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# USAID/SENEGAL HIV/AIDS AND TUBERCULOSIS PROGRAMS INTERIM ASSESSMENT

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## ACRONYMS

4FDC	Four-drug fixed-dose combination
ABC	Abstinence, be faithful, correct and consistent condom use
ACI	Africa Consultants International
ADEMAs	Agency for the Development of Social Marketing
AGR (IGA)	Income-generating activities
ANCS	National Alliance for the Fight Against AIDS
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavior change communication
BR	Regional Offices
CCF	Christian Children's Fund
CCM	Country Coordination Mechanism
CDC	Centers for Disease Control and Prevention
CDV	Cidofovir
CNLS	National Committee for the Fight Against AIDS
CPI	Counterpart International
CQ (QC)	Quality control
CRD	Regional Development Committee
CRLS	Regional Committee for the Fight Against AIDS
CRS	Catholic Relief Services
CTA	Ambulatory treatment center
CTR (TRC)	Technical Restricted Committee
DLSI	Division for the Fight Against AIDS and STIs
DOD	U.S. Department of Defense
DQA	Data quality assessment
ECD	District Leadership Team
ECR	Regional Leadership Team
EDS (DHS)	Demographic and Health Surveys
FHI	Family Health International
HACI	Hope for African Children Initiative
HKI	Helen Keller International
HSB (MSM)	Men who have sex with men
IP	Implementing partners

IST (STI)	Sexually transmitted infection
M&E	Monitoring and evaluation
MARP	Most at-risk populations
MSPM	Ministry of Health and Preventive Medicine
OCB (CBO)	Community-based organizations
OEV	Orphans and vulnerable children
OI	Opportunistic infection
OMS (WHO)	World Health Organization
ONG (NGO)	Non-governmental organization
PIR	Intervention Strengthening Package
PNQ	National Quality Program
PNT	National Program Against Tuberculosis
PRIM	Regional Integrated Multi-Sectoral Plan
PS	Health post
PTA	Pavilion outpatient treatment
PTME	Prevention of mother-to-child transmission
PVVIH (PLWHIV)	People living with HIV
REC	Discussion and Consensus Meeting
SP	Strategic partners
SPE	Synergy for Children
SWAA	Society for Women and AIDS in Africa
TB	Tuberculosis
TDO (DOT)	Directly observed treatment
TPM+	Smear-positive pulmonary tuberculosis
TS (SW)	Sex worker
TTC	Tuberculosis Treatment Center
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
VIH (HIV)	HIV (Human Immunodeficiency Virus)
WV	World Vision

## **EXECUTIVE SUMMARY**

On June 22, 2006, USAID/Senegal awarded a five-year contract to Family Health International (FHI) (Cooperation Agreement No. 685-A-00-06-00059-00) for the implementation of activities in the areas of HIV and tuberculosis in five regions of Senegal.

The goal of this assessment is to determine how far USAID/Senegal's HIV/AIDS and TB programs have achieved their specific objectives with regard to identifying potential leads for improvement that are likely to make it easier to reach the planned results.

After responding to the issues developed in various themes of the assessment, the results are placed in context and specific conclusions to each component are provided. The assessment also identifies the lessons learned from USAID/Senegal's HIV/AIDS and TB programs and provides recommendations for future intervention.

The assessment team, consisting of a consultant from the GH Tech Project and two local consultants, visited four regions—Thies, Kaolack, Kedougou, and Kolda. The team also met with representatives from USAID, the Ministry of Health, and the partners and organizations charged with the implementation.

### **KEY ACHIEVEMENTS OF THE HIV/AIDS AND TB PROGRAMS**

The USAID/Senegal HIV/AIDS and TB programs have achieved encouraging results. Currently, coverage of the HIV/AIDS and TB programs is sufficiently broad and the packet of activities is solid. The contributions of the program cover various aspects of the prevention and control of HIV/AIDS and TB, including the prevention of HIV/AIDS and TB; support of treatments; the psychosocial take-over of the co-infection of HIV/AIDS and TB; nutritional support; and the strengthening of the health system. The program lends equal support to the coordination of efforts by the National Committee for the Fight Against AIDS (CNLS) at the national as well as the regional level. Activities are implemented through close cooperation with the National Program Against Tuberculosis (PNT), the AIDS/STIs division of the Ministry of Health, service providers, civil society organizations, and the private sector.

#### **Community-level Achievements**

At the community level, the assessment team found notable progress in the achievement of objectives.

With regard to the HIV/AIDS component, 200 peer educators originating from high-risk groups were designated and trained in 2008 to reduce the transmission of HIV in high-risk behaviors. Awareness-raising activities through interpersonal communication to promote changes in behavior reached 53,500 people in 2007. In 2008 they reached 72,224 people among high-risk groups, compared to a target of 54,000.

The activities conducted at the community level by the network of care providers and services have allowed 7,880 people to benefit from psychosocial and nutritional support in 2008 (compared to a target of 6,500). They have also allowed 953 people living with HIV (PLWHIV) to begin income-generating and micro-credit activities with a view to financing the costs of their medical care. Concerning the fight against the stigmatization and discrimination on the part of PLWHIV, 80 people, including PLWHIV, religious leaders, and service providers benefited in 2008 from orientation sessions on themes on the two phenomena, and the program made a strong effort to involve 155 additional people in 2009.

With regard to the TB component, indicators show that 86.7% of TB patients in the regions benefiting from support of the U.S. Government have completed their treatment, compared to an estimated national average of 77%. Analysis of three principal objectives specified for 2008 shows that notable progress has been made in the area of TB. One hundred eighty-three radio broadcasts were made at the national and regional levels in 2008 for the screening of at least 70% of smear-positive pulmonary tuberculosis (TPM+) cases due; 300 peer educators were created to look for and refer those with a chronic cough, and 75% of planned supervision visits were completed and documented. For the treatment of at least 85% of those diagnosed with TPM+, 585 service providers were created in six regions in 2008 to address the co-infection of TB/HIV. At the health district level, 30 traditional healers (later 110) were involved in the management of activities run by the posts. As far as the administration adapted to vulnerable groups and TB/HIV co-infection cases is concerned 45% of TB/HIV patients were diagnosed in the treatment centers.

In spite of these encouraging results, it is important to note that, at present, activities are geographically very spread out and should be grouped and consolidated. Any expansion of activity could pose great difficulties due to financial constraints, which could add to the logistic difficulties needed to ensure appropriate follow-up.

In terms of orientation, FHI is advised to focus on the component quality and on assessing the strengths of partners with regard to the quality of services offered to beneficiaries. However, if additional resources become available, emphasis should be placed on communities living along the borders—because of regulated and underground prostitution, the poverty level of the populations, and the insufficiency of human and financial resources at the district level. The areas concerned are Kedougou, Kolda, and Ziguinchor.

## **QUALITY OF OVERALL MANAGEMENT**

The overall management of the program is well-organized.

With regard to the goal of coordination of the program with partners, a multi-sector plan has been implemented to streamline resources and ensure that it complements the finance activities of the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria. FHI's central team in Dakar has established close collaboration with the CNLS and the PNT. FHI has also contributed by setting up committees that meet monthly or quarterly to discuss strategies with partners, interim reviews, and so on; these committees constitute platforms for the exchange of ideas between partners and donors. In terms of synergy, collaboration with other partners such as ChildFund, Abt Associates, the Peace Corps, the Centers for Disease Control and Prevention (CDC), and the agencies of the U.S. Department of Defense has been shown to be very effective.

Within the framework of the national response to HIV/AIDS and TB, the program has applied a model of operation that allows action at the macro or national level, the intermediate level, and the micro or peripheral level. Implementation of this strategy is conveyed by involving various levels of players in the planning and implementation processes. Packages of support activities, strengthening, awareness-raising, and advocacy concerning different levels of the production line of services in the fight against HIV/AIDS and TB must also be specified.

Relationships with partners on the ground—the CNLS, the PNT, the medical regions of the areas of intervention, the district health centers, the NGOs, etc.—are organized through Letters of Agreement and under contracts that specify activities to be implemented, detailed budgets, timeframes for completion, and objectives. This kind of set-up is specified and is seen as a very good innovation.

Amid the worry over bringing together services for beneficiaries, the program has decentralized its operations by establishing regional offices mandated to monitor directly the activities of the beneficiaries in the contracts. The regional offices ensure the monitoring and strengthening of capacities and constitute a solid link between the field (regions and districts) and FHI in Dakar. For this reason, all problems and concerns on the side of the partners are forwarded quickly to FHI in Dakar, which tries to deal with them and provide responses and solutions as quickly as possible.

In terms of orientation, emphasis must be placed on the search for lasting solutions to identified obstructions. These are, among others: (i) to reconsider decreasing the number of partners charged with the implementation; (ii) to strengthen logistical means to ensure regular follow-up on the ground via bicycles, motorcycles, and automobiles; (iii) to study the feasibility of a contractual scheme (Letters of Agreement) established on a biennial basis (every two years); (iv) to set up a task force to examine and identify various financing channels for regions, districts, and community-based organizations (CBOs), and decide upon the most appropriate method and channel; and (v) to allocate additional resources to the TB program for better consolidation of gains.

## **COVERAGE AND RESPONSE OF BENEFICIARIES**

The total population of MARPs (most at-risk populations) was not reached because the initial objective was unrealistic; a target of 275,000 individuals for 2011 would be more realistic.

At the community level, several civil society organizations work with the target groups Enda Santé, AWA, Inter-Worlds, KEOH, and SWAA. FHI works with 11 NGOs in the fields of awareness-raising and education, the support of care, and activities strengthening the skills of beneficiaries and players. FHI provides them with technical assistance according to their needs, targets, and strategies.

FHI has supported the decentralization of HIV/AIDS and TB treatments at the peripheral level. The program provides the structure of public care with a wide range of support activities comprising (i) personnel support; (ii) training sessions; (iii) supervisory visits; (iv) HIV screening equipment for centers and structures; (v) STI diagnosis and treatment; and (vi) the management of HIV and TB.

Capacity has been strengthened for vulnerable groups at high risk, but it remains insufficient. PLWHIV, sex workers (SWs), and men who have sex with men (MSM) regularly use the resources and services of associations. Nevertheless, they continue to hide their status from their spouses and families for fear of being rejected. Furthermore, they wish to develop income-generating activities or obtain an advantage with the initiatives and opportunities associated with micro-credits. The underground SWs point out that in general they are unable to cease their activities because of lack of resources for their subsistence. Generally there is a need to develop more activities to strengthen the capacities of direct beneficiaries, particularly groups of women.

## **CONTINUITY OF OPERATIONS**

The HIV/AIDS and TB programs must continue and be consolidated.

Letters of Agreement are useful tools for controlling the process of implementation and for specifying services that are appropriate and adapted to the needs of the populations. The progress of activities in the fight against HIV/AIDS and TB, by way of the Letter of Agreement between the medical region and the district, is a unique form of contract between the medical regions and the health districts. It has, in effect, brought about some remarkable innovations in the fight against HIV/AIDS at the level of the medical regions concerned, and contributes to the continuity of action. The results of the program have great relevance and deserve to be main-

tained. However, it is necessary for the partners to shoulder their responsibilities and to think in the future about the diversification of financial sources to ensure lasting resources. As such, it is important to look for solutions in the vacuum left by key partners at the national level, such as the World Bank and LHL (a Norwegian NGO) which are in the process of closing down their programs. Furthermore, FHI must concentrate its efforts on those partners with the same synergies and the same concern for the quality of the components of the program.

The additional structures able to ensure durability include the consolidation of institutional support; better collaboration with the partners; working directly with the beneficiaries; reinforcement of the social and cultural environment; consolidation of capacity-strengthening; promotion of female leadership in the associations; reinforcement of micro-gardening and quality of care; and collaboration in the reorganization of the National Program for Quality Control.

## **I. INTRODUCTION**

Senegal currently finds itself in political and economic transition due to an increased poverty level and a government faced with many crises. The population of 12 million (with over 40% living in urban areas) increases at a rate of 2.6% per year. Almost 60% of the rural population and 45% of the urban population survive on less than a dollar a day. A substantial increase in the rate of economic growth is necessary if the country wants to reduce its poverty level dramatically. The literacy rate for the adult population is 43% while the enrollment rate for girls in primary education is 70%. Distribution by gender reveals a certain disparity in favor of boys; only 43% of those finishing primary education are female, and this difference is more and more pronounced in the higher echelons of the education system.

After the last DHS survey in 2005, maternal and infant mortality rates remain elevated. They are respectively estimated at 401 per 100,000 live births, and 121 per 1,000 for the infant mortality rate. Life expectancy at birth has increased from 40 in the 1970s to between 57 and 61. The country has known several years of armed conflict between the government and the separatist movement of the Casamance, even though a ceasefire agreement was signed in 2004. These circumstances have made Senegal particularly vulnerable as it attempts to combat HIV.

### **USAID SUPPORT TO HIV/AIDS AND TB PROGRAMS IN SENEGAL**

USAID is the U.S. Government's principal agency for implementation of strategy and plays a key role in collaboration with the Ministry of Health and the CNLS to implement and support action on HIV/AIDS and TB. USAID provides technical assistance to the Ministry of Health to strengthen the health system and guarantees quality of service for all components of the program. Furthermore, USAID reinforces the roles and capacities of local organizations, in particular by conducting activities at the community level aimed at strengthening the health system. Family Health International (FHI) is USAID's main contractor mandated to monitor the implementation of interventions relating to HIV/AIDS and TB. ChildFund is charged with community intervention for TB.





## II. BACKGROUND

As an integral part of its strategic plan for Senegal, USAID supports the efforts of the Government of Senegal (GS) to reach the UN Millennium Development Goals as stipulated in the National Health Development Plan. By focusing on these objectives, funding of USAID/Senegal moves toward a mutual reinforcement of: (i) the policies and funding of the healthcare system; (ii) community health; (iii) maternal and infant health, and family planning; and (iv) the prevention and control of HIV/AIDS and TB, including the marketing of products and behaviors.

Until 2002, USAID assumed the role of head of the queue of donors to Senegal with regard to HIV/AIDS, with annual financial support of about \$4.5 million. Since then, contributions to the MAP Project by the World Bank and the Global Fund have surpassed USAID's support for Senegal. This has ended, thanks to an increase in available resources to Senegal for HIV/AIDS, which has contributed to expanding the field of intervention. This situation has also created a specific need for better coordination between the various donors. USAID/Senegal has continued to provide financial support and technical assistance through program-implementing organizations such as FHI, so the interventions are concentrated essentially on the prevention of HIV, and the support, coverage, and targeting of groups that are at high risk and greatly vulnerable to HIV/AIDS.

The Demographic and Health Survey of 2005 (DHS 2005) estimated the prevalence of HIV/AIDS to be 0.7% of the general population. The results of recent epidemic monitoring corroborate the weak prevalence in the midst of the general population. However, regional distribution shows a high prevalence in the general population situated along the borders because of the mobility and movements of populations linked to economic activities (mining activities and international markets) or conflicts. Furthermore, the results of epidemic monitoring reveal a strong prevalence with sex workers and MSM, rising respectively to 19.5% and 21.5%.

The rate of prevalence for TB is 111 per 100,000 people. Tuberculosis therefore seems to be a major public health problem in Senegal. Since 2003 USAID/Senegal has contributed \$800,000 to complete the technical support provided by LHL (a Norwegian NGO) to the National Program Against Tuberculosis (PNT). USAID/Senegal has also been instrumental in completing the national proposal to the Global Fund. Support for the HIV/TB program is an important catalyst for management of TB/HIV co-infection. To this day, 45% of patients with TB have tested positive for HIV.

On June 22, 2006, USAID/Senegal awarded a five-year contract to FHI (Cooperation Agreement No. 685-A-00-06-00059-00) for the implementation of activities in the areas of HIV and TB in five regions of Senegal. For the HIV and TB programs, FHI and its partners are targeting the regions of Kaolack, Kolda, Louga, Thies, and Ziguinchor.

FHI is also targeting Dakar for TB activities and has chosen HIV activities following the precedent of a bilateral program. Since the end of 2008 FHI has initiated activities in Kedougou, one of the new regions of Senegal, located outside the initial area of intervention by USAID's health programs. Beginning in 2010, FHI intends to expand its activities into two new regions, Kaffrine and Sedhiou, which have been created from the regions of Kaolack and Kolda. FHI's targets include the whole population for the TB program, PLWHIV, and high-risk groups that are highly vulnerable such as SWs, MSM, and mobile populations. In order to fulfill its commitments, FHI works directly with the PNT, the AIDS division, intra-group services, civil society organizations, and the private sector to carry out activities, among which are the prevention of TB and HIV/AIDS, healthcare and support, and the strengthening of the health

system. FHI also supports the coordination of efforts by the National Committee for the Fight Against AIDS (CNLS) at the national as well as at the regional level. The other players supporting FHI in the implementation of activities are:

1. The Agency for the Development of Social Marketing (ADEMAS), which has been mandated with implementing the national social marketing program for PROTEC and FAGARU, two brands of condom that are targeted to the general population and youths respectively.
2. ChildFund, which leads a consortium charged with implementing TB activities on the community scale in the regions of Kaffrine, Kaolack, Kolda, Louga, Sedhiou, Thies, and Ziguinchor.
3. Counterpart International (CPI), which has implemented healthcare and support activities that include nutrition services for PLWHIV, principally in the northern regions of Senegal.
4. The Centers for Disease Control and Prevention (CDC), which supports central activities linked to the management of strategic information, including sentinel surveillance.
5. The U.S. Department of Defense (DOD), which has financed activities for the prevention of sexually transmitted diseases, counseling and voluntary screening, mother-to-child transmission, and associated costs.

USAID's HIV/TB component has enjoyed some success, such as the coordination of efforts of control. Other significant accomplishments have been made in the last few years in the area of HIV/AIDS and TB in Senegal. These include:

- Developing or changing policies and directives, including (a) national regulations and protocols concerning treatment of TB; and (b) protocols for the clinic costs of the TB/HIV co-infection.
- A success rate of 75% in the treatment of TB with new cases of positive smears.
- Maintaining the national prevalence of HIV below 2%.
- Extending services to groups at high risk and in zones of strong prevalence, including the new region of Kedougou.
- Creating a network of service providers and a support peer group to improve the access of MSM to STI treatments and HIV screening.
- Integrating CDV (cidofovir) services in health centers.
- Decentralizing healthcare and support services at the health district level, based on a model of nutritional and psychological healthcare in the outpatient treatment units.
- Strengthening regional committees' capacities for coordination of HIV activities in (a) the integrated and multi-sectoral development and management of regional HIV plans, and (b) the management and use of strategic information.
- Introducing the quality approach of intervention for TB and HIV.
- The immense effort involved in managing TB/HIV co-infection.

In spite of these key accomplishments, implementation of the program has encountered some difficulties due to impeding factors such as: (1) the social and religious environment becoming less receptive to interventions aimed at high-risk groups; (2) the difficulties of effectively coordinating all the players to ensure complementarity in scheduling; and (3) the challenges of

maintaining the quality of services while achieving the objectives of universal access to prevention, treatment, and healthcare.

The current assessment, carried out from September 28, 2009, through October 22, 2009, seeks to respond to the main questionings of the TDR on the basis of interviews with partners, players, and members of governmental organizations. It also analyzes the responses of high-risk groups met in Kaolack, Kedougou, and Kolda.

In tandem with the current assessment, three other assessments/pieces of research relating to strategies aimed at MARPs, the feminization of the HIV epidemic, and the Letters of Agreement are in the process of being analyzed. However, the assessment team was able to meet with the leaders in charge of the assessments on the feminization of HIV and the interventions for MARPs. The team was also able to examine the preliminary results and to look through the provisional report of the assessment of the Letters of Agreement. The results will be examined in the body of the report.



### III. OBJECTIVES AND METHODS

#### GOAL

The goal of the interim assessment is:

- To determine the level of achievement of anticipated results.
- To identify the areas of potential improvement likely to facilitate achievement of planned results.

#### OBJECTIVES

Specifically, these are to:

- Determine the impact of environmental damage on the original objectives of the program.
- Identify the problems linked to implementation and unsatisfied needs.
- Prioritize the activities to be integrated in the plans of action for 2010 and future years.
- Specify needs, opportunities, and constraints.

#### METHODOLOGY

The methodology of the assessment consists of a documentary review, interviews with key players, and focus groups. The team's analysis takes into account dimensions linked to human rights, ethics, age, and gender (e.g., feminization of the HIV pandemic).

The team reviewed all of the documents relating to TB and HIV activities in Senegal. Both in Dakar and in the regions the team interviewed representatives from the public sector, NGOs, donors, partners of implementation, and other players (Appendix B).

- Documentary Review: USAID provided the team with documents relating to the assessment at the introductory meeting, which included, among others, concept notes, project quarterly reports, plans of action, and other documents relating to making an integral part of regular monitoring of the project (Appendix C).
- Planning of the Meeting of the Assessment Team: In the two days leading up to the assessment, the team carried out various activities, including:
  - Review and development of assessment questions.
  - Design of a data collection methodology, tools, instruments, and guides collections.
  - Review and clarification of logistical and administrative aspects linked to the mission.
  - Development by the team of a draft plan to adopt for the compilation of the final report.
  - Delegation of roles and responsibilities for the different members of the assessment team for the preparation of the final report.
- Introductory Meeting: A preliminary meeting was organized with USAID's management team and FHI to examine the TDR and to reach agreement on the central issues of research, with a view to finalizing the timetable of execution. A detailed workplan was

created for the assessment, which included defining the principle stages and documents to submit on the clearly established dates.

- Interviews with the Key Players, Meetings, and Discussions in Focus Groups:

The team met and conducted qualitative research with the key players and partners in Dakar and in the four regions of Thies, Kaolack, Kedougou, and Kolda. The selection of these regions was made according to the specific nature of the target and the epidemic profile. The region of Thies was chosen especially for the underground SW target; the region of Kaolack due to its situation as a transport crossroads, for the intervention at the level of this specific target of transporters, and for the experience of its association with PLWHIV. The region of Kolda was selected due to the characteristic of its border zone with certain countries of the sub-region with a rate of HIV prevalence above the national average. The region of Kedougou was selected because it is a new region with a very high rate of vulnerability due to its nature as a mining zone. The team held four focus groups of 12 individuals each with the beneficiaries. At Thies, interviews were completed with the SWs, and at Kaolack, Kedougou, and Kolda with the PLWHIV.

- Visits on the Ground: The assessment team visited sites at the regional office level charged with the implementation of activities of FHI's partners as well as the health district level in four regions. These visits have allowed assessment of the problems and provision of advice before the contracts are signed in seven regions involved in a series of activities—the formation, supervision, and data collection being destined to support the decentralization of the national TB and HIV programs for the years 2010 and 2011.

## **IV. RESULTS**

### **RELEVANCE OF ACTION**

#### **Combination and Scope of Activities**

The composition of the package of activities in the HIV/AIDS program is well-balanced and appropriate. On the other hand, in the area of TB, it has become necessary to expand the activities of behavior change communication (BCC) in populations, and to bolster the laboratories and competencies of the service providers as well as the mechanisms and structures of TB/HIV coordination at the regional level.

In the current situation, coverage of HIV/AIDS and TB programs is comprehensive and the package of activities sufficiently large. The interventions of the program incorporate various aspects of the prevention and control of HIV/AIDS and TB, including the prevention of HIV/AIDS and TB; healthcare support; psychosocial support of the HIV/AIDS-TB co-infection; nutritional support; the strengthening of the health system; reinforcement of the management of TB at all levels; support for the implementation of the directly observed treatment (DOT) in the community; and support for the networks of laboratories used for the screening of TB. The program also supports the coordination of efforts by the National Committee for the Fight Against AIDS (CNLS) and the PNT at the national as well as at the regional level. Implementation of activities is undertaken through a close collaboration with the PNT, the AIDS/STI division, the service providers, civil society organizations, and the private sector.

#### **Repercussions in Terms of Expansion in the Range of Activities**

Implementation of the package of activities extends to eight regions (Dakar, Thies, Kaolack, Kedougou, Kolda, Ziguinchor, Sedhiou, and Kaffrine). Currently, in certain districts, it is the complete package that is offered, while in others it is just the minimum package. This difference in the offering of services does not allow the interventions of USAID to be seen with favorable eyes and does not maximize the impact. The activities need to be regrouped and consolidated. Every expansion of the activities could pose great difficulties due to financial constraints, which could themselves add to the logistic difficulties to ensure appropriate follow-up.

However, it would be a very good opportunity to focus more on the community approach regarding TB, especially the search for those who have disappeared. The systematic referencing of all cases of positive screenings during advanced strategies must also be ensured.

It is recommended that FHI focus on the component quality and assess the strong points of the partners regarding the quality of services offered to the beneficiaries.

However, if additional resources were made available, emphasis should be placed on the communities living along the borders because of the crossborder movements of the population, the level of poverty of the population, and the insufficiency of human and financial resources at the district level. The areas concerned are Kedougou, Kolda, and Ziguinchor.

#### **Completion of Activities within Prescribed Timeframes**

The program has been able to complete the planned activities within the prescribed timeframes and has even succeeded in expanding certain activities in the new region of Kedougou from the perspective of overcoming the vulnerability of HIV favored by mining activities, which attract many individuals who indulge in risky behavior.

### *HIV/AIDS Component*

To reduce the risk of HIV being transmitted through high-risk behavior, over 1,150 peer educators from high-risk groups were created between 2007 and 2009. Interpersonal communication activities to promote changes in behavior reached 53,550 people in 2007, 72,224 people in 2008, and 56,229 people in 2009. However, the beneficiaries continue to demand tools of information and sensitization at the community level due to certain deficiencies that they observe in the implementation of their activities.

To improve the quality of STI management at the level of healthcare structures, the staff of 28 health districts were supervised on the adoption of a syndromic approach to the STI support. This has allowed consultations with 1,992 SWs and MSM in 2009, including 460 STI cases that were diagnosed and treated. However, due to frequent turnover of personnel at the health district level, such initiatives need to be renewed regularly.

Access to CDV services has been improved through major interventions. From 2007 to 2009, about 350 service providers received training in quality of surveillance and diagnostic approach in the health centers, principally concerning pre-counseling and post-counseling, and referencing at the level of adapted services.

Therefore 39,775 people were tested and received their results in 2008, with 44,870 in 2009. Nevertheless, the program needs to concentrate more effort on the quality of its interventions. Screening activities in mobile strategies are completed by partners who come into contact with large numbers (of patients) without thinking too much about referencing, psychosocial accompaniments, or treatment. At Kolda and Kaolack the beneficiaries expressed regret about the fact that not everyone testing positive has benefited from support and follow-up in the health trainings.

To reinforce the decentralization of the medical support and the support of PLWHIV, six structures of healthcare and treatment, including those in Dakar, offer outpatient services for HIV/AIDS that exceed the support for TB. A new structure was integrated in 2009. This comprises healthcare and social support services, including nutrition, which answers the real needs of beneficiaries since they complete ARV treatment offered by the government or by other partners. In certain regions like Kolda, where the structure is located in the health center, the PLWHIV prefer to use the services offered in this structure rather than go to the hospital where the quality of service "is not satisfactory," according to the beneficiaries. The number of PLWHIV receiving ARV treatment at the level of the centers rose from 2,124 in 2008 to 3,551 in 2009 out of the 12,249 in the national program in 2009. The number of PLWHIV receiving benefits from healthcare and social support services rose from 4,811 in 2007 to 8,107 in 2009.

Management of HIV at the community level is still in the reinforcement phase. From 2007 to 2009, more than 510 health service providers and partners at the community level received training in psychosocial support and remedial healthcare.

In 2008, 7,880 people benefited from psychosocial and nutritional support (compared to a target of 6,500). This number went up to 8,107 in 2009, compared to a target of 7,800. This was made possible due to the network of service providers and players at the community level. Relating to the goal of responding to the needs of beneficiaries, several types of income-generating activities have been initiated. Therefore, in 2008, 953 PLWHIV benefited from the activities of micro-gardening and micro-credit that allowed them to meet the costs of their medical care. This number of beneficiaries went up to 1,096 in 2009, compared to a target of 450. However, the problems of transporting them to health centers, the weakness of the nutritional support, and the cost of medications for certain opportunistic infections remain another concern for the beneficiaries.



To fight against the stigmatization and discrimination on the part of PLWHIV, 80 people, including PLWHIV, religious leaders, and service providers benefited in 2008 from orientation sessions on themes relating to the two phenomena, and the program continues in its efforts in training 155 people in 2009.

Reinforcement of monitoring activities (assessment and research) is a major preoccupation of the program. Five annual action plans have been developed and monitored at the national level, five sessions have been organized where players from different regions can share experiences, and three technical assessments in specific domains have been completed with the partners.

Management and coordination of systems have been strengthened at the national and regional levels. In 2008, 35 coordinating entities (the TCR parts of the CRLS and CDLS benefited from a certain amount of support in planning activities, coordination, and data collection; 25 others benefited from this support in 2009.

### *TB Component*

In general, the level of execution of activities financed by USAID/FHI is good. However, it remains weak compared to those activities financed by the other partners of PNT (87% and 66% respectively for the central level and for the regional level in 2008, compared to other sources of finance such as the State at 99.80%, LHL at 99%, IDA at 100% and OMS/OFLOTUB at 99%).

The explanations provided revolve around delays in the reception of funds at the regional level, and the difficulties of understanding and mastering the procedures because of a lack of communication. At the level of the health districts, it is the insufficiency of logistical methods to provide supervision that seems to pose a greater problem. With reference to the three principal objectives specified for 2008, it appears that notable progress has been achieved.

For the screening of at least 70% of anticipated TPM+ cases, 183 radio broadcasts were completed in 2008 at the national and regional level. Three hundred peer educators were created to look for and refer those with a chronic cough. Due to concerns over improvement in the quality of services, three laboratories have benefited from equipment. In addition, 85% of laboratories have succeeded in ensuring the quality of X-ray images, with an efficiency level of 95%. Furthermore, 75% of planned supervisory visits were completed and documented.

For the treatment of at least 85% of those diagnosed with TPM+, 585 service providers in six regions were trained to manage TB/HIV co-infection in 2008. It is anticipated that 200 others will be trained in 2009. The management of TB activities in the health posts will continue, after having involved 30 and then 110 traditional practitioners at the level of health districts. In Dakar, the health center at Pikine arranges its own treatment center which for that matter was restored within the framework of the program—it constitutes a model of success regarding support of TB at the level of the region of Dakar. Home visits also make up one of the most relevant activities conducted by the agents of community health for treating irregular patients and finding again those who had disappeared.

Within the framework of appropriate management of vulnerable groups and of cases of TB/HIV co-infection, 45% of TB/HIV patients have been diagnosed in the treatment centers.

A breakdown of the results shows a net progression of the TB indicators in the six regions of Senegal covered by the program (Dakar, Louga, Thies, Kaffrine, Kaolack, and Kolda) in comparison with the national average.

<b>TABLE I: EVOLUTION OF TB INDICATORS IN THE SIX REGIONS OF THE INTERVENTION PROGRAM</b>							
<b>Indicators</b>	<b>2007</b>		<b>2008</b>		<b>2009</b>		<b>National Average 23%</b>
	<b>Est.</b>	<b>Actual</b>	<b>Est.</b>	<b>Actual</b>	<b>Est.</b>	<b>Actual</b>	
% of TB patients tested for HIV via the U.S. Government's support programs	50%	42%	45%	44.73%	60%	52.87%	44%
% of patients completely treated at the sites supported by the U.S. Government programs	75%	75.75%	79%	75.09%	81%	86.09%	77%

Temporal analysis of the indicators reveals a positive progression of the results between 2007 and 2009. The percentage of TB patients who submitted to an HIV test rose from 42% in 2007 to 52.8%, compared to an estimated national average of 44%. During that period, the percentage of patients completely treated at the sites supported by U.S. Government programs went up from 75.75% to 86.9%, compared to a national average of 77%. Even more than the positive progression noted in the evolution of the indicators, it is important to point out that the indicators and results obtained at the sites supported by U.S. Government programs are better than the national average. The results obtained are also very close to the forecasts; this indicates the high quality of the work completed by FHI at the time of planning and implementation of the program. The success of the treatments is especially reassuring. These results are linked to the efforts made in training, monitoring, and supervision at the central and regional levels, but also to the decentralization of TB treatments and to the improvements in referencing and the strategies of monitoring TB patients.

**Principal Contributions to National Response**

One of the key contributions of the HIV/AIDS and TB programs in Senegal has been the support of the implementation of a multi-sectoral approach. The approach is based on support for vulnerable groups at high risk, the reinforcement of the capacities of medical personnel, the promoters, and community-based organizations. Furthermore, the institutional and administrative support to partners and the collaboration with the players of the national health system have been determining factors. In terms of the involvement of beneficiaries in the process, it is admittedly pointed out that the participation of target groups next to key players created a synergy which served to raise awareness of the advance of HIV and TB and to take adequate action such as the strategic national plan of the CNLS, and the strategic plans of the PNT and the PLWHIV associations.

*HIV/AIDS Component*

An annual plan of work is provided after the multi-sectoral planning meeting at the district and regional levels. It is the only plan used by those responsible for the management of the program to implement the activities. The essential activities are implemented consistently with the deadlines of the program's schedule. The good organization in the TCR and regional offices as well as the good performance of certain AIDS groups at the district level has allowed regular monitoring of activities and the taking of corrective measures when necessary.

In general, the collaboration and engagement of the players has allowed the realization of the anticipated results and planned objectives. FHI listed seven principal indicators in the five-year

workplan of 2006. For the first two years of the implementation of the Letters of Agreement, FHI provided a report on the results achieved to the complete satisfaction of USAID. In the course of the third year, FHI suggested a certain number of revisions while taking into consideration a variety of factors.

All of the planned results have been achieved within the timeframes initially forecast, thanks to good planning of the implementation process. This has been made possible because of the contribution of all the partners. The inter-institutional structures are large enough to allow efficient implementation of the project. The design of the program has facilitated the access of beneficiaries to services. The strengthening of the capacities of the implementation partners and the provision of services has been made possible thanks to relevant and concerted planning with the players. The beneficiaries have played a key role in the implementation of activities due to active promotion and support provided by the project management team.

### *TB Component*

Within the framework of the national response to TB, the program has assumed a model of intervention allowing it to be conducted at the macro or national level, at the intermediate level, and at the micro or peripheral level. The implementation of this strategy has been expressed by involving different levels of players in the process of planning and implementing interventions. It has also necessitated the specification of packages of support activities, reinforcement, sensitization, and advocacy relating to different levels in the supply chain of services in the fight against TB. The consideration of different levels of players has allowed the planning and conduction of activities specific to different components and scales of intervention.

**At the macro or national level:** The program set in place has allowed reinforcement of the capacity of the PNT through supervision, training, communication, and logistical maintenance. The institutional reinforcement of the laboratory network, including the reference laboratory, has been a milestone.

Support and technical assistance are provided for a pilot program to improve the quality of services and activities implemented. The program started in Mbao with the collaboration of the national quality program and the organization Intrahealth. This pilot project showed positive results with the improvement of seven indicators (rate of TB treatment, proportion of TB patients who have disappeared, proportion of TB patients tested for HIV, proportion of TB patients having undergone three bacteriological examinations, proportion of patients under daily DOT treatment, proportion of TB patients who started treatment the day the diagnosis was made, and patients with a chronic cough who had their first sampling within 24 hours). This pilot project has great potential in terms of continuity and a potential for replication on a large scale for the national program. It also has great potential to be applied to other health components such as reproductive health and immunization.

**At the intermediate level:** The institutional organization at this level is not as well-structured as the multi-sectoral program for the fight against HIV/AIDS. The emphasis is put on the regions and districts with a particular stress on diagnosis and treatment. The treatment and healthcare units are adequate and enjoy a good level of decentralization. The system of data and information management is built around the national system.

**At the micro or community level:** The emphasis was placed on sensitization, educational activities, detection of suspected cases, and references for diagnostic tests. One notes also a certain focus on the abandonment of treatments and DOTs. The implementation of nutritional support activities based on community meals and nutrition kits, conducted in collaboration with CPI, has been very much appreciated at the community level and deserves to be reinforced. FHI involved itself in the community mobilization, which makes up an important part of the fight

against TB. This allows a guarantee of direct community involvement, improves the rate of detection, and ensures continuity and success in the treatments. The community mobilization is conducted by three NGOs in five regions. Other community-based activities are supported by the Ministry of Health at the health district level. They include, among others, reinforcement of the capacities of the community health players for monitoring TB patients, and sensitization at the community level. Through the activities conducted around 623 health huts by ChildFund, 804 ASCs shifts, matrons, health committee members, and parents and friends of the ill were trained in directly observed treatment (DOT) of the TB patients in 2009. During the same year, 309 suspected cases were directed toward the health structures by the community players for checks, and 172 (55.6%) were confirmed positive. All the patients confirmed positive benefited from counseling. Eleven hundred twenty-five new cases were monitored during the third year of implementation of intervention. Eight hundred five people (347 women and 458 men) have been trained in DOT. Thirty-three patient support units and four community associations for the fight against TB have performed regularly during the whole of 2009.

### **Achievement of Anticipated Results**

Since their implementation, USAID/Senegal's HIV/AIDS and TB programs have achieved encouraging results. The indicators reveal that 87% of TB patients benefiting from support have completed their treatment in regions benefiting from U.S. Government support. In these same locations, 10,964 individuals have visited the CDV services and have received their results. The indicators relating to the execution of activities show a good level of progression with reference to the objectives (see Table II).

However, the beneficiaries and those responsible for management of the program have underlined a certain number of major constraints likely to delay or limit achievement of the overall results at the end of the program if adjustments and revisions are not applied. The main bottlenecks center around three points.

**Exchange rate volatility:** Most of the partners have underlined delays in the achievement of certain results because of problems linked to exchange rate volatility in 2008. If a solution is not found, the persistence of this situation could prejudice achievement of the overall results of the program. In response to the risks posed by the variations in the exchange rate, FHI has suggested to certain partners that they explore alternatives. Certain activities have been reduced and others planned again (USAID/FHI Annual Report 2008).

**Availability of financial resources at the operational level:** By leveraging the Letters of Agreement, financial resources have been made available at the level of the DLSI, the PNT, and the medical regions. The sub-contracts with the NGOs and the CBOs are conducted at the community level. On receiving funds, the medical region is responsible for redistributing financial resources to different districts. The transfer of funds takes into account an outstanding balance regarding financial demands and takes into consideration the unspent or no longer justified balance of the previous quarter. The medical region guarantees the monitoring of monthly expenditures. The regional office of USAID's health program is responsible for justifying expenditures submitted by the approval of expenses not subject to objection by the DLSI or the PNT.

The transfer of funds to beneficiaries under contract is made through the banking system to the accounts belonging to the medical regions and dedicated exclusively to the reception of FHI funds. However, owing to delays linked to the consignments of supporting documents on the part of the districts, or the consignment of funds on the part of managers of the medical region, this procedure presents a certain number of problems for the players.

**Monitoring activities:** It follows that monitoring of visits conducted in the four medical regions and health centers is not guaranteed as often as originally planned. The staff have underlined for special consideration a logistical problem—a lack of bicycles, motorcycles, and other vehicles. In the regions of Kedougou, Kaolack, and Kolda, it is very difficult to conduct monitoring activities because of the isolation of the populations, the difficulties of transport, and the fact that this is a state lacking in roads and tracks. This has especially limited the search for those who have disappeared and the referencing recourse to people screened under mobile strategies at the peripheral level.

<b>TABLE II: EVOLUTION OF INDICATORS</b>						
<b>Indicator</b>	<b>2007 Data</b>		<b>2008 Data</b>		<b>2009 Data</b>	
	<b>Target</b>	<b>Actual</b>	<b>Target</b>	<b>Actual</b>	<b>Target</b>	<b>Actual FY 2009</b>
Number of individuals reached through community outreach for HIV prevention beyond abstinence	53,650	53,550	54,000	70,224	60,000	56,229
Number of medical consultations for sex workers and MSM					1,840	1,992
Sex workers					1,240	1,512
MSM					600	692
Number of consultations during which STIs were diagnosed					781	460
Sex workers					581	425
MSM					200	35
Number of individuals who received counseling and testing for HIV and who received their test results	28,208	35,970	35,000	39,775	42,000	44,670
Number of individuals provided with HIV-related palliative care	2,096	4,811	6,500	7,880	7,800	8,107
% of all TB patients who are tested for HIV through U.S. Government-supported programs	50%	32%	45%	44.73%	60%	52,87

<b>TABLE II: EVOLUTION OF INDICATORS</b>						
<b>Indicator</b>	<b>2007 Data</b>		<b>2008 Data</b>		<b>2009 Data</b>	
	<b>Target</b>	<b>Actual</b>	<b>Target</b>	<b>Actual</b>	<b>Target</b>	<b>Actual FY 2009</b>
% of patients who were cured and completed treatment in U.S. Government-supported sites	75%	75.75%	79%	75.09%	81%	86,09

### **Contribution to Fight against Stigmatization and Discrimination**

In terms of perception, the partners describe USAID as an important player that has played a key role in the fight against discrimination and stigmatization to which the MSM, SWs, and PLWHIV are exposed. However, the PLWHIV require greater support for their families, and the only development at the level of their respective associations is not enough for them to integrate well into the community. With regard to the MSM, it remains to point out that society is not yet ready to accept their behavior. Cultural changes are slow and must be managed with care.

Through certain NGOs, the program is in the middle of coming to grips with a whole host of sociocultural problems. Vulnerable groups are organized into associations to take part in the response. However, the main worry is the visibility of the MSM who have not been accepted well by the local population. Sensitization and advocacy campaigns have not reached the general population which, moreover, does not understand “the phenomenal promotion of MSM.”

To fight against the stigmatization and discrimination of PLWHIV, 80 people, including PLWHIV, religious leaders, and healthcare providers, benefited in 2008 from orientation sessions on themes relating to the two phenomena, and the program continued its efforts by having trained 155 people in 2009.

Some of the strategies relating to the fight against stigmatization and discrimination include reinforcement of the capacities of organizations of vulnerable groups, implementation of continuing healthcare with ACI, and integration with national policies. The forum of partners is in the process of creating a favorable environment through the establishment of committees of vigilance and alertness with participation from NGOs, traditional leaders, lawyers, delegates, experts, and vulnerable groups.

### **Multi-disciplinary Activities to Consider if Resources Are Made Available**

Due to the insufficiency of multi-disciplinary activities, the areas of priority that would benefit from reinforcement (should USAID manage to deploy additional resources to the HIV/TB program) are:

- Reinforcement of the management capacities of departments central to the national TB program.
- Reinforcement of the capacities of services to increase the rate of detection of cases of contagious TB, and training of staff, healthcare providers, and community agents for whom a training module has been designed.
- Reinforcement of the capacities of treatment units with a view to improving the rate of successful treatments and confirmation of TB cases.

- Reinforcement of a network of laboratories for diagnosis from the central laboratory to the level of district laboratories through support in the form of equipment and consumables.
- Development of combined strategies for the treatment of TB/HIV co-infection for treatment units in six main regions.
- Decentralization of TB and HIV treatments at the level of health posts by training the head of mission nurses, regularly monitoring patients undergoing treatment, and regularly planning laboratory tests.
- Promotion of community participation in the fight against TB through an active search for those with a chronic cough and their referencing to the health system for diagnosis and treatment, the direct observation of treatment (DOT), the active search for those who have disappeared (for treatment purposes), etc.
- Contribution to the implementation of the national policy of support for multi-drug resistant TB, which has been prepared with the support of FHI.
- Reinforcement of the healthcare system, especially the system of information relating to preventive and remedial activities concerning TB and HIV at the national and regional levels, with particular emphasis on the operational level that constitutes the district level.
- Reinforcement of the strategic management capacity of CTRs for better coordination and planning of activities at the regional level.
- Reinforcement of activities in a new project to improve the quality at Mbao and expand into other regions.
- Support of a pilot project to be launched in Kaolack and inclusion of TB in the portfolio of activities.

## **MERITS OF PROPOSED APPROACHES**

### **Coordination with BM and FM Projects**

The existence of a network of coordination at all levels has created a high level of coordination with financial activities within the framework of projects of the World Bank and the Global Fund, especially at the level of the technical secretariat of the CCM with a good representation from USAID. This coordination has also been facilitated by a planning approach that climbs from the base to the summit, from the POCL and passing the district PTAs and the PRIMs.

The new PRIME approach is multi-sectoral planning based on a bottom-up approach to guarantee harmonization of activities while taking account of real and specific needs. It was put in place to ensure complementarity between financial activities by the different donors, and it falls within the framework of rationalization of resources.

The pilot committee of USAID's health program, directed by the Secretary General of the Ministry of Health, organizes two annual meetings. It constitutes a platform for the exchange of ideas between the partners and the donors. In addition to monthly and quarterly meetings, FHI has established a committee that meets each month to examine strategies with the partners. The interim assessments are also occasions for appraisal and harmonization of interventions.

## **Effectiveness of Collaboration with Other Partners**

The committee for policy reform piloted by Abt Associates has been a good tool for strengthening coordination. The collaboration with other partners such as ChildFund, Abt, DOD, the Peace Corps, and the CDC has been shown to be very effective.

The activities are currently more strategic with a focus on the problems of quality. This is made through a pilot project in Mbao in partnership with the National Quality Program (PNQ) under the coordination of Abt to ensure a high level of cohesion and complementarity between the various support activities conducted by the USAID agencies. The participatory assessments of interventions are made to provide strategies for vulnerable groups at high risk, and the experience-sharing sessions are organized at the operational and central levels to examine the lessons learned as well as best practices. On the basis of previous results and successes, monitoring and evaluation (M&E) activities and management and coordination support are maintained by the CTRs. In addition to M&E specialists from the regional offices, the partners are used to provide substantial support at the strategic level.

The pilot program, “The initiative to improve the financial accessibility of the PLWHIV to treatments of opportunistic infections and laboratory tests,” is another major innovation. Before the establishment of the pilot initiative, access to ARV was free in Kaolack, but laboratory tests and treatment of opportunistic infections were not. The recurring costs of these two services constitute a major concern for PLWHIV in the sense that they considerably reduce their purchasing power and have a negative effect on other needs such as nutrition, education of children, etc. The majority of PLWHIV come from poor social classes, and the pilot project is aimed at contributing to raising their socioeconomic level. If scaled up, this could be a powerful lever to strengthen the fight against HIV and TB.

This strategic partnership is excellent. It constitutes a very good model that allows reinforcement of the collaboration between the Ministry of Health and two USAID cooperative agencies (FHI and Abt, which have succeeded in applying their comparative advantage in common) and other players in the fight against HIV/AIDS. This model of partnership contributes to ensure three major elements: reduction of the costs of medical healthcare through mutual communities, easy access to micro-credit to develop income-generating activities (IGA), and reinforcement of capacities for the performance of such activities. The initiative also contributes to raising the responsibility and capacity of PLWHIV to assume the costs of their own healthcare and heightens improvement of their economic level. The monitoring mechanism has been well thought out and could direct the implementation and the expansion.

## **Links with State, Private Organizations, and Civil Society**

Those responsible for management of the program have established a solid link with governmental agencies and civil society organizations with which periodic meetings are arranged to examine collaboration and its results. FHI has also developed a partnership with the Ministry of Health and various NGOs.

USAID/FHI supports the national HIV/TB program at the national level. It also works in conjunction with the Ministry of Health to develop and implement policies against discrimination and stigmatization of PLWHIV in the population and health sectors.

There are meetings, termed “interim reviews,” during which the players examine the program. There are also annual meetings which assemble the players and the community of donors. The key players (PNT, DLSI, CTA, CNLS) are heavily involved in the program and therefore benefit from the experience of USAID and the NGOs. The partnership with the Ministry of Health has also been reinforced, thanks to FHI’s experience in the areas of prevention of HIV/AIDS and TB.



## **Validity of Intervention Strategies after 36 Months of Implementation**

The interventions are still valid. However, it is necessary to focus on new strategies (regrouping of activities, concentration on quality) in order to consolidate the program and the activities at all levels. The interventions are large and must not be expanded without prior consolidation.

However, new strategies for 2010–2011 must be developed, such as the selection of partners based on criteria that are central to performance, quality control, efficient monitoring, and the regrouping and durability of activities. Furthermore, it will be necessary to reposition the interventions while favoring a concentration in the regions that require more attention—Kedougou, Kolda, and Ziguinchor—and the development of an FHI niche for the support of women.

## **MERITS OF OVERALL MANAGEMENT**

### **The most Important Practicalities of Management**

**Strengthening of partners:** The overall management of the program is well-organized. The partners are well-trained and benefit from support through reinforcement of capacities on the part of FHI personnel. The coordination, management, and financial arrangements are clear and contribute to supporting institutional reinforcement and national suitability. A powerful network of partners and players at the central level, as well as at the operational level, participates actively in the implementation of activities.

FHI is represented in the regional offices in Thies and Kolda and has recently posted a new agent at the level of the new region of Kedougou. The regional office teams work in close collaboration with the teams from the medical region and the health district (MCR, MCD, EPS, etc.) and participate in activities of planning, observation, review, and coordination meetings for monitoring, data collection, and analysis which constitute the foundation of the quarterly reports. The regional offices work closely with the NGOs and the CBOs to which FHI has subcontracted the implementation of activities. Within the regions of intervention, the program has installed a coordinator mandated to implement the activities. Monitoring is generally conducted on a monthly or quarterly basis by the CBOs or promoters trained for the purpose.

**Coordination:** Within the goal of coordinating the program with the partners, FHI has created several committees, including a steering committee for interim reviews with a system of meeting monthly or quarterly. FHI's central team in Dakar has established close collaboration with the CNLS, the DLSI, and the national TB program.

**Letters of Agreement:** At the national level, the partners are required to sign partnership agreements called “Letters of Agreement” in order to receive funds for the program.

FHI works with the partners through Letters of Agreement which specify the activities to be implemented, detailed budgets, timeframes for completion, and objectives. This type of set-up is defined and seen as a very good innovation. The Letters of Agreement are made official with the DLSI, the national TB program, the medical regions within the areas of intervention, and the district health centers. To complement these, subcontracts are signed with the NGOs. Apart from these subcontracts, the NGOs subcontract with community-based organizations and some beneficiary associations for the implementation of activities. The annual contracts with the organizations charged with the implementation are based on their comparative advantage. The goal was to put in place a mechanism which could aid in achieving the anticipated results and also strengthen the entire system by making the national response more lasting.

## Effectiveness of Practicalities

USAID/FHI provides technical and financial assistance to the national program and conforms completely with the strategic national plans of the HIV/PNMLS and the PNT. FHI is using the strategic objectives of the PNMLS and the PNT from 2007 to 2011 as a framework for its work on annual action plans. The program conforms perfectly with its original target group which is vulnerable groups at high risk, such as truck drivers, hauliers (persons or firms that transports goods by truck), fishermen, sex workers, MSM, and PLWHIV. Furthermore, the program is well-integrated into both the healthcare structures and poor communities with high population densities.

The design of the program is very efficient. Currently, the program is feasible and very flexible. Some adjustments have been applied at different moments in the project cycle, such as the revision of Letters of Proposal selected for cooperation agreements between FHI and USAID. In February 2006 certain results proposed in the five-year workplan were readjusted to make the objectives more realistic.

In terms of achieving the results, analysis of the differences shows very positive results for the period 2007–2008. In the majority of cases the actual results of the program have exceeded the anticipated results (see Table III).

<b>TABLE III: HIV/AIDS INDICATORS—ACTUAL RESULTS VS OBJECTIVES</b>						
<b>Indicator</b>	<b>2007 Data</b>			<b>2008 Data</b>		
	<b>Target</b>	<b>Actual</b>	<b>Difference</b>	<b>Target</b>	<b>Actual</b>	<b>Difference</b>
Number of individuals reached through community outreach for HIV prevention beyond abstinence	53,650	53,550	-100	54,000	70,224	+16,222
Number of individuals who received counseling and testing for HIV and who received their test results	28,208	35,970	+ 7762	35,000	39,775	+4775
Number of individuals provided with HIV-related palliative care	2,096	4,811	+2715	6,500	7,880	+1380
% of all TB patients who are tested for HIV through U.S. Government-supported programs	50%	32%	-18% points	45%	44.73%	- 0.27% points
% of patients who were cured and completed treatment in U.S. Government-supported sites	75%	75.75 %	-0.75% points	79%	75.09%	- 4.09% points

These results were obtained thanks to a combination of rigorous selection of partners, reinforcement of partners' capacities, the search for synergies with other intervening bodies, the articulation of interventions with national programs, etc. The set-up of the program and

adjustments applied during the course of the implementation have also played a major role in the achievement of these results.

Four key points merit consideration:

**Flexibility in the financing of activities:** The partner NGOs have a fair amount of flexibility in the financing of activities. They are allowed to finance certain planned activities in advance and to receive reimbursement. Quarterly monitoring allows for a good balance between cost and effectiveness in the implementation of activities. Resources are managed in a transparent and efficient manner. This transparency of management encourages the partners to anticipate necessary expenses according to clearly defined procedures and methods, and helps ensure continuity of activities.

The partners have made an important effort in their financial execution in order to maintain the level of activities. Table IV shows a healthy development of the disbursement rate, with an especially positive variation of 81% to 84% for FHI's partners between 2007 and 2008 (see Table IV).

<b>TABLE IV: DEVELOPMENT AND LEVEL OF EXECUTION OF THE BUDGET IN THE OVERALL PROGRAM<sup>1</sup></b>									
	<b>FY 2007</b>			<b>FY 2008</b>			<b>FY 2009</b>		
	Budget	Executed	TE	Budget	Executed	TE	Budget	Executed*	TE*
Contractual	\$1,712,579	\$1,285,012	81%	\$2,211,176	\$1,862,797	84%	\$2,225,000	\$1,759,924	76%
FHI	\$1,352,421	\$1,319,921	98%	\$1,934,590	\$1,731,190	90%	\$1,573,000	\$1,398,137	89%
Total	\$3,065,000	\$2,604,933	85%	\$4,145,766	\$3,593,987	87%	\$3,798,000	\$3,158,061	83%

Flexibility in financing has allowed a very good execution rate for the program. However, it is important to point out that the financing of activities in advance is an alternative to which not all partners have recourse. Partners such as ENDA Graf, AWA, AIDS SERVICE, and CRS have achieved a rate of budgetary execution close to 90% in 2007 and 2009, while others such as the PNT maintain a rate of budgetary execution that varies between 50% and 60% (see Table V).

<b>TABLE V: DEVELOPMENT OF BUDGET OF PARTNERS CHARGED WITH IMPLEMENTATION<sup>2</sup></b>									
	<b>FY 2007</b>			<b>FY 2008</b>			<b>FY 2009</b>		
Strategic Partners Charged with Implementation	FY 2007 Budget	Executed	TE	FY 2008 Budget	Executed	TE	FY 2009 Budget	Executed*	TE*
ACI	\$100,006	\$62,815	63%	184,378	\$157,097	85%	\$150,000	\$113,478	76%
ANCS	\$148,593	\$122,566	82%	195,000	\$187,952	96%	\$150,000	\$120,067	80%

<sup>1</sup> Data for the period 10/01/2008 to 08/31/2009.

<sup>2</sup> Data for the period: 10/01/2008 to 08/31/2009.

**TABLE V: DEVELOPMENT OF BUDGET OF PARTNERS CHARGED WITH IMPLEMENTATION<sup>2</sup>**

Strategic Partners Charged with Implementation	FY 2007			FY 2008			FY 2009		
	FY 2007 Budget	Executed	TE	FY 2008 Budget	Executed	TE	FY 2009 Budget	Executed*	TE*
AWA	\$100,000	\$100,482	100%	120,000	\$114,193	95%	\$110,000	\$71,813	67%
CPI	\$174,952	\$99,352	57%	230,000	\$200,213	87%	\$200,000	\$155,057	78%
CRS	\$169,998	\$144,061	85%	180,000	\$173,607	96%	\$135,000	\$100,747	75%
CTA	\$87,339	\$73,644	84%	95,505	\$83,937	88%	\$85,000	\$82,050	100%
DLSI	\$309,000	\$270,784	88%	388,634	\$326,097	84%	\$385,000	\$397,051	86%
ENDA GRAF	\$65,000	\$68,131	105%	75,000	\$66,020	88%	\$70,000	\$64,491	92%
ENDA SANTE	\$70,042	\$48,450	69%	120,018	\$99,434	83%	\$120,000	\$98,416	82%
PNT	\$249,932	\$124,687	50%	352,572	\$245,127	70%	\$400,000	\$239,689	59%
AIDS SERVICE	\$90,028	\$93,714	104%	130,040	\$118,819	91%	\$110,000	\$72,947	66%
SYNERGIE	\$75,404	\$63,311	84%	89,292	\$83,103	93%	\$115,000	\$76,250	66%
SWAA							\$50,000	\$35,966	72%

**Decentralization of support:** The regional offices are an excellent initiative of the program. They represent a form of decentralization to assimilate further the program of the beneficiaries.

The teams in the regional offices are also mandated to monitor the activities of the institutional beneficiaries. They ensure the monitoring and reinforcement of capacities and make up a solid link between the players on the ground in regions and districts and FHI in Dakar. This collaboration between the teams from the regional offices and the partners of FHI, for the purposes of exchanging information and monitoring implementation of activities, is seen as very positive. Because of this, all of the problems and concerns of the partners are rapidly transmitted to FHI in Dakar which tries to handle them and give responses and apply solutions as quickly as possible. The regional teams are in direct contact with the regional offices, TRC, CRLS, and AIDS Pool, and have established a link between the community-based organizations (CBOs) and the governmental bodies.

The mechanism of management functions very well. However, a certain number of constraints have been pointed out:

- There is a delay each year in the commencement of activities because the Letters of Agreement are renewed on an annual basis. The Letters of Agreement are no longer renewed until mid-October (the period of assessment).
- USAID's financial year (October to September) does not coincide with Senegal's financial year (January to December), which has created problems and gives the impression that the duration of contracts is less than a calendar year. It has been advised to proceed on biannual contracts.

- The level of financing predefined for activities does not take into account fluctuations in the U.S. dollar. This situation has created a bottleneck for the NGO partners charged with implementation of activities.
- The activities submitted in FHI's financial tenders as well as the subcontracts are specified in local currency (CFA Franc). The amounts are converted into U.S. dollars at the time of approval and reconverted into CFA Francs when the funds are disbursed. The fluctuations of the U.S. dollar and the effect on the variations in the exchange rate lead to significant losses and gains likely to have a positive or negative effect on activities. The partners suggest that the contracts be signed off in local currency with a commitment by FHI to cover or manage the effects and costs of fluctuations in the exchange rate.
- The management teams at the district level have complained about delays involved in the reception of funds for the financing of activities since the funds first pass through the medical region before being transferred to the operational level. It has been suggested to proceed with direct transfers to the districts with official notification to the medical regions. This seems difficult, but a discussion must take place on this question in order to find the arrangements and agreements necessary to reduce the time taken to deploy funds to the districts. One solution could be to have periodic requests for financing activities on a half-yearly basis or direct involvement by the regional offices in the process.
- Taking into account the large number of subcontractors, the funds that the beneficiaries receive are very small. It is necessary to consider seriously a mechanism of direct finance of the CBOs that have been strengthened to conduct activities and manage finances (e.g., KEOH in Kedougou has been significantly reinforced by ACI and is ready to act independently in much the same way as the group of women trained by SWAA in Kolda).

### **Necessary Changes**

In spite of difficulties, the partners have achieved their objectives. However, there remain three areas requiring attention:

**Reinforcement of monitoring at the regional level:** The regional teams play a key role in monitoring the implementation of activities, and they need to be made stronger on the tasks of management as well as M&E activities. They need to be equipped logistically to perform a job that will allow them to achieve better results more efficiently. The regional office in Kedougou was new and required greater attention in terms of logistics, even more so because it is in a difficult geographical zone with high risk populations, especially at the level of the mining areas.

**Grouping and consolidation of activities currently judged sparse:** The activities are scattered about geographically and the number of partners is ever-increasing. It is essential to consolidate gains. Such an orientation requires more concentration on the covered zones in order to achieve a more noticeable impact on the beneficiaries, but also to ensure a certain continuity of intervention. This must be accompanied by a renewal of interest and emphasis on quality through a more effective collaboration with the National Quality Program (PNQ). The PNQ is in charge of specifying strategies to improve the quality of services under the direct tutelage of the Ministry of Health, including a mandate to provide assistance to all components and programs of the Ministry of Health.

**Improvement of the financial mechanism:** The availability and volume of financial resources constitutes a fundamental input to the implementation of activities. It is imperative to find lasting solutions to obstacles concerning: (i) the effects of the fluctuating exchange rate on the conduct of activities; (ii) the transfers and access of the operational levels to funds as well as the financial

reporting system between the peripheral level and FHI; and (iii) the allocation of additional resources to the TB program, which will result in better consolidation of gains.

With regard to the transfers of funds earmarked for the operational level, it has transpired that it is necessary to favor the pilot method<sup>3</sup> which allows avoidance of delays and leads toward a decentralization of the management of funds after these activities. The management of quarterly transfers allows avoidance of delays at all levels.

Furthermore, the design of requests and reporting are seen as excess work for the players who are already overwhelmed by the execution of several programs at standard regional levels.

Outside these three major areas, it is imperative to find solutions or alternatives to the bottlenecks noted in the management of the program, in order to guarantee achievement of results and an impact that is strongly appreciated by the beneficiaries. Above all it is necessary to:

- Reconsider the number of partners mandated with implementation and specify criteria for selection while prioritizing performances (according to well-defined indicators), quality control (to the satisfaction of the beneficiaries), an efficient monitoring (observation/assessment), and the capacity to diversify financial resources.
- Consider subcontracting directly with those CBOs which have proved to be the most experienced at implementing activities under the direct supervision of regional offices.
- Put in place a “task force” to examine and identify different financial channels for the regions, districts, and CBOs, and decide on the most appropriate method and channel.
- Consider the feasibility of a contractual scheme (Letters of Agreement) established on a biennial basis (every two years), with monitoring coming closer to the rate of usage of funds (budget execution rate).

## **COVERAGE AND RESPONSE OF BENEFICIARIES**

### **Coverage of Targets**

The initial objective set for the MARPs in 2011 was difficult to achieve. This is why it was revised to 275,000 after two years of implementation. Several civil society organizations work with target groups—Enda Santé, AWA, Inter-Worlds, KEOH, and SWAA.

The program has succeeded in conducting scheduled activities and facilitating access to services by the beneficiaries up to the point of expanding its intervention in Kedougou. The FHI program has contributed to the decentralization of TB treatments at the peripheral level and has shown improvements in the strategies of referencing and monitoring of patients. The beneficiaries are well-sensitized and well-organized, as witnessed by the development of micro-gardening activities by the PLWHIV associations, and the development of self-esteem.

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<sup>3</sup> Until 2008, the activities of each Letter of Agreement were financed directly by FHI on the basis of a request sent to the medical regions (standard mechanism), in accordance with USAID regulations which did not authorize the advance of funds delivered to governmental partners. Faced with an increased budget allocated to local authorities (approx. 177,832,805 CFA Francs in 2009, compared to 122,976,479 CFA Francs in 2008), USAID accepted the establishment of another mechanism (pilot), which made an exception to this regulation by allowing medical regions to receive funds in advance based on quarterly planning.

However, two major problems should be noted: (i) the nutritional kits given free to beneficiaries are not provided as regularly as wished, and (ii) the PLWHIV, SWs, and MSM continue to hide their status from their families for fear of being rejected, which contributes greatly to limiting their self-integration into society. A reinforcement of capacities of vulnerable groups was put in place, but it remains inadequate. Furthermore, vulnerable groups wish to develop income-generating activities or have access to micro-credit initiatives and opportunities. In general, there is a need to reinforce capacities at the level of beneficiaries, particularly for women. Due to the lack of resources for their subsistence, the underground SWs generally show that they are unable to cease their activities or even to use condoms regularly. This is corroborated by assessment of interventions for vulnerable groups.

**Reinforcement of public, private, and civil society organizations:** The program has essentially concentrated its interventions on high-risk vulnerable groups. Resources are put at the disposal of communities, NGO partners, the public health system, and programs at the central level.

**Reinforcement of players at the community level:** At the community level, FHI works with 11 NGOs in the area of sensitization, education, medical coverage, and activities that strengthen competencies aimed directly at beneficiaries and players. In the annual contracts signed with FHI, each NGO proposes and specifies its target population, the areas of intervention, and the contributions, together with objectives to be achieved. The partners traditionally involved in activities related to control of HIV have started to incorporate the TB dimension into their target groups. FHI provides them with technical assistance according to their needs and in terms of their adherence to national policy with regard to their messages, targets, and strategies. This is greatly appreciated by the NGOs. Furthermore, the two regional offices of USAID assist the partners in reinforcing their collaboration with the health districts.

**Reinforcement of the public health system:** FHI supports the availability and quality of HIV and TB services offered by the public health bodies through the national HIV and TB program implemented by the Ministry of Health. FHI provides a range of support activities, including: (i) personnel support; (ii) training sessions; (iii) observation visits; (iv) equipment for HIV screening centers and bodies; (v) STI diagnoses and treatments; and (vi) HIV and TB management. FHI also supports the decentralization of these services through peripheral structures in accordance with the National Policy of the Ministry of Health. The resources are allocated within the framework of the Letters of Agreement through the DLSI and PNT to enable the direct financing of activities conducted at the level of medical regions. These bodies also benefit from support provided by other partners, which creates a certain complementarity.

**Reinforcement of national programs at the central level:** At the central and regional level, FHI supports the implementation of activities aimed at strengthening the intervention coordination mechanism, and at reinforcing and ensuring the monitoring of HIV and TB programs. All of the regional authorities (CRLS, TCRs, AIDS Pool, etc.) are regularly supported in their coordination, monitoring, and assessment of activities. The financing of staff is covered by certain strategic posts such as the logistical management of medications in order to avoid losses and running out of stock. On this point, the management of activities relating to the HIV component is superior to those relating to the TB component which demands greater assistance, especially in terms of strengthening capacities in the transfer of market and in product quality control.

## **CONTINUITY**

The program is economically viable because the services are supported by the national programs and by various partners who have all honored their financial commitments. At the end of the program, the services must be more affordable for the beneficiaries. However, the

program managers must continue to reinforce the capacities of the target groups and the principal institutions before placing them in a position enabling them to support and maintain their gains.

### **Obstacles to Overcome in Order to Achieve Desired Results**

The results of the program are highly relevant and deserve to be maintained. However, it is important to point out that the key partners at the national level such as the World Bank and LHL are in the process of closing down their programs, leaving a vacuum to fill for HIV/AIDS and TB. It is recommended to:

- Appeal for a new program from the World Bank.
- Increase the TB budget in order to: (i) fill the void left by LHL and consolidate current activities, and (ii) consolidate and expand the program of improvement of quality in collaboration with the National Quality Program (NQP).
- Implement a pilot project in Kaolack.
- Reinforce the nutritional component of the TB program through a strategic partnership.
- Place a much stronger emphasis on TB/HIV integration.
- Reinforce mobile strategies with sufficient logistical methods.
- Place a much stronger emphasis on BCC activities by establishing appropriate communication tools.

### **Letters of Agreement and Intervention Approaches that Favor Durability**

The Letters of Agreement are good tools to control the process of implementation and to specify services that are appropriate and adapted to the needs of populations. The roll-out of activities in the fight against HIV/AIDS and TB through a Letter of Agreement between the medical region and the district is a unique form of contract between medical regions and health districts. It has, in effect, brought remarkable innovations to the fight against HIV/AIDS at the level of the medical regions concerned and contributes to the continuity of actions. A certain number of gains likely to contribute to the continuity of interventions and to strengthen the impact have been identified. They include, among others:

**Decentralization of activities:** Before 2004, activities were all concentrated at the level of the capital of the region (the hospital or health center). Little by little, as the Ministry of Health supported the effective integration of HIV/AIDS services in all of the health districts, the operational level with regard to Letters of Agreement was not limited to the region, but was also concerned with all of the districts. This decentralization has led to a support closer to AIDS patients who were obliged to move to Dakar. The health districts, inasmuch as they had been responsible at the operational level, increased their volume of activities significantly and focused the activities more on the real demands of TB and HIV.

**Better guidelines for role of players:** The roles of players are clearly identified through the documentation signed between FHI and the DLSI or PNT on one side, and between the DLSI or PNT with the medical region on the other side. The DLSI and PNT are more visible in the strategic orientation of health policies and programs and in the monitoring of activities; the medical region serves as their go-between at the regional level for monitoring that is closer to the planning of activities and their implementation, financing, and supervision.

**Direct involvement of medical region in all activities linked to HIV and TB:** The medical region has become the authority for all work representing activities at the regional level within



the framework of the Letter of Agreement. The central level is limited in the control, supervision, and monitoring assessment of activities.

***Matching and integrated planning of activities in the fight against HIV and TB:*** The Letter of Agreement has systemized the combined support of HIV and TB in the majority of health districts, which, in the opinion of the players met, is a major act that allows for development of a package of healthcare, not merely separate care services. With regard to psychosocial and community support, this teaming up has had a considerable impact on the management of patients.

***Reinforcement of the volume of HIV and TB activities:*** The Letter of Agreement has contributed to improving activities at the regional and health district levels right up to the level of health posts. The rate of support for HIV and TB patients, the voluntary screening rates for HIV and TB, and the TB recovery rate have been considerably improved.

***Reinforcement of framework of community intervention:*** There has been greater collaboration with the CBOs in community-based activities such as sensitization, communication, the search for patients who have “disappeared,” and improvement in the psychosocial support of patients. Specific activities, such as the training of traditional practitioners in the diagnosis of TB, have been conducted in certain health districts in order to increase the number of TB patients that are directed to available health care options.

***Reinforcement of technical capacities of service providers:*** The most frequent training of service providers has been deemed an innovation, and the reinforcement of the technical capacities of service providers has been much improved with the implementation of the Letter of Agreement.

***Improvement in financial process and volume of financing:*** The financial process introduced by the Letter of Agreement is the first of its kind in that it puts the operational level at the heart of the arrangement process (planning of activities) and of the financial implementation. The funds demanded by the medical region for financing activities in the districts are paid into a separate account from that of the treasury. This money is, in turn, apportioned at the district level according to a procedure that is well-defined but quite flexible through its connection to procedures in force in public finances.

Even if it still largely falls short of what is needed, the Letter of Agreement has contributed to considerable increases in budgets for the medical regions and health districts. By helping to make the role of players more clear and by rationalizing their intervention, the Letter of Agreement has improved the effectiveness of the financial implementation of activities at the levels of medical regions, health districts, and health posts.

### **Transfer of Capacities and Maintenance of Gains**

Collaboration with organizations working with beneficiaries and partners directly involved with the national response shows that the program is strongly anchored in national structures and at the community level. The fact that the program adopts a local approach based on regions and districts has contributed to strong participation by the beneficiaries and all the relevant interest groups or players in the planning process. These players are also actively involved in decision-making regarding major orientations relating to implementation of the project.

The program has supported national programs such as the CNLS, DLSI, and PNT. Civil society organizations are also key players in the process. While working closely with vulnerable groups and reinforcing the capacities of organizations, the program has contributed to a promotion based on institutional and beneficiary participation, and concern for human rights. However, the private sector, which has played a key role in the response, has not always been involved.

In terms of content, it is important to point out that the content and methodology of the program reflect a true approach to gender. The institutional partners, as well as the beneficiaries, are involved on the basis of an analysis founded on differentiation in the gender of target groups. The different interests of men and women are well reflected in the implementation of the program with regard to target groups (SWs, MSM, hauliers, and female organizations), institutions, and policies. The fact that women now play a key role in PLWHIV associations is an example of improvement in gender equality.

Within the framework of implementation of activities, the program has taken strong consideration of women, often regarded as more vulnerable and more exposed. The table below shows that for the period 2007–2008 prevention activities affected 39,207 women, compared to 31,017 men. During the same period, counseling activities attracted 27,555 women, compared to 12,222 men.

The program also respects environmental needs. With regard to this, players and beneficiaries, and especially PLWHIV, are aware of their environmental responsibilities and they have started to establish micro-gardens in health centers. The USAID collaboration with the organization Wula Nafaa in the region of Kedougou, a program of agriculture and management of natural resources, is a key element likely to show that environmental factors are taken into account within the framework of the program.

<b>TABLE VI: BENEFICIARIES OF PREVENTION, COUNSELING, AND HEALTHCARE ACTIVITIES, GROUPED ACCORDING TO GENDER</b>					
<b>Indicator</b>		<b>2007 Data</b>		<b>2008 Data</b>	
		<b>Target</b>	<b>Actual</b>	<b>Target</b>	<b>Actual</b>
Number of individuals reached through community outreach for HIV prevention beyond abstinence		53,650	53,550	54,000	70,224
	M				31,017
	F				39,207
Number of individuals who received counseling and testing for HIV and who received their test results		28,208	35,970	35,000	39,775
	M				12,222
	F				27,553
Number of individuals provided with HIV-related palliative care		2,096	4,811	6,500	7,880
	M				2,994
	F				4,886

For the sustainability of the program, the partners must start to think about:

- **Developing initiatives aimed at diversifying sources of financing:** The staff of the partners are well-trained. They have a good knowledge of the management of the project, and they have at their disposal a network of collaborators and many ideas to improve their activities on the ground.

- **Improving quality control of interventions:** Seeing that the project is leading gradually to 2012, it will be opportune to start thinking about quality control of activities and the long-term continuity of activities. FHI must play a fundamental role in this sense and implement a range of tools and directions in collaboration with the National Quality Program in order to reinforce the competencies of partners in these areas.
- **Reinforcing local players further:** The program has contributed to accelerating the appropriation and participation of players (NGO partners, PLWHIV associations, and other community groups) to implement actions. However, it remains to take an important step in terms of reinforcement for the continuity of interventions at the end of the program. It is evident from various discussions that the partners are still not ready to go it alone. They are used to depending on the directives and finances of FHI. The program's exit strategy must be clearly examined with the partners. It must take into account institutional and technical reinforcement but also consider the time necessary to maintain activities technically and financially in collaboration with governmental bodies.

The institutional reforms likely to ensure continuity of the program concern the development of policies protecting women from violence and against stigmatization of MSM, SWs, and PLWHIV. Within this framework, the assessment suggests that the program plays a strong but discreet role in providing support to the monitoring and vigilance committee while involving ministers, religious leaders, partners, the private sector, and players.



## V. CONCLUSIONS

It is evident from this assessment that the TB and HIV/AIDS programs of USAID/Senegal have improved considerably since 2006. More than 10,964 individuals at high risk have been tested for HIV and have received their results. Many are undergoing ARV treatment thanks to CDV, but especially thanks to the management of FHI and its partners and to the involvement of the national players of the health system. In spite of the paltry \$600,000 invested in the TB program, the positive results achieved bear witness to the relevance of the resources mobilized—53% of patients have been tested through the programs supported by the U.S. Government, and 87% of TB patients have completed their treatment, compared to the national average of 77% in 2009.

The management method developed with the partners has led to a synergistic collaboration and continuity of the actions undertaken. FHI has trained the staff of partners, accountants, coordinators, and community representatives who have worked directly with the beneficiaries. The high-risk groups have been sensitized and, according to the observations of the beneficiaries, the program functions well and responds to their main concerns.

The SWs greatly appreciate the opportunities to meet, which have allowed them to support each other during meetings of their associations. The program has also helped them to manage their economic and psychosocial stress. However, the main concern to think about is the behavior (“They continue to go out”), which has still not changed because of their level of poverty. For the future the SWs therefore wish to have at their disposal access to micro-credit for their financial autonomy and their social reintegration.

With the reinforcement of implemented programs, the MSM have more access to HIV tests and treatment in identified sites. They have been able to benefit from strengthening of capacities in self-esteem and have become more aware of their vulnerable situation. However, there is still a long way to go before reducing stigmatization and discrimination against them within the general population.

The high level of sensitization of PLWHIV, implemented especially through associations, has allowed for their strong bonding to healthcare and support and their greater involvement in the response. However, they need more support on the part of their families since the associations are not able to provide a substitute for blood relations.

The feminization of the AIDS epidemic reflects the biological vulnerability of the women of Senegal as well as their level of socioeconomic poverty.

USAID/FHI must consolidate the activities of the HIV/AIDS and TB programs for the groups at high risk. USAID/FHI must also emphasize the problems associated with the health of women, the conditions of women, the reinforcement of power for women through education and the reinforcement of capacities.



## **VI. RECOMMENDATIONS**

### **REGARDING USAID**

- With regard to the HIV/AIDS program, women must be a priority target because of their high vulnerability but also because of the feminization of the pandemic. The results of a study on the feminization of HIV/AIDS would be very useful. It is essential to strengthen support for the partners working with organizations and women's groups to help the latter have at their disposal competencies allowing them to have access to and benefit from economic opportunities (micro-credit, training, etc.).
- TB activities must receive more substantial financial support, having taken into account the excellent results achieved. It has been proved necessary to support the activities initially implemented by the LHL (a program that has been completed) in order to: (i) help the PNT concentrate its efforts on patients with multi-resistant TB; (ii) expand and replicate the quality program launched in Mbao to other zones; and (iii) incorporate the TB component into the multi-partner pilot initiative in Kaolack.
- A strong case must be made for the renewal of the World Bank program that is due to end soon. Otherwise it will be difficult to fill the void because the national program is still not adequately supported and will need more support in the years to come.
- FHI has funded two relevant research activities—one relates to the feminization of HIV/AIDS, and the other relates to the assessment of interventions aimed at vulnerable groups such as SWs and MSM. It is important to take into consideration the results and recommendations of these studies for the financial years that follow.
- It is recommended that USAID play a stronger but discreet role in the fight against damage to the environment of the response and discrimination while providing support to the task forces and the awareness and vigilance committee, by supporting the adoption and diffusion of policies and the law regarding HIV.
- Special emphasis must be placed on the regions of Kedougou, Ziguinchor, and Kolda, areas with high HIV and TB prevalence. These are enclosed regions marked by limited access geographically and situated in border zones characterized by highly mobile populations and precarious socioeconomic conditions.
- It is recommended that the logistical capacities of the regional offices be reinforced before enabling monitoring activities, particularly at the level of the new unit in Kedougou. In addition to the monitoring activities, it has proved important to strengthen the competencies in management of the team frameworks.

### **REGARDING FHI**

- For 2010 and 2011, FHI must try to reduce the number of partners benefiting from contracts to implement activities. Furthermore, the selection of partners must prioritize criteria based on:
  - Performance (based on well-defined indicators).
  - Quality control (to the satisfaction of beneficiaries).

- Efficient monitoring (observation/assessment).
- Continuity (diversification of sources of financing).
- It is recommended to reinforce the case and to start to focus on vulnerable groups in the fight against HIV/AIDS and TB; to continue to concentrate essentially on specific groups such as SWs, MSM, and hauliers is a limited approach if one takes into account the progression of feminization of the HIV pandemic; this risks creating a two-speed response if the general population does not have the same level of knowledge as the specific target groups.
- It is important to reinforce support for the partners working with groups of women who must be considered priority targets.
- Special emphasis must be placed on the regions of Kedougou, Ziguinchor, and Kolda, areas with high HIV and TB prevalence. These are enclosed regions marked by limited access geographically and are situated in border zones characterized by highly mobile populations and precarious economic conditions.
- It is recommended that the logistical capacities of the regional offices be reinforced before enabling monitoring activities. In addition to the monitoring activities, it has proved important to strengthen the competencies in management of the team frameworks.
- The partnership, which is a key element of the success of the program, needs to be reinforced through:
  - Better coordination for the mapping and implementation of activities.
  - A strategic partnership especially in the areas of IGAs (income-generating activities) for mutual insurance companies, micro-credit, and nutrition; the pilot project launched in Kaolack seems to be going in this direction and requires more substantial support.
  - Direct collaboration with the associations of women at the community level such as the female groups in Kolda.
- In the light of weaknesses identified in the area of activities of communication to change behavior (CCB), it will be necessary to reinforce support for PNT for the development of CCB tools, develop a national communication strategy, and strengthen CCB activities with special attention to the community level and a more solid media coverage for TB.

## **REGARDING GOVERNMENTAL INSTITUTIONS (CNLS, PNT, DLSI)**

- It is recommended that coverage of national HIV/AIDS and TB programs be expanded, while treating women as a priority group because of their high vulnerability and the feminization of the HIV pandemic.
- The CNLS must focus more on the coordination of partners for mapping and implementation of activities.
- The CNLS must play a key role in the awareness and vigilance committee aimed at favoring an improvement in the hostile environment in which the MSM find themselves.
- All of the institutions must support the case regarding local authorities before engaging them further in the financing of activities dedicated to vulnerable groups through the establishment of subsidy funds; in effect, the line dedicated to “fund assistance for the



needy” in the budget of local authorities (LAs) could serve up to a certain percentage the contribution of the LAs to the national response.

- The DLSI must monitor more closely the activities of CDV at the community level using more appropriate advanced strategies. The objective to screen a certain number of people must be improved while adding the effective referencing of screened people to the level of the healthcare structure.
- It is important that the PNT seek to fill the void left by the LHL in terms of financing before ensuring the continuity of activities in order to avoid a certain depreciation and loss of gains.
- It is recommended to reinforce the “TB Quality Improvement” project launched at the health district level in Mbao and implement ways allowing for the replication on a larger scale and in the other regions.
- It is recommended to strengthen the leadership of the PNT in order to develop a strategic vision for a community-based approach; the activities of the PNT which stop at the level of the health posts are able to be extended to the level of medical huts and the more peripheral communities in close collaboration with organizations such as ChildFund (e.g., CCF).
- The DLSI and PNT must reinforce their collaboration with the national Nutrition Enhancement Program (PRN) because of their heavy involvement in the national response to HIV/AIDS and TB. The nutrition task force, through the real leadership of the DLSI, would be able to play a significant role in this collaboration with the PRN and CPI.

## **REGARDING PARTNERS MANDATED WITH IMPLEMENTATION OF ACTIVITIES**

- Each partner must be considered wholly responsible for the quality regarding direct management, and the monitoring and observation of its activities.
- It is recommended that more new strategies be developed in the area of risky behavior with the associations (SWVs, MSM, PLWHIV). The beneficiaries have benefited from a reinforcement of capacity likely to help them to develop their self-esteem and to develop initiatives of mutual support. However, they still have not adequately taken control of risk-taking; these strategies, which also serve to make them more visible, must be accompanied by measures tailored to the community.
- It is recommended that the CBOs, which have benefited from a reinforcement of capacities to conduct their own activities, should be given more responsibility and financial resources. That could help them to bolster the continuity of initiatives and strategies at the community level.

## **REGARDING FRAMEWORKS OF REGIONAL AND DISTRICT TEAMS**

- It is essential to establish a good effective coordination mechanism with the other donors in order to improve monitoring and observation and use time and resources more efficiently.
- It is recommended to respect timeframes and procedures developed through the Letters of Agreement.
- It is necessary—indeed vital—to develop strategies that efficiently track cases where treatment has been abandoned or patients have disappeared for TB as well as for HIV/AIDS. The involvement of associations and leaders at the community level, as well as the creation

of an efficient information system that includes telephone directories of people undergoing treatment, are options that should be analyzed with interest.

- The district must involve PLWHIV more in its sensitization strategies because their experiences and voices can serve to promote and act as a vehicle for powerful messages on education and sensitization.
- Medical staff must have a more positive attitude toward SWs and MSM because the SWs complain that they are very often faced with a negative attitude on the part of medical staff.

## **REGARDING BENEFICIARIES**

- PLWHIV associations must promote and strengthen their relations with the members of their families because PLWHIV often fear to share their status with their spouses.
- Vulnerable groups and PLWHIV beneficiaries need to be involved more actively in sensitization through the activities of CCC
- Vulnerable groups within the associations must expand their activities to activities of micro-finance for a continuity of nutritional activities at the community level.
- It is recommended that particular emphasis be placed on use of the femidom, a female condom, by registered and underground SWs since it is a form of self-protection they can use independently of their clients.
- It is recommended that the activities of CCC be reinforced with regard to the risk-taking of the SWs, because the latter have a tendency not to use condoms when engaging in sexual intercourse with their partners or regular clients.
- It is recommended that synergies with micro-finance organizations be developed before enabling the access and launch of income-generating activities for beneficiaries. These actions are likely to strengthen their economic power.

## VII. LESSONS LEARNED

Since their establishment, the HIV/AIDS and TB programs of USAID/Senegal have achieved some notable results. Indicators reveal that 87% of TB patients benefiting from support have completed their treatment in the regions benefiting from the support of the U.S. Government. In these same locations, 10,964 individuals have visited CDV sites and have received their results. The indicators relating to the implementation of activities show a good level of progress with regard to the objectives.

The strong points of the activities are the integration of the TB and HIV/AIDS programs into the national programs, the collaboration with partners, and the Letters of Agreement that have allowed the actions of the donors to be better oriented toward the needs of the populations. The emphasis placed on the CDVs, the treatments, the search for those people that have disappeared—especially for the TB component—and the concentration of interventions for the vulnerable groups at high risk (the MSM, SWs, and PLWHIV) constitute a gauge for the success of interventions.

The support relating to strengthening of capacities and the technical assistance provided to the medical staff in the regions make up elements of the continuity of the action.

The research and assessment activities conducted on important components of the program, such as the study of vulnerable groups, the study of the feminization of HIV/AIDS, and the assessment of the Letters of Agreement, constitute gains that are likely to boost the visibility and impact of the project on the beneficiaries.

The partners have highly appreciated the flexibility of FHI and the provision of technical support responding to their needs.

On the other hand, there are a certain number of weaknesses and concerns likely to limit achievement of the results. These include, among others: the not very favorable working conditions at the level of healthcare structures; the difficulty of conducting regular observations on the ground due to the absence of logistical means; and the major concern over the feminization of the HIV/AIDS pandemic.

The lack of financial resources to support the expansion of activities; the dearth of opportunities or limited possibilities for PLWHIV to gain access to micro-credit; the fact that in spite of sensitization efforts, stigmatization and discrimination toward PLWHIV, SWs, and MSM continue—all these constitute bottlenecks for the program.

It is also important to mention that the financial years of USAID and the partners that do not match constitute a limitation to planning at the operational level in spite of the excellent multi-sectoral approach developed (the fact also that the Letters of Agreement are set up on the basis of only one year).

The coordination between partners during the process of planning what action to take seems real, but it would profit from being reinforced during the implementation phase in order to be more efficient.

The increase in the number of partners since the launch of the program constitutes a strong point for FHI, but it is also a flaw. The intensification and expansion of activities in the regions is often accompanied by the creation of new committees and associations. The program manages 13 partners, which is a heavy burden in terms of coordination and planning. Seen from a more

positive angle, the partners are known to be highly satisfied with the support from FHI, the clarity of the objectives, and FHI's capacity to respond to their specific needs.

Some synergies between the partners and FHI have been developed, and the progress made in the TB and HIV/AIDS programs attests to this collaboration.

The weak point of the partnership lies in the fact that many of the partners are still not ready to go it alone. They are accustomed to depending on the directives and financing of FHI. For the continuity of the program, the partners must start to think about developing initiatives aimed at the diversification of their sources of financing.

The staff of the partners are well-trained. They are very knowledgeable about the implementation of the project; they have at their disposal a network of collaborators and have many ideas to improve their activities on the ground. As the project makes progress toward 2012, it will be opportune to start thinking about quality control of activities and continuity in the long term.

The program must not be expanded until there is consolidation, and the partners must emphasize quality control and actions aimed at establishing the continuity of the interventions.

FHI has demonstrated a good capacity for managing the partners. It has realized that it must differentiate itself on the ground while introducing innovations such as the Letters of Agreement and the pilot project which constitute results and approaches likely to change for the better the national response to HIV/AIDS and TB. Therefore, the USAID/Senegal program must carry on with additional financing, and the gains must be consolidated.

## **APPENDIX A. SCOPE OF WORK**

### **Global Health Technical Assistance Project**

#### **GH Tech**

**Contract No. GHS-I-00-05-00005-00**

### **SCOPE OF WORK**

(Revised: 09-21-09)

#### **I. TITLE**

Activity: **Mid-term Evaluation of the USAID/Senegal HIV/AIDS and TB Program**

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

#### **II. PERFORMANCE PERIOD**

This assignment is envisioned to begin the end of September 2009 and to be completed by the end of December 2009. The activity duration will be approximately 3 months.

#### **III. FUNDING SOURCE**

USAID/Senegal: Program Development and Learning funds

#### **IV. PURPOSE**

The purpose of this mid-term evaluation is to:

1. determine the extent to which the expected results have been achieved; and
2. identify areas for improvements that will facilitate the attainment of the planned results.

The evaluation will focus on the program relating to HIV/AIDS and tuberculosis (TB) prevention and control. The implementation of this program has been underway for about 36 months. This comprehensive look at it will help to identify needed corrective actions relating to the intervention approaches, nature and range of services and inputs. The external consultants conducting this evaluation will gather a wide-range of background information from USAID/Senegal and implementing partner staff to ensure that the findings and recommendations are based on an accurate understanding of the program.

#### **V. OBJECTIVES**

The objectives for this assignment are as follows:

1. Determine the impact of the deteriorating environment on the achievement of the original objectives of the program;
2. Address implementation concerns/issues and unmet needs; and
3. Prioritize the activities to be integrated into the FY10 and subsequent years' workplans; and
4. Define needs, opportunities and constraints.

## VI. BACKGROUND

As part of its current strategic plan for Senegal, USAID supports the efforts of the Government of Senegal (GOS) to achieve the Millennium Development Goals, as outlined in the “Plan National de Développement Sanitaire” (PNDS). In keeping with those health specific goals USAID/Senegal funded mutually reinforcing programs relating to (1) health care policy and financing; (2) community health; (3) maternal and child health, and family planning; and (4) HIV/AIDS and TB prevention and control.

Up to 2002, USAID used to be the lead donor for HIV programs in Senegal by providing annually about \$ 4-5 million. Since then, the World Bank MAP and the Global Fund have supplanted USAID/Senegal. As a result, there have been increased HIV resources in Senegal, which has thus expanded the scope of interventions. This has also created the need for better coordination amongst various donors programming. USAID/Senegal has continued to provide funds and technical assistance through implementing partners like Family Health International (FHI) focusing on HIV prevention, care and support, and TB/HIV targeting high risk and vulnerable groups.

The 2005 Demographic and Health Survey (DHS) estimated HIV/AIDS prevalence in Senegal at 0.7% among the general population. The most recent epidemiological surveillance results corroborate this low prevalence among the general population. However, the regional breakdown shows high prevalence among the general population in the border regions because of population movements relating to economic activities (mining and weekly international markets) or conflict. Furthermore, the epidemiological surveillance results show high prevalence among commercial sex workers (CSW) and men having sex with men (MSM), respectively 19.5% and 21.5%.

The TB incidence rate is 110 per 100,000 persons<sup>4</sup>. As a result, TB is another major public health problem in Senegal. Since 2003, USAID/Senegal has provided annually about \$800,000 to complement the LHL (a Norwegian NGO) support to the national TB control program (NTP). USAID/Senegal has been also instrumental in completing the Senegal’s proposal to the Global Fund. Supporting a comprehensive TB-HIV program is an important catalyst for the management of the TB-HIV co-infection. To date, 50%<sup>5</sup> of TB patients are tested for HIV.

On June 22, 2006, USAID/Senegal awarded FHI the five year Cooperative Agreement number 685-A-00-06-00059-00 to implement activities relating to HIV/AIDS and TB in the 5 Tanzania: Community Care COP Technical Writer target regions for the USAID Health program: Kaolack, Kolda, Louga, Thiès, and Ziguinchor. FHI also targeted Dakar for TB activities and selected HIV activities that were continued from the previous bilateral program. Starting at the end of 2008, FHI initiated activities in one of the newly created regions, Kédougou, which is outside of the original target zone of USAID’s Health program. Starting in FY10, FHI will also target two more new regions, Kaffrine and Sédhiou, which have been created from within the regions of Kaolack and Kolda. FHI’s targets include general population for TB; people living with HIV/AIDS; and high risk and vulnerable groups such as CSW, MSM, and mobile population. To fulfill its agreement FHI closely works with the NTP, HIV/AIDS division, service delivery points, civil society and private organizations to execute activities, including TB and HIV related prevention, care and support, and system strengthening. FHI also supports the coordinating

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<sup>4</sup> The TB incidence in Senegal was recently revised to 119 per 100,000 population in the 2009 WHO Report, but the national TB control program (NTP) has not yet integrated these revisions into the national TB plan or M&E table.

<sup>5</sup> The NTP just estimated this statistics at 50%.

efforts of the national committee for fighting AIDS (CNLS) at both the national and regional levels. Other partners supplementing FHI activities include:

1. Agency for the development of social marketing (ADEMAS, after its French acronym) implements a nationwide social marketing program of PROTEC and FAGARU, two condom brands that target respectively the general population and the youth group.
2. Christian Children's Fund (CCF) has led a consortium to implement community level TB activities in the regions of Kaffrine, Kaolack, Kolda, Louga, Sédhiou, Thiès, and Ziguinchor.
3. Counterpart International (CPI) has implemented care and support activities, including nutrition services for people living with HIV/AIDS in mainly the northern regions.
4. Center for Disease Control (CDC) has supported centrally activities relating to strategic information management, including sentinel surveillance.
5. Department of Defense (DOD) has funded activities relating to prevention, sexually transmitted infections, voluntary counseling and testing, mother to child transmission, and care and support.

FHI has built on success stories like coordination of the control efforts. Some other positive major achievements of HIV/AIDS and TB programming in Senegal in recent years include, but are not limited to:

- Development or change of policies and directives, including (a) national norms and protocols for TB treatment; and (b) national protocol for clinical management of TB/HIV co-infection.
- Achieving 75% TB treatment success rate among new smear positive cases.
- Maintaining the national average HIV prevalence below 2%.
- The expansion of services for high risk groups in high prevalence areas, including the new region of Kédougou.
- Creation of a network of providers and peer support groups to increase MSM access to STI treatment and HIV testing.
- Integration of VCT services into public health centers.
- Decentralization of care and treatment services at the district level based upon a comprehensive model of nutritional and psychological care.
- Strengthening capacity of regional HIV coordinating committees in (a) developing and managing integrated multi-sectoral regional plans for HIV and (b) managing and using strategic information.
- The introduction of quality intervention approach for TB and HIV.
- Intense effort to manage TB/HIV co infection.

Despite these key accomplishments, the program implementation has experienced some difficulties due to hindering factors such as (1) the social and religious environment becoming less conducive to interventions that target high risk groups; (2) difficulties in effective coordination across all the major donors to ensure complementary programming (3) the challenge of maintaining HIV service quality while at the same time meeting the objective of universal access to prevention, treatment and care.

It is expected that this evaluation and other studies will help find ways to overcome most of these hindering factors. These studies worth mentioning include the three internal evaluations FHI, the Cooperative Grantee, will complete by end of August 2009. The three evaluations relate to the (1) strategies targeting MARPS; (2) letters of accord, a mechanism put in place in 2004 to help decentralize support to the regional and district levels; and (3) study on the feminization of the HIV epidemic in Senegal. The results of these internal evaluations should feed into this evaluation.

## **VII. SCOPE OF WORK**

### **Issues to be Investigated**

The evaluation shall provide general and specific conclusions and recommendations on ways to maintain and continue program progress, expand the program, and/or make the most appropriate modifications in the program, if needed. USAID/Senegal is interested in knowing about the adequacy of the program's activities, the soundness of the approaches, the quality of overall program management in service delivery and implementation processes, the appropriateness of program inputs, the beneficiary coverage and response, and the potential of sustaining aspects of the program.

The team will review, revise and finalize the questions prior to initiating the key informant interviews or the site visits. Specific illustrative questions:

### **Adequacy of Activities**

- Are the activities the right mix?
- To what extent is the range of activities sufficiently broad?
- If there are additional areas that USAID/Senegal should be addressing, what are they and what are the cost implications of expanding the activity array to incorporate these activities?

### **Appropriateness of Program Inputs to Achieve Desired Outcomes and Impacts**

- Has the program been able to complete the planned activities within the stipulated times?
- What are the key contributions to the HIV/AIDS and TB programming in Senegal?
- Are the planned (output, outcome and impact-level) results achievable with hindering factors like the exchange rate fluctuation?
- How can USAID play a more effective role in the area of stigma and discrimination as well as addressing the factors that are deteriorating the overall environment for HIV prevention and care?
- Should resources become available, what kinds of cross-border activities should USAID consider incorporating into programming?

### **Soundness of the Approaches**

- How well have the activities been coordinated with World Bank and Global Fund supported projects?
- How effective has collaboration been with other USAID implementing partners and USG agencies?
- Are there areas for additional synergy with existing partners?



- How successful has been the approach to increasing participation of target groups and key stakeholders?
- Were any formal or informal mechanisms established for involving key stakeholders?
- Did the program managers establish necessary linkages with governmental agencies, and private and civil society organizations?
- Are the intervention approaches still valid in light of 36 months of implementation?
- What needs to be changed to speed-up or expand the interventions?

### **Soundness of the Overall Management**

- What are the most important management features (staffing, materials, activities, financial and administrative arrangements)?
- 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?
- Do the features contribute to not achieving the desired outcomes/impact? If so, how?
- What adjustments will be needed to achieve desired outcomes/impact?
- How feasible is it to make those adjustments?

### **Coverage and Response of Beneficiaries**

- Did the services and inputs provided reach the MARPs and other target population in the expected numbers and locations?
- Are the targets realistic?
- To what extent did the target groups use the services and inputs provided?
- To what extent were public, private and civil society organizations developed or strengthened?
- To what extent was progress made in identifying, developing and implementing capacity building activities within GOS, private sector and civil society?

### **Sustainability**

- What legal, regulatory, or administrative barriers to achieving desired outcomes/impacts need to be addressed/mitigated?
- Are the letters of accord and other intervention approaches conducive to sustainability? How can activities and capacities be transferred and sustained after the program ends?
- What institutional reforms will help sustain the momentum?

### **Required Tasks and Timeframe**

The tasks in this SOW will be implemented over the period of about three months, starting on or about end of September 2009. The schedule below is illustrative and will be discussed and revised, as required.

<b>TASKS</b>	<b>LOE - TL</b>	<b>LOE – TMS (X2)</b>
Literature Review	3 days	3 days
Travel to Washington DC	1 day	
Meetings in Washington with USAID and FHI	2 days	
Travel to Dakar	2 days	
Team Planning Meeting (TPM); team submits workplan, including methodology and tools for approval at end of TPM	2 days	2 days
Meeting with USAID to (a) discuss the draft workplan; (b) review and confirm planned dates of submission of deliverables; and (c) brainstorm on key accomplishments, weaknesses, opportunities and threats.	0.5 days	0.5 days
Meetings with FHI to (a) review the information sources and contact list; (b) discuss appointment dates and times; and (c) brainstorm on key accomplishments, weaknesses, opportunities and threats.	0.5 days	0.5 days
In-briefing with GOS representatives	1 day	1 day
USAID review of workplan, including data collection methods and tools (reviewed and finalized before key informant interviews begin)		
Meetings with Dakar-based key informants	3 days	3 days
Field travel and data collection	6 days	6 days
Report Drafting – review information, discuss and analyze data, begin draft report	5 days	5 days
USAID/Dakar debriefing	1 day	1 day
First draft revision based on comments (In English)	1 day	1 day
Debriefing with key stakeholders	1 day	1 day
Full draft submission (in English) - to USAID prior to departure from country	1 day	1 day
Depart Dakar	2 days	
Feedbacks from USAID/Senegal and FHI (5 -10 business days)		
Revisions to report and submission of final report (in English)	5 days	3 days
GH Tech Editing (2 weeks)		
French Translation (2-3 weeks)		
Team reviews French version	2 days	2 days
GH Tech Formatting Final report (2 weeks)		
<b>LOE Total</b>	<b>39 days</b>	<b>30 days (x2)</b>

\*A six day work week is authorized when consultants are in country.

## METHODOLOGY

The team conducting this mid-term evaluation shall review all the relevant documents relating to TB and HIV activities in Senegal, including those listed in the background section. In Dakar and in a sample of targeted localities and sites, the team will also meet and interview representatives from GOS, donors, partners and other stakeholders.

The evaluation team shall propose its own methodology but it is expected that the evaluation will be implemented through document review, key informant interviews, site visits, and focus group meetings. USAID/Senegal expects that the analysis will consider issues relating to human rights, ethics, age, and gender (e.g., the feminization of HIV infection).

Document Review: USAID will provide the evaluation team with a package of briefing materials relevant to the evaluation. This documentation will include strategy/concept papers, project quarterly reports, workplans, and any management reviews or other documents that are developed and reviewed as part of the continuous monitoring of the project.

- **Team Planning Meeting**

A two-day team planning meeting will be held in country before the evaluation begins. This meeting will allow USAID to present the team with the purpose, expectations, and agenda of the assignment. In addition, the team will:

- Clarify team members' roles and responsibilities,
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion,
- Review and develop final evaluation questions
- Develop data collection methods, instruments, tools and guidelines,
- Review and clarify any logistical and administrative procedures for the assignment,
- Develop a preliminary draft outline of the team's report, and
- Assign drafting responsibilities for the final report.

- Pre-Evaluation Briefing: During the Team Planning Meeting period (below), the assessment team will hold a preliminary meeting with the management team of USAID to review the scope of the evaluation, agree on the key research questions, and finalize the schedule. The outcome of this meeting will be a detailed workplan for the assessment, including milestones and deliverables with due dates clearly established.

In addition to formal briefing and debriefing meetings, the evaluation team may contact the USAID management team as necessary to provide updates on their progress and obtain additional guidance on logistics, additional data and information sources

- Key Informant Interviews, Meetings and Focus Group Discussions (as indicated): The evaluation team will conduct qualitative, in-depth interviews and meetings with key stakeholders and partners
  - Key informants should include GOS representatives such as DLSI, CNLS, NTP, and ambulatory treatment center of the Fann hospital (CTA/OPALS)
  - Other USAID partners, including ADEMAs, CCF, CPI, CDC, and DOD.

- Additional key informants: SWAA, ANCS, Sida Service, AWA, Synergie pour l'enfance, ACI, Intermonde, Enda Santé (the evaluation team may draw a sample depending on criteria to be agreed upon during the first meeting with USAID/Senegal)
- **Field Visits:** The evaluation team is expected to conduct site visits to local offices/activities implemented by the partners noted above, as well as to the regional and district medical offices in the target zones. In FY09 FHI signed contracts with seven regions for selected training, supervision, and data collection activities to support decentralization of the national HIV and TB programs. The evaluation team is expected to advise on this.

## **VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT**

### **Team Composition**

It is expected that this evaluation team will be comprised of one evaluation team leader, recruited internationally, and up to two locally hired experts with skills defined below. All candidates must be approved by USAID/Senegal. The evaluation team will work under the overall direction of the Team Leader. All team members will contribute to day-to-day problem solving, technical questions, etc.

### **Desired Qualification for the Key Personnel**

GH Tech is responsible for hiring the local and international consultants, clarifying the scope and timeline with USAID, compiling and distributing the background materials to the team members, team management and coordination. The team leader is responsible for coordinating and overall writing assignments, making transportation and logistics arrangements, field work preparation/scheduling, and briefings/debriefings. Working in conjunction with other team members, s/he will be responsible for data analysis, lessons learned, and recommendations.

The Evaluation Team Leader must have the following skills and qualifications:

- A post graduate degree in public health, or related fields;
- An extensive (at least five years) experience in assessment/evaluation of health activities;
- An extensive (at least five years) experience in multi-sectoral approach;
- Extensive experience in HIV/TB programs is desirable
- A proven record of leadership in assessment/evaluation of health activities;
- Knowledgeable of USAID policies, objectives and programs;
- A proven team player experience; and
- Excellent spoken and written skills in French and English.

Additionally, other team members to be recruited locally must have proven experience in evaluation and expertise in the following areas:

- Health policy and financing;
- Spoken and written skills in French and English;
- At least five years experience in public health, HIV/AIDS, and TB

## IX. LOGISTICS

The team leader will arrange all of the partner meetings, site visits and debriefings in advance, if possible. All associated travel and per diem costs for non-USAID staff will be covered by GH Tech. The Mission will not provide any office space. However, it can help to set appointments and confirm meetings. In principle, the locally hired consultants should have the necessary contact lists to tackle the logistics issues.

## X. DELIVERABLES AND PRODUCTS

The Evaluation Team shall provide the USAID/Senegal Contracting Office Technical Representative with:

1. A workplan including data collection methodology and tools –USAID will provide comments on the workplan, and data collection tools before the team begins key informant interviews or site visits;
2. USAID, FHI, and OHA debriefings - The Team will present the major findings of the evaluation to USAID (OHA and FHI, as appropriate) through a PowerPoint presentation before submission of the draft report and before departure from country. The debriefing will include findings, conclusions and any recommendations.
3. A draft evaluation report (in English) – that incorporates comments and feedback from the USAID and FHI debriefings into the draft that will be left with USAID/Senegal prior to departure of the team from country. USAID will provide comments to the Evaluation Team Leader within five working days of receiving the draft evaluation report; and
4. A final evaluation report - the Team Leader will submit a **final report** that incorporates the team responses to Mission comments and suggestions. The draft final report should be completed within 5 days after USAID provides its feedback on the draft report incorporating the comments received from the review of the draft and sent to the Mission.

After the final but unedited draft report has been reviewed by USAID, GH Tech will have the document (English) edited (2-4 weeks). After the editing occurs, GH Tech will then send the English version to be translated into French to be finished within a two-three week period. The French version will then be technically reviewed by the evaluation team (in 2 days) Formatting will take place within approximately two weeks following the review of the French version, and GH Tech will provide the final reports to USAID/Senegal for distribution (10 hard copies in English, 20 copies in French and a CD ROM with both versions included). It will take approximately 30 days for GH Tech to complete the edit/format and print of the final English document.

If there is procurement sensitive information in the report, it will be removed from the public report and prepared as a separate Memo marked for Internal USAID Distribution Only – Procurement Sensitive.

The evaluation team shall propose its own evaluation report outline but it is expected that the main body (sections Introduction through Lessons Learned) of the final assessment report will not exceed 40 pages. It is also expected that the report will include the following sections:

1. Acknowledgement
2. Acronyms list
3. Executive Summary

4. Table of contents
5. Introduction
6. Background
7. Purpose and Methodology of the Assessment
8. Findings (re performance, management system, etc.)
9. Conclusions
10. Recommendations and strategic options
11. Lessons learned
12. Bibliography
13. Annexes (terms of reference/scope of work; organizations contacted; a discussion of the methodology and data collection tools, etc.)

The evaluation team leader shall submit all deliverables to Ramatoulaye Dioume, HIV/AIDS Advisor the Contracting Office Technical Representative at USAID/Senegal. If delivered by e-mail, send to [rdioume@usaid.gov](mailto:rdioume@usaid.gov).

Upon final approval of the content by USAID/Senegal, GH Tech will have the report edited and formatted. This process takes approximately 3-4 weeks.

GH Tech shall submit one either electronic or hard copy to Development Experience Clearinghouse at <http://dec.usaid.gov> or M/CIO/KM, RRB M01, USAID, Washington DC 20523.

## **XI. MISSION AND CONTACT PERSON**

The COTR is Ramatoulaye Dioume: [rdioume@usaid.gov](mailto:rdioume@usaid.gov). She can be reached at 221 33 869 61 98.

## **XII. COST ESTIMATE**

TBD

## **XIII. REFERENCES (PROJECT DOCUMENTS)**

### **Information Sources**

The Evaluation team shall familiarize itself with USAID and implementer documentation. USAID/Senegal will ensure that all relevant documents are available to the Team prior to the field work. The documents will include, but not limited to:

- Annual workplans, annual and quarterly reports submitted by the implementing partners;
- Performance Management Tools prepared by USAID;
- Monitoring and Evaluation manuals prepared by the implementing partners;
- Activity reports;
- Field trip reports;
- “Plan National de Développement Sanitaire et Social” (PNDSS);

- Decrees, directives, norms, and protocols ;
- Senegal HIV/AIDS strategy plan;
- National Committee for fighting AIDS (CNLS)'s annual report;
- NTP annual report;
- TB strategic plan;
- World Bank and Global Fund projects' documents;
- Letters of accord evaluation report;
- Report of the evaluation of strategies targeting MARPS;
- Report of the study on the feminization of the HIV epidemic in Senegal;
- Recent sectoral and/or program assessment/evaluation documents; and
- Other documents, as required.





## APPENDIX B. REFERENCES

- Family Health International, in collaboration with ACI, ANCS, CPI, CRS. *Action Plan 2009: Agreement to Subsidy No. 685-A-00-06-00059-00, with Final Version from September 2008.*
- Family Health International, in collaboration with ACI, ANCS, CPI, CRS. *Action Plan 2008: Final Version.*
- Family Health International, in collaboration with ACI, ANCS, CPI, CRS. *Action Plan 2007: Agreement to Subsidy No. 685-A-00-06-00059-00.*
- Family Health International, in collaboration with ACI, ANCS, CPI, CRS. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Activity Progress Report: April–June 2009 (Final Version).*
- Family Health International, in collaboration with ACI, ANCS, CPI, CRS. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Activity Progress Report: April–June 2007.*
- Ministry of Health, Prevention and Public Hygiene (Senegal). *National Program Against Tuberculosis (PNT): Annual Report 2008.*
- United States Agency for International Development/Family Health International. *Enda-Sante. Quarterly Report: April–June 2009.*
- United States Agency for International Development/Family Health International. *Enda-Sante. Quarterly Report: January–March 2009.*
- United States Agency for International Development/Family Health International. *Enda-Sante. Quarterly Report: October–December 2008.*
- United States Agency for International Development/Family Health International. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Activity Progress Report: October–December 2007.*
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- United States Agency for International Development/Family Health International. *Project: Prevention—Medical and Social Monitoring—Reducing the Impact of HIV for Underground Sex Workers and Their Masculine Sexual Partners' PSR.*
- United States Agency for International Development/Family Health International. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Annual Report: October–September 2007.*
- United States Agency for International Development/Family Health International. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Quarterly Activity Report: January–March 2009.*
- United States Agency for International Development/Family Health International. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Quarterly Activity Report: October–December 2008. Cooperative Agreement No 665-A-00-06-00059-00.*

United States Agency for International Development/Family Health International. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Quarterly Activity Report: April–June 2008.*

United States Agency for International Development/Family Health International. *USAID Health Program: HIV/AIDS and Tuberculosis Component. Quarterly Activity Report: January–March 2008.*

## **APPENDIX C: INTERVIEW GUIDES**

### **GUIDE BENEFICIAIRES**

Qu'est ce que vous pensez des services qui vous sont offerts ?

1. Est-ce que vous êtes satisfaits de ces services ?
2. Quels sont les problèmes que vous rencontrez ?
3. Combien de bénéficiaires êtes vous ?
4. Combien de fois par semaine vous vous rencontrez ?
5. Qu'est ce que vous faites pour améliorer votre vie ?
6. Est-ce que ces services s'adaptent à vos besoins ?
7. Comment êtes vous traités par le personnel au niveau des structures de soins ?
8. Est-ce qu'il y a un effort pour éviter la stigmatisation et la discrimination au niveau des services de santé ?
9. Est ce que vos proches sont au courant de votre condition ?
10. Qu'est ce que vous pensez des témoignages de PVVIHs ?
11. Quelles sont vos contraintes ?
12. Quelles sont vos recommandations ?

## **GUIDE FHI**

### **I. CONTEXTE DU PROGRAMME**

1. Qu'elles étaient vos perspectives et les objectifs visés pour ce programme ?
2. Quels sont les fonds reçus pour les deux volets ?
3. Est-ce qu'il y avait d'autres sources de financement ?
4. Quels sont les mécanismes de financements ?

### **II. ADÉQUATION DES ACTIVITES**

1. Quelles sont les activités menées dans le cadre du programme ? cibles ? acteurs ?
2. Les résultats obtenus ? positifs ? négatifs ? les gaps ?
3. Les couts sont t'ils raisonnables, suffisants ?
4. Les contraintes / les goulots d'étranglement ?
5. Recommandations d'amélioration, en terme financier

### **III. COHÉRENCE DU PROGRAMME**

1. Est-ce que le programme a pu réaliser les activités planifiées dans les délais requis ?
2. Qu'elles sont les principales contributions au programme TB/VIH du Sénégal ?
3. Est-ce que la fluctuation du taux de change du \$ a impacté les résultats attendus ?
4. Si oui comment ? si non qu'est qui a été fait ?
5. Comment FHI pourrait jouer un rôle plus effectif dans la prévention du stigma et de la discrimination ?
6. Comment faites-vous face à la détérioration de l'environnement de la réponse ?
7. Quelles sont les activités transfrontalières qui pourraient être intégrées dans le programme en cas de ressources additionnelles ?

### **IV. PERTINENCE DES APPROCHES**

1. Comment les activités on été coordonnées avec celles financés dans le cadre du FM ou de la BM ?
  - Quel est le niveau de collaboration avec les autres agences d'exécution de l'USAID et les autres agences du gouvernement américain ? (Les différentes agences impliquées, Le type de collaboration, Opinion sur la collaboration)
2. Recommandations d'amélioration de cette collaboration
3. Est qu'il y a d'autres domaines pour une synergie d'activités complémentaires avec les partenaires existants ?
4. Quel est le niveau de réussite de l'approche dans l'amélioration de la participation des groupes cibles et des acteurs principaux ?

5. Est-ce qu'il y a eu des moyens formels ou informels pour une implication des acteurs principaux ?
6. Est-ce que les responsables du programmes ont établi les liens nécessaires avec les agences gouvernementales, le secteur privé et les organisations de la société civile ?
7. Est-ce que la durée de 36 mois était suffisante pour la mise en œuvre du projet ?
8. Quelles sont vos recommandations (pour permettre d'accélérer ou de passer à l'échelle) ?

#### **V. PERTINENCE DE LA GESTION**

1. Selon vous, quels sont les caractéristiques les plus importantes de la gestion dans le cadre de ce programme (personnel, matériel, les activités, les aspects financiers et administratifs) ?
2. Quel est le niveau de satisfaction par rapport à ces aspects quant à l'atteinte des objectifs dans les délais spécifiés ?
3. Quels sont les changements nécessaires pour l'atteinte des résultats ?
4. Quel est le niveau de faisabilité de ces changements ?

#### **VI. COUVERTURE ET RÉPONSE DES BÉNÉFICIAIRES**

1. Est-ce que les biens et services offerts ont atteint les bénéficiaires principaux et autres populations cibles ?
2. Est-ce que les objectifs étaient réalistes ?
3. Quel est le niveau d'utilisation des biens et services par les groupes cibles ?
4. Quel est le niveau de progrès réalisé dans le développement, la mise en œuvre du renforcement des capacités au sein des services gouvernementaux, des organisations du secteur privé et de la société civile ?

#### **VII. SYSTÈME DE SUIVI ÉVALUATION**

1. Quel est le système de monitoring mis en place dans le cadre de ce programme ?
2. Est-ce que ce système a donné des résultats comme prévus ?
3. Êtes-vous satisfait des résultats atteints ?

#### **VIII. PÉRENNISATION**

1. Quels sont les lois et règlements, ou barrières administratives auxquels le programme doit faire face pour atteindre les résultats escomptés ?
2. Est-ce que les lettres d'accord ou les autres méthodes d'intervention ont favorisé la pérennisation ?
3. comment assurer le transfert des activités et des compétences dans le sens d'une pérennisation à la fin du programme ?
4. Quelles réformes institutionnelles pourraient aider la continuation de l'élan ?

#### **IX. RECOMMANDATIONS GÉNÉRALES**

## **GUIDE GH TECH**

**Septembre 28 Premier meeting 9h Meridien Ngor:**

### **GUIDE D'INTERVIEW**

#### **Adéquation des activités (pertinence et cohérence des activités)**

1. Quelles sont les activités menées dans le cadre du program? les cibles ? les acteurs ?
2. Les résultats obtenus ? positifs ? négatifs ? les gaps ?
3. Les couts sont t'ils raisonnables, suffisants ?
4. Les contraintes ?
5. Que feriez vous de différent si le programme est à reprendre ; recommandations d'amélioration, en terme financier ?

#### **Cohérence du programme**

1. Est-ce que le programme a pu réaliser les activités planifiées dans les délais requis ?
2. Qu'elles sont les principales contributions au programme TB/VIH du Sénégal ?
3. Est-ce que la fluctuation du taux de change du dollar a impactés les résultats attendu ?
4. Si non qu'est qui a été fait ?
5. Comment l'USAID pourrait jouer un rôle plus effectif dans la prévention du stigma et de la discrimination ? et comment pourrait on faire face à la détérioration de l'environnement de la lutte contre le VIH (prévention et traitement) ?
6. Quelles sont les activités transfrontalières qui pourraient être intégrées dans le programme en cas de ressources additionnelles ?

#### **Pertinence des approches**

1. Comment les activités on été coordonnées avec celles financés dans le cadre du FM ou de la BM ?
2. Quel est le niveau de collaboration avec les autres agences d'execution de l'USAID et les autres agences du gouvernement américain ?
  - a. Les différentes agences impliquées
  - b. Le type de collaboration
  - c. Opinion sur la collaboration
  - d. Recommandations d'amélioration
3. Est qu'il y a d'autres domaines pour une synergie d'activités complémentaire avec les partenaires existant ?
4. Quel est le niveau de réussite de l'approche dans l'amélioration de la participation des groupes cibles et des acteurs principaux ?
5. Est-ce qu'il y a eu des moyens formels ou informels pour une implication des acteurs principaux ?

6. Est-ce que les responsables du programmes on établi les liens nécessaires avec les agences gouvernementaux, le secteur privé et les organisations de la société civile ?
7. Est-ce que la durée de 36 mois était suffisante pour la mise en œuvre du projet ?
8. Qu'est qui doit changer pour permettre d'accélérer ou de passer à l'échelle ?

## **GUIDE D'ANALYSE**

### **Pertinence de la gestion**

1. Selon vous, quels sont les caractéristiques les plus important de la gestion dans le cadre de ce programme (personnel, matériel, les activités, les aspects financiers et administratifs) ?
2. Est-ce que ces aspects contribuent à l'éteinte des objectifs dans les délais spécifiés ? Comment ces aspects contribuent a l'atteintes des résultats attendus ?
3. Est-ce ces aspect ont contribués à une non atteinte des résultats attendus? si oui comment ?
4. Quels sont les changements nécessaires pour atteindre les résultats attendus ?
5. Quel est le niveau de faisabilité de ces changements ? (personnel, matériel, les activités, les aspects financiers et administratifs) ?

### **Couverture et réponse des bénéficiaires**

1. Est-ce que les bien et services offerts on atteints les bénéficiaires principaux et autres populations cibles ?
2. Est-ce que les objectifs étaient réalistes ?
3. Quel est le niveau d'utilisation des biens et services par les groupes cibles ?
4. Quel est le niveau de renforcement des organisations publiques, privé ou de la société civile ?
5. Quel est le niveau de progrès réalisé dans le développement, la mise en œuvre du renforcement des capacités au sein des services gouvernementaux, des organisations du secteur privé et de la société civile ?

### **Pérennisation**

1. Quels sont les lois et règlement, ou barrières administratives auxquels le programme doit faire face pour atteindre les résultats escomptés ?
2. Est-ce que les lettres d'accord ou les autres méthodes d'intervention ont favorisé la pérennisation ? Comment assurer le transfert des activités et des compétences dans le sens d'une pérennisation à la fin du programme ?
3. Quels reformes institutionnelles pourrait aider la continuation l'élan ?

## **GUIDE GOUVERNEMENT**

1. Qu'elle est votre point de vue du programme USAID/SENEGAL/VIH/TB ?
2. Quelle est sa contribution par rapport aux programmes nationaux VIH/TB ?
3. Que pensez vous de la détérioration de l'environnement ?
4. Que pensez vous du focus des bailleurs de fond sur les groups á risque ?
5. Quels sont les problèmes associés aux MSM ?
6. Que doit faire l'USAID au sujet des MSM ?
7. Avez vous des contraintes avec the Programme HIV/AIDS/TB ?
8. Quels sont les problèmes de prise en charge des TB-MDR ?
9. Quelles sont vos recommandations d'amélioration ?



## **GUIDE PARTENAIRES IMPLEMENTATION**

### **I. CONTEXTE DU PROGRAMME**

1. Qu'elles étaient vos perspectives et les objectifs visés pour ce programme ?
2. Quels sont les fonds reçus pour les deux volets ?
3. Est-ce qu'il y avait d'autres sources de financement ?
4. Quels sont les mécanismes de financements ?

### **II. ADÉQUATION DES ACTIVITES**

1. Quelles sont les activités menées dans le cadre du programme ? cibles ? acteurs ?
2. Les résultats obtenus ? positifs ? négatifs ? les gaps ?
3. Les couts sont t'ils raisonnables, suffisants ?
4. Les contraintes / les goulots d'étranglement ?
5. Recommandations d'amélioration, en terme financier

### **III. COHÉRENCE DU PROGRAMME**

1. Est-ce que le programme a pu réaliser les activités planifiées dans les délais requis ?
2. Qu'elles sont les principales contributions au programme TB/VIH du Sénégal ?
3. Est-ce que la fluctuation du taux de change du \$ a impacté les résultats attendus ?
4. Si oui comment ? si non qu'est qui a été fait ?
5. Quel est votre rôle dans la prévention du stigma et de la discrimination ?
6. Comment faites-vous face à la détérioration de l'environnement de la réponse ?
7. Quelles sont les activités transfrontalières qui pourraient être intégrées dans le programme en cas de ressources additionnelles ?

### **IV. PERTINENCE DES APPROCHES**

1. Comment les activités on été coordonnées avec celles financés par le FM ou la BM ?
2. Quel type de collaboration a été mis en place avec les autres partenaires dans le cadre de la mise en œuvre de ce projet ?
3. Est qu'il y a d'autres domaines pour une synergie d'activités complémentaires avec les partenaires existants ?
4. Quel est le niveau de réussite de l'approche dans l'amélioration de la participation des groupes cibles et des acteurs principaux ?
5. Est-ce qu'il y a eu des moyens formels ou informels pour une implication des acteurs ?
6. Est-ce que les responsables du programmes on établi les liens nécessaires avec les agences gouvernementaux, le secteur privé et les organisations de la société civile ?

7. Quelle est la durée de votre intervention ? Était-elle suffisante pour la mise en œuvre du projet ?
8. Quelles sont vos recommandations (pour permettre d'accélérer ou de passer à l'échelle) ?

#### **V. PERTINENCE DE LA GESTION**

1. Quel est le niveau de satisfaction par rapport aux différents aspects du programme (personnel, matériel, les activités, les aspects financiers et administratifs) quant à l'atteinte des objectifs dans les délais spécifiés ?
2. Quels sont les changements nécessaires pour l'atteinte des résultats ?
3. Quel est le niveau de faisabilité de ces changements ?

#### **VI. COUVERTURE ET RÉPONSE DES BÉNÉFICIAIRES**

1. Est-ce que les biens et services offerts ont atteint les bénéficiaires principaux et autres populations cibles ?
2. Est-ce que les objectifs étaient réalistes ?
3. Quel est le niveau d'utilisation des biens et services par les groupes cibles ?
4. Quel est le niveau de progrès réalisé dans le développement, la mise en œuvre du renforcement des capacités au sein des services gouvernementaux, des organisations du secteur privé et de la société civile ?

#### **VII. SYSTÈME DE SUIVI EVALUATION**

1. Quel est le système de monitoring mis en place dans le cadre de ce programme ?
2. Est-ce que ce système a donné des résultats comme prévus ?
3. Êtes-vous satisfait des résultats atteints ?

#### **VIII. PÉRENNISATION**

1. Est-ce que les lettres d'accord ou les autres méthodes d'intervention ont favorisé la pérennisation ?
2. Comment assurer le transfert des activités et des compétences dans le sens d'une pérennisation à la fin du programme ?
3. Quelles réformes institutionnelles pourraient aider la continuation de l'élan ?

#### **IX. RECOMMANDATIONS GÉNÉRALES**

## **GUIDE USAID**

### **I. CONTEXTE DU PROGRAMME**

1. Qu'est ce qui sous tendait la mise en place de ce programme ?
2. Quels sont les objectifs visés ?
3. Quelles sont les interventions majeures ?
4. Quels sont les fonds engagés pour les deux volets ?
5. Quels sont les mécanismes de financements ?

### **II. COORDINATION**

1. Que pensez-vous de la coordination de ce programme ?
  - a. Est-ce qu'il ya eu une coordination avec les programmes du FM ou de la BM ?
  - b. Quel est le niveau de collaboration entre les agences d'exécution de l'USAID et les autres agences du gouvernement américain dans le cadre de ce programme ?
2. Recommandations d'amélioration

### **III. COHÉRENCE DU PROGRAMME**

1. Est-ce que vous avez d'autres contributions au programme TB/VIH du Sénégal ?
2. Est-ce que la fluctuation du taux de change du dollar a été une contrainte majeure pour le programme ? comment et qu'est ce qui a été fait ?
3. Avez-vous joué un rôle dans la prévention du stigma et de la discrimination ?
4. Quel a été votre rôle face à la détérioration de l'environnement de la lutte contre le VIH ?

### **IV. ADÉQUATION DES INTERVENTIONS ET NIVEAU DE SATISFACTION**

1. Les contraintes / les goulots d'étranglement dans la mise en œuvre de ce programme ?
2. Quel est votre niveau de satisfaction par rapport au fonds programmés ?
3. Quel est votre niveau de satisfaction par rapport à la mise en œuvre de ce programme ?
4. Recommandations d'amélioration, en terme financier

### **V. SYSTÈME DE SUIVI EVALUATION**

1. Quel est le système de monitoring mis en place dans le cadre de ce programme ?
2. Est-ce ce système a pu fournir des résultats ?
3. Quel est votre niveau de satisfaction par rapport à ces résultats ?

### **VI. PÉRENNISATION**

1. Quelles reformes institutionnelles pourrait aider la continuation l'élan ?
2. Quels sont vos plans et recommandations pour le future (continuation, passage à l'échelle) ?



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