to incorporate these activities?	• Project quarterly and annual reports • Key informant interviews with USAID, Abt, MOH (Central and decentralized), Partners, other donors, civil society	• Document review • Interview guides that include common open-end items asked of all identified respondents. • Site visit protocols • Focus group protocols
2	**APPROPRIATENESS OF THE TECHNICAL ASSISTANCE**		
2. a	Has the program been able to complete the planned activities within the stipulated times?	▪ HCFPP work plans and progress reports ▪ Interviews with USAID and HCFPP staff	• Document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents.
2. b	What are the key contributions to the health care policy and financing programming in Senegal?	▪ HCFPP work plans and progress reports ▪ Reports from other donors involved in Policy ▪ Interviews with USAID and HCFPP staff, with MOH, MEF, and with other donors	• Document review • Interview guides that include common open-end items asked of all identified respondents. • Specific interview questions to MOH and MEF
2. c	Are the planned (output, outcome and impact-level) results achievable with all those hindering factors such as exchange rate fluctuation, low internal resource mobilization, possible "délégations spéciales",	• Project workplans, project quarterly and annual reports • Interviews with USAID, Abt field and home office staff, and with other USAID partners	• Document review • Interview guides that include common open-ended items asked of all identified respondents • Specific interview questions for USAID,

	newly elected officials, delay in reforming the health committees, etc.…		Abt, and partners
2. d	How can be minimized dependency on allotted devolution fund mobilization so that the planned technical assistance is provided as scheduled?	• Interviews with USAID, Abt, MOH	• Specific interview questions related to fund mobilization
2. e	How effective/efficient have been the Health Policy Initiative Team and Steering Committee to speed-up issuance of reform texts?	• Review of minutes of HPI and S.C. minutes • Interviews with Team and Committee members • Interviews with MOH and Partners	• Document review • Specific interview questions related to HPI and steering committee members
3	**SOUNDNESS OF THE APPROACHES**		
3. a	How well have the four components of the USAID health program been coordinated?	• HCFPP work plans and progress reports • Interviews with USAID, HCFPP, MOH and other partner organization staff in Dakar and regional centers	• Document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents • Site visit and focus group protocols
3. b	How effective has collaboration been with sub-grantees and other donors intervening in health care policy and financing?	• HCFPP reports • Reports of other sub grantees • Interviews with other grantees and donors	• Document review • Specific interview questions for other grantees and donors
3. c	How successful has been the approach to increasing participation of collectivities, civil society, private sector, and (central and local) governments?	• Quarterly and annual reports • Interviews with civil society, private sector and collectivites	• Document review • Interview guides that include common open-end items asked of all identified respondents • Site visits and focus group protocols
3. d	Were any formal or informal mechanisms established for involving key stakeholders?	• Interviews with Abt staff	• Specific targeted interview questions
3. e	Did the program managers establish necessary linkages with governmental agencies, and civil society and private organizations?	• Interviews with Abt staff, MOH, local government, civil society and NGOs	• Interview guides that include common open-end items asked of all identified respondents • Site visits and specifically targeted interview questions
3.f	Has the approach for accomplishing policy reform been effective?	• Interviews with central MOH and MEF staff	• Interview guides that include common open-end items asked of all identified respondents • Specifically focused questions
3. g	What constraints or challenges have hindered	• Quarterly and annual reports • Interviews with Abt staff, USAID	• Interview guides that include common open-

	successful implementation of project approaches?	staff, and other identified key informants	end items asked of all identified respondents
3.h	How has the project dealt with or adapted to those challenges?	• Quarterly and annual reports • Interviews with Abt staff, USAID staff, and other identified key informants	• Interview guides that include common open-end items asked of all identified respondents
3.i	Are the intervention approaches still valid in light of 36 months of implementation?	• Quarterly and annual reports • Interviews with Abt staff, USAID staff, and other identified key informants	• Interview guides that include common open-end items asked of all identified respondents
3.j	What needs to be changed to speed-up or expand the interventions?	• Quarterly and annual reports • Interviews with Abt staff, USAID staff, and other identified key informants	• Interview guides that include common open-end items asked of all identified respondents
4	**SOUNDNESS OF THE OVERALL MANAGEMENT**		
4.a	What are the most important management features staffing, materials, activities, sub-grants, administrative and financial arrangements)?	• Reports on the status and changes in Senegal's health system • Data on health system financial inputs and expenditures • Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar and regional centers	• Data and document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents • Site visit and focus group protocols
4.b	Are those features contributing to the attainment of the objectives within the specified timeframe?	• Reports on the status and changes in Senegal's health system • Data on health system financial inputs and expenditures • Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar and regional centers	• Data and document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents • Site visit and focus group protocols
4.c	How do the features contribute to achievement of desired outcomes/impacts?	• Reports on the status and changes in Senegal's health system • Data on health system financial inputs and expenditures • Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar and regional centers	• Data and document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents • Site visit and focus group protocols
4.d	How do the features contribute to not achieving the desired outcomes/impacts? If so, how?	• Reports on the status and changes in Senegal's health system • Data on health system financial inputs and expenditures • Interviews with USAID, HCFPP, MOH and other partner	• Data and document review summary forms and checklists •

		organization staff, and with civil society expert observers in Dakar and regional centers	
4.e	What adjustments will be needed to achieve desired outcomes/impacts?	• Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar and regional centers	• Interview guides that include common open-end items asked of all identified respondents • Site visit and focus group protocols
4.f	How feasible is it to make those adjustments?	• Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar and regional centers	• Interview guides that include common open-end items asked of all identified respondents • Site visit and focus group protocols
5	**SUSTAINABILITY**		
5.a	What legal, regulatory, or administrative barriers to achieving desired outcomes/impacts need to be addressed or mitigated?	• Legislative and policy documents • Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar	• Data and document review summary forms and checklists • Interview guides that include common open-end items asked of all identified respondents
5.b	Are the intervention approaches conducive to sustainability?	• Quarterly and annual reports • PMP reports • Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar	• Document review • Interview guides that include common open-end items asked of all identified respondents
5.c	How can activities and capacities be transferred and sustained after the program ends?	• Quarterly and annual reports • PMP reports • Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar	• Document review • Interview guides that include common open-end items asked of all identified respondents
5.d	What institutional reforms will help sustain the momentum?	• Interviews with USAID, HCFPP, MOH and other partner organization staff, and with civil society expert observers in Dakar	• Interview guides that include common open-end items asked of all identified respondents
5.e	How can be institutionalized involvement of the local collectivities in the development committees at various levels?	• Annual and quarterly reports • Interviews with MOH, local government, civil society and private sector	• Document review • Site visits and focus groups • Interview guides that include common open-end items asked of all identified respondents

ANNEX 3 PEOPLE MET

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