



USAID | **SENEGAL**
FROM THE AMERICAN PEOPLE

**USAID/Senegal Health 2006 to 2011
Strategic Objective Completion Report
December 2012**



STRATEGIC OBJECTIVE (SO) COMPLETION REPORT

ACRONYMS AND ABBREVIATIONS

| | |
|--------|---|
| ACT | Artemisinin Combination Therapy |
| ANC | Antenatal Care |
| ARI | Acute Respiratory Infection |
| ART | Antiretroviral Therapy |
| BCC | Behavior Change Communication |
| CBO | Community Based Organizations |
| CDA | Community Development Agent |
| CH | Community Health |
| CHW | Community Health Worker |
| CPI | Counterpart International |
| CRS | Catholic Relief Services |
| DHMT | District Health Management team |
| DHS | Demographic and Health Survey |
| ENC | Essential Newborn Care |
| FGC | Female Genital Cutting |
| FHI | Family Health International |
| FP | Family Planning |
| GBV | Gender Based Violence |
| GOS | Government of Senegal |
| HCPF | Health Care Policy and Financing |
| HPIT | Health Policy Initiative Team |
| HSS | Health Systems Strengthening |
| IEC | Information, Education, and Communication |
| IOP | Initial Offer of Pills |
| IRS | Indoor Residual Spraying |
| LAPM | Long Acting and Permanent Methods |
| LLIN | Long Lasting Insecticide Treated Net |
| MARP | Most At Risk Population |
| MCH | Maternal and Child Health |
| MCHFPP | Maternal and Child Health and Family Planning Program |
| MDRTB | Multi Drug Resistant Tuberculosis |
| MHO | Mutual Health Organization |
| MLI | Ministerial Leadership Initiative |
| MNCH | Maternal, Newborn, and Child Health |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| MSM | Men Who Have Sex with Men |
| MTEF | Medium Term Expenditure Framework |
| NAC | National AIDS Council |
| NHA | National Health Account |
| NHP | National Health Plan |
| NTP | National TB Program |
| OPLGA | Operational Plan for Local Government Authorities |
| ORS | Oral Rehydration Solution |

BASIC ADMINISTRATIVE DATA

- I. SO Title and number: SO 685-012: Improved Health Status of Families
 II. SO Approval Date: September 2, 2006
 III. SO start and end dates: September 2, 2006 – September 30, 2011
 IV. Country assisted: Senegal

FINANCIAL DATA

1. Total SO Funding: \$157,739,000
 2. Fund Account: CSH
 3. Actual or estimated host country contribution: \$ 65,491,191 (FCFA 32,745,595,484)
 4. Other partner contributions (if applicable):

PRINCIPAL IMPLEMENTING PARTNERS

| NAME | ACTIVITY | INSTRUMENT TYPE | START/END DATE | TOTAL COST | DATE OF CLOSE-OUT REPORT |
|-------------------------------------|---|--|------------------------------------|--|--------------------------|
| Family Health International (FHI) | HIV/AIDS | Cooperative Agreement | 06/22/06--09/30/11 | \$18,312,840 | 003/27/12 |
| IntraHealth International | Maternal Health and Family Planning | Cooperative Agreement | 10/09/06-09/30/11 | \$23,974,925 | 12/23/11 |
| ChildFund | Child Survival/Community Health | Cooperative Agreement | 07/10/06—09/30/11 | \$26,827,390 | 12/01/11 |
| ADEMAs | Contraceptive Social Marketing | Cooperative Agreement | 09/03/2003 - 09/30/11 ¹ | \$8,043,893 | 01/30/12 |
| Abt. Associates | Health Policy and Finance | Cooperative Agreement | 06/22/2006-09/30/2011 | \$13,660,300 | 01/30/12 |
| Academy for Educational Development | NETMARK Long Lasting Insecticide Treated Nets | Cooperative Agreement (Field Support) | 09/30/09--09/30/14 | \$ 7,965,000 | N/A |
| Research Triangle International | Indoor Residual Spraying | Indefinite Quantity Contract (Field Support) | 09/30/09--09/30/14 | \$12,675,000 | N/A |
| TOTAL | | | | \$90,819,348 (not including field support) | |

¹ In 2007, ADEMAs received a follow on modification to an existing award.

SUMMARY OF OVERALL IMPACT

Achievements

USAID's 2006 - 2011 health program ended September 30, 2011. The program had significant achievements in the areas of child survival, maternal health, family planning, HIV/AIDS, and decentralized health financing. As reported in the 2010-2011 Demographic and Health Survey (DHS), there has been a positive impact on the health of Senegalese families (the target population); in particular, on improving maternal and child health and family planning objectives. Given that USAID is the principal donor in health, the USAID Health program made a major contribution to these improvements.

When compared to the previous DHS conducted in 2005, the 2010-2011 DHS showed improvements for most maternal health and family planning indicators. Modern contraceptive prevalence increased; the number of births at a health facility increased; the number of prenatal care visits increased; total fertility fell, and immunization coverage increased. HIV/AIDS prevalence remained low at 0.7 percent and the possession of mosquito nets saw dramatic gains. Senegal also saw an increase in number of deliveries by a skilled birth attendant and a corresponding decrease in neonatal mortality rates. Significantly, under-five mortality and newborn mortality showed major decreases falling from 121 to 72 per 1,000 and 61 to 47 per 1,000 respectively. Please note that data strikes throughout the life of the program led to underreporting of some data.

Major Indicators

| Indicators | DHS | FY 2007 | | FY 2008 | | FY 2009 | | FY 2010 | | FY 2011 | | LOP 2007-2011 | |
|--|------|-----------|---------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------------|-----------|
| | 2005 | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| Under-five Mortality Rate | 121 | | | | | | | | 72 | | | | |
| Maternal Mortality Ratio | 434 | | | | | | | | 392 | | | | |
| Newborn Mortality Rate | 61 | | | | | | | | 47 | | | | |
| % of children age 6-36 months whose weight is more than two standard deviations below the median weight achieved by children of that age: Weight-for-Age | 14 | | | | | | | | 17.7 | | | | |
| % of children of a given height whose weight is more than two standard deviations below the median weight achieved by children of that height: Weight-for-Height (wasting or acute malnutrition) | 9 | | | | | | | | 10.1 | | | | |
| % of children age 6-36 months whose height is more than two standard deviations below the median height achieved by children of that age: Height-for-Age (stunting or chronic malnutrition) | 19 | | | | | | | | 26.5 | | | | |
| % of women of reproductive age (15-49 years) with anemia | 59.1 | | | | | | | | 54.3 | | | | |
| % of in-union women age 15-49 using, or whose partner is using, a modern method of contraception at the time of the survey | 10.3 | | | | | | | | 12.1 | | | | |
| % women who gave birth in the past five years who received at least four prenatal visits prior to giving birth | 39.8 | | | | | | | | 50 | | | | |
| % births attended by qualified personnel | 51.9 | | | | | | | | 65.1 | | | | |
| % children under five that slept under a bed net the previous night | 13.9 | | | | | | | | 41 | | | | |
| % children under five that slept under a treated bed net the previous night | 9.7 | | | | | | | | 34.5 | | | | |
| % of households that own at least one insecticide treated bed net | 27.1 | | | | | | | | 62.9 | | | | |
| Percentage of registered new smear-positive pulmonary TB cases that were cured and completed treatment under DOTS (i.e. treatment success rate) in USG-supported areas | | 70 | 76 | 79 | 75 | 81 | 89 | 85 | 81 | 85 | 86 | 85 | 86 |
| Number of women receiving Active Management of the Third Stage of Labor (AMTSL) through USG-supported programs | | 5,000 | 3,751 | 8,000 | 47,946 | 55,000 | 68,225 | 80,750 | 56,286 | 30,000 | N/A | 178,750 | 176,208 |
| Couple Years of Protection | | 123,017 | 318,047 | 260,000 | 279,484 | 300,000 | 247,923.5 | 330,000 | 231,991.1 | 330,000 | 183,817.8 | 1,343,017 | 1,261,263 |
| # of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs | | 20,440 | 4,778 | 9,972 | 10,846 | 9,972 | 15,115 | 20,907 | 18,709 | 25,785 | 23,387 | 87,076 | 72,835 |
| Number of individuals who received counseling and testing for HIV and received their test results | | 19,589 | 43,798 | 42,800 | 48,578 | 49,500 | 53,026 | 50,000 | 23,318 | 43,500 | 41,152 | 86,940 | 168,862 |
| Number of individuals receiving antiretroviral therapy at the end of the reporting period | | 2,415 | 1,387 | 3,000 | 2,421 | 3,600 | 3,551 | 2,500 | 3,752 | 3,600 | 4,100 | 3,600 | 4,100 |
| Number of pregnant women receiving counseling and testing for HIV and received their test results | | 1,000 | 975 | 1,040 | 1,585 | 1,500 | 1,694 | 1,600 | 1,761 | 1,800 | 2,289 | 6,940 | 8,304 |
| Number of houses sprayed with Indoor Residual Spraying with USG funds | | 78,181 | 76,279 | 76,000 | 153,942 | 155,000 | 176,279 | 222,000 | 254,559 | 225,000 | 240,770 | 225,000 | 254,559 |
| Number of persons living in the houses sprayed with Indoor Residual Spraying with USG funds | | 630,264 | 614,507 | 655,351 | 645,346 | 680,379 | 661,814 | 980,116 | 959,727 | 898,080 | 887,315 | 980,116 | 959,727 |
| Number of malaria cases in children under five years treated according to standards and protocols set by the MOH | | N/A | 27,509 | 38,080 | 39,519 | 38,842 | 36,683 | 8,226 | 9,238 | 7,790 | 7,265 | 92,938 | 120,214 |
| Number of newborns receiving essential newborn care through USG-supported programs | | 25,240 | 7,697 | 79,585 | 171,681 | 213,854 | 101,141 | 112,513 | 90,464 | 54,580 | 12,710 | 485,772 | 383,693 |
| Number of antenatal care visits by skilled providers from USG-assisted facilities | | 100,000 | 297,702 | 204,200 | 690,477 | 855,031 | 877,262 | 905,800 | 501,984 | 402,900 | 2,559 | 2,467,931 | 2,369,984 |
| Number of postpartum/newborn visits within three days of birth in USG-assisted programs | | 81,125 | 14,455 | 91,665 | 72,611 | 116,547 | 150,706 | 172,618 | 127,848 | 67,773 | 21,482 | 529,728 | 387,102 |
| Number of deliveries with a skilled birth attendant (SBA) in USAID-assisted programs | | 75,240 | 78,739 | 82,085 | 134,686 | 159,979 | 95,668 | 105,133 | 79,155 | 51,930 | 14,186 | 474,267 | 402,434 |
| Total number of individuals provided with HIV-related palliative care (including TB/HIV) | | 3,498 | 4,845 | 6,564 | 7,970 | 7,935 | 8,244 | 8,187 | 7,140 | 8,237 | 7,593 | 8,237 | 7,593 |
| Number of people trained in FP/RH with USAID funds | | 2,341 | 889 | 2,966 | 6,701 | 1,015 | 1,637 | 1,855 | 7,007 | 1,514 | 1,600 | 2,966 | 7,007 |
| Number of people trained with USG funds in malaria treatment or prevention | | 2,636 | 1,578 | 11,190 | 4,486 | 1,116 | 4,370 | 4,505 | 12,662 | 6,036 | 3,991 | 6,036 | 12,662 |
| Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG fund | | N/A | 170 | 3,299 | 1,786 | 0 | 297 | 1,324 | 2,629 | 241 | 537 | 3,299 | 2,629 |
| Number of people trained in maternal/newborn health through USG-supported programs | | 2,596 | 2,126 | 3,086 | 8,951 | 537 | 711 | 1,664 | 6,654 | 1,251 | 2,788 | 3,086 | 8,951 |
| Number of people trained in DOTS with USG funding | | 3,602 | 618 | 10,110 | 1,988 | 814 | 879 | 459 | 475 | 340 | 1,199 | 10,110 | 1,988 |
| Number of counseling visits for Family Planning/Reproductive Health as a result of USAID assistance | | 313,862 | 112,352 | 1,108,055 | 215,520 | 1,146,160 | 1,397,018 | 1,693,080 | 1,031,780 | 641,150 | 182,402 | 4,902,307 | 2,989,072 |
| Number of people that have seen or heard a specific USAID-supported FP/RH message | | 1,753,655 | 27,314 | 2,280,176 | 7,003,955 | 5,177,980 | 7,800,738 | 8,255,521 | 9,656,409 | 3,083,843 | 4,168,571 | 8,255,521 | 9,656,409 |
| Number of individuals reached with malaria education and prevention activities | | 101,268 | 156,225 | 189,720 | 746,106 | 369,645 | 785,214 | 949,811 | 1,528,569 | 755,296 | 1,420,533 | 949,811 | 1,528,569 |
| Number of USAID-assisted service delivery points providing Family Planning counseling or services | | 2,368 | 2,079 | 2,655 | 2,341 | 2,341 | 2,685 | 3,303 | 2,618 | 3,915 | 4,086 | 3,915 | 4,086 |
| Number of Insecticide Treated Nets (ITNs) purchased with USG funds | | N/A | 295,302 | 1,110,000 | 948,966 | 900,000 | 513,661 | 1,000,000 | 1,025,000 | 1,400,000 | 3,170,000 | 4,410,000 | 5,952,929 |
| Number of Health mutual organizations established | | 32 | 35 | 47 | 49 | 67 | 67 | 88 | 87 | 93 | 103 | 93 | 103 |
| Number of people covered by health financing arrangements | | 50,000 | 61,785 | 65,000 | 76,257 | 85,000 | 98,043 | 100,000 | 115,056 | 100,000 | 124,804 | 100,000 | 124,804 |

SUMMARY OF ACTIVITIES UNDER 2006-2011 HEALTH STRATEGY

COMPONENT 1: MATERNAL & CHILD HEALTH (MCH) AND FAMILY PLANNING (FP)

Achievements:

- Modern contraceptive prevalence rate increased from 10.3 percent to 12 percent.
- Increased access to long acting and permanent methods (LAPM) (which include implants, intrauterine devices, and male and female sterilization) broadened the range of methods available to populations of 609 of the 1,039 health facilities of the public sector and 30 structures of the private sector. Updated policies that included LAPMs as part of the official protocols and standards contributed to this increase in access as did the increased capacity of providers to provide these methods and to counsel on family planning. Decentralization and task shifting allowed greater access to an extended range of FP methods offered at health posts by multiple providers.
- Working with the Ministry of Health (MOH) and the implementing partners of the other USAID health components, the MCH/FP program organized an annual “National Family Planning Day” to promote FP in targeted regions. Accompanied by a mass media campaign on FP, this campaign helped to create a vision for a positive and renewed image of FP. Combined with concerted advocacy efforts, this renewed image contributed to policy advances from the MOH, including an increased budget for purchasing contraceptives and reproductive health products.
- The component targeted men as well as religious leaders to strengthen their commitment to the promotion of FP and to include FP messages in sermons. Resource persons led dialogue sessions in which they: addressed misconceptions surrounding Islam and FP; clarified that contraceptives are allowed under Islam; prepared participants with arguments to counter false rumors related to the use of FP; and led clients and providers to make commitments for access to quality services.
- The effective integration of healthcare services for mothers and children contributed to the decrease in maternal and neonatal morbidity and mortality. Program results show a 30 percent increase from 47,946 deliveries under Active Management of the Third Stage of Labor (AMTSL) in 2008 to 68,225 in 2009. AMTSL is an important tool in decreasing maternal and neonatal mortality.
- One thousand twenty-four providers and advisors (including 100 men) were trained in FP counseling and 1,225 in contraceptive technology through a performance based, on-site mentoring approach known as *Tutorat*. Provider knowledge and skills in the area of MCH/FP/Malaria services improved. Because of the ineffectiveness of traditional training methods, the MOH, developed and implemented a training strategy based on performance-based learning. The strategy, which focuses on mentoring, is “an on-site training approach.” The approach makes it possible to adapt the content of the on-site training to the actual needs and professional tasks of the providers based on the results of the situational analysis. The MCH/FP component introduced and implemented *Tutorat* in 144 health facilities with 420 providers and allowed programs to strengthen the overall system and not just individual staff.

- The MCH/FP component developed a collection of reference tools for providers to improve the quality of service. The tools were: 800 provider booklets on addressing rumors and misconceptions about FP; 1,200 pouches for providers, that included 4 quick reference sheets on FP and a sheet on the WHO eligibility criteria for contraceptive use; 1,500 sheets on the steps of AMTSL and essential newborn care; 1,500 posters on the 5 specific points to prevent infections during birth; 1,300 sample kits for FP methods; 150 guides on the logistical management of contraceptives; 1,500 posters on the logistical management of contraceptives; 1,500 posters produced by USAID on family planning options .
- The component implemented the Mother-to-be care Package, consisting of tools to facilitate access to information on RH and to assist the providers in the dissemination of information on RH to customers in 227 health facilities with the training of 35,737 health workers. As a result, 835 provider guides; 6,583 *Nafas* (a pocket book resource filled with information on maternal health); and 92,162 counseling cards were distributed.
- A mass media campaign was developed as part of the promotion of MCH/FP services in the media. Known as the *Badiene Awa* spots, each spot featured a key message wherein the main character, Badiene Awa, played the role of a social mediator by giving appropriate advice to couples or individuals whose behaviors did not conform to accepted norms. Three thousand two hundred and sixty-three spots were broadcast by 38 community radio stations. Additionally, contracts with national television and radio stations made it possible to broadcast 163 messages on MCH and FP via television and 732 via radio.
- The component implemented a “Leadership and Responsibility Strategy”. In the seven targeted regions, roles and responsibilities were clearly defined for seven out of seven RHMTs and for 35 of 43 DHMTs, and MCH/FP performance expectations were established in 25 of 43 districts. Between 2007 and 2009, the number of health facilities supervised increased from 58 to 371. Technical and financial support led to an improvement of supervision systems through training of members of the DHMT and regional medical teams in formative supervision and the strengthening of supervision.
- The component introduced a range of activities to improve comprehensive training for health personnel. These activities included more participative training methods; improved processes for the selection and training of trainers; and improved training modules, tools and materials for trainers. Documentation of trained staff and better mapping of skills at the operational level provided decision makers with better data to analyze problems and performance at the national, regional and district levels.
- Important activities to strengthen the health information system were successfully undertaken. Indicators for monitoring the national RH Program were harmonized and a standardized list of indicators was created. Management and data tools were distributed; and 1,695 providers were trained on how to use the new and updated tools. Annual and quarterly RH reviews began as did quarterly monitoring of district performance.
- The pilot phase of the automatic data exchange system using mobile phones was tested in two districts in the region. This system facilitates the transmission of health data in real time from the health post to the national level and enables data and information on reproductive health to be transmitted from a computer or mobile phone.
- Three hundred twenty-eight people received training on gender, a gender integration strategy, and gender audit tools following the development of a training guide on integrating gender
- To improve access to quality malaria information and services and the level of provider and client knowledge, the component trained 5,081 persons on malaria case management and prevention and communication; 664 technicians and prescribers on the biological diagnosis of malaria; and 42 senior

managers in monitoring evaluation, epidemiological surveillance; distributed 131 microscopes and materials to all public sector laboratories ; and provided formative supervision of 1,273 personnel at health facilities on the integrated package or RH and malaria services.

- Unwanted pregnancies among targeted students declined as a result of a multisectoral approach that strengthened the capacity of teachers, of school administrative staff; and of parents and empowered adolescents to make decisions on reproductive health through the acquisition of competencies in life skills and RH.
- The Minister of National Education established committees to fight gender based violence (GBV) and national multisectoral committee on GBV.
- School staff demonstrated their increased commitment to fighting GBV when 534 of 538 teachers in the targeted areas and administrative staff signed a letter of commitment to combat the GBV at school. By participatory methodologies, 112 school mediators, including 27 women, trained 9,197 out of 11,228 students on life skills and 565 parents on GBV in three regions. In the areas of gender based standards and school attendance, the fundamental rights of children, school-related GBV, HIV/AIDS and sexually transmitted infections (STI), and reproductive health, teachers and students showed increased knowledge and more positive attitudes and behaviors regarding GBV. Teachers more clearly understood their responsibilities towards students and students in turn became more aware of their rights. More restraint was noted among teachers since they are more aware that students can report them. Students are now more likely to discuss issues of sexuality without embarrassment, especially at the adolescent counseling centers and with mediators.

Lessons Learned:

- The institutional instability of the Division of Reproductive Health and the MOH negatively affected the start of the skills delegation activities and of innovations such as the automatic data exchange system. Lack of joint planning of program activities led to a lack of leadership regarding strategy and programming.
- The achievements were made possible through:
 - Maintaining close coordination with the personnel from the MOH at the national, regional, and district levels for all aspects of decision-making related to the training, curriculum creation and program approaches
 - Encouraging the adoption of an evidence-based approach
 - Supporting the existing staff from the MOH with technical assistance
 - Supporting the review of the tools and the coordination for the management of data between the various levels of the system
 - Developing public-private partnerships through the signature of the Memorandum of Agreement between companies and the MOH.
 - The consolidation of innovations such as AMTSL, essential newborn care (ENC), tutoring, long-acting methods.

Significant Issues or Concerns to Be Addressed:

- Weaknesses in the inputs and RH product supply policy as well as strikes by personnel caused serious obstacles.

- Weaknesses in the supervision of providers by the executive teams in the districts and region.
- Though USAID ended its support for immunization in 2006, falling immunization rates made it increasingly apparent that technical assistance to the immunization program was necessary and is included under the 2011 to 2016 strategy.
- Lack of synergy between the MCH/FP and the CH component.

The USAID/Senegal 2011 to 2016 strategy addresses these concerns. The five major components under this strategy will work together to jointly coordinate activities where appropriate and will support regional offices. Immunization is now included as part of program activities, and the Health Systems Strengthening component specifically supports activities to strengthen the pharmaceutical logistics management and strengthen supervision at all levels of the health system. Though data strikes are not within the control of USAID, the election of a new administration in February 2012 and the subsequent appointment of a new Minister of Health have led many to be optimistic that the underlying issues behind the strikes will be resolved.

COMPONENT 2: HEALTH CARE POLICY & FINANCING

The Health Care Policy and Financing (HCPF) component worked with the MOH to accelerate and strengthen the process of health systems. USAID/Senegal awarded Abt Associates Inc. the five year HCPF Cooperative Agreement in June 2006 with the objectives of making the health environment conducive to transparency and accountability and mobilizing public and private resources for health. The overarching goal was to increase use and to improve quality of priority services, particularly for the poor and disadvantaged.

Achievements:

- Policy Dialogue and Coordination:
 - This is the strongest of the HCPF technical areas with significant successes and the anticipated scope of work has been exceeded. As a result of the HCPF component'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 MOH and are more quickly and effectively implemented.
 - Fifteen policies and decrees were developed with the HCPF component's technical support. Important examples include:
 - Reference framework for scaling-up successful community-based interventions defined the selection criteria and the conditions under which interventions would be scaled up. Following this process, the decision was made to scale up the initial supply of hormonal contraceptive pills
 - A national health insurance strategy and guidelines to assist vulnerable persons
 - Food fortification standards that include compulsory fortification of soft wheat flour with iron and folic acid and of edible oils with Vitamin A
 - A public-private consultation framework and implementation tools of contracting policy

- Development of curricula for training registered nurses and midwives to include new health technologies and approach.
- The Health Policy Initiative Team (HPIT) was created early in the life of the HCPF component to enhance the policy and reform formulation and implementation process, and at the end of the program, the Government of Senegal (GOS) had assumed full ownership, expanding its membership to include representatives of all donor and development partners in health.
- The HPIT took on major policy reform areas, including the below:
 - The completion of the National Health Accounts for 2005, publication and distribution of the documentation, and development of a reproductive health sub-account
 - Support in making the strategic planning process at the central level into a practical policy in collaboration with the MOH and MOF;
 - 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. A presidential decree, expected to be signed by the end of 2012, will merge the two into a single Committee de Development de Santé and clearly define the role of the committee.
 - Planning and financing policy through the Operational Plan for Local Government Authorities (OPLGA). The HCPF component's support has enabled the redefinition of the OPLGA process to align it with the new NHP. A new manual has been developed to support this (and is awaiting reproduction and distribution), and regulations have been appropriately modified to require the inclusion of the OPLGA in district health plans;
 - Health Insurance policy reform has become a high priority as a result of the findings of the national health account (NHA) that 37 percent of health sector income comes directly from households and that only 12 percent of households have any form of health insurance.
 - The facilitation or elaboration of several plans and reports: the development of the National Health Plan (NHP) and the first ever NHP Monitoring and Evaluation plan and the elaboration of the strategic planning reports in such a format that they have proven useful to both the MOH and the Ministry of Finance (MOF).
- Capacity Strengthening for Resource Use in the Ministry of Health:
 - THE HCPF component worked to provide an evidence base to enable the GOS to allocate additional resources to deal with public health problems and to ensure that these resources are used in an effective, transparent, and participatory manner.
 - Both central and decentralized staff of the MOH, along with senior staff in the MOF, attests that the MOH's capacity to plan, budget and monitor the implementation of the budget has been increased as a direct result of the HCPF component's interventions, which also contributed to raising the awareness of the MOF about the health priorities of the country through its support to the Medium-Term Expenditure Framework (MTEF). In discussions with the MOF during the portfolio review meetings, the impact of the work with the MTEF is apparent. The key counterpart at MOF stated that "for the first time ever, we are able to clearly understand the budgetary and planning priorities of the MOH and measure their performance." While it is true that this is the object of the MTEF, and that the MTEF was a process adopted by the MOH prior to the HCPF component's involvement, it is the quality of technical assistance and capacity building brought by the HCPF component that is almost wholly responsible for these remarkable advances. In addition, the MTEF process is now

being rolled out to the regional and district levels and will have similar effects there.

- The HCPF component successfully advocated with the MOH to add a budget line-item of 2 billion FCFA to support the planning and implementation process of the local government unit local health plan.
- Social Financing Mechanisms:
 - The HCPF component worked to expand insurance coverage, particularly among economically vulnerable populations, and to improve the sustainability of social financing mechanisms, such as mutual health organizations (MHO). Advisory support, training and awareness activities encouraged new memberships, boosted recovery pay rates of membership and strengthened organizational development. The technical assistance to the MHO Regional Federations enabled the provision of advisory-support on administrative and financial management to 52 mutual health organizations in collaboration with the regional federations, partner NGOs, local communities, medical regions and health districts. These partnerships were key in the significant increase in the number of MHOs created and the number of beneficiaries covered. Seventy-six new MHOs have been created over the target of 60 covering 124,804 beneficiaries (19,459 of whom were classified as vulnerable).
 - In coordination with the HIV/AIDS/TB component, a project in Kaolack piloted the implementation of assistance of persons living with HIV/AIDS (PLWHA), providing health insurance from a community based health insurance provider and linkages to microfinance institutions for funding for income generating activities.

Lessons Learned:

- Policy Dialogue and Coordination:
 - The approach to technical assistance that the HCPF component took at the central level was extremely effective in placing government counterparts in the leadership role, with the HCPF component staff taking a “rear seat.” In this way, there was no sense that policies that were developed were anything other than those desired by the GOS. Stakeholders identified the approach taken by the USAID/Health Program as being one of supporting the GOS and not coming in with their own agenda.
 - The HCPF component showed great flexibility in responding to changing demands and requests from the MOH and this flexibility built enormous good will and increased the willingness of counterparts to listen to, and draw upon the HCPF component resources. It is important to stress the positive aspect of this flexibility because responding to these requests poses significant logistical, technical, and financial challenges and was often seen as a negative aspect by managers.
 - The HCPF component’s ability to seize new opportunities for partnerships was invaluable for building capacity of the MOH. Specific examples include the partnership developed between the HCPF component and the MOH to develop a proposal for the establishment of the Ministerial Leadership Initiative (MLI) and the ability to seize the chance to work with the National Program for Local Development to supplement health plans being developed through the OPLGA process.

- Capacity Strengthening for Resource Use in the Ministry of Health:

- The small gains in understanding by the MOF about health priorities have not met the expectation of changing the perception that the health sector is over-financed. In fact, the MOF 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 HCPF component's decision to delay significant engagement with civil society until the third year of implementation 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.

- Institutions of Decentralization:

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 an OPLGA 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.

Significant Issues or Concerns to Be Addressed:

- At the central level of the MOH, the Secretary General expressed concern that the HCPF component's policy support frequently ended with the publication of a policy, which left the MOH unprepared for implementation of the policy in the absence of implementation frameworks
- At the decentralized level, locally elected government and civil society were not substantially engaged in the policy process. While local government had 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.
- Coordination of policy efforts of all USAID components was not always effectively carried out.
- The MHO 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 MHO should develop a business plan that will follow the standard elements of a business planning approach. Even the oldest of MHOs have very little capital and are limited in the services that they can offer without risking bankruptcy. The newer MHOs are very small and revenues are so low that services are very limited. At present, for the newer MHOs, the fact that any service is offered represents an improvement, but without improvements in quality of service it is likely that adherents will drop.

The 2011 to 2016 USAID/Senegal Health program addresses the above concerns. As mentioned above, the components under this strategy will work together to jointly coordinate activities where appropriate and will

support regional offices. The strategy includes support for engagement at the community level, including supporting the development of systems for MHO oversight boards and associations at a more central level to support the local MHOs with professional staff and supervision. A mechanism known as “Initiative to Policy” identifies, at the beginning of each year, the policies which the MOH will prioritize and places the MOH in the lead role in collaboration with their partners.

Component 3: HIV/AIDS/Tuberculosis (TB)

During the implementation period, major changes occurred in financing opportunities for the national HIV and TB programs including: Global Fund financing for (a) HIV public sector, with the National AIDS Council (NAC) as primary recipient; (b) HIV community sector, with the National Alliance Against AIDS as primary recipient, (c) TB health sector with the National TB Program (NTP) as primary recipient; and (d) Health Systems strengthening with the Division of HIV/AIDS as primary recipient. During this period, funding for the World Bank Multi-Country HIV/AIDS Program for Africa, a project to directly support the implementation of national HIV/AIDS strategies and sub-regional HIV/AIDS activities was completed. The majority of TB activities were implemented in direct collaboration with the NTP either at the national level through the sub-agreement or at the regional level through letters of agreement with nine regions. These activities addressed all objectives in the national strategic plan for TB.

Achievements:

- Prevention of New HIV Infections
 - Communication activities primarily focused on Most At Risk Populations (MARPs) peer educators and community agents from community based organizations. A total of 1,341 peer educators/agents were trained in HIV prevention. Results from the Combined Surveillance Survey regarding prevention knowledge and practice among MARPs were integrated into the communication campaigns and messaging.
 - USAID continues to be Senegal’s primary partner for STI prevention and treatment. A total of 743 health providers were trained in STI management. Each year service providers were invited to national workshops to review protocols and share experience. The level of specific STIs among MARPS remained constant or decreased, as evidenced by data from the two national combined surveillance surveys². Based upon service statistics, an average of 18 percent of medical consultations of MARPS during the past 3 years confirmed presence of an STI, compared to an average of 38 percent during the previous years.
 - A national network of trained health providers who provide STI treatment and HIV care prevention services to men who have sex with men (MSM) was created and MSM “mediators” or peer educators were introduced to help each other manage stigma and to access health care services and support.
- Care and Treatment of People Living with HIV
 - The HIV/AIDS/TB component implemented a comprehensive care and treatment strategy of HIV that included medical care, psychosocial support, and nutrition support. The component developed a model with the Outpatient Treatment Centers (OTC) for comprehensive ambulatory care of HIV in

² Enquête Nationale de Surveillance Combinée 2005 and 2010, conducted by APAPS.

2001 and helped the Division of HIV/AIDS extend this model to the decentralized level through the integrated outpatient services in district health centers.

- Care and treatment services were supported by integrating outpatient HIV treatment and psychosocial care activities in 7 health centers in 6 regions and training providers in clinical care in 32 district health centers to ensure a minimum of care services at these sites. Starting in 2009, TB and malaria prevention and care were integrated into the service package at the ambulatory sites, and then later at the other health centers. Psychosocial care included nutrition training, direct food aid group discussions, group meals, house visits and hospital visits.
- Creating a Favorable Environment:
 - Creating a favorable environment through stigma reduction and strengthening associations of PLWHA is a critical component of providing quality HIV care. Beyond the psychosocial support that is provided within the context of clinical care, as described above, FHI worked with the civil society organizations and OTCs to strengthen PLWHA associations in order to provide a social context to share experiences and to help each other address the challenges of living with HIV.
 - In coordination with the HCPF component, the HIV/AIDS/TB component supported a pilot project to establish an MHO specifically for PLWHA. The Association of PLWHA in Kaolack, known as *Bokk Lepp*, has been accompanied by the USAID program during the implementation period and has emerged as a leading organization in terms of fundraising capabilities, increased membership, and the variety of activities that it provides its members. By the end of the program, *Bokk Lepp* had enrolled 133 members in the local MHO system and provided loans to 31 members for a total of more than \$17,000, of which an average of 89 percent was reimbursed.
 - In response to the 2008 attacks on MSM in Senegal that came as a surprise to national leaders, the HIV/AIDS/TB component supported the NAC to putting in place a “National Watchdog/Alert Committee” that would serve to identify problems early on and help find solutions. FHI provided direct support for the technical groups for MSM and gender.
- Tuberculosis:
 - Due to increased public communication on Tuberculosis, the level of stigma and fear around the disease has been reduced. Elected officials, health care personnel, PLWHA, NGOs are able to discuss TB and present correct information regarding the prevention and cure of TB.
 - Training of 1,208 community based agents by DHMTs on TB detection and referrals helped to integrate TB activities within the district and reduced the marginalization of TB personnel at the district level. Quality of TB treatment determines the success rate for curing TB patients. The success rate increased from 76 percent to 86 percent during the implementation period in the USAID zones. The national objective is 85 percent.
 - Development and dissemination of a national protocol for treatment of Multi-drug resistant TB (MDRTB) in 2008-9.
 - Initiation of treatment in 2010 for MDRTB patients, with co-financing from Global Fund Round 7, through training of providers, production of monitoring tools, and funding of clinical exams required for treatment enrollment as well as transport and food support for MDRTB patients.

- Integration of Quality Improvement strategies for laboratory and clinic activities by the NTP into their supervision and training tools, thereby ensuring scale-up of key lessons learned for improving TB detection and care.
- Systematic reporting by the NTP on HIV indicators with 67 percent of TB patients tested for HIV, 86 percent of HIV/TB co-infect patients put on cotrimoxazol and 37.5 percent started on ART.

Lessons Learned:

- There is a need for comprehensive and innovative prevention strategies that bring together BCC, STI, and VCT activities and that address causes of vulnerability associated with gender and poverty.
- Prevention activities for MARPS need to be better integrated into the health care system to ensure permanent access.
- Integrating HIV care at all health centers requires significant oversight since the time and psychological burden of treating HIV patients can become overwhelming for providers.
- Food support is a valuable contribution for improving treatment adherence during initial phase, but was not sustainable due to cessation of financial support for this activity in Senegal from Food for Peace.
- Psychosocial care package needs to vary by cohort of PLWHA because needs of recently diagnosed PLWHA vary tremendously from those of people living with HIV for more than five years.
- Economic support activities are a critical component of any HIV program given that PLWHA are able to live longer and healthier lives with ART and are eager to work for financial and social wellbeing. These activities need to be integrated into existing development institutions to ensure sustainability.
- The human rights dimension of the fight against HIV/AIDS is important to include as part of the larger integration of HIV into a development framework, one that goes beyond the medical domain.
- A comprehensive package of services greatly improves treatment adherence.
- Health district personnel, including community agents, and local authorities have readily integrated TB into their health programs and messages thus reducing the stigma surrounding TB. The result is that TB, previously treated as a parallel and marginalized health issue, has been successfully mainstreamed along HIV and other national health priorities.
- The Quality Improvement activities illustrated that it is possible to significantly improve service delivery and performance indicators at the district level through small changes identified and monitored by health personnel.

Significant Issues or Concerns to Be Addressed:

- Treatment of MDR treatment is limited outside Dakar and patients with MDRTB should be enrolled in treatment in greater numbers. Similarly, it is important to develop TB MDR messages that confirm it is still possible to treat MDR TB and avoid potential increase in discrimination.

- Integrated HIV and TB prevention messages that target high risk groups as well as PLWHIA need to be expanded.
- Improved management of nosocomial infection risks in health structures where TB and HIV patients share space and services should be addressed>
- A significant quantity of TB health personnel trained in Quality Improvement across all regions to influence national level performance indicators needs to be established.

Under the new HIV/AIDS/TB component, support for integrated treatment of patients co-infected with HIV and TB will continue as will increased support for Quality Improvement. The strategy also includes continued support for integrated health programming which should ensure that PLWHA can receive services for, for instance, co-infections, during the course of normal care.

COMPONENT 4: SOCIAL MARKETING & BEHAVIOR CHANGE COMMUNICATIONS

Since September 2003, ADEMAs has been the implementer of USAID/Senegal's health social marketing activities under an initial and follow-on Cooperative Agreement (2007). As a key part of the USAID/ Senegal Health Program, ADEMAs markets male condoms (Protec), injectable (Depo-Provera®) and oral (Securil®) contraceptives, and a point-of-use water purification tablet, (Aquatabs.®) ADEMAs' work over the years capitalized on several opportunities for social marketing in Senegal.

Achievements:

- Increase in private sector product coverage: socially marketed products are now available nationwide in pharmacies, public sector health structures, and private sales points.
- Increased access to contraceptives, especially condoms through the private sector. As of the end of this strategy, socially marketed condoms account for approximately 50 percent of the total market share of condoms in Senegal. Since 2006, the Protec,® the USAID supported brand name, has seen steady sales increases. It should be noted that ADEMAs also socially marketed the brand name Fagaru ® condoms for KFW, the German development agency. Sales of these two products have seen annual increases of about 14 percent and an overall increase in sales of 70 percent.
- Expanded contraceptive product line: In 2009, ADEMAs embarked on a campaign to revitalize the Protec ® brand, which was started more than five years before. Accompanied by a nationwide mass media campaign, in 2011, scented condoms entered the market, expanding the variety of condoms available. ADEMAs, in a public-private partnership with Pfizer, launched Depo-Provera® in 2009.
- Expanded socially marketed product line: In another public-private partnership, this time with Medentech, ADEMAs branched out of family planning and HIV/AIDS prevention to help address the persistent challenge of diarrhea in Senegal by launching Aquatabs,® a point-of-use water purification product.
- Establishment of a Senegalese social marketing agency: the existence of ADEMAs is a testament to USAID's investments over the past eight years to build host country capacity. The agency has maintained clean audit records over the time it has received USAID funding and has built both its organizational and technical capacity. It is in a strong position to take social marketing in Senegal to the next level.

- The program saw steady or rising sales of socially marketed products during implementation. A total of 3,273,150 Aquatab tablets were sold to treat 65,463,000 liters of water. A total of 27,889,007 male condoms were sold; 31,180 female condoms, 1,246,396 cycles of the oral contraceptives under the brand name Securil; and 49,169 syringes pre filled with Depo-Provera.
- ADEMAs' activities in social marketing address demand barriers by promoting a safe, effective, socially acceptable method of family planning to potential users, as well as supply barriers, by increasing access to family planning methods through private sector providers to couples who choose them. The percentage of contraceptives supplied through the private sector in Senegal was low compared to other West African countries; tapping into this network presented a great opportunity to address the high unmet need for FP/RH in Senegal.
- In terms of behavior change, the entertainment-education approach presents targeted health values by integrating them into a primarily entertainment-based production in which positive and negative health values are acted out over an extended period of time by characters that become familiar to the listening audience. In the end, the positive behaviors become more socially acceptable for the general public to act on, and the negative behaviors prove to have negative consequences. ADEMAs, supported this approach in the form of a radio drama series called Ngalewu Nawet (or Winds of Change), which complemented the efforts of all implementing partners in the 2006-2011 health strategy.

Lessons Learned:

- ADEMAs, as an institution manages USAID and other donor funding very well; however, there are technical shortcomings in programming that hinder a sophisticated approach to designing and implementing social marketing and behavior change communication programs.
- In-country capacity exists to design and manage these types of programs, and with targeted technical assistance, these agencies can be strengthened. In other words, limiting the competition to local organizations for the behavior change communication (BCC)/ social marketing program of the next strategy ensures continued country ownership of the program and will continue to build local capacity in this area.

Significant Issues or Concerns to Be Addressed :

- BCC is generally weak and poorly coordinated despite the existence of the National Health Education and Information Service. Stakeholders noted the lack of: a national strategy and of materials for health promotion and behavior change; of capacity at the central and decentralized levels to lead and coordinate BCC programming; development and use of targeted, coordinated messages and approaches; and ineffective implementation and coordination of information dissemination and campaigns.
- Private sector as a potential resource for services, information, and systems support is under-appreciated and underutilized. Social marketing as an approach for getting key health products and particularly messages and information to people has not been fully exploited. There are few incentives to draw potential private providers into the system. Pharmacists, although better trained than community health workers (CHW), are less empowered to provide family planning and other health products. As a result, overall engagement by the private sector is weak and capacity in the private sector is limited.

Going forward, a new, separate Program Component for the promotion of services, products and healthy behaviors is envisioned that directly responds to concerns raised by partners and stakeholders regarding the lack of effective BCC programming. The Program Component will: strengthen national capacity in BCC, with particular focus on the

SNEIPS and its capacity to lead comprehensive and coordinated BCC programming; ensure an effective, comprehensive (covering all priority health areas and interventions), national strategy and implementation plan for BCC; develop effective BCC tools for use at all levels of the system; strengthen capacity of the National Health Education and Information Service regional offices to coordinate BCC programs and campaigns at the decentralized levels; and develop skills and local capacity in community mobilization and use of BCC tools.

COMPONENT 5: COMMUNITY HEALTH:

A consortium of NGOs led by ChildFund (formerly Christian Children's Fund Senegal) and including Africare, PLAN and World Vision led implementation. In the second year, Senegal was named a President's Malaria Initiative (PMI) country and the CH program expanded its activities to include malaria programming in 11 regions and 58 health districts. The consortium of NGOs was also expanded to include Counterpart International and Catholic Relief Services.

Achievements:

- During five years of implementation the CH program expanded to 13 regions, 65 health districts, 1,620 health huts, and 703 sites. Program funds were pooled with community financial contributions to renovate 933 health huts out of an originally planned 1,007.
- Over the five years of implementation, with support from the Community Health component the basic package of services available at health facilities increased from 20 services in the first year to 24 at the fifth year with the introduction of five new basic services (screening of chronic coughers with a persistent cough for more than 15 days; reference to health facilities and reference monitoring; active hepatitis case screening, reference of suspected hepatitis cases, population information and educating about vaccine treatable diseases). This package was implemented at all huts as they were enrolled in the program.
- Complementing the basic package the specific package includes services related to perinatal and neonatal health, post abortion care, community-based management of acute respiratory infection (ARI) with cotrimoxazole, management of diarrhea with oral rehydration solution (ORS) / zinc, community-based monitoring of TB, initial offer of pill or contraceptive method called "standard days method," and the fight against female genital cutting (FGC). The specific package originally included seven separate services but was streamlined to three during the course of implementation. By the end of program implementation, those three services were: ARI management with cotrimoxazole, community-based monitoring of TB, initial offer of pill or the standard days method.
- Artemisinin Combination Therapy (ACT) was used in all health huts to treat malaria. With the introduction of rapid diagnostic tests (RDT) during the second year of the implementation, the protocol changed so that all cases of fever with presumptive malaria were tested to confirm malaria before treatment with ACT. In the beginning of the program, increases in malaria cases were seen however, with the introduction of ACTs, RDTs and mass distribution of long lasting insecticide treated nets (LLINs) cases began dropping significantly between 2009 and 2010. However, RDT and ACT stock outs remained a perennial problem given the weak drug distribution system, forcing community health workers (CHW) to refer patients to the health posts or centers or to simply treat them using the former protocol before the RDT. As a result of efforts under this component, 146,811 patients with malaria were seen and 120,204 were treated. Of those, 3,293 were treated for severe malaria. Ninety-nine percent of pneumonia cases among children 0 to 59 months seen in the health huts received treatment with cotrimoxazole, which has a roughly 98% cure rate Twenty-five

percent of cases were referred for monitoring at the community level by community actors. Of the 73,922 cases seen for pneumonia, 72,835 were treated and 537 were treated for severe pneumonia cases: 537.

- Ninety-eight percent of diarrhea cases of 0 to 5 year olds seen at health huts were managed with ORS or ORS and Zinc. Twenty-one percent of cases were referred for monitoring at the community level by CHWs. The cure rate of cases treated has always exceeded 95 percent. Diarrhea remains a major cause of child illness, as confirmed by the 2010 DHS. Active case finding was implemented at the community level through household visits, however much more sensitization needs to be done
- Community based monitoring of TB increased over the five years of implementation. By the end of the fifth year of implementation, there were 164 functional tuberculosis-control Associations; 1,516 children 0 to 5 years old in chemoprevention: 1,284 new cases detected; and 3,856 cases referred.
- Growth promotion monitoring was carried out in close partnership with the Nutrition Reinforcement Project. Over the five years, 1,206,382 children aged 0-5 years were monitored; 945,645 children aged 0-36 months were weighed regularly during weighing and nutrition monitoring sessions (87 percent of those had an adequate weight gain.). Malnutrition was observed 9 percent of cases while 83 percent were classified as moderately and 11 percent as severely malnourished. Among the children classified as moderately malnourished and managed at the site level, 55 percent recovered as a result of treatment provided with support from the CH component.
- A pilot to study whether or not matrons, instead of medical doctors or nurses, could offer contraceptive pills to patients enrolled 3069 out of a planned 360 health huts. After 18 months of implementation 196 health huts offered the pills. The final evaluation of the study was conducted in the period from January 25 to March 18, 2010 in partnership with FHI Progress and the Regional Training Center for Reproductive Health under the coordination of the Initial Offer of Pills (IOP) Steering Committee of the Division of Reproductive Health. By September 2011, 2011, 449 health huts were offering the service, demonstrating that, with proper training and support, a variety of health personnel could provide the pills.
- In 32 villages, the CH component piloted a program to provide iron supplementation through flour fortification. Initially, the program targeted iron fortification of local flours using non-industrial processes. Within the framework of food diversification and promotion of the consumption of micronutrients, 9,000 fruit trees were acquired and 3,090 were planted in the community. Members of the fortification monitoring committee were trained on the non-industrial techniques of making bread fortified with iron, folic acid and zinc. A concentrated premix composed of iron-folic acid and zinc was distributed to households in the targeted area.
- The CH component partnered with the Grandmothers Project, an NGO to develop a strategy to promote abandonment of FGC.
- The CH component participated in the working group on the AMTSL at the community level and coordinated a pilot study on prevention of postpartum hemorrhage with the use of misoprostol by the matrons of the health huts. During the fifth year, a decision was made to integrate the study on misoprostol coverage into the study planned to test two strategies to prevent post-partum hemorrhage using Uniject oxytocin and misoprostol, in collaboration with Gynuity Health Project. This study couldn't be conducted during the fifth year and was shifted to the Phase II of the USAID Health Program.
- The CH component supported activities in two sites, Mboss and Neorane to identify how an organized use of the mobile phone can contribute to improved levels of performance of BCC interventions at the

community level. Two types of messages were distributed: the "general messages" that all persons receive on their mobile phones and the "specific messages" to specific individuals and to a CHW to remind the targeted individual to follow up. In Mboss, 95 percent of women receiving prenatal consultations received messages and 42 percent of women in Neorane did so. Among the sources of information on the project interventions, the mobile phone was mentioned by 100 percent of women in Mboss; in Neorane the primary source cited was educational talks conducted by community actors, the sources of information that gave the most satisfaction to women in Mboss are cell phone (100 percent) and the educational talks in Neorane (91 percent).

Lessons Learned:

- Maintaining relationships and coordination mechanisms between government and donors at central level and partners for implementation at regional and district levels inevitably leads to improved program performance.
- Local authorities and communities are able to mobilize resources and play an important role in achieving the objectives of a program and ensuring its sustainability.
- When carefully selected and trained, the CHWs are able to play key roles in providing quality services at the health hut.
- The range of services offered in the basic package at health huts is appropriate and should not, at the moment be expanded. The basic package, including the initial offer of pills should be available at all health huts. On the other hand, the mastery of services included in the basic package by CHWs and midwives should be enhanced through continuous training and retraining of workers. The introduction of new services such as provision of injectable contraceptives should not be considered without assessing the ability of suppliers and ensuring regular supervision by the chief nurse.
- The availability and use of reference/counter-reference sheets created by the program should be systematized and done in all health huts. This will ensure a more consistent and standardized management of huts and better monitoring of patients referred between health huts and posts.

Significant Issues or Concerns to Be Addressed :

- The skills of the community development agent, who play the central role in overseeing the management of health huts and mentoring CHWs, matrons and community relais, must be strengthened and expanded to the areas of supportive supervision. Because of weaknesses identified by the evaluation team in the management of health huts, additional training of CDAs in the techniques of supportive supervision is required.
- USAID should provide the lead in systematizing periodic reviews and mixed supervisions, at both central and decentralized levels (districts), among the different health programs it supports.
- The USAID/CH component investment in supporting logistics, repair, and rehabilitation of health huts is low and more contribution is required to ensure service quality.

- The fact that some CHWs are not literate often makes it difficult to ensure proper monitoring and effective use of management tools in the health hut. Literacy in the context of the overall training could be considered as a solution to this issue.
- Greater attention must be paid to capacity building of members of the health hut committees, to enable them to better fulfill their leadership role in monitoring services in the health huts and mobilizing community support.
- Consider logistical support to facilitate the supervision of health huts by the chief nurses who have been hampered by, among other things, a lack of available transportation.
- Improve coordination between the CH component, that supports health huts, and IntraHealth that supports the implementation of outreach activities for health posts. This is essential to achieve a more systematic and workable organization that would allow the head nurse at a health post to discharge their responsibility for supervision of health huts.
- The Community Health consortium led by ChildFund is expected to develop and implement an operational mechanism to involve communities and community leaders in generating resources to support health huts and therefore tending towards a sustainable community health. To do so, it must rely on models developed by its members to support their efforts and the ideas put forward by the Ministry of Health and Prevention partners at national, regional and district levels. Doing otherwise would be tantamount to jeopardizing the enormous achievements to date obtained by the CH component.
- Despite strategies developed to encourage women to give birth at health facilities with assistance from qualified personnel, it is clear that women still continue to give birth at the health huts. 57,164 deliveries were recorded by birth attendants at health huts. According to the data recorded, they have performed 52,986 deliveries while 4,575 pregnant women were referred to a health facility for delivery.

PRESIDENT'S MALARIA INITIATIVE (PMI):

Senegal was one of the four countries selected for PMI in 2006, the second year of the initiative. As malaria was already an element of the MCH/FP and CH components of the USAID/Senegal Health program, funding to these partners was increased to allow national scale-up of their malaria activities. Several field support mechanisms were utilized to help implement the four key areas of the initiative: 1) Distribution and promotion of insecticide treated nets, 2) indoor residual spraying, 3) diagnosis and treatment, and 4) intermittent preventive treatment of malaria in pregnancy. Malaria programming was integrated into three of the bilateral components – Community Health; Maternal, Child, Family Planning and HIV/AIDS TB. Two centrally managed agreements that closed out during the strategy were NetMark, which focused on targeted subsidized sales of long lasting insecticide treated nets for vulnerable groups and commercial sales; and Research Triangle Institute that was responsible for implemented Indoor Residual Spraying in 5 districts in Senegal.

According to routine data collected by the National Malaria Control Program (NMCP), the proportion of all outpatient visits due to malaria fell from 25 percent in 2007 to 6 percent in 2008. The proportion of all deaths in children under five in health facilities that were attributed to malaria also fell from 40 percent in 2001 to 21 percent in 2007 and to 7 percent in 2008. Steady progress has been made for most malaria indicators in Senegal, as measured by two Demographic and Health Surveys (DHS, 2005 and 2010), two Malaria Indicator Surveys (MIS, 2006

and 2008) and a post-LLIN campaign survey (PCS, 2009). These will be discussed under the relevant activities in the following sections.

Achievements:

- **Periodic mass free distribution of LLINs:** In 2007 the NMCP began to work with PMI and other partners on large-scale mass “catch-up” distributions of LLINs to children under five integrated with vitamin A supplementation and deworming. This culminated in a national campaign in 2009 and more than 3.2 million LLINs were distributed using this approach, including nearly 1.4 million procured by PMI. In 2010 the NMCP began mass distribution of LLINs using a universal coverage approach that targets all sleeping spaces. The distribution started with high malaria transmission and/or underserved regions and is progressively covering the entire country. At the end of the 2006-2011 strategy, ten of 14 regions had been completed and 2.5 million LLINs distributed. PMI provided 1.5 million nets and the majority of funds for operations.
- **Targeted subsidies for vulnerable groups:** From 2007 to 2009, PMI supported the subsidized sale of more than 350,000 insecticide treated nets (ITN) and later LLINs to pregnant women and children under five. This system involved agreements between facility health committees and private sector net distributors, with beneficiaries contributing a copayment of \$2 to \$3 per net depending on the shape.
- **Untargeted sales of subsidized bednets:** From 2006 to 2007, the NMCP supported bednet sales to the general population at health facility pharmacies and through community based organizations (CBO) at a subsidized price of about \$2, a portion of which was retained by the health districts and CBOs. PMI began working with the NMCP and partners in 2010 to design a new routine distribution system that would make LLINs available to the general population – free to pregnant women attending prenatal consultations and subsidized for all others.
- **Commercial bednets sold at market prices to the general public:** Most major manufacturers at one time or another supplied ITNs/LLINs for sale in the private sector. Commercial suppliers were generally present in all regions, though they often did not reach rural areas. These bednets were sold at \$6.50 – \$16.50 each. PMI supported efforts of local private net distributors to expand their markets and sales, particularly in urban areas of Senegal, targeting those consumers who can afford to pay full price for the commodity. Nearly 750,000 bednets were sold locally by commercial partners supported by PMI between 2007 and 2009.
- **In the early years of the strategy, PMI social marketing support funded such communications channels as billboards, newspaper ads, TV and radio spots and “road shows.”** Messages sought to identify the advantages of LLINs over other types of bednets and to promote brand identity for distributors. With the introduction of universal coverage, communications activities began to center on the “Trois Toutes” slogan, which emphasized that LLINs should be used by all members of the family, every night, and all year long (*toute la famille, toute l’année, tous les nuits*). Health districts developed local communications plans using multiple channels such as community radio, marketplace activities, traditional communicators, household visits, and local press. Pamphlets and counseling cards were developed to help community volunteers communicate the appropriate messages, in French and local languages.
- **Household ownership of at least one insecticide-treated net rose from 20 percent in 2005 to 63 percent in 2010.** Utilization of ITNs by children under five rose from 7 percent in 2006 to 35 percent in 2010. Similar trends in utilization were observed with pregnant women and in the general population.
- **PMI began supporting indoor residual spraying (IRS) activities in 2007 in three health districts chosen in collaboration with the NMCP: Vélingara, Nioro, and Richard Toll, each representing one of Senegal’s three**

ecological zones. Spraying was carried out just before the high transmission season in each district. In 2010, IRS activities were expanded to three additional districts chosen from among health districts prioritized by the NMCP.

- Spray operations were organized by PMI implementing partners under the direction of the NMCP, the Hygiene Service, the University of Dakar, and district health management teams. PMI support for IRS implementation included training and equipping locally-recruited spraying agents with help from the NMCP and its vector-control partners with supervision by the Hygiene Service. With each spray round, PMI placed increasing emphasis on building national and local capacity for IRS, engaging agents of the National Hygiene Service and MOH personnel at many levels of the health system in IRS activities.
- PMI also worked closely with scientists at the University of Dakar to conduct entomological monitoring in the sprayed districts, with resulting data on insecticidal efficacy being used to assess the quality of operations and the selection of insecticide for future rounds.
- Despite the many challenges involved in IRS implementation, high rates of acceptance have been consistently achieved in all spray rounds.

| Year (# Districts) | 2007 (3) | 2008 (3) | 2009 (3) | 2010 (6) | 2011 (5) |
|----------------------|----------|----------|----------|----------|----------|
| Structures targeted | * | 162,439 | 200,761 | 259,967 | 242,098 |
| Structures sprayed | * | 153,942 | 176,279 | 254,559 | 238,198 |
| Percent acceptance | * | 95% | 88% | 98% | 98% |
| Population protected | 678,971 | 645,346 | 661,814 | 959,727 | 859,309 |

* In 2007 data collected on number of households, not number of structures

- In Senegal, malaria microscopy is available almost exclusively at hospitals and district-level health centers. To expand malaria diagnostic testing, the NMCP developed an algorithm for the diagnosis and treatment of uncomplicated malaria using RDTs and ACTs and introduced RDTs nationwide in late 2007.
- PMI supported the procurement and distribution of 131 microscopes and related consumables to all public health facility laboratories (including military health centers that serve the general public and national hospitals) and set up a microscopy teaching center at the national Parasite Control Service using three specialty microscopes and computer equipment. Technicians from all sites receiving microscopes received refresher training on malaria diagnosis and supervisory technicians from the central level and all 14 regional reference laboratories were trained in quality assurance and quality control. With PMI support, a quality assurance/quality control protocol for parasitological diagnosis of malaria was developed and implemented.
- The roll-out of rapid diagnostic tests required training of actors at all levels, including a new category of CHW called DSDOM (*dispensateurs de soins à domicile*). In addition, PMI supported the development and distribution of 1,500 job aids for RDT performance and 1,000 laboratory registers and initiated an operations research protocol with the NMCP to evaluate the facility-level diagnostic algorithm.
- PMI has supported case management through the training of district health team members and health providers in malaria case management and interpersonal communication skills, accompanied by the development and distribution of job aids on the treatment of uncomplicated and severe malaria. Supportive supervision activities at all levels of the health system, as well as outreach visits by health post nurses to community health huts, were key to ensuring that quality standards were being respected.

- PMI began procuring ACTs in 2010 and during the last two years of the strategy provided more than one million treatments, meeting Senegal’s ACT needs for the time period.
- The proportion of children with fever who receive prompt treatment with an ACT increased from 2 percent in 2008 to 6 percent in 2010. The low rate is partially explained by the treatment algorithm that mandates testing of all suspected cases – those who do not show signs of another illness - and treatment only for those testing positive. According to the 2010 DHS, only 23 percent of children had experienced a fever within the previous two weeks. Parasite prevalence among children also continues to fall, from 6 percent in 2008 to 3 percent in 2010.
- The NMCP’s strategy for increasing intermittent preventive treatment of malaria in pregnancy (IPTp) uptake includes advocacy for health workers and the population at large, training and supportive supervision of health workers, and support for outreach activities by health post staff to provide antenatal care (ANC) services at the community level. PMI has supported the production, dissemination, and use by health care workers of new ANC registers and ANC cards that allow for accurate recording of IPTp treatments; job aids to promote the correct management of malaria in pregnancy and improve the counseling skills of health care providers; water filters/dispensers and re-usable cups for directly observed treatment; and refresher training and supportive supervision. Malaria in pregnancy training was part of an integrated ANC training and covered data collection and record-keeping, the prevention of malaria in pregnancy including IPTp and use of LLINs, and diagnosis and case management of malaria in pregnancy with quinine.
- The drug used for IPTp, sulfadoxine-pyrimethamine (SP), is procured through the Central Medical Stores and paid for by the government. However, since 2009 there have been several problems in the procurement and distribution system that have led to periodic but recurrent stock outs of SP. PMI conducted an assessment of the CMS and supports the NMCP to quantify needs and closely monitor stocks in an effort to address these problems. The proportion of pregnant women receiving two doses of IPTp with SP increased from 12 percent in 2005 to 52 percent in 2008, but fell to 39 percent in 2010 due primarily to stock outs of SP.

Lessons Learned:

- The rapid, nationwide scale up of rapid diagnostic tests, particularly to the community level, helped clarify the true burden of malaria in the country and allowed rational utilization of ACTs.
- Attitudes toward LLIN use have changed dramatically over time. Mosquito nets are now widely accepted by the population and in high demand. However, challenges remain to increasing consistent use.

Significant Issues or Concerns to Be Addressed :

- Difficulties in assuring a consistent supply of malaria commodities at all levels have hindered the program’s success. In particular, the results are seen in the drop in IPTp coverage, as well as frustration expressed by beneficiaries. The next strategy will put more emphasis on supporting the supply chain.
- The regularity and quality of supervision need to be improved in order to ensure the respect of norms in malaria diagnosis and treatment.
- More work needs to be done to identify the messages and/or activities that will encourage consistent, year-round LLIN use by the population. Spray operations ceased in Richard Toll district after the 2010 round due to decreased mosquito susceptibility to the insecticides used and low malaria rates, making it not cost effective to continue spraying.

Program Areas and challenges to be addressed in the upcoming strategy

Despite the significant progress made in the health sector, many challenges remain:

- Insufficient access to health services
- Poor quality and low efficiency and accountability in health
- Insufficient emphasis on prevention and behavior change
- Weak institutional capacity
- Insufficient coordination with communities and the private sector
- Inadequate sector financing and budgetary procedures
- High financial barriers to access and utilization of health services

In order to improve the health status of the Senegalese population, USAID will continue to support the Government of Senegal and the Ministry of Health in facing these challenges. The 2011-2016 Health Strategy is outlined in the following program components:

USAID/Senegal Health Systems Strengthening (HSS) Program Component – Abt Associates

- Geographic focus: 9 regions. Main activities in Kolda, Sedhiou, Ziguinchor, Louga plus the Departments of Pikine and Rufisque; targeted technical assistance with Belgian Technical Cooperation in Thiès, Diourbel, Kaolack, Kaffrine, and Fatick.
- The principle objective of the Senegal Health System Strengthening Component is improved performance of the decentralized public health system, supported by effective and efficient policies, planning and budgeting at the central level of the Ministry of Health. Specific interventions are focused at different levels of the health system. The first sub-component is to improve the functioning and performance of regional and district health management systems and teams. The introduction of Performance Based Financing will be an important aspect of this effort. This program will also support alternative financing mechanisms, such as community based health mutual organizations, to strengthen their reach and sustainability. At the national level, the USAID/HSS Program will be the key partner participating in policy dialogue and reforms to improve results across the USAID health portfolio.
- The USAID/HSS Program will also play a coordination role for the multiple USAID-funded health activities and partners across the country. The USAID/HSS will set up and provide operational support for three regional bureaus in Kaolack, Thiès, and Kolda, which will house staff assigned from other USAID/Senegal Health Program components.

USAID/Senegal Health Services Improvement (HSI) Program Component – IntraHealth International

- Geographic focus: nation-wide for malaria. Minimum package in 11 regions (Thiès, Diourbel, Kaolack, Kaffrine, Fatick, Kolda, Sedhiou, Ziguinchor, Louga, and St. Louis, plus the Departments of Pikine and Rufisque in Dakar Region)
- The principal objective of this component is increased use of an integrated package of quality health services. The focus of interventions is on health posts and health centers, with strong linkages to community based services and to regional hospitals to ensure a well-coordinated continuum of care. The USAID/HSI Program is expected to improve not only availability of the integrated package of services but also functioning of the facilities and teams that deliver these services. Working with the Expanded Program on Immunization division, the USAID/HSI program will strengthen the immunization system. The program will support optimal performance of health posts and health centers throughout Senegal, to help them establish well-functioning linkages with community health

programs, to strengthen their technical linkages and referral networks with regional hospitals, and to assist in strengthening the relationship of these facilities with district and regional health teams.

USAID/Senegal Community Health Program Component – ChildFund International

- Geographic focus: nation-wide
- The CH Program Component is intended to improve access to and quality of CH services and information; to enable the active engagement of beneficiaries in seeking health care at the community level throughout Senegal; and to contribute to the establishment of well-functioning technical linkages and referral networks for health huts. Community level health activities are increasingly recognized by the central MOH for their potential impact on the health status of the population. More than ever, community-level service delivery is seen as an indispensable part of the health system and can be considered the de facto base of the health system pyramid. USAID/Senegal will assist in the development and implementation of a CH policy that supports a nationwide network, supported by their communities, to provide an integrated package of health services, information, and commodities to most under-served segments of the population. Information, products and services will encompass FP/RH, MNCH, nutrition, malaria, TB (information only), HIV/AIDS (information only), and water, sanitation, and hygiene.

USAID/Senegal HIV/AIDS and Tuberculosis (HIV/TB) Program Component – FHI 360

- Geographic focus: 8 regions; Thiès (Mbour), Kaolack, Kedougou, Ziguinchor, Sedhiou, Kolda, Diourbel (Touba), and Dakar
- The principal objective of the HIV/AIDS and TB Component is to provide targeted, relevant technical assistance and other types of support to the Government of Senegal and its partners in order to maintain a low national prevalence of HIV; to improve the quality and availability of treatment, care and support for People Living With HIV/AIDS (PLWHA); and to improve detection and treatment of TB. Strengthening national capacity to plan and oversee these programs and advocate for appropriate policies is key to the success of this component. Given the concentrated nature of epidemics, this component will mainly focus on specific populations vulnerable to HIV.

USAID/Senegal Health Communication and Promotion (HCP) Program Component – ADEMAs

- Geographic focus: nation-wide; product specific
- Under this Program Component, ADEMAs will apply state of the art social marketing approaches in communication to market USAID-supported family planning, water purification and other commercial products. Activities will encourage the behavior changes needed to adopt the use of these products to improve health in the priority technical areas of reproductive health, maternal and child health, malaria, HIV/AIDS, tuberculosis and other infectious diseases, maximizing the use of relevant approaches, materials and media products already developed and used successfully in Senegal.

The President's Malaria Initiative

- Geographic focus: nationwide
- Malaria activities and concerns will continue to be integrated into the bilateral health program components, while a few field support programs will provide support in targeted areas (LLIN distribution and IRS). Particular focus will be placed on resolving the supply chain bottlenecks and facilitating supervision for improved quality. Communications activities will utilize creative approaches and partnerships to help people adopt and maintain the behaviors necessary for

effective malaria control. This is critical as malaria cases continue to fall so that people do not let down their guards.

PROSPECTS FOR LONG-TERM SUSTAINABILITY OF SO IMPACT

Several factors favor the long term sustainability of the program:

- **Close alignment with the Government of Senegal:** Senegal has a comprehensive set of strategy documents and plans that outline the objectives to be met and the priority actions necessary to achieve these objectives. USAID/Senegal Health Program worked closely with the GOS to set targets and priorities that directly supported GOS strategic objectives and policies.
- **Strengthening and using Senegalese capacity:** Every component of the program promoted the growth and development of Senegalese professionals and local non-governmental and civil society organizations.
- **Fostering accountability and transparency:** The ultimate success of USG foreign assistance in Senegal rests on the ability of Senegalese counterparts to practice good governance, primarily defined by accountability and transparency.
- **Ensuring scale-up of high-impact interventions:** The use of proven interventions and successful approaches, as well as tools and materials already developed from former USAID, Ministry of Health and other donor programs, is essential to cover all target areas with a specific program intervention.
- **Effective collaboration and coordination:** USAID/Senegal coordinates with other bilateral donors and multilateral donors and participates in a coordination mechanism chaired by the WHO representative to Senegal. USAID also convenes a specific Steering Committee Meeting on a bi-annual basis, chaired by the Secretary General of the MOH and attended by all National Directors in the MOH, with representation from the Ministry of Finance. These close collaborations highlighted well-targeted interventions, for better results, while maximizing resources available to Senegal from all sources.
- **Smart Integration –** Building on the national platform developed by PMI, partners were able to scale-up an integrated package of services at each service delivery point, be it a USAID supported health center, health post, health hut or outreach site, leveraging more resourced sectors (PMI) to expand services of less financed areas (MCH).

ASSESSMENT OF PERFORMANCE INDICATORS

See page 5 with indicators and results listed.

EVALUATIONS AND STUDIES

(List evaluations and special studies conducted during the life of the SO, including annual reports)

1. Demographic and Health Survey -2010-2011
2. Malaria Indicator Survey – 2008
3. Pharmaceutical Supply Chain Assessment – 2011
4. Immunization Situational Assessment – 2011
5. Mid-Term Performance Evaluation of four of the five components (Social Marketing component still pending) – 2009
6. Pilot Study – Contraceptive Pills at Community Level – 2010
7. Pilot Study – Injectable Contraceptive at Community Level – 2011
8. Documentation Activity—Integrated Community Case Management of Childhood Disease--Documentation Activity—Malaria in Pregnancy
9. Documentation Activity—Maternal Health

KEY CONTACT PERSONS

USAID:

Matar Camara
Ramatoulaye Dioume
Sounka Ndiaye
Amadou Baye Mbow
Akua Kwateng-Addo
Debbie Gueye
Izetta Minko-Moreau

CDC:

Robert Perry

MINISTRY OF HEALTH:

Moussa Mbaye, Secretary General

IMPLEMENTING PARTNERS:

Malick Niang, Abt Associates, Health Policy and Finance Component
Babacar Gueye, Intrahealth, Maternal Health and Family Planning Component
Mamadou Diagne, ChildFund, Community Health Component
Barbara Sow, FHI360, HIV/AIDS and TB Component
Cheikh Sarr, ADEMAs, Social Marketing Component

Recommendation to USAID/Senegal Mission Director:

The Health Office recommends that you approve the Strategic Objective Completion Report for the USAID/Senegal 2006-2011 bilateral Health program.

Approved: Henderson Patrick
Henderson Patrick
Mission Director

Date: 12/20/2012

CLEARANCES:


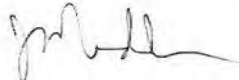
Prepared by A. Sullivan  on 09/28/12

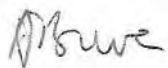
Approved by (Team Leader) A. Kwateng-Addo *with edits*  on 9/28/12

Approved by (PRM) C. Tocco *A. Gardner*  on 11/6/12

Approved by (RAOO) B. Conde  on 11/9/2012

Approved by (RLA) J. Alumbaugh *Miller*  on 11/18/2012

Approved by (OFM) J. Redder   on 1/27/12

Approved by (DMD) A. Brewer  on 12/13/12

