

FHI 360 Pilot Project of Technical Support For Health System Strengthening Activities in Senegal: Evaluation Report

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Acronyms

AIDS: Acquired Immune Deficiency Syndrome

AP: Action Plan

CAS/PNDS: National Health and Social Development Plan and Monitoring Unit (Cellule d'Appui et de Suivi du Plan National de Développement Sanitaire)

CDMT: Medium-Term Expenditure Framework (Cadre de Dépenses à Moyen Terme)

CDSMT: Medium-Term Sectoral Expenditure Framework (Cadre de Dépenses Sectoriel à Moyen Terme)

CNTS: National Center of Blood Transfusions (Centre National de Transfusion Sanguine)

DEM: Direction of the Equipment and Maintenance

DLSI: Division of the Fight against AIDS and STI (Division de Lutte contre le SIDA et les IST)

DOSA: Discussion Oriented Organizational Self-Assessment Tool

DPL: Direction of Pharmacy and the Laboratories

EDS: Social and Health Survey

FHI: Family Health International

FY: Fiscal Year

GFATM: Global Fund to Fight against AIDS, Tuberculosis and Malaria

GMS: Grant Management Solutions

HD: Health District

HIV: Human Immunodeficiency Virus

HSS: Health System Strengthening

IPS: Integrated Package of Services

LA : Letter of Agreement

LNCM: National Laboratory for Drug Quality Control

MNCH: Maternal Neonatal and Child Health

MOST: Management Organizational Sustainability Tool

MR: Medical Region

ORCAP: Tool for Capacities Reinforcement by Participative Self-Analysis (Outil de Renforcement des Capacités par Auto-analyse Participative)

PNA: National Procurement Pharmacy (Pharmacie Nationale d'Approvisionnement)

PNDS: National Health and Social Development Plan (Plan National de Développement Sanitaire)

PNT: National Program against Tuberculosis (Programme National de lutte contre la Tuberculose)

POCL: Community Health Plan (Plan Opérationnel de Collectivité Locale)

PRONALIN: National Program of for the Fight against the Nosocomial Infections (Programme National de Lutte contre les Infections Nosocomiales)

PRSP: Poverty Reduction Strategy Paper

PTA: Annual Work Plan (Plan de Travail Annuel)

SNIS: National Health Information Division (Service National de l'Information Sanitaire)

TOCAT: Technical and Organizational Capacity Assessment Tool

USAID: United States Agency for International Development

WHO: The World Health Organization

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Executive Summary

FHI 360 undertook a pilot project of technical support for the implementation of health system strengthening activities in Senegal as part of its health systems strengthening strategy. In 2010, the Ministry of Health - through the Division of the Fight against AIDS and STI (DLSI) - was nominated as the principal recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria's grant (Round 9) for the responsibility of health system strengthening activities in Senegal. To implement the grants, agreements were signed between the DLSI and twenty-two (22) sub-recipients including the fourteen (14) medical regions and eight (8) entities of the health systems at the central level. At the peripheral level, each region was at the forefront of the implementation of the activities of the Global Fund to Fight AIDS, Tuberculosis and Malaria's grant (Round 9). The technical assistance brought by the Grant Management Solutions project¹ to Senegal did not include technical support for the medical regions.

By engaging its own funds, FHI 360 responded positively to the request for technical assistance from the DLSI in the three (3) Medical Regions of Kolda, Sedhiou and Ziguinchor. FHI 360 already had a partnership with the DLSI in these three (3) regions through a co-operative agreement between the United States Agency for International Development and FHI 360 to fight the Human Immunodeficiency Virus in Senegal. This request was anchored in a long-term collaboration in which FHI 360 has been considered as a "go-to" partner for technical assistance by the DLSI. Moreover, this partnership had led to the creation of an effective mechanism of direct financing of the public health activities at the decentralized level named the "Letter of agreement." The letter of agreement is a technical and financial agreement between FHI 360 and the health systems entities in Senegal. Over the years, this mechanism has been a key instrument of the decentralization policy implemented by the Ministry of Health in Senegal.

The FHI 360 pilot project to support health system strengthening activities has three (3) components:

- The introduction of the Tool for Capacity Reinforcement by Participative Self-Analysis (ORCAP) into the Medical Regions of Kolda, Sedhiou and Ziguinchor;
- Technical assistance with the implementation of the health system strengthening activities in the three (3) regions and at the DLSI; and
- The training of sub-recipients' staff in the methods of financial and operational arrangements of the Global Fund grant (round 9)

The ORCAP is a technical and organizational assessment tool developed in close cooperation with the DLSI. This tool is tailored to six (6) domains of the health systems equivalent to the building blocks framework defined by the World Health Organization in 2007. These building blocks outline the essential functions of a health system and can be used as a framework for planning and priority-setting.

The ORCAP is designed to self-assess the technical and organizational capacities of medical regions using the six (6) health system domains as a framework. The participative self-assessment approach underlines the preliminary question of "how to better work" within the domains. This approach is displayed as a cycle of quality improvement. This continuous cycle of self-assessment is integrated into planning activities of the medical regions, including the activities of various disease-oriented programs as well as health system strengthening interventions. This cycle combines planning and

¹ The Grants Management Solutions (GMS) Project is a project funded by the United States Agency for International Development lead by the Management Sciences for Health (MSH). GMS provides urgent, short-term technical assistance to countries with grants from the Global Fund in four areas: guidance to Country Coordinating Mechanisms; financial and grants management; procurement and supply management; and monitoring, evaluation, and reporting.

evaluation: ORCAP allows the identification of specific needs, translated into activities that are part of an action plan ORCAP. The action plan ORCAP then is integrated partially or completely into the annual work plan of each region.

The second component of the pilot project is the technical assistance with the implementation of the health system strengthening activities. Six staff members of FHI 360/Senegal worked part-time during a nine-month period to support the implementation of health system strengthening activities. A consultant recruited by FHI 360 was worked 60% of his time to support the DLSI and the medical regions to implement these activities. The human resources deployed by FHI 360 from January to September 2011 represent the equivalent of a full-time person over 9.5 months.

The third component of the pilot project is the training of the sub-recipients' staff in the methods of financial and operational arrangements of the Global Fund round 9 grants. A workshop was held in November 2010 in collaboration with the DLSI. The National Health Information Division facilitated the training of health planners while a joint team of financial experts from FHI 360, the Grant Management Solutions and the DLSI organized the training of finance and administrative staff of Global Fund's sub-recipients.

This evaluation report focuses on the relevance, the effectiveness and the results of the FHI 360 pilot project. The methodology used is a rapid appraisal method involving: (1) the collection and analysis of existing documentation; (2) nineteen (19) semi-structured qualitative interviews and two (2) focus groups at the central and operational levels; and (3) the collection and analysis of quantitative data. Although commissioned by FHI 360, the evaluation was conducted by an independent consultant with no prior collaboration with FHI 360. The evaluation presented in this report thus can be described as semi-independent.

The principal limitations of the data collected in this evaluation are that: (1) the evaluation was held before the end of the first year technical support implementation; (2) the information generated by rapid appraisal methods is less valid and reliable than that in more formal methodology; (3) the underrepresentation of the eight (8) sub-recipients of the Global Fund at the central level; and (4) the gathering of the data was affected by strikes of the health sector in two (2) of the (3) regions.

The qualitative data of the study reveal that ORCAP is perceived in the medical regions as a relevant and effective tool in the first year of implementation of health system strengthening activities. ORCAP is perceived as an innovative tool, which complements the traditional approach of supervision. It provides "a place to exchange" issues within the regional medical teams, which is perceived as legitimate by the respondents.

ORCAP is perceived as a "dashboard" and allows a systemic approach that gives a holistic vision of the health care system at a medical regional level. ORCAP fills the gaps of the programmatic approach that traditionally frames the structure of health plan. While the annual work plans developed by medical regions are mainly centered on objectives that aim to address specific diseases, ORCAP allows planning for health system strengthening activities, which were identified by the self-assessment and which previously might be ignored.

The degree of appropriation of the tool at medical region level is high in spite of a very recent introduction. On the other hand, the perception of ORCAP remains conceptual and unclear at the central level.

The relevance of ORCAP depends on the right selection of the participants who will take part in the self-assessment. The domains are perceived as unequal in quality, particularly the one dealing with governance.

At the quantitative level, the effectiveness of the ORCAP is illustrated by the strong correlation between the domains which were self-evaluated with a low score (and, therefore, in need of improvement) and the number of planned actions carried out in these low-score functions of the health system. The domains identified as priority by the three regions were service delivery, health workforce and leadership and governance.

The analysis of the ORCAP action plans in the three (3) regions reveals that the medical regions identified an average forty-seven (47) health system strengthening activities over six (6) months. These activities are divided into two groups: activities which require additional means (financial or material) and activities which do not require additional means. The evaluation was made in the fourth month of the implementation of the ORCAP action plans which were validated at the end of May 2011.

The medical regions of Kolda and Sedhiou chose to integrate 100% of the ORCAP action plan's activities into their annual work plans, leading to one (1) single tool for planning health activities in the regions. The region of Ziguinchor decided to integrate on 12% of ORCAP activities in their annual work plan supporting the fast execution of ORCAP actions while avoiding their dilution in the annual work plan. The data analysis shows a rate of execution of the ORCAP action plan of 31% and 39% for the regions of Kolda and Sedhiou respectively, and a rate of execution of 47% for the region of Ziguinchor.

ORCAP is perceived as a flexible tool that assists in filling planning gaps in the Global Fund proposal with the solutions that it generates. Changing an activity funded by the Global Fund is a long and very bureaucratic process. ORCAP makes it possible to "catch up" with the activity planning included in the Global Fund proposal.

Some respondents clearly highlighted the relevance of the combination ORCAP - Letter of agreement for the mobilization of the resources in the medical regions in which multiple donors are present. After the integration of the ORCAP action plan in the annual work plan, the annual work plan is presented to the local partners during the fourth quarter of the year. Health system strengthening activities which do not find funding or require fast-track funding might be eligible for a letter of agreement request to FHI 360.

The regional medical teams thought of FHI 360 technical assistance as relevant and effective up to and including the planning of the ORCAP action plan. The teams felt that they needed a more constant technical assistance during the implementation and monitoring phase of ORCAP plans. At the level of the DLSI, the respondents focused on the need for a feedback loop between the central and operational level providing feedback pilot project information to the central level.

The training workshop which was held in November 2010 is perceived as relevant in the context of the year 1 implementation of health system strengthening activities, particularly in the newer medical regions, such as Sedhiou. Moreover, the training relevance is also linked to its content: some cross-cutting activities of the Global Fund Proposal round 9 aim at strengthening the health information system and the financial management of grant. The effectiveness of the training remains difficult to evaluate because the first annual planning cycle was not yet completed at the time of the evaluation.

The result of the ORCAP exercise was the creation of a performance baseline of the technical and organizational capacities of medical regions, setting up the foundations necessary to the later cycles of performance evaluation. The respondents estimate that, in the long run, ORCAP facilitated the implementation of the activities of the annual work plan - an assertion to be checked by quantitative data to be collected at the end of the annual planning cycle.

After four months of implementation, the rates of execution of ORCAP plans are satisfactory. This result corroborates the perception of the respondents that ORCAP strengthens their competencies in

organizational, financial, and technical management. Because the second ORCAP self-assessment of the performances of the medical regions has yet not taken place, it is difficult to evaluate the impact of ORCAP on the competencies of the medical region teams.

The lessons drawn from this evaluation make it possible to design an effective model of technical support to the health system strengthening activities funded by the Global Fund at the regional level beyond Senegal. The FHI 360 technical support model consists of three (3) pillars:

- A continuous cycle of quality improvement of the performance of the health care system using participative self-assessment (ORCAP) integrated in the planning cycle of the medical regions;
- A contractual mechanism supporting health system strengthening activities using “Letter of agreement”, making possible a flexible and decentralized funding to activities identified by the regions; and
- A technical assistance to build the capacities of the medical regions and districts in health system strengthening activities, with a strong quality improvement component, together with a feedback loop between the operational and central level.

In the light of this preliminary evaluation, the technical support model should allow an improvement of the capacities of the medical regions as regards to organizational, financial, and technical management in the six domains. Since the health system strengthening interventions are cross-cutting, an improvement of the quality of the services in the health care system at regional level should be reflected in the health indicators. In the same way, the Global Fund Proposal Round 9 indicators related to health system strengthening should be improved by this model. These two assumptions remain to be checked by a later evaluation.

This evaluation recommends the institutionalization of the ORCAP at the districts and regional levels as a next step. The integration of an annual self-evaluation preceding the formulation of the annual work plan should be institutionalized to complement disease specific programs work plans. ORCAP could be a precondition to the annual planning to optimize the powerful combination of ORCAP - Letter of agreement.

The implementation of a monitoring and evaluation plan of the technical model is an important stage to measure the impact of this approach on:

- The improvement of the capacities related to organizational, financial, and technical management of the medical regions and districts in the six domains;
- The improvement of the quality of the services in the health care system at the regional and district levels;
- The outreach of health system strengthening objectives funded by the Senegalese government, the Global Fund and other donors.

The FHI 360 technical model of support allows countries to better coordinate an effective and efficient response to the needs of the Ministry for Health and Prevention for health system strengthening activities, including those not taken into account by programs targeting a disease (or a group of population) or by an incomplete planning of the activities included in the Global Fund proposals. The added-value of this model for the Global Fund is that it supports the top priorities of the Fund. The Fund acts like a financial instrument, and not like an implementation entity, relying on a vast network of partners, promoting the diffusion of knowledge at the local level, and supporting a technical assistance according to the needs expressed by countries. The Fund fills the gaps of the national efforts just as the FHI 360 model fills the existing gaps of the health system interventions at the regional level. The combination ORCAP-Letter of agreement precedes a better rationalization of health system

resources coming from various donors at regional level, including those of the Global Fund to Fight against AIDS, Tuberculosis and Malaria.

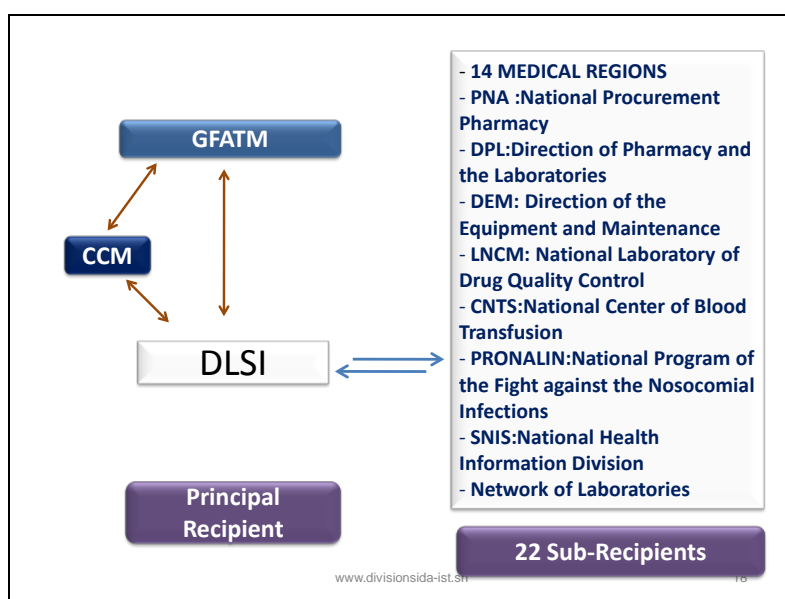
I. Introduction

FHI 360 has a long history of implementing programs to fight the Human Immunodeficiency Virus (HIV) in Senegal, and, for more than fifteen years, has built a close cooperation with the Division of Fight against AIDS and STI (DSL) of the Ministry for Health and Prevention. The FHI 360 approach is based on the principle of the institutionalization of interventions, building the capacities of the local institutions and stakeholders.

The United States Agency for International Development (USAID) funded several successful collaborations with FHI through the HIV/Syndrome of Acquired Immunodeficiency (AIDS) and Tuberculosis Health program (2006 - 2011), including a financial instrument developed by FHI 360 called the “Letter of Agreement” (LA). The LA is defined as a tripartite partnership agreement between the medical chief of the region, the head of the DSL, or of the National Program against Tuberculosis (PNT) for TB activities, and FHI 360 as the agency executing the USAID program. Through this contractual mechanism, the Medical Region (MR) can obtain technical assistance and financial resources for HIV/AIDS and Tuberculosis interventions in the region. The interventions are planned at the regional level and the districts according to their priorities and the orientations of the national programs. Incontestably the LA imposed itself as a Senegalese mechanism of decentralized partnership. The complete LA coverage of the nine (9) regions supported by USAID within the framework of this program was already reached in 2009.

In 2010, the Ministry Health, through the DSL, was nominated principal recipient of the Global Fund to Fight against AIDS, Tuberculosis and Malaria (GFATM) Round 9 grant for Health System Strengthening (HSS) activities. According to the DSL, the budget of the HSS component of phase 1 is 11,472,932 Euros for an implementation period running from July 2010 to December 2012. This first phase focuses on six (6) underprivileged priority regions: Matam, Tambacouda, Kedougou, Kolda, Sedhiou and Ziguinchor. For its implementation, agreements were signed between the principal recipient - the DSL - and 22 sub-recipients, namely the fourteen (14) MR and eight (8) specialized structures of the central level. (Figure 1)

Figure 1: GFATM grant’s recipients (Round 9)



The support given by the Grant Management Solutions (GMS) to the Senegalese government provides valuable central –level support, but does not include technical assistance at the regional levels that

carry out a large portion of GFTAM Round 9 activities. As a result, the DLSI asked for FHI 360 technical support.

By committing its own funds, FHI 360 undertook a pilot project of technical support for the implementation of HSS activities in Senegal as part of FHI 360 HSS strategy. The strong partnership between FHI 360 and the DLSI led to a one-year memorandum to support the implementation of the activities “HSS Year-1.”

The FHI 360 pilot project to support HSS activities has three (3) components:

- The introduction of the Tool for Capacities Reinforcement by Participative Self-Analysis (ORCAP) into the MRs of Kolda, Sedhiou and Ziguinchor
- The technical assistance for the implementation of the HSS activities in the three (3) regions and at the DLSI
- The training of sub-recipients’ staff to the methods of financial and operational arrangements of the GFTAM round 9 grant.

This report presents the results of the evaluation of the pilot project of technical support of FHI 360 to three (3) regions of Senegal which received GFTAM grant for HIV/AIDS activities. Although commissioned by FHI 360, the evaluation was held by an independent consultant with no prior collaboration with FHI 360. The evaluation presented in this report can thus be described as semi-independent.

This evaluation has three specific objectives:

- To document the process and the results of the pilot project to support the Ministry for Health and Prevention and the MRs in the implementation of the HSS activities funded by GFATM;
- To collect stakeholders’ views (DLSI, MRs and others sub-recipients) on pilot’s factors of success and constraints;
- To make recommendations to improve the effectiveness of a technical model of support to the HSS activities in Senegal (and in general) based on lessons learned.

The complete terms of reference of this evaluation are presented in Appendix I.

II. Evaluation context

The Republic of Senegal is located in West Africa. In 2009, the population of Senegal was estimated at 12.1 million inhabitants with a strong concentration of the population on the coast and in the center of the country. The region of Dakar concentrates 22.4% of the total population whereas it covers only 0.3% of the national surface. The regions of Kolda, Sedhiou and Ziguinchor combined represents 12% of the Senegalese population.

Table 1: Senegal: quick facts

Indicators	2009
Population, total (millions)	12.1
Population growth (annual %)	2.7
GDP (current US\$) (billions)	12.8
GDP per capita (US\$)	1,056
GDP growth (annual %)	2.2
Life expectancy at birth, total (years)	58.6
Infant Mortality rate, (per 1.000 live births)	50.8
Prevalence of the HIV, total (% of the population ages 15-49)	0.9

Source: World Indicators Development

The Senegalese population has more than doubled in thirty (30) years. This population growth is mainly due to the natural increase in the population with an annual growth rate between 2000 and 2009 estimated at 2.9%. In 2009, the aggregative index of fertility was estimated at 4.9 per woman and the crude of birthrate was of 38 per thousand (source UNICEF).

Senegal is often cited as a country that did respond quickly and effectively to the AIDS crisis. Indeed, the HIV prevalence within the general population was estimated at 0.7% by the Demographic and Health Survey in 2005. Regional disparities were also noted with strong HIV prevalence in the regions of Ziguinchor (2.2%) and Kolda (2%).

The health system in Senegal has a three-level pyramidal structure:

- The central level: National hospitals, the office of the Minister, the National Directorates and attached services.
- The intermediate level: Medical Regions (RMs)
- The peripheral level: Medical districts

The MR corresponds to an administrative region and is directed by a doctor of public health who is the medical chief of the region. There are 14 MRs in Senegal. Some MRs were recently created, including Sedhiou created in 2008. These new MRs suffer from a lack of infrastructure². Remote regions suffer from a serious insufficiency in human and logistic resources.

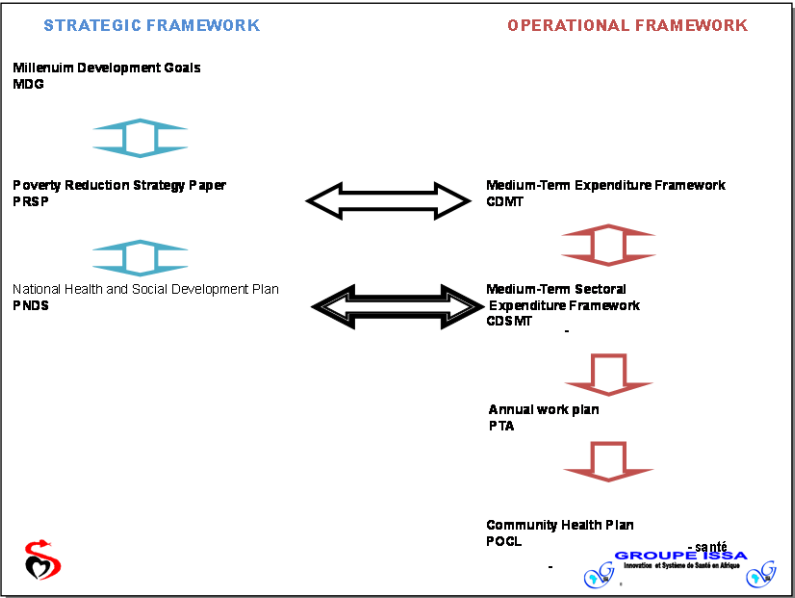
The MR is a structure of regional coordination in charge of:

- The inspection and control of public and private medical entities of the region
- The technical collaboration between all the health system’s regional entities
- The technical support to these entities in the area of administration, management and planning.

The peripheral level is made up by the medical districts, the smallest level of the health care pyramid. Senegal counts 75 medical districts managed by a medical chief of district. It consists of health centers (78) and a network of health posts (1,112) that supervise the health huts and rural maternities units.

Figure 2 below described the framework of the strategic and operational planning in Senegal.

Figure 2: Strategic and Operational Planning in Senegal



The Implementation of the Poverty Reduction Strategy Paper (PRSP) is made through the Medium-Term Expenditure Framework (CDMT) which translates PRSP into public expenditure programs within a coherent multiyear macroeconomic and fiscal framework.

The Implementation of the National Health and Social Development Plan (PNDS) is made through the Medium-Term

² Carte Sanitaire du Senegal 2009

Sectorial Expenditure Framework (CDSMT) which is a three-year plan outlined in annual work plans (PTA) which take into account the Community Health Plan Plans (POCL)

The major identified weaknesses of the Senegalese health care system are: (1) the limited availability and access to care services; (2) insufficient human resources in quality and quantity; and (3) limited capacities in the fields of planning, information system, supervision and coordination. Consequently, cross-cutting HSS interventions of the GFTAM proposal round 9 are:

- The increase of coverage by public, private, and community health facilities integrating HIV, tuberculosis and malaria priority interventions in services provisions, including maternal, neonatal, and infant health and curative consultation ;
- The strengthening of technical equipments and improvement of access to quality medical products at all levels of the health pyramid ;
- The increase of availability of skilled human resources to implement the package of key services integrating HIV, Tuberculosis, and malaria ;
- The strengthening of the Monitoring and Evaluation System;
- The Strengthening of the management and coordination system.

III. Pilot Project Tools

FHI 360/Senegal has a long tradition of collaboration with the DLSI and is regarded as a key strategic partner. The Fiscal Year (FY) budget 2011 for the FHI 360 sub-agreement with the DLSI is of \$ 395,000 (US) and is funded through the USAID/Senegal HIV/AIDS and Tuberculosis program (2006-2011). Fifty percent of these funds are sub-contracted at the regional medical offices using the LA mechanism to facilitate the decentralization of HIV and tuberculosis programs at the medical district level.

The LA is a contractual arrangement signed by each MR, the head of the PNT or the DLSI, and FHI 360. This contractual arrangement requires five stages: (1) the planning and preparation of the contractual documents; (2) the development of the requests; (3) the transfer of the funds; (4) the implementation of interventions; and (5) the technical and financial justification of the expenditure. Planning is a participatory process that is performed annually at the district level based on the technical orientation of the national programs and the budget available for the FY. The medical district and the MR formulate the requests based on quarterly plans. The MR validates the requests transmitted by the medical district, merges them in the same document, and sends them to FHI 360 for a funding request. FHI 360 studies the requests and wire funds to a MR bank account specific to FHI 360/USAID transfers. Two positive evaluations of this contractual mechanism showed the value of this instrument to build operational capacities in the area of technical coordination, financial administration, and formulation of technical and financial reports. It should be noted that in FY2011, HSS activities under by the GFTAM are not eligible for funding through LA.

Strengthening a health care system implies knowing its strengths and weaknesses. For this purpose, it was important for the DLSI and its partner FHI 360 to: (1) understand the baseline situation of the health care system at the MR level, (2) develop realistic actions; (3) analyze these actions; and (4) adjust them, if needed, for a greater effectiveness. It is within this framework that the ORCAP was used in the three (3) targeted MRs.

Examples of cross-cutting HSS interventions of the GFTAM proposal (round 9)

-Strengthening the regional executive teams in human resources with adequate skills in activity planning and monitoring

- Support for the implementation of annual reviews of HIV, Tuberculosis and Malaria programs in national level workshops on monitoring/review

- Technical assistance for strengthening Monitoring and Evaluation systems

The ORCAP is a tool for situational analysis adapted from the TOCAT (Technical and Organizational Capacity Assessment Tool), itself developed by FHI 360 in 2003 using three tools: Management Organizational Sustainability Tool (MOST) of Management Sciences for Health, the Discussion Oriented Organizational Self-Assessment (DOSA) of the Educational Development Center and the technical tool to evaluate the capacities related to HIV/AIDS interventions developed by FHI 360 named FACT. The DLSI and FHI 360 adapted the ORCAP to the Senegalese HSS context and to the medical regions during several planning meetings. During this process, the ORCAP tool was tailored to reflect the domains of HSS interventions funded by the GFTAM, so that it matches Senegal's GFTAM HSS proposal Round 9. The domains reflect the building blocks of the health systems framework defined by the World Health Organization (WHO) in 2007.

The ORCAP can cover all the levels of services offered by the MR: the regional level; the level district (health center); and the health post level. However during the first exercise in Senegal it was applied only to the regional level. It analyzes the health structure's capacities and needs around six (6) domains subdivided into components. The 6 domains are the following ones:

Domain 1. Health service delivery

- Component 1: Adequate readiness of the physical infrastructure and equipment
- Component 2: Number, composition and capacities of technical staff
- Component 3: Policies, standards and protocols of services
- Component 4: Availability of services and quality assurance
- Component 5: Readiness of service delivery
- Component 6: Supervision and monitoring

Domain 2. Medical products, vaccines and technology

- Component 1: Adequate supply of drugs, commodities and technical equipment
- Component 2: Storage, distribution and inventory control of the drugs, commodities and equipment
- Component 3: Procurement, supply and storage systems
- Component 4: Quality assurance control
- Component 5: Cross-cutting issues with commodities, vaccines and technology

Domain 3. Health workforce

- Component 1 : Human resources management
- Component 2 : Management of Workforce motivation

Domain 4. Health information systems

- Component 1 : Operational planning
- Component 2 : Data collection and dissemination system
- Component 3 : Monitoring and Evaluation

Domain 5. Leadership and governance

- Component 1: Coordination and facilitation
- Component 2: Organisational Structure
- Component 3: Delegation of responsibilities and decision making
- Component 4: Governance

Domain 6. Health system financing

- Component 1: Formulation and submission of funding requests
- Component 2: Development of financial reports

- Component 3: Financial planning and budgeting
- Component 4: Cash management , bank account and accounting
- Component 5: Financial management
-

The performance of each component is defined by standards. The process of self-assessment encompasses two levels: individual evaluation (using an individual form) and consensus building (group discussions dealing with domains and specific components). An individual form exists for each component. For example, the form used for the domain 1 is presented in Appendix II. Each indicator included in the individual form is evaluated as follows: 0 for none (indicator does not exist), 1 for yes - partly, 2 for yes - a majority, and 3 for yes - entirely.

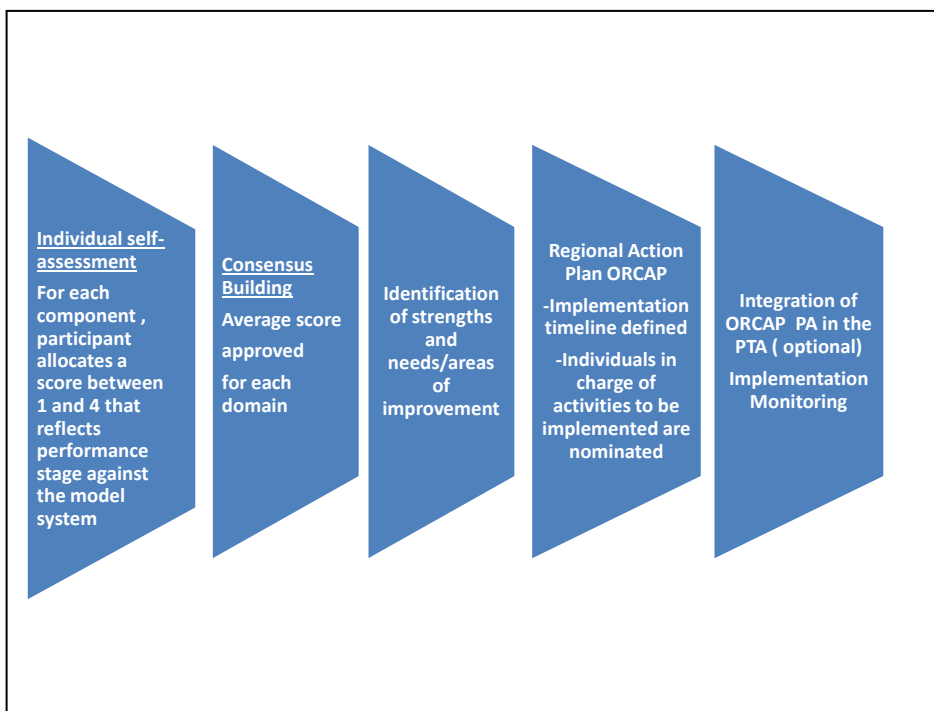
The compilation of the grades for all the standards allows the calculation of a percentage which reflects the level of performance of the health care system for each component: between 0 and 25%=1 (initial stage); between 26 and 50%= 2 (visible results); between 51 and 79%=3 (systematized visible results); and between 80 and 100%=4 (“model” system).

Once, the exercise of self-assessment carried out, the MR can:

- Identify the RM strengths and fields requiring improvements
- Formulate solutions translated into actions
- Define an action plan (AP) ORCAP
- Integrate the ORCAP PA in the PTA (optional)

Figure 3 described ORCAP self-assessment process.

Figure 3: ORCAP self-assessment process



The ORCAP approach is a key element of a continuous cycle of quality improvement of the health care system performance at MR level, which comprises periodic self-assessments and a harmonization with the PTA activities that includes at the same time activities of various disease-specific programs and HSS

interventions by the GFTAM.

IV. Evaluation Questions

The evaluation questions formulated by the FHI 360 team concentrate on the relevance, the effectiveness and the results of the FHI 360 pilot project to support to HSS activities at the central level (DLSI and other sub-recipients) and at the operational level (medical regions of Sedhiou, Kolda and Ziguinchor).

Relevance of FHI 360 pilot project to HSS activities

The evaluation questions are linked to relevance, that is, what is perfectly appropriate to the identification of the health care system's issues, and, thus, to the planning of the HSS activities.

- *Did ORCAP identify additional HSS issues that were unknown by the regional medical teams?*
- *Did the suggested solutions prove to be suitable and feasible?*
- *Was the use of ORCAP perceived as a practical tool that helps improving the quality of health care services at the MR level in order to reach the quality standards?*

Effectiveness of FHI 360 pilot project to HSS activities

Effectiveness refers to the extent to which the objectives of the FHI 360 pilot project are achieved or are likely to be achieved.

- *Was there a true integration of ORCAP activities in the PTA?*
- *Did the use of ORCAP lead to the empowerment of the regional medical teams with respect to HSS activities?*
- *What is the LA role in the context of multiple financing of HSS activities?*
- *Do the sub-recipients (MRs) perceive/use LA agreements as a tool to help harmonize funding from different sources?*

Long-term results of FHI 360 pilot project to HSS activities

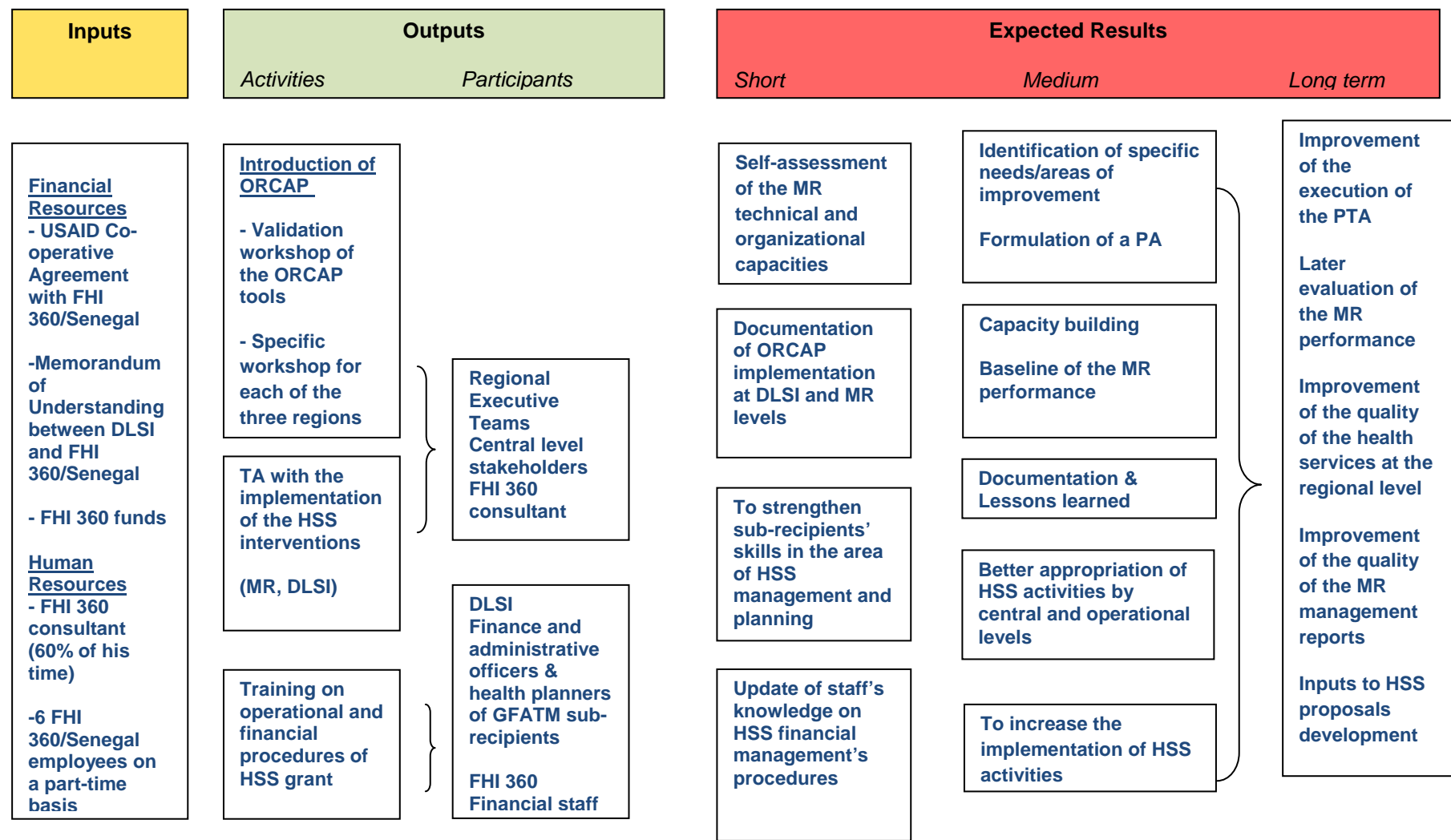
The questions below return to the concept of long-term results i.e. to the effects which are caused by (or due to) FHI 360 technical support.

- *Did ORCAP effect the implementation of PTA HSS activities in the three regions?*
- *Which are the constraints that hinder the implementation of FHI 360?*
- *Does the DLSI intend to carry ORCAP self-assessments in other regions in the years to come?*

V. Evaluation logic model

The logic model of the evaluation is presented below (Figure 4). This framework helps define what the FHI pilot is and what it will do. It displays the sequence of interventions of the pilot project and determines the causal links between the various elements of the chain of actions of the pilot. For the purpose of this evaluation, three (3) core components depict this sequence of intervention: inputs, outputs and outcomes (results expected in the short, medium and long term).

Figure 4: Logic model of the evaluation of FHI 360 Pilot Project to support HSS activities



1. Inputs: Human and Financial Resources

Human Resources

Table 2 below illustrates the human resources deployed by FHI 360 from January to September 2011 to support the implementation of HSS activities by attending coordination meetings at the central and regional levels, by facilitating ORCAP workshops and by ensuring a follow-up of the pilot activities at the MR level. A FHI 360 consultant worked 60% of his time during a nine-month period to document the implementation of HSS activities in order to support and prepare the rollout of ORCAP to other regions. The human resources described in Table 2 below represent the equivalent of a full-time person over 9 ½ months for a total of \$40,423 (US). It should be noted that DLSI mobilized five (5) members of his team on a part-time basis to support the pilot project.

Table 2: Human resources of the FHI 360 Pilot Project (January to September 2011)

Institution	Function	% of time HSS	# of months
Consultant FHI 360	Technical Assistance	60%	9
FHI 360	Technical Assistance	15%	9
FHI 360	Program	30%	3
FHI 360	Technical Assistance	10%	6
FHI 360	Finance	5%	9
FHI 360	Finance	3%	9
FHI 360	Management	5%	9

Source FHI 360 Senegal

Financial Resources

The FHI 360 budget devoted to the pilot project activities over the January-September 2011 period is included in the agreement signed between the DLSI and FHI 360/USAID. It is presented in the table 3 below by type of activity and funding sources. This budget represents a total of about \$110,000 (US) over nine (9) months (human resources included).

Table 3: Budget of the FHI 360 pilot project in US Dollars (January-September 2011)

Type of Activity	Funding FHI 360/USAID	Funding FHI360/Headquarters
Technical Assistance		
FHI/Senegal	33,660	
Consultant		30,600
Field Visits	14,280	
ORCAP		
Workshops	26,520	
Follow-up Visits	4,896	
TOTAL	79,356	30,600
Overall Total	109,956	

2. Outputs

The outputs include the interventions implemented during the FHI 360 pilot project.

The introduction of ORCAP by the FHI 360 team comprised of the following activities:

- Meetings between the DLSI and FHI 360 to formulate the first ORCAP draft at the end of 2010;
- A workshop in order to validate the ORCAP tools in January 2011 in Ziguinchor;
- A specific workshop for each of the three (3) regions from January to February 2011.

Technical assistance with the implementation of the HSS interventions included:

- Field trips to support the formulation of ORCAP PAs in each region in March 2011;
- Support for the validation of the ORCAP plan in May 2011;
- A follow-up with the implementation of the HSS activities at the regional and central level (DLSI).

A workshop was held in November 2010 in collaboration with the DLSI. The SNIS facilitated the training of health planners while a joint team of financial experts from FHI 360, GMS and the DLSI organized the training of finance and administrative staff of GFATM sub-recipients. The workshop aimed at achieving the following goals:

- To give an orientation on operational procedures of HSS grant;
- To strengthen sub-recipient staff knowledge on the procedures of financial management within the framework of the HSS;
- To strengthen health planner skills in health data statistics management;
- To improve the coherence of management reports at the district and MR levels;
- To strengthen management skills in the area of planning and implementation at the regional and district level.

The three (3) following modules were presented by the teams of FHI 360, GMS and the DLSI to the finance and administrative staff of GFATM sub-recipients:

1. Operational procedures - DLSI;
2. Role and responsibility of HSS managers - FHI 360: one half-day of workshop;
3. Financial management tools - GMS/FHI 360 /DLSI: 2 days of workshop. The FHI 360 tools for financial management used by the DLSI were adapted to the GFTAM procedures.

3. Expected Results

The expected results relate to the pilot project's achievements or the change in individuals, groups, organizations or systems due to FHI 360 pilot project exposure within the short, medium or long-term.

The self-assessment of the technical and organizational capacities of medical regions using ORCAP tool should produce the following results in the short and mid-term:

- The creation of a baseline for MR performance which will be the basis for measuring change over time;
- The identification of specific needs/areas of improvement and the formulation of an AP.

In the short and mid-term, the technical assistance of FHI 360 to the implementation of HSS activities in MRs at the DLSI - in particular through the technical assistance provided by the FHI 360 consultant - should allow the documentation of the ORCAP process and the lessons learned.

The short-term result of the training of GFATM sub-recipient's staff should be to improve the methods of financial and operational arrangements of the GFTAM round 9 Grants. In a more specific way, the expected results are:

- To strengthen sub-recipient skills in the areas of the management and planning of HSS interventions;
- To update of the knowledge of finance and administrative staff on the procedures of financial management of HSS activities.

In the mid-term, this activity is aimed at increasing the implementation level of HSS activities and a better HSS appropriation by the MR and the central level.

On the long run, the anticipated results of the pilot project of FHI 360 are as follows:

- Improvement of the execution of the PTA;
- A later evaluation of the performance of the MR;
- An improvement of the quality of the health services at the regional level;
- An improvement in the quality of the MR management reports;
- A contribution to the development of future proposals through the knowledge gained.

VI. Study Methodology

The methodology used is a rapid appraisal method. It includes the review and analysis of existing documentation and the collection and analysis of qualitative and quantitative data.

Annex III displays the list of the documentation reviewed and analyzed. It can be divided into three groups:

- Relevant general documents related to the Senegalese health care system, HSS the literature, and the GFTAM;
- Reports of workshops, assignments, and other internal FHI 360 documents;
- Documentary material and reports generated by the DLSI and the MRs.

Nineteen (19) individual key informant interviews were conducted at the central and operational levels on the basis of semi-structured qualitative interviews. An interview guide listing a pre-determined set of questions or issues to be explored during an interview was designed. The approach used open-ended questions asked of respondents selected due to the following reasons:

- Their knowledge of and exposure to FHI 360 technical support and/or their status of sub-recipients of the GFATM Round 9. Each interview of a key informant was conducted without the presence of a member of FHI 360 team or the hierarchically superior of the respondent.
 - ✓ GFATM sub-recipients : eleven (11) key informants
 - ✓ SNIS: one (1) key informant
 - ✓ MR of Kolda: three (3) key informants
 - ✓ MR of Sedhiou: four (4) key informants
 - ✓ MR of Ziguinchor: three (3) key informants
 - ✓ DLSI: one (1) key informant
 - ✓ Kolda Regional Office of the USAID Execution Agencies: one (1) key informant
 - ✓ National Health and Social Development Plan and Monitoring Unit (CAS/PNDS): one (1) key informant
- Their participation as a FHI 360 team member in the FHI 360 pilot project at central or operational level: five (5) key informants

Two focus groups were carried out: one at the central level with the DLSI and another one in the MR of Ziguinchor. These two groups contained 5 and 6 respondents respectively. The focus groups were held without the presence of a FHI 360 team member or the superior of the respondents. This method facilitated the exchange of view among several participants selected from the beneficiaries of FHI 360 support. The exchanges were recorded and transcribed into interview cards.

Collection and Analysis of Quantitative Data

The data collection and analysis of quantitative primary data related to ORCAP self-assessments and related action plans was carried out in the three MRs.

Data Limitations

The principal limitations of the data collected in this evaluation are as follows: (1) the evaluation is held before the end of the first year of implementation of the technical support, (2) as in any study using rapid appraisal method, the information generated is less valid and reliable than in more formal methods, (3) the underrepresentation of the eight (8) sub-recipients of the GFTAM at the central level, and (4) the data gathered was affected by strikes of the health sector in two (2) of the (3) regions.

The results of the evaluation presented in this section focus on the relevance, the effectiveness and the results of the three (3) interventions of the FHI 360 pilot project. Since the pilot project lasted less than one year, this evaluation highlights the short and mid-term results.

The relevance of the FHI 360 pilot project

According to the three (3) regional medical teams, and also to the DLSI, the qualitative data of the study reveals that ORCAP is a relevant tool. ORCAP is perceived as an innovative tool that complements the traditional supervisory approach. It provides “a place to exchange” issues to the regional medical teams, which is perceived as legitimate by the respondents. The ORCAP approach of participative self-assessment asks the preliminary question of “how to better work” within the domains of the MR health system. It is the regional executive team itself who carries out their own assessment, even if they have the assistance of an outside contributor. This approach provides a continuous cycle of quality improvement of the performance of the MR due to the periodic self-assessment embedded in the course of HSS activities. This cycle combines both planning and periodical evaluations.

ORCAP has a systemic approach which gives a holistic vision: it matches the HSS framework, in that it supplements the programmatic approach traditionally used in regional planning. While the PTA developed by the regions are centered mainly on the objectives of various disease-specific programs, ORCAP allows the planning of HSS activities (some of which had been ignored) identified by the self-assessment itself. ORCAP is perceived as a genuine diagnostic tool and a “dashboard”: not only does it identify certain new HSS needs, but it also highlights some HSS needs previously known. ORCAP is perceived as an action tool which contributes to the implementation of the activities. ORCAP allows the identification of a limited number of actions relevant to the efficient implementation of HSS activities. The solutions suggested through these actions are considered to be suitable and realizable. They are often implemented with the already existing resources.

ORCAP is perceived as a flexible tool helping to fill the planning gaps of a GFATM proposal by the solutions that it generates. Changing an activity funded by the GFATM is a long and very bureaucratic process. ORCAP thus makes it possible to catch up with a planning of the activities included in GFATM proposal. ORCAP makes it possible to include certain necessary interventions -which were not included in the GFATM proposal- for the good implementation of HSS activities. The ORCAP relevance is linked to the selection of appropriate participants who will take part in the self-assessment: the choice of the participants must be done according to their competences in the self-assessed domain. The regional medical teams prefer to position each participant in one domain, thus setting up groups of participants who will evaluate only one domain during each self-assessment exercise. Some respondents perceive the domains like unequal in quality, particularly the one related to governance.

Most of the results described above apply to the perception of the ORCAP relevance at the operational level. This perception is based on the use of the ORCAP tool. At the central level the perception of ORCAP relevance by respondents DLSI and SNIS is real but remains more conceptual.

The technical assistance provided to regional medical teams was perceived as highly relevant. This relevance is anchored in the previous collaboration between FHI 360 and the DLSI. In the region of Kolda, an employee of FHI 360 ensured permanent support for the MR team. Indeed, his assistance built the capacity of the MR actors engaged in HSS activities. FHI 360 technical assistance was described as an active listening about the needs expressed by the program's implementers, a support to the formulation of solutions translated into activities funded through LA mechanism if need be. This active listening is also mentioned by the MR financial officers who were able to call the financial FHI 360 experts whenever needed. The flexibility of the FHI 360 technical assistance is one of the key elements contributing to the relevance of the project: FHI 360 technical assistance is flexible, on request, and according to the emergent needs.

Field trips to support the formulation of ORCAP AP in each region were perceived as extremely useful by the regional medical teams: FHI 360 technical assistance was the key in consolidating the AP drafted by the regional teams. The support of the ORCAP focal point within each MR was perceived as relevant in the context of the first year of the implementation of HSS activities.

Some respondents clearly highlighted the relevance of the

Key informants' views

“ORCAP fills a vacuum that the system did not fill.”

“ORCAP is part of the tools that create exchange, coordination and evaluation bodies.”

“Where people pained to sit down to speak about it.”

“Information is not anymore the prerogative of only one individual.”

“ORCAP, it is a true dashboard.”

“One does not make any more blind flying, ORCAP is a tool which says you that your problems are here.”

“ORCAP allows a targeted surgical operation on what's wrong with the HSS.”

“ORCAP lubricates the implementation of the HSS, it fills the gaps.”

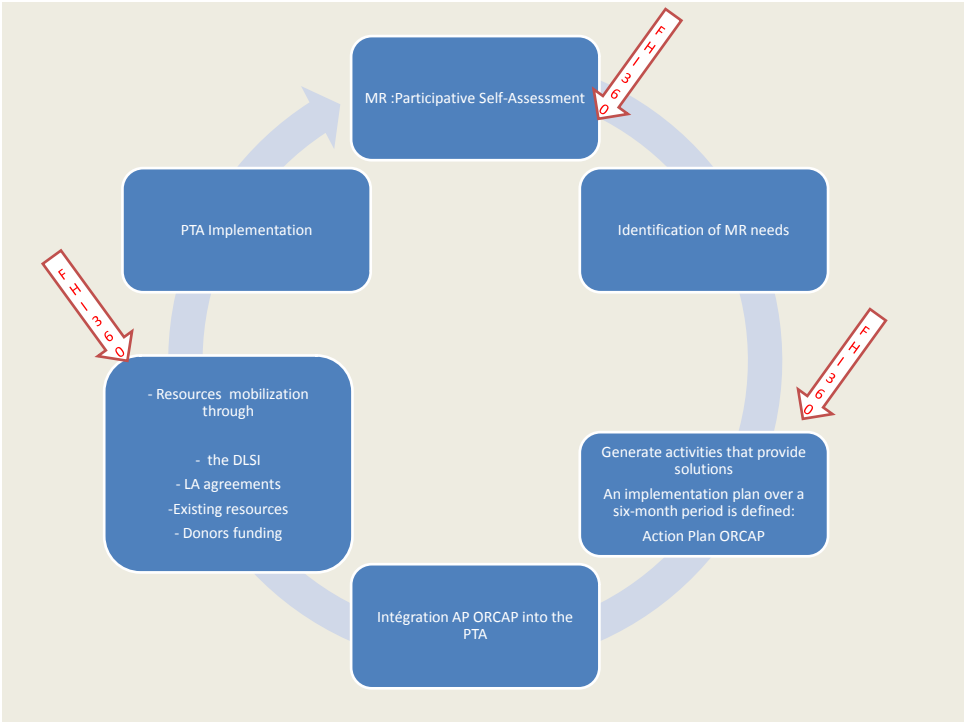
“Could ORCAP be a preliminary step to an accreditation of health facilities?”

“The systemic vision of ORCAP improves the links between donors: a donor will fund what ORCAP highlights”

“ORCAP is a Senegalese label”

combination ORCAP-LA. The diagram below illustrates the use of ORCAP in the operational planning cycle and the mobilization of the resources by the MR in which multiple donors are present. This diagram was suggested by a medical chief of district and it shows the deep comprehension of the relevance of the combination of the two tools. The technical assistance brought by team FHI 360 in the different stages of this cycle is symbolized by the red arrows.

Figure 5: ORCAP use in the operational planning cycle (Diagram of a respondent)



ORCAP self-assessment allows the identification of MR needs and generates activities that provide solutions to fill the identified needs. After the integration of the ORCAP AP into the PTA, the regional executive team will present the PTA to the local partners in the FY last quarter. The activities not finding adequate funding or requiring a fast-track financing calendar could be the object of a request for agreement by LA.

It should be noted that, in FY2011, HSS activities funded by the GFTAM were not eligible for funding through LA. On the other hand, some of LA funds were reallocated to support HSS activities in RM Sedhiou, which allowed the appearance of the synergy between LA, HSS financing, and other funding sources in order to better rationalize local resources. The ORCAP-LA model allows implementing needs expressed by the region and the district. It is perceived as a powerful instrument in the policy of decentralization of the Ministry of Health, thus, allowing a better appropriation of HSS activities at the operational level.

The training workshop held in November 2010 is perceived as relevant in the context of the year 1 implementation of HSS activities. Moreover, the training relevance is also linked to its content: some cross-cutting activities of the GFATM proposal round 9 aim at strengthening the health information system and the financial management of grants. The training format consisted of a practical session using management tools, cards, and report templates and appeared perfectly adapted. The training is perceived as particularly relevant in the more recently regions created, such as the region of Sedhiou.

Effectiveness of FHI 360 pilot project

This section analyzes the effectiveness of the three (3) interventions of the FHI 360 pilot project. For the purpose of this study, effectiveness refers to the extent to which the objectives of the pilot project either are achieved or are likely to be achieved through its short and mid-term results. The effectiveness of ORCAP introduction in the MR is evaluated using both qualitative data of key informant interviews and focus groups and quantitative data of the ORCAP self-assessment exercises in the three regions, their AP and their level of integration into the PTA.

Quantitative data

During the ORCAP exercise, the calculation of a percentage that reflects the performance stage against the model system for each domain is performed: between 0 and 25% = 1 (initial stage); between 26% and 50% = 2 (visible results); between 51 and 79% = 3 (systematized visible results); and between 80 and 100% = 4 (model system).

Table 4, below, illustrates the self-assessment scores by domain and region.

Table 4: Average of ORCAP self-assessment scores by domain and region (January-February 2011)

Domain (D)	D 1 Service Delivery	D 2 Product	D 3 Health Workforce	D 4 Information System	D 5 Leadership and Governance	D 6 Health System Financing	Average (by MR)
MR Ziguinchor	<u>2.25</u>	2.33	2.5	2.6	2.5	<u>2.25</u>	2.40
MR Kolda	2	3	<u>1.5</u>	2.6	3.2	3	2.55
MR Sedhiou	2.3	3	2	2	<u>1.7</u>	2.4	2.25
Average (by domain)	2.2	2.8	2	2.4	2.5	2.55	

It is interesting to note that the MR which presented the lowest average score per region is the region of Sedhiou - the most recent administrative region of the three - created in 2008. In this new region, leadership and governance was the field evaluated which were in need of capacity building.

In the region of Kolda, the domain having the lowest score was the health workforce. This result corroborates the fact that the region of Kolda was classified, in 2009, as one of the regions of Senegal most lacking in human resources, having only three (3) medical specialists and three (3) private sector physicians in the entire region³.

In the oldest region of Ziguinchor, on which the two others depended, the domains most in need of capacity building were service delivery and health systems financing.

Self-assessment scores were key elements of the baseline data of the MR performance. The self-assessment thus allows the identification of MR strengths, of fields which require improvements and

³ Mbengue Cheikh S.A., Yann Derriennic (Health Systems 20/20), Fodé Diouf (Groupe Issa), Demba A. Dione (ISED), Lamine Diawara (OMS) et Abdoulaye Diagne, Evaluation du système de santé du Senegal, Abt Associates Inc, Septembre 2009.

of the formulation of solutions translated into actions or activities. These activities will be merged into an AP.

The analysis of the ORCAP APs of the three (3) MRs reveals that the average plan has forty-seven (47) activities and runs over six (6) months. The three (3) plans were validated at the end of May 2011. AP is a tool for operational planning in opposition to strategic planning. AP activities are related to the coordination and management of HSS activities at regional level in the following fields:

- Implementation of PTA activities;
- Management and supervision of human resources;
- Internal communication and relations with the partners;
- Supervision of administrative and finances management;
- Management of relationships with the local donors;
- The supervision and management of domains' logistics;
- The monitoring and documentation of best practices;
- The management of the MR technical and managerial capacity

They are divided into two groups: activities which require means (financial or material) and activities which do not require additional means. These last often reflect the capacity to act of an entity or a person (such as advocacy work). This can explain a zero-execution rate for certain domains in the context of the agents of the health sector going on strike.

Table 5, below, illustrates the number of activities planned by domain and region. The domains that were previously evaluated as priorities (with a weak evaluation score) are underlined.

Table 5: ORCAP AP activities planned by domain and region (May 2011)

Domain (D)	D 1 Service Delivery	D 2 Product	D 3 Health Workforce	D 4 Information System	D 5 Leadership and Governance	D 6 Health System Financing	Total by MR
MR Ziguinchor	<u>14</u>	5	3	4	13	<u>12</u>	51
MR Kolda	10	3	<u>4</u>	7	6	5	35
MR Sedhiou	11	6	7	7	<u>12</u>	11	54
Average	11.6	4.6	4.6	6	10.3	9.3	47

Domain 1 (Service Delivery) is the domain that has, on average, the highest number of activities planned for the three regions, followed by the domain 5 which deals with leadership and governance.

It is interesting to note the perfect correlation between the domains self-assessed with a low score - therefore a priority as regards to capacity building - and the number of actions planned in the MRs of Ziguinchor and Sedhiou. That corroborates the dashboard function of ORCAP previously mentioned by a respondent. In the case of the MR of Kolda, this correlation also exists because domain 1 is the second domain identified as a priority and the results shows the highest number of actions planned in this domain in the Kolda region

The fact that the domain 1 has a higher average number of activities than other domains could also be explained by the fact that MR teams are mainly composed of health care providers, whose job duties now consist of administrative or management tasks. These participants would feel more at ease when planning domain 1 activities. Another explanation would be related to the fact that the domain 1 accounts for 37% of the total budget of HSS activities- HSS activities being funded by the GFTAM (round 9)⁴.

Table 6 illustrates the number of activities completed or being implemented by region and domains by the fourth month of the AP.

Table 6: HSS ORCAP activities completed or being implemented and rate of execution (%) by domain and regions (September 2011)

Domain (D)	D 1 Service Delivery	D 2 Product	D 3 Health Workforce	D 4 Information System	D 5 Leadership and Governance	D 6 Health System Financing	Average By region
MR Ziguinchor	<u>8</u> 57%	3 60%	0 0%	3 75%	3 23%	<u>7</u> 58%	47%
MR Kolda	4 40%	1 33%	<u>1</u> 25%	0 0%	2 33%	3 60%	31%
MR Sedhiou	4 36%	2 33%	4 57%	2 28%	<u>7</u> 58%	2 18%	39%
Average By Domain	16 45%	6 43%	5 35%	5 27%	12 39%	12 43%	39%

Domain 1 (Service Delivery) is the domain that comprises, on average, the highest number of activities completed or being implemented in the three regions, followed by domain 5 (Leadership and Governance) and domain 6 (Health System Financing).

There is perfect correlation between the underlined domains self-assessed with a low score - therefore priorities as regards to capacity building - and the number of action completed or being implemented in the MR of Ziguinchor and Sedhiou. In the case of the MR of Kolda, this correlation also exists because the domain 1 is the second area identified as a priority.

The AP execution rate is defined by the number of actions completed or being implemented since May 2011 (the validation date of the ORACP AP) divided by the total number of AP activities planned. The

⁴ Source DLSI

rates of execution of ORCAP plans are only satisfactory in the priority domains in the MR of Ziguinchor and Sedhiou after four months of implementation: 47% and 39% respectively. The MR of Kolda suffers from a delay of implementation of its activities (execution rate of 31%) related to the human resource deficit.

This quantitative analysis shows the effectiveness of ORCAP in the identification of the activities in the domains which were evaluated as a priority.

Two (2) MRs (Sédhiou and Kolda) out of three (3) chose to integrate 100% of the AP ORCAP activities in their PTA. According to them, the best place for the ORCAP AP is in the PTA which leads to only one tool for planning of their activities, integrating all the actions to come in one place.

The MR of Ziguinchor chose a rate of integration of the ORCAP AP activities of 12%. The Regional executive team view was to support the fast execution of the actions identified by the self-assessment ORCAP by not diluting them in an annual PTA.

The rate of execution of ORCAP plans prove satisfactory in the three regions in a context of scarce qualified human resources. The analysis of the execution rates should be carried out with great caution: The implementation of AP ORCAP (particularly since June 2011) in the areas of Sedhiou and Kolda was seriously disturbed by the social movements prevailing in these areas. The boycott of the supervisory meetings hampered the execution of AP as well as the absence of transmission of the routine health system data.

Qualitative data

At the time of the study, this cycle of quality improvement had just begun with the first self-assessment carried out by RMs with the support of the FHI 360 team. Evaluating a potential increase of MR competences as regards to organizational, technical, and financial management using quantitative data proved premature. The rates of execution of ORCAP plans are satisfactory after four months of implementation. This result corroborated the perception of the respondents that ORCAP strengthens their competences as regards to organizational, financial, and technical management.

The degree of use of the tool at the medical region level is high in spite of a very recent introduction. Objective indicators of the use of ORCAP were found three times:

- The use of ORCAP in the reports of the Regional Joint Annual Meetings (Réunion Annuelles Conjointes régionales)
- The use of ORCAP in the evaluation of the Integrated Package of Services;
- The use of ORCAP by some respondents already trained to use self-assessment tool for their own performance unit leading to an empowerment of health workers.

Nevertheless, the perception of the respondents is that the use of ORCAP is not yet sustainable without further support because the ORCAP has not been fully mastered.

FHI 360 technical assistance is anchored in a longstanding collaboration with DLSI and has been perceived very positively by most respondents. The regional medical teams thought of FHI 360

Examples of planned activities completed or being implemented

To work out and post the services available and their costs in all health facilities

To recruit midwives at the local level through the health committees.

To purchase equipment: Video projector, computer, printer, fax and scanner.

To re-establish the systematic supervision of staff including scorecard's update.

Update manager's knowledge on partners' assistance and Government support.

technical assistance as relevant and effective up to and including the planning of the ORCAP action plan. The teams would have preferred more regular technical assistance during the implementation and monitoring phases of ORCAP plans. The FHI 360 had difficulties in planning follow-up visits to regional medical teams because of conflicts between the schedules of the MR teams and the consultant during the summertime: the availability of the consultant did not always match with the busy schedules of regional medical teams. The monitoring plan for ORCAP activities does not exist, per se. As a result, the planners added a column to existing AP ORCAPs noting whether an activity had been completed was being implemented or had not started yet. Moreover, the USAID bilateral project ended during this period, creating some uncertainty among the USAID sub-contractors. DLSI also cancelled a workshop in which the three (3) regions were slated to share their experience about HSS support provided by FHI 360. In addition, the regions witnessed an intensification of the social movements in the health sector. All these factors contributed to the perception of the respondents of the need of more continuous assistance during this period.

At the level of DLSI, the respondents highlighted the need for a feedback loop between the central and operational level with a focus on technical assistance, implementation, and feedback of the pilot project information back to the central level

According to key informants' interviews, the training of the sub-recipients to the methods of financial and operational arrangements of the GFATM grants has improved their competencies in planning and financial management. Nonetheless, it is not possible at this stage of PTA implementation to have quantitative information confirming this perception.

Several respondents suggested a link between the introduction of the ORCAP and a better implementation of the Integrated Package of Services (IPS) beginning in five disadvantaged regions including Kolda, Sedhiou and Ziguinchor. Indeed the implementation of IPS requires the development of a performance score card in the targeted units. No quantitative data makes it possible at this stage to evaluate if ORCAP has an impact on the quality of the health services in the targeted units.

VII. Lessons learned and next steps

The lessons learned describe the broader implications for a potential roll-out of the FHI 360 pilot project. Since, during the study DLSI expressed its intention, to expand the use of ORCAP to other MRs in the in the years to come, it is interesting to present some of the lessons learned and to suggest the next steps based upon this evaluation.

The lessons drawn from this evaluation make it possible to design an effective model of technical support to HSS activities funded by the GFATM both at the regional level and beyond Senegal. The FHI 360 technical support model has three (3) pillars:

- A continuous cycle of quality improvement of the performance of the health care system using participative self-assessment (ORCAP) integrated in the planning cycle of the medical regions;
- LA mechanism supporting HSS activities, thus making possible a flexible and decentralized funding for activities identified by the regions;
- Technical assistance to build the capacities of the MRs and districts in HSS activities, with a strong quality improvement component, together with a feedback loop between the operational and central levels.

In the light of this preliminary evaluation, the FHI 360 model of technical support should strengthen RM capacities as regards organizational, financial, and technical management in the six (6) domains. Since the activities of HSS are cross-cutting, the evaluation should find an improvement of the quality of MR health care services. In the same way, the GFATM Round 9 indicators related to HSS should be improved by this model. These two assumptions remain to be determined by a later evaluation.

This evaluation recommends the institutionalization of ORCAP at the district and regional levels as a next step. An annual self-evaluation preceding the formulation of the annual work plan should be institutionalized to complement disease specific program work plans. ORCAP could be a precondition to the annual planning to optimize the powerful combination ORCAP-LA.

One of the respondents recommended the gradually expansion of ORCAP to the district level in order to strengthen the use of the tool at the operational level. During his interview, this key informant suggested the following roadmap to reach that point:

- *To Organize a “grooming” of ORCAP to adapt the tool to the district level*
- *To use a participatory approach toward grooming*
- *To add ORCAP to the essential list of district tools*
- *To ensure a monitoring of ORCAP activities*
- *To integrate all the activities of ORCAPAP in the PTA*
- *To ensure the periodicity of ORCAP in cycle with PTA: ORCAP should take place before the end of October/mid-November of each year long cycle*
- *To use the information data and to improve MR performance*
- *To improve MR visibility and to influence health policies at the peripheral level.*

The implementation of a monitoring and evaluation plan of the technical model is an important stage to measure the impact of this approach on:

- The improvement of organizational, financial, and technical management capacities in the MRs and districts in the six (6) domains
- The improvement of the quality of the services in the health care system at the regional and district levels
- Reaching HSS objectives funded by the Senegalese government, the GFATM and other donors.

VIII. Conclusion

The FHI 360 technical model of support allows countries to better coordinate an effective and efficient response to the needs of the Ministry for Health and Prevention in HSS activities, including those not taken into account by programs targeting a disease (or a group of population) or by incomplete planning of the activities funded by the GFATM. The added-value of this model for GFATM pertains to the support of the top priorities of the Fund. GFATM acts like a financial instrument and not like an implementation entity, relying on a vast network of partners, promoting the diffusion of knowledge at the local level, and supporting technical assistance according to the needs expressed by the countries. GFATM fills the gaps in national efforts just as the FHI 360 model fills the existing gaps of the health system interventions at the regional level. The combination ORCAP-LA provides a better rationalization of health system resources coming from various donors at regional level, including those of the GFATM.

Appendix I: Terms of references of the evaluation mission

Level of effort:	18 days
Scope of Work :	Evaluation of the process and the results of the FHI 360 technical support to Health System Strengthening (HSS) activities of the health care system in Senegal
Context:	FHI pilot project to provide technical support to the medical regions that are sub-recipients of the Global Fund to Fight against AIDS, Tuberculosis and Malaria (GFATM) Round 9 for the HSS component of the HIV/AIDS program of the Ministry of Health.
Dates of the Mission:	September 2011 (to be specified)
Client and	FHI Office Country/Dakar: Barbara Sow
	FHI/Arlington: Bruno Bouchet
Recipients:	Division of the Fight against AIDS and STI (DLSI) of the Ministry for Health; Medical regions; FHI 360; GFATM

Evaluation Mission Goals & Objectives

The goal of the mission is to evaluate the effectiveness of the process of FHI 360 technical support to HSS activities to three medical regions of Senegal that are sub-recipients of GFATM Round 9 for the HSS component of the HIV/AIDS program of the Ministry of Health. This mission has three specific objectives:

1. To document the process and the results of the pilot project to support the Ministry for Health and the MRs in the implementation of the HSS activities funded by GFATM
2. To collect stakeholders' opinions (DLSI, MRs and others sub-recipients) on pilot's factors of success and constraints
3. To make recommendations to improve the effectiveness of a technical model of support to the HSS activities of the HIV/AIDS programs in Senegal (and in general) based on lessons learned.

Evaluation Context

The DLSI requested the FHI 360 technical support for financial management and implementation of the HSS activities funded by the GFATM. FHI accepted this request for the 3 medical regions with which we already have a partnership within the HIV/ AIDS and Tuberculosis Health program funded by USAID. FHI committed its own funds, to a total value of \$30.000 to recruit a consultant over a ten- month period, who will be responsible for the technical support and its documentation. This funding complements the USAID bilateral program funding and DLSI funds from GFATM. (Ref. MOU FHI and DLSI that includes the description of the roles and responsibilities for each one)

The description of this pilot project is described in the document:

“The case for a Technical Assistance Partnership with Ministry of Health in Senegal to Strengthen Health Systems through a Global Fund grant. Barbara Sow, Jessica Price, Audrey Sullivan & Bruno Bouchet. September 30, 2010”.

Specific tasks

The consultant, with the support of FHI 360/Senegal and FHI 360/Arlington, will lead the following activities:

1. Before the fieldtrip:
 - a. To Discuss, by teleconference, the context and the terms of reference of the mission with the FHI 360/Senegal and the HSS department of FHI/Arlington;

- b. To gather and review the relevant documentation for this mission: HSS program of the GFATM, similar intervention elsewhere, letters of agreement between FHI 360 and the medical regions, description of ToR of the consultant and the pilot project, workshops and reports of the pilot experiment, etc.;
- c. To develop the evaluation methodology and its tools to describe the pilot project, to evaluate its effectiveness, and to collect the views and suggestions of the stakeholders (to prepare the interview guide for key informant interviews and focus groups, review of documents and indicator, etc.);
- d. To suggest a draft outline of the final report to be validated during the field trip;
- e. To develop a work plan and a meeting schedule to maximize in-country consultant's time and trips to regions;
- f. To inform the partners (DLSI and medical regions, mainly) of this mission of evaluation, to obtain their agreement and to ensure their availability to work with the consultant (responsibility of FHI 360/Senegal).

The level of effort is estimated at 5 days

2. During the field trip:

The consultant will work in close collaboration with office FHI 360/Senegal and the DLSI

- g. To finalize and validate the instruments of evaluation, the mission's program and the format of the final report;
- h. To interview key informants who are part of this pilot project;
- i. To arrange an evaluation meeting with the key partners (DLSI) to identify the elements of success, the constraints and suggestions to solve them;
- j. To gather the existing data on the indicators identified to validate information using documents review at the central and operational levels.
- k. To finalize the lessons learned and to present them to the partners during a debriefing meeting organized at the end of the mission
- l. To present, during the debriefing meeting, the recommendations on a technical model of support.

The level of effort is estimated at 10 days

3. After the fieldtrip:

- m. To finalize the evaluation report in French and English;
- n. To Disseminate the evaluation report within FHI 360 (responsibility for FHI 360/Arlington) and to discuss its strategic importance.

The level of effort is estimated at 3 days

Deliverables and results

- Evaluation of this pilot project, lessons learned and recommendations for follow-up interventions in Senegal
- Recommendations for a generic model of technical support to the HSS activities of GFATM
- Evaluation Report in French and English

Program visit and people to be met

- Office FHI 360: Barbara Sow, technical team and HSS consultant Abdoulaye Diagne
- DLSI: Director and technical staff in charge of/dealing with HSS activities
- Three medical regions of Ziguinchor, Sedhiou and Kolda: Medical Chief, Health Planner (staff HSS), and UAR (unit of regional support CNLS) focal point or other people suggested by the Medical Chief of Region
- Regional Office USAID/Kolda: Abt, FHI 360 etc
- Ministry of Health: staff in charge of the GFTAM grants (SNIS, DSSP etc...)
- USAID
- WHO

Appendix II: ORCAP Individual Form (Domain 1)

Domain 1: SERVICE DELIVERY

Components:

- Component 1: Adequate readiness of the physical infrastructure and equipment
- Component 2: Number, composition and capacities of technical staff
- Component 3: Policies, standards and protocols of services
- Component 4: Service offered and quality assurance
- Component 5: Organization of the delivery of service
- Component 6: Supervision and monitoring

DOMAIN 1/ SERVICE DELIVERY						
Component 1: Adequate readiness of the physical infrastructure and amenities						
Description of the model system						
The physical infrastructure and the amenities meet the Standards as regards to number, space, installation, and functioning. The management and the maintenance of the infrastructure and the amenities are implemented. The management of stocks of products (consumable drugs, reagents and, etc) is handled in an adequate way.						
Scores		0	1	2	3	
		None	Yes-Partly	Yes-In majority	Yes-Entirely	Not applicable
1	The health services have adequate infrastructure and space to deliver the IPS*					
2	The amenities are well maintained					
3	The health services use adequate equipment to deliver the IPS*					
4	The equipment is well maintained					
5	Furniture and equipment are recorded, documented and controlled (inventory) according to the standards					
6	The drugs and consumable necessary are available in quantity and adequate quality to deliver IPS					
7	Means of transport (vehicles and motor bikes) are available to support the MR in coordination and other activities					

Please fill out the sections from A to E of the A1 form to grade this section on a scale from 1 to 4, with summary observations to support of the grade.

NB: to refer to the definition of IPS

DOMAIN 1/ SERVICE DELIVERY						
Component 2: Number, distribution and skills of technical staff						
Description of the model system						
The MR relies on adequate resources human with regards to adequacy and technical skills to ensure the delivery of IPS. A system is in place to ensure education and training of personnel on the innovations.						
Points		0	1	2	3	
		None	Yes-Partly	Yes-In majority	Yes-entirely	Not Applicable
1	The MR has an adequate number of technicians to deliver health services at the regional level					
2	The MR has an adequate number of technicians to deliver health services at the district level					
3	The MR has an adequate number of technicians to deliver health services at the health post level					
4	The technical team has an adequate skill mix: executive staff providing services, administrative officers, experts in development assistance, other experts, and supporting staff					
5	The technical team has an adequate skill mix: executive staff providing services, administrative officers, experts in development assistance, other experts, and supporting staff at regional level					
6	The technical team has an adequate skill mix: executive staff providing services, administrative officers, experts in development assistance, other experts, and supporting staff at district level					
7	The technical team has an adequate skill mix: executive staff providing services, administrative officers, experts in development assistance, other experts, and supporting staff at health post level					
8	The facility has a technical staff with specific skills for each of the technical field of the IPS at the regional level					
9	The facility has a technical staff with specific skills for each of the technical field of the IPS at the district level					
10	The facility has a technical staff with specific skills for each of the technical field of the IPS at health post level					
11	The technical personnel has access to technical innovations and upgrade using various sources, such workshops/refresher courses, supervision, Internet, the newspapers, and professional publications					

Please fill out the sections from A to E of the A1 form to grade this section on a scale from 1 to 4, with summary observations to support of the grade.

DOMAIN 1/ SERVICE DELIVERY					
Component 3: Policies, standards et protocols of services					
Description of the model system					
The national technical standards of quality of service are regularly updated, available and are used on all the sites by well-trained health workers.					

Points		0	1	2	3	
		None	Yes-Partly	Yes-In majority	Yes-entirely	Not applicable
1	The national service Policies, Norms and Protocols(PNP) in use are available for all the technical fields of the IPS on all the sites at the regional level					
2	The national service PNP in use are available for all the technical fields of the IPS on all the sites at the district level					
3	The national service PNP in use are available for all the technical fields of the IPS on all the sites at the health post level					
4	Health care staff are trained/directed towards the PNP used in each technical field of the IPS at the regional level					
5	Health care staff are trained/directed towards the PNP used in each technical field of the IPS at the district level					
6	Health care staff are trained/directed towards the PNP used in each technical field of the IPS at the health post level					

Please fill out the sections from A to E of the A1 form to grade this section on a scale from 1 to 4, with summary observations to support of the grade.

DOMAIN 1/ SERVICE DELIVERY						
Component 4: Availability of services and quality assurance						
Description of Model System						
The organization of the services relies on the principles of the equitable and continuous accessibility of the customers to integrated and full services. This organization clearly takes into account the customers' satisfaction.						
Points		0	1	2	3	
		None	Yes-Partly	Yes-In majority	Yes-Entirely	Not applicable
1	Measures are taken to ensure an efficient delivery of health services with satisfactory level of quality in remote areas difficult to reach					
2	Key services ,such as testing services, drugs dispensation, and essential IPS commodities, are available-at least- at the health post and the heath center levels					
3	There is an integrated approach of services at Preferred Provider System (PPS) level and the customer has access to a package of health services meeting his needs at any time.					
4	Customers' views are collected on a regular basis to determine if the services offered are accessible and meet their expectations.					
5	All the IPS inputs are the object of an integrated management					
6	The customers are solicited actively to take part in the determination of the priorities of prevention, care, and support for each field of the IPS					
7	A continuous system is set up to evaluate and improve the services to better meet the customer's needs					
8	There is an orientation staff on quality assurance or improvement					

Please fill out the sections from A to E of the A1 form to grade this section on a scale from 1 to 4, with summary observations to support of the grade.

DOMAIN 1/ SERVICE DELIVERY					
Component 5 : Readiness of service delivery					
Description of the model system					
The IPS standards are enforced and based on patient-centeredness with a regular update of the health care workers' knowledge. The referral services and network is accessible and are used by the most remote populations.					

Scores		0	1	2	3	
		None	Yes-Partly	Yes-In majority	Yes-Entirely	Not applicable
1	The standards of service are enforced for each technical field of the IPS					
2	The services are available and accessible to the targeted populations					
3	The customers circuit is well defined to allow a delivery of services in conformity with the IPS					
4	The waiting period of the customers is reduced to its lowest level					
5	The hours of operation of services allow accessibility to health care services to all the targeted populations					
6	Staff has adequate means of transport allowing them to reach the most remote zones					
7	There exists a schedule of the mobile/advanced strategies for the delivery of the IPS					
8	The referral system is operational and used in an adequate way at the various level of the health system services					
9	Staff is in place and organized in an adequate way in order to offer the IPS services in a suitable way					

Please fill out the sections from A to E of the A1 form to grade this section on a scale from 1 to 4, with summary observations to support of the grade.

DOMAIN 1/ SERVICE DELIVERY						
Component 6 : Supervision and monitoring						
Description of the model system						
The supervision is effective, operational and obeys all the principles of the formative supervision. Monitoring is implemented on a regular basis.						
Points		0	1	2	3	
		None	Yes-Partly	Yes-In majority	Yes-Entirely	Not applicable
1	There is an integrated supervision grid for the IPS					
2	The medical regions teams have orientation on the integrated supervision of the IPS					
3	There is a supervision calendar that is shared with all the levels					
4	The health care staff is supervised in the technical fields of the IPS to ensure that their practice is based on the PNP					
5	There is a follow-up system of the supervisions' recommendations					
6	There is a reward system to motivate the health care provider in the provision of high quality services					
7	There is a system of support provided to the technical staff in order to prevent the burnout effect					
8	There is an adequate system of monitoring of the services					
9	Monitoring is carried out regularly					

Please fill out the sections from A to E of the A1 form to grade this section on a scale from 1 to 4, with summary observations to support of the grade.

Appendix III: Reviewed Documents

1. COGEMAP : Rapport Revue Atelier de partage des résultats de la Lettre d'accord et du RSS, juillet 2011
2. COGEMAP : Rapport d'évaluation des lettres d'accord, 2009
3. Commission Nationale de Coordination du Fonds mondial de lutte contre le VIH/SIDA, la Tuberculose et le Paludisme, République du Sénégal, Proposition Sénégal – Série 9 du Fonds Mondial, Dakar, 2009
4. DLSI, Rapport de réunion du comité de suivi de la mise en œuvre du IPS, 29 août 2011
5. DLSI, FHI 360, USAID : Rapport de l'atelier de formation des gestionnaires des sous bénéficiaires et des planificateurs des régions médicales Fonds Mondial Appel à propositions de la série 9 /RSS, Décembre 2010
6. DLSI, FHI 360, USAID : Convention de partenariat Appui FHI 360 aux activités RSS Fonds Mondial 2010
7. DLSI, FHI 360, USAID : Rapport de synthèse de l'introduction de l'ORCAP dans les trois régions du Sénégal, juin 2011
8. DLSI, SNIS : Carte sanitaire du Sénégal, 2008
9. FHI 360, Positioning West African Institutions and Networks, Strengthening West Africa's Response to the HIV/AIDS Epidemic, 2008
10. FHI 360 : Renforcement des Capacités des institutions/ Régions Médicales par l'Auto-évaluation Participative (ORCAP), Guide de l'utilisateur, Novembre 2010
11. Mbengue Cheikh S.A., Yann Derriennic (Health Systems 20/20), Fodé Diouf (Groupe Issa), Demba A. Dione (ISED), Lamine Diawara (OMS) et Abdoulaye Diagne, Evaluation du système de santé du Sénégal, Abt Associates Inc, Septembre 2009.
12. Ministère de la Santé et de la Prévention, République du Sénégal ; Plan National de Développement Sanitaire (PNDS) 2009-2018.
13. Ministère de la Santé et de la Prévention, République du Sénégal ; Politique Nationale Hospitalière du Sénégal (Draft), Février 2009.
14. Ministère de la Santé et de la Prévention, République du Sénégal Plan de Suivi et Evaluation du
15. PNDS 2009 – 2018 Gouvernement du Sénégal
16. Plan ORCAP des régions médicales de Kolda, Sedhiou et Ziguinchor, 2011
17. Plan Annuel de Travail des régions médicales de Kolda, Sedhiou et Ziguinchor, 2011

Appendix IV: List of respondents

Key informant interviews

Organization	Name	Job title (original title in French)	Activity	Date Sept. 2011
DLSI	Dr Abdoulaye Sidibé Wade	Chef de Division	Coordination	16/09
SNIS DLSI sub-recipients	Dr Moussa	Chef SNIS	LA	16/09
CAS/PNDS	Dr Amadou Djibril BA	Coordonnateur	Coordination RSS	16/09 Introduction
Kolda Regional Office of the USAID Execution Agencies	Dr Ibra SENE	Chef de BR	Coordination	21/09
FHI 360/ USAID Kolda	Mr Ibrahima DIALLO	Chargé du S&E	ORCAP/LA/Suivi	21/09
FHI 360	Abdoulaye MBallo	RAF	LA	En congés
	Abdoulaye Anne	Ass. director Care and support	ORCAP/LA	15/09
	Seynabou Kasse	Senior program officer	ORCAP/LA	15/09
	Abdoulaye Diagne	RSS consultant	Appui Tech	11/09
MR Sédhiou	Dr KONTE	Médecin-Chef région	ORCAP LA	Malade
	Aziz DIEYE	Planificateur	ORCAP	20/09
	Ibrahim Toure	Gestionnaire	ORCAP/LA	20/09
	Dr Mustapha Ballo	Médecin chef de district	ORCAP/LA	20/09
MR Ziguinchor	Dr Mame SY	Médecin-Chef région	ORCAP	19/09
	M M. THIAM	Planificateur		19/09
	Mr. Malik DIEME	Gestionnaire		19/09
MR Kolda	Dr Amath MBAYE	Médecin-Chef région	ORCAP	20/09
	Dr Arona DEMBELE	Médecin Supviseur PNT	ORCAP LA	20/09
	Malik NDAN	Supviseur Régional des Soins de Santé Primaire RMde la RM Kolda	ORCAP/LA/ SNIS	20/09

Focus Groups

Organization	Name	Job Title (original titles in French)	Activity	Date
DLSI	Abdoulahat Mangane Mariama GUEYE Dr Cheikhou SAKHO Dr Oulimata DIOP Soukeyna Sylla	Chef de Division Adjoint Chargé du S&E Chargé de projet FM Chargé de programmes Chargé des SB	Coordination	16 Sept
RM Ziguinchor	Mr. Lamarama BA Mr. FAYE Meme M. Gueye Tall Mr. Malik DIEME SYLLA Saliou Mr. THIAM	Chargé de programme UAR/CNLS Supviseur SSP region Secrétaire UAR/CNLS Gestionnaire RM (finances) Directeur centre régional en de formation en santé Planificateur	Executive Team	19 Sept