EVALUATION OF THE CONTINUOUS DEMOGRAPHIC AND HEALTH SURVEY IN SENEGAL 2012–2017

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Cover photo: A pregnant woman in Bignona, Senegal, exchanges a coupon for a long-lasting insecticidal net. Credit: © 2013 Diana Mrazikova/ Networks/ Senegal, Courtesy of Photoshare.
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ABSTRACT

An evaluation of the Senegal Continuous Survey (SCS) (Continuous Demographic & Health Survey [CDHS] and Continuous Service Provision Assessment [CSPA]) was conducted between April and September 2018 to assess whether it achieved its objectives to increase evidence use in policy and to strengthen national ownership and capacity for survey design, implementation, analysis, and dissemination.

We found that the CDHS data are used extensively by both government ministries and partners in planning and evaluating their activities. The only major user of CSPA, with data on the quality of health services, is the Ministry of Health and Social Action (MSAS), to correlate health service performance with household-level data.

ICF has strengthened the capacity of the National Agency of Statistics and Demography (ANSD), the entity with which the Government of Senegal (GoS) has institutionalized this survey. ANSD has the capability to sustain the SCS with minimal support from ICF. The main challenge is that most expertise required for SCS lies with ANSD's non-permanent staff, but plans are underway to solve this problem by year’s end.

The GoS has so far contributed little to the SCS costs. The prime minister is working to create a fund to support statistical activities, including the SCS.

Continuation of the SCS should be the responsibility of ANSD with limited technical support from ICF. Should the GoS decide to move away from the continuous survey model, another option suggested by various stakeholders was to conduct both the Demographic and Health Survey (DHS) and the Service Provision Assessment (SPA) at intervals of two to three years with representative samples at the regional level. The data would then be more useful in all 14 regions.
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ACRONYMS

AIS  AIDS Indicator Survey
ANSD  L’Agence Nationale de la Statistique et de la Démographie (National Agency of Statistics and Demography)
CDHS  Continuous Demographic and Health Survey
CNS  Le Conseil National de la Statistique
CSPA  Continuous Service Provision Assessment
CSPro  Census and Survey Processing System
DHIS-2  District Health Information System 2
DHS  Demographic and Health Survey
DHS-7  Demographic and Health Survey 7
DPRS  Direction de la Planification, de la Recherche et des Statistiques (Directorate of Planning, Research, and Statistics)
GoS  Government of Senegal
MCD  Médecin Chef de District (District Medical Officer)
MDGs  Millennium Development Goals
MEFP  Ministère de l’Economie et des Finances et du Plan (Ministry of Economy, Finance, and Planning)
MICS  Multiple Indicator Cluster Survey
MIS  Malaria Indicator Survey
MSAS  Ministère de la Santé et de l’Action Sociale (Ministry of Health and Social Action)
PMI  President’s Malaria Initiative
PSE  Plan Sénégal Emergent (Emergent Senegal Plan)
SCS  Senegal Continuous Survey
SPA  Service Provision Assessment
UNFPA  The United Nations Population Fund
UNICEF  The United Nations Children’s Fund
USAID  United States Agency for International Development
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EXECUTIVE SUMMARY

OBJECTIVE AND EVALUATION QUESTIONS

This is a final evaluation of the USAID-funded Continuous Demographic and Health Survey (CDHS) and Continuous Service Provision Assessment (CSPA), launched after the combination 2010/11 Demographic and Health Survey (DHS)/United Nations Children’s Fund (UNICEF) Multiple Indicator Cluster Survey (MICS). The CDHS and CSPA constitute the Senegal Continuous Survey (SCS).

The purpose of this final evaluation is to assess the extent to which the SCS has achieved its objectives: 1) To increase the use of data for planning and policy; 2) To strengthen national capacities, in particular with regard to planning, implementation, and dissemination of survey results; and 3) To foster ownership of the survey by the Government of Senegal (GoS).

CONTEXT OF THE PROJECT

The SCS was formulated with three main objectives:

1) Meet ongoing data needs for planning, monitoring, and evaluating health and population programs.

2) Strengthen the capacity of Senegalese institutions to collect, process, analyze, disseminate, and use the data.

3) Foster ownership of the survey by the host country.

In short, the logic was that the maintenance of a central office and field staff over a continuous period would lead to the institutionalization of DHS processes and an increase in staff capacity. These two results were expected to give rise to improved data quality and a reduced need for technical assistance, resulting in cost savings and increased ownership of the survey by the GoS.

EVALUATION QUESTIONS, DESIGN, METHODS, AND LIMITATIONS OF THE EVALUATION

The evaluation was designed to answer the following questions:

Concerning the use of data:

1a. How have SCS data been used by various stakeholders to plan, monitor, and evaluate health programs?

1b. Is the concurrent implementation of CDHS and CSPA useful? In what sense? And for which stakeholders?

2. What have been the achievements and challenges in capacity-building since the beginning of the SCS?

3. Has the Government of Senegal gradually taken ownership of SCS over time?

In addition, because the issue was raised by many of our interviewees, the team added a fourth question:

4. What are the requirements of a sustainable SCS that can guide the steering of public policies and the Emergent Senegal Plan (Plan Sénégal Emergent or PSE)?
METHODOLOGY

Three main methods were used for this evaluation: 1) a review of USAID documents and other publications related to the SCS, 2) individual and group interviews, and 3) a brief review of CDHS and District Health Information System 2 (DHIS-2) data quality.

For the first, USAID provided the evaluation team with about 20 documents related to the survey as well as the evaluation of the ongoing survey in Peru which has the only other CDHS in the world. (Professor Becker was on the evaluation team for that survey in 2007.) The team also reviewed a publications list provided by ICF on publications that utilized SCS data.

For the second, the team was provided with a list of people and/or organizations to contact for interviews, and during our work, the team added a few other people we considered important to meet. The list includes five main groups: 1) USAID, 2) ICF, 3) National Agency of Statistics and Demography (L’Agence Nationale de la Statistique et de la Démographie or ANSD), 4) GoS, and 5) Partners.

For the third, the team reviewed some of ICF’s data quality indices from tabulations of CDHS data as well as one indicator produced from the DHIS-2.

RESULTS AND CONCLUSIONS

Question 1a: How have SCS data been used by various stakeholders to plan, monitor, and evaluate health programs?

The SCS data are used extensively by both government ministries and partners in planning and evaluating their activities in the country. That all ministries are required by the Ministry of Economy, Finance and Planning (Ministère de l'Economie et des Finances et du Plan or MEFP) to produce an annual report on their performance makes data indispensable for a large number of government bodies.

Question 1b: Is the concurrent implementation of CDHS and CSPA useful? In what sense? And for which stakeholders?

The only major user of CSPA is the Ministry of Health and Social Action (Ministère de la Santé et de l'Action Sociale or MSAS). Having both surveys done at the same time allows ministry staff to correlate health service performance with data collected at the household level. It should be noted that the CSPA is the only source on the assessment of the quality of health services by the population.

Question 2: What have been the achievements and challenges in capacity-building since the beginning of the SCS?

ICF made a good start in the area of capacity-building at ANSD. Initially, ICF did almost everything: sampling, programming for data entry and reconciliation, calculating weights for different files, as well as developing the tabulation program. Capacity-building of ANSD technical staff has been successful in almost all aspects related to conducting surveys.

The main challenge that emerges from our interviews is that much of the expertise required to conduct the surveys lies with ANSD’s non-permanent staff. Further analysis is another challenge that will need to be addressed if the SCS is to continue.

Question 3: Has the Government of Senegal gradually taken ownership of SCS over time?

We considered the ownership of the SCS from two angles: technical and financial.
At the technical level, the GoS has institutionalized the survey within ANSD, the government organization responsible for producing national statistics.

However, the GoS has so far contributed little to the costs of the two surveys.

**Question 4: What are the requirements of a sustainable SCS that can guide the steering of public policies and the Emergent Senegal Plan (Plan Sénégal Emergent or PSE)?**

Results-based financing, a practice that ties the continued funding of programs to their proven positive results, is now the norm in Senegal, thus making program monitoring and evaluation essential. In the absence of a fully functional routine health information system, CDHS and CSPA are the primary data sources for health system performance indicators at the national level. They are essential for monitoring PSE and sectoral policies.

All our interlocutors wish to see the CDHS and the CSPA continue.

Ideally, a representative sample should be taken from all 14 regions of Senegal each year, but this would potentially require significantly higher costs.

District medical officers (Médecins Chef de District or MCDs) face the challenge of getting reliable population health data for their districts. In the absence of such data, they have to use the regional average for their planning and monitoring needs, which is far from adequate. This constitutes a persistent challenge in the 76 health districts that represent the operational level of Senegal's health system. Obviously, this need cannot be met with CDHS.

**RECOMMENDATIONS**

1. **Funding:** Advocate with the prime minister and, if necessary, the president of the republic so that they can see through the effective implementation of the Statistical Development Fund that they have already initiated (see below). Also, encourage the participation of interested non-governmental partners, both in the financing and steering committee of the SCS.

2. **Contracting authority:** Continue collaborating with ANSD and ensure that the regularization of professional contract staff is effective by the end of 2018.

3. **Technical assistance:** Continue the relationship with ICF as long as necessary to ensure quality in technical aspects not yet mastered by ANSD.

4. **Frequency and level of representativeness of the SCS:** Ideally, the CDHS and CSPA should continue to be conducted each year with a sample size sufficient to provide reliable estimates at the regional level. Several alternatives have been suggested for the continuation of the SCS if the available funds are not sufficient to carry out the ideal survey.

Given the difficulties created by the instability of most indicators from one year to the next (including at the national level), the best solution would be to conduct a household survey every two or three years, as well as the Service Provision Assessment (SPA) survey on a larger sample to allow stable estimates at the regional level. In addition to solving the problem of indicator instability, such a solution would give much more time for data analysis.
Regarding the production of reliable population health data at the district level, we suggest strengthening and using the routine DHIS-2 as an alternative.\(^1\)

5. **Dissemination:** Dissemination should take place as soon as possible after reports are available. Also, ANSD should strive to have dissemination in all regions. Reports should be widely shared well in advance of dissemination to ensure that at least all regional and district medical officers have received them so that they may actively participate in dissemination.

6. **In-depth analyses:** To advance the science and understanding of population and health interrelations in Senegal, in-depth analyses of this large body of data are essential. The GoS might consider setting up a competitive fund with calls for proposals where all experts could compete.

Also, as many interviewees noted, CSPA data should help to better facilitate understanding of what is happening at the population level. Therefore, a joint analysis of the data from the two surveys is required. ICF could assist in the use of appropriate analytic methods.

\(^1\) To obtain estimates at the district level, it is necessary to ask a limited number of questions to women who come to give birth in the health services or who go there after giving birth. The proposed approach produces a continuous series of estimates of the level of mortality before the third birthday and of birth weight, two key indicators of maternal and child health at the lowest level.
I. INTRODUCTION

The United States Agency for International Development (USAID) places a high value on the collection, analysis, dissemination, and use of timely, quality, nationally representative health data for the purposes of program planning, monitoring, evaluation, and policy-making. As a result, USAID has been the steadfast leader of the Demographic and Health Survey (DHS) Program since its launching in 1984. In its 34 years, the DHS Program has provided technical assistance in the implementation of more than 320 surveys in 90 countries. It is the largest and longest enduring program of its type. Thanks to a standardized methodology and approach, the surveys are comparable across time and place. And because of a longstanding open data approach, DHS data are freely available for download and widely used. Over time, the DHS Program has taken an increasingly larger role in strengthening local capacities, fostering data access, and facilitating data use. The current iteration of the program, DHS-7, aims to improve the collection, analysis, and presentation of population, health, and nutrition data and to facilitate the use of these data for planning, policy-making, and program management to promote evidence-based decision-making.

The technical support that the DHS Program provides generally pertains to a specific set of surveys and their related activities. Surveys in the program include several household surveys: the standard DHS; the AIDS Indicator Survey (AIS), which collects data for monitoring and evaluating HIV/AIDS programs; and the Malaria Indicator Survey (MIS), which collects data used for monitoring the performance of malaria programs. In addition, the program includes the Service Provision Assessment (SPA) surveys, which collect health facility-level data on service availability, facility readiness to provide essential health services, the quality of those services, and the satisfaction of clients and providers alike.

In addition to this suite of surveys, there have been two experiments with a continuous DHS (CDHS) in lieu of a once-in-five-years standard DHS. The basic objective of a continuous DHS is to produce information on a regular basis (annually or semiannually) by a permanently maintained DHS office and staff. The first such survey was conducted in Peru starting in 2004; the second, a five-year program in Senegal in 2012 that included both a continuous DHS and continuous SPA. Further information regarding the Senegal Continuous Survey (SCS) is provided below as it was the focus of this endline evaluation.

EVALUATION PURPOSE

The purpose of this final evaluation was to assess the extent to which the SCS has achieved its objectives: 1) Increase the use of data for planning and policy; 2) Strengthen national capacities, particularly with regard to planning, implementation, and dissemination of survey results; and 3) Foster ownership of the survey by the host country. The evaluation will address both technical and management considerations to better understand the challenges and successes of implementing an ongoing survey. This evaluation will be used by the various stakeholder groups: relevant Senegalese government ministries, USAID/Senegal, other donors supporting the Ministry of Health and Social Action (Ministère de la Santé et de l’Action Sociale or MSAS) and National Agency of Statistics and Demography (L’Agence Nationale de la Statistique et de la Démographie or ANSD), and USAID/Washington, D.C., program managers.
EVALUATION QUESTIONS

The evaluation was to answer four specific questions from USAID (1a, 1b, 2, and 3). As many of our respondents inquired about sustainability, an additional question (4) was added, which aims to guide the Government of Senegal (GoS) in its efforts to sustain the SCS:

1. Concerning the use of data:
   a. How have SCS data been used by various stakeholders to plan, monitor, and evaluate health programs?
   b. Is the concurrent implementation of Continuous Demographic and Health Survey (CDHS) and Continuous Service Provision Assessment (CSPA) useful? In what sense? And for which stakeholders?

2. What have been the achievements and challenges in capacity-building since the beginning of the SCS?

3. Has the Government of Senegal gradually taken ownership of SCS over time?

4. What are the requirements of a sustainable SCS that can guide the steering of public policies and the Emergent Senegal Plan (Plan Sénégal Emergent or PSE)?

EVALUATION TEAM

The team members were Stan Becker (demographer and team leader), Cheikh Mbacke (demographer and team member), and Olivia Padis (team member assisting Becker and Mbacke).
II. BACKGROUND OF THE SCS

BACKGROUND
USAID’s first continuous survey began in 2004 in Peru and continues today. The continuous approach was adopted in response to a push from countries and donors: 1) to have DHS-type data more frequently available than the standard five-year interval, and 2) to better institutionalize local capacity to conduct large-scale surveys. The Peru Continuous Survey provides key data on population, health, and nutrition every year. Within approximately five years of the continuous survey’s start, the Government of Peru had institutionalized it, providing the lion’s share of funding and further expanding the survey sample to allow for annual estimates at the subnational level.

Following the successful Peruvian experience and given increased demand for more frequent data, USAID became interested in expanding the continuous approach to sub-Saharan Africa. Increasingly recognizing the benefits of having population- and facility-based data collected contemporaneously, USAID also became interested in implementing a continuous survey that would incorporate both DHS and SPA data collection activities. As a result, in 2010–11, USAID began exploring a second continuous survey experiment, with both DHS and SPA elements, to be tested in a country of sub-Saharan Africa. Soon thereafter, thanks to mission and host country government interest, Senegal was chosen to become the site of the second continuous survey, which would be framed as an experiment with formal baseline, midterm, and endline assessments.

One of the benefits of experimenting with the continuous survey approach in Senegal was the country’s long history of DHS Program survey implementation. Prior to the start of the SCS, Senegal had six rounds of the standard DHS (1986, 1992–93, 1997, 1999, 2005, and 2010–11) and two MISs (2006 and 2008–09).

In addition to its long history with the DHS Program, another prime reason for Senegal’s interest in implementing the continuous survey experiment is the national data strike that began in 2010, during which health providers withheld data routinely collected by the health system. Important health information and results were either unavailable or unreported to the GoS, negatively impacting public health information systems as well as various stakeholders. In response, the GoS established the SCS in 2012 to monitor and ensure progress toward the achievement of the Millennium Development Goals (MDGs) and other health program objectives. In an effort to maintain a continuous data flow to better inform policy, the SCS replaced the standard DHS model that supported household data collection approximately once every five years.

SCS OBJECTIVES
The SCS was formulated with three main objectives: 1) meet ongoing needs for data to plan, monitor, and evaluate health programs and populations, 2) build capacity within Senegalese institutions to collect, process, analyze, disseminate, and use data, and 3) foster ownership of the survey by the host country.

In addition to these two main objectives, there were additional hypothesized benefits. First, in the case of the CSPA, a frequent assessment of health data availability of client services in health care facilities as well as of facility readiness to provide services would allow swift programmatic improvements through a faster feedback loop. Second, the maintenance of a central office and field staff over time would reduce costs and lead to institutionalization of the DHS process. This, in turn, would bring benefits outside the scope of a cross-sectional DHS, such as improved data quality and a reduced need for technical
This would ultimately allow for a greater degree of survey ownership by the GoS. Additionally, the SCS design, unlike the standard DHS with a five-year interval, would allow greater flexibility and quicker responsiveness to country data needs as survey rounds could be tailored to address special topics.

This evaluation will identify whether these planned benefits were realized, including successes and challenges encountered.

**SCS METHODOLOGY AND STRUCTURE**

The SCS was built from lessons learned from the Peruvian experience, particularly in regard to sample size and its relationship to yearly reporting. Specifically, as in the original sampling design for Peru, the CDHS component of the SCS does not produce estimates that are representative at the regional level each year. Data from two consecutive phases must be pooled in order to yield representative indicators for each of Senegal’s 14 regions. In contrast, the CSPA is able to provide regional estimates for each phase of data collection.

Phase 1 of the SCS was conducted in 2012–13, followed by Phase 2 in 2014, Phase 3 in 2015, Phase 4 in 2016, and Phase 5 most recently completed in December 2017. Regarding the CDHS, the core elements of the DHS remained the same across the five phases, but other elements changed during the process as a result of initial plans or necessary adaptations. For example, the sample size was fixed at 200 clusters and approximately 4,000 households for the first four phases, but increased to 400 clusters in the fifth phase because of the inclusion of HIV testing and maternal mortality measurement. Women aged 15 to 49 were surveyed in each phase, but from Phase 2 onward, men aged 15 to 59 were also surveyed. Each phase included anthropometry, anemia testing, and malaria testing for children, while Phase 5 also included anemia and HIV testing for men and women in the sample. Each phase used an abridged standard DHS questionnaire and included a special questionnaire module following national priorities.

Like CDHS, CSPA was also designed to have five phases with certain elements remaining the same across the five phases, while others changed from one phase to the next. The indicators for each of the five phases were representative by facility type, managing authority, and Senegal’s 14 regions. During each phase, 50 percent of Senegal’s hospitals and health centers were surveyed, as well as 20 percent of health posts including a sample of the latter’s associated health huts. In the third, fourth, and fifth phases, 10 percent of the facilities surveyed in the previous phase were re-surveyed. The CSPA used four data collection methods for each phase: inventories, interviews with health care providers, consultation observations, interviews with health facility clients, and, in some years, a special questionnaire for health huts. During each phase, the themes for the consultation observations were the same as those for the interviews with health facility clients. However, the topics of these themes changed between phases. For example, during Phase 1 the themes were family planning and curative care for children, while in Phase 2 they were antenatal care and curative care for children.

**SCS STAKEHOLDERS AND FUNDING**

Since the beginning, the SCS has been conducted in compliance with the action program of the ANSD in close collaboration with the MSAS, with technical assistance from ICF, and funding provided by the GoS, Global Fund, USAID, United Nations Children’s Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank, President’s Malaria Initiative (PMI), and Nutrition International (formerly, Micronutrient Initiative; see Table 1 in Annex I. Scope of work).
III. EVALUATION METHODS AND LIMITATIONS

METHODOLOGY

Three main methods were used for this evaluation: 1) document review, 2) individual and group interviews, and 3) review of CDHS and District Health Information System 2 (DHIS-2) data. The evaluation began in April 2018 and the final report was approved in January 2019. For the first, USAID provided the team with about 20 documents related to the survey as well as the evaluation of the continuous DHS in Peru which is the only other CDHS in the world. (Professor Becker was on the evaluation team for that survey in 2007.) For the second method, we were given a list of people and/or organizations to contact for interviews; during our work, we added a few other people we considered important to meet. For the third method, we added a review of CDHS data quality since the analyses of the Peru Continuous Survey data showed a deterioration in data quality for some measures. USAID also provided temporary access to the DHIS-2 database. The review of the DHIS-2 data gave the team a better idea of the limits and possibilities offered by this routine data collection system.

Previously, with USAID's help, we had prepared a list of questions to ask respondents. Although there were some common questions, the list varied for the five main stakeholder groups: 1) USAID, 2) ICF, 3) ANSD, 4) GoS, and 5) Partners. The questionnaires can be found in Annex II.

Individual and Group Interviews

In Washington, D.C.

1. USAID
2. ICF

In Senegal

3. USAID/Senegal
4. ANSD
5. MSAS
6. Other GoS bodies
7. Partners
   a. UNICEF
   b. UNFPA
   c. Nutrition International
   d. Global Bank
   e. Helen Keller International
   f. Sustaining Health Outcomes through the Private Sector (SHOPS)-Plus
   g. IntraHealth
   h. Population Council
A list of all interviewees is provided in Annex III. We presented each person with an informed consent form to sign which included permission to record the interview and use anonymous quotes (Annex IV). All our interviewees agreed to sign the form.

Finally, ICF prepared tabulations for CDHS data quality indices that we analyzed (see section on data quality below).

**LIMITATIONS**

The limitations of the evaluation are:

1. Some interviewees may have been inhibited in what they said — or in speaking at all — by the presence of a person who is his/her superior or otherwise dominant person in the organization.

2. Quite a few of our interviewees have not been in their current position for the entire period since 2012. Conversely, several of the interviewees were present and involved with SCS in the early part of the project but not in the more recent past or at present.

3. Team members sometimes “led the witness” (i.e., interrupted the speaker to complete the thought or restated the question in a leading or somewhat biased manner). This was only noticed to be a — nontrivial — problem upon listening to the tapes. In effect, the team had discussions with the interviewees rather than simply posing questions and listening to them. In some ways this led to richer discussions but it is also not acceptable in typical qualitative methodology.

4. Some of the interviewees — for example, ANSD employees — had vested interests in one or another aspect of the SCS. This is an acceptable “bias” since we specifically wanted to hear comments from those involved with SCS in different ways.

5. A few interviewees had to hurry the interview because of other commitments and several joined the conversation (i.e., started with other colleagues) late.

6. It is likely that the authors of the report selected quotes that they agreed with more than quotes with which they disagreed. For example, a couple of respondents said it would be good to continuously have estimates of HIV prevalence or maternal mortality from the CDHS. These persons evidently did not understand the implications of those requests vis-à-vis sample size and associated very elevated costs, and the team chose not to include those statements.

7. Two quite minor limitations were:
   
   a. The tape malfunctioned for one interview.
   
   b. Some points may have been lost in translation.

8. With more time, we could also have interviewed more stakeholders who were not available during the team’s presence in Senegal.
IV. FINDINGS

DOCUMENT REVIEW

Several points emerged from the evaluation team’s review of the documents listed in Annex V as follows:

1. It was instructive to see that in Peru, when USAID withdrew and the government took over the survey financially, the sample size of women of reproductive age was increased to 20,000–25,000 so that estimates of key indicators could be available at the regional level each year.

2. We note that the following recommendations of the 2015 Midterm Review are still valid:
   - On data access and use: “(2) A technical committee. . . . can serve as an efficient vehicle for defining strategies to reinforce capacities.”
   - On the need to improve communication and dissemination: “(3) MSAS needs to be involved more effectively in the activities of dissemination of results including at decentralized levels.”
   - Relating to human resources: “(4) Creation of a post for a medical person involved in the technical team is important.”

3. The report with the combined DHS data for three years (2012–2014) makes it difficult to accurately date the estimates, especially for indicators that already have a multi-year reference period, such as fertility and infant and child mortality.

4. In searching the DHS publications on the ICF website, we were unable to find documents using CDHS and/or CSPA under analytic studies or under further analyses reports.

INTERVIEWS

This section directly answers the specific questions asked in the evaluation’s scope of work, illustrated by direct quotes from our interviewees.

Question 1a: How have SCS data been used by various stakeholders to plan, monitor, and evaluate health programs?

The SCS data are used extensively by both government ministries and partners in planning and evaluating their activities in the country.

[For MSAS,] the results of these surveys were used mainly for planning. We set targets based on what has happened in the past to better measure our progress. Since 2012, all decisions reflected in strategy documents have been influenced by the DHS. Examples include the sectoral development policy letter, multi-year expenditure documents, the national health financing strategy. [GoS]

Certainly, the Embassy uses the DHS data for referencing things when they’re reporting back to Washington. [USAID]

The first source is the DHS. It is the DHS modules that inform the impact of interventions on the population. [USAID]
In relation to planning, strategic plans are made for the annual work . . . and these are based on DHS indicators. [GoS]

There is good ownership. In all planning there is a use of data, in all sectors. [Partner]

In terms of nutrition advocacy, for example, DHS data are used extensively. They are also used to develop strategic plans for the next 5 years. [Partner]

The main user within the government is the MSAS, many of whose directorates depend heavily on the availability of this data. [Partner]

DHS is mainly used by MSAS. At the Ministry, there are several programs and virtually all programs use DHS to plan their activities. [Partner]

If the survey shows the coverage isn’t good, we can do something. [GoS]

As our interlocutors said, almost all divisions in the MSAS need these data for their annual planning as well as for monitoring their activities.

The Directorate of Planning, Research, and Statistics (Direction de la Planification, de la Recherche et des Statistiques or DPRS), which coordinates the preparation of the National Health Development Plan and monitors its implementation and evaluation, is the focal point for the SCS within the ministry, although the Directorate of Maternal and Child Health (Direction de la Santé de la Mère et des Enfants) is the largest user.

SCS is extremely useful for the National Malaria Control Program and the Expanded Program on Immunization.

Between the continuous DHS, every 2 years we do the MIS (Malaria Indicator Survey). We are looking at how to use the resources in the ongoing DHS to drop this survey. We have all the malaria indicators in DHS. [GoS]

The Ministry of Economy, Finance, and Planning (Ministère de l’Économie et des Finances et du Plan or MEFP) is the largest user outside MSAS.

That all ministries are required by the MEFP to produce an annual report on their performance makes data essential for all ministries in their performance reporting. SCS data are indispensable for the following ministries: national education; women, family and gender; good governance and child protection; economy, finance, and planning.

Each department is required to produce a performance report in the first quarter of each year and DHS data are essential for this work. [GoS]

The DHS data are used because they need them to complete their performance reports. There are in fact data that can only be found in the DHS . . . I think that under the PSE there is a monitoring plan in place and all departments are normally accountable to the Ministry of Finance. . . . There are progress reports that are requested all the time from these ministries. [GoS]

From the point of view of aiding in decision-making, DHS is extremely important. Especially since the Ministry of Finance also uses DHS data because now, in the program budget
approach, we are all required to correlate the resources we have with the performance we have. [GoS]

The various branches of the ministry need the data from the SCS for monitoring public policies, the PSE, and progress toward the MDGs.

All departments are involved today. I’m just giving the example of PSE. [GoS]

Partners also rely heavily on CDHS data availability to develop their work plans and evaluate their activities. All partners agreed that, in the absence of CDHS, it would be impossible for them to properly plan and monitor their activities unless they conducted their own surveys.

It is obvious that no one survey can meet all data needs, but the fact that CDHS is an annual survey allows the needs of different partners to be met by including different modules from one year to the next.

MSAS is the main user of the CSPA, which provides data specific to the health system. The CSPA data are complementary to those produced by the MSAS information system, DHIS-2, but as a data source, DHIS-2 suffers from a number of limitations: 1) reliability of the denominator, which needs to be estimated and projected for each health district; 2) incomplete coverage even for public services, which are their priority target; 3) very low coverage of the private sector; and 4) selection bias resulting from the health system seeing only a fraction of the events of interest.

Because of these limitations, the CSPA, which also contains many questions that are not in DHIS-2, remains an essential source.

The national system doesn’t always work. [Partner]

DHIS-2 provides service delivery indicators, routine data. The DHS gives a more global vision. [USAID]

DHIS-2 is administrative, numerator can be good, but we have denominator issues. [GoS]

The two sources are complementary. Routine data is not enough to make very good decisions. [GoS]

When we do the data quality audit, we say that the DHIS2 data are not good. I’m telling you it’s not good and we know why. In fact if the person who puts the data does not have this information culture, it goes without saying that the data will not be good; he puts whatever he wants. [GoS]

However, it should be noted that the use of CSPA is limited. Analyses are complicated by the different levels of service delivery sampling and types of data available.

In reality, the CSPA is being conducted for the first time in this project, and people don’t know much about it. [ANSD]

The CSPA is not used much. The only user is MSAS. [USAID]

Finally, the retention of DHIS-2 data following multiple strikes in the health system regularly calls into question their usefulness for decision-making at MSAS. As a reminder, CDHS and CSPA were launched in a context of data retention for several years, making them the only data available in the health field.
At the time of this evaluation, data retention had been in force since April 2018 following a directive of the health workers’ union, which has been protesting for better salaries and an increase of retirement age from 60 to 65. The strikes and confrontations with government continued during the time of the team’s visit.

**Question 1b: Is the concurrent implementation of CDHS and CSPA useful? In what sense? And for which stakeholders?**

The only major user of CSPA is MSAS. For this reason, the question is most relevant to them and many respondents outside MSAS were more or less ambivalent in their responses.

For MSAS staff, having both surveys done at the same time allows them to correlate health service performance with data collected at the household level.

> There is a training project on this [to analyze the two surveys together] . . . we asked if there could be capacity building on analyses integrating SPA and DHS. [ANSD]

> If prevalence is low, we can see if it is due to the level of use of services. [Partner]

> How both of the surveys are managed needs to probably come together in a more meaningful way. Even though it’s a continuous survey umbrella, the continuous DHS and the continuous SPA are still implemented like two separate surveys with different managers, etc., which makes sense because they are two different surveys. But the problem with that is that then there is no point at which they really come back together under this umbrella of the SCS. There is a lack of vision about how you can really make the most of both of these data sources and having them on a yearly basis. [USAID]

> I don’t think we’re very good at presenting the [facility] data. Unlike the DHS where everybody has their indicator, everybody has their chapter, people don’t have that for facility [data]. Even thinking of ways to pull the [facility and household] data together so that it told a better story, presenting those data together also was so challenging. [USAID]

> Why not, they don’t have the same indicators. We can put them in parallel. We triangulate with the routine data. [GOS]

> Basically we have not done too much in terms of combining, not in Senegal. I think what we have done in terms of combining, we produce every year what we call the synthesis report. The synthesis report presents the data at the level of region for SPA, at the level of region for DHS for 2 years. In there we combine by topic. [ICF]

In other words, the performance of services in a given region can help better understand and explain the indicators recorded by the household survey in the same region. For example, a region where contraceptive shortages are common will have more difficulty increasing its contraceptive prevalence rate.

It should be noted, however, that it is technically impossible to link a particular individual or event recorded in a household to a specific health facility or its activities. Of the 25 publications using the SCS data, only two attempted to analyze CDHS and CSPA jointly because the service delivery sites in the CSPA came from a representative sample of these services but were not related to the selected clusters in the DHS.
Question 2: What have been the achievements and challenges in capacity-building since the beginning of the SCS?

ICF made a good start in the area of capacity-building at the ANSD level. Initially, ICF did almost everything: sampling, programming (using Census and Survey Processing System [CSPro]) for data entry and reconciliation, weight calculation for the different files (i.e., households, women, children, men) as well as the tabulation program (also in CSPro). They also provided considerable assistance in drafting the reports. Over time, ICF has been successful in building the capacity of ANSD technical staff in almost all aspects of survey implementation, from adapting the questionnaire to training interviewers in data collection and processing. The capacity-building effort has been so successful that ANSD data processing specialists are currently being used to train experts from other African countries. Also the malaria and HIV programs in Senegal gave technical assistance to ANSD for collection of those samples.

The sampling, they did by themselves. The questionnaires, they did by themselves. The data entry, they did by themselves. A complete change from the beginning where we did everything for them. . . . we have two people from data processing that didn’t know anything about surveys, they started with zero, and now we are sending them to other countries to help us as consultants. Data processing is very complex for DHS from beginning to end. They are doing almost everything. But, we have been fighting with ANSD to hire them. They are contractors. [ICF]

It’s one of the successes, we had capacity building workshops which we did at a regional level. We involved them originally as participants, and as time went on they were actually facilitators. [ICF]

The Data Processing people trained in Senegal are also supporting other DHS countries in activities. [ICF]

They still need TA [technical assistance] for sampling and data processing and report writing. . . . One of the biggest challenges that is not recognized is how difficult it is to write these reports. [ICF]

They can do everything except dissemination. . . . they didn’t have an internal dissemination unit per se that can work with our team here. [ICF]

They still need further capacity strengthening on the sampling. Now they do the sample design, the sample selection, but they’ve never calculated the sampling weight and the sampling error. They need some more basics. For the sampling error calculation, it’s more complicated. It depends also on what software they have. We did several workshops, but the workshops are mainly concentrated on design and sample selection. We covered weight and sampling error calculation, but . . . we had less time for these topics. We think we need a special workshop for the sampling weight and sampling errors. [ICF]

When I arrived, the competence was very limited. SCS is the most complex survey I’ve ever seen. When Abibata arrived in 2015, we started to learn. . . . Capacity-building is a great success. I was trained by ICF. [ANSD]

The main challenge emerging from our interviews is that most of the expertise required to implement surveys lies with ANSD’s non-permanent staff. The CSPA coordinator, the two data processing specialists and all supervisors and interviewers are contract workers who could leave at any time if they
had a better offer elsewhere. The departure of data processing specialists in particular is more likely and would be a blow to the Agency.

Currently we have staff with requisite skills that could continue the survey and we will have to do everything to keep them at ANSD. These are resources that are in great demand by others. We are taking the necessary steps to integrate them. Normally it should have been done this year, but for budgetary reasons we had to wait. This will happen next year. [ANSD]

Some of our interlocutors also think that beyond the integration of contract staff, ANSD should create an office entirely dedicated to SCS with all the required skills.

We need a dedicated office where we try to put all the expertise together. . . . As long as we don’t have a dedicated office with all the expertise, we can’t support the project. [ANSD]

However, as SCS is an integral part of the statistical system development strategy, which includes many other surveys, ANSD should organize itself to ensure that none of these surveys are left behind. It has been the case in the past that staff working on SCS have been pulled to work on other surveys or the census leading to delays in SCS work.

In-depth analysis is another challenge that will need to be addressed if the SCS is to continue. ANSD staff told us about a series of seven articles being written. However, this staff should not be expected to become very productive in terms of publications. They simply do not have the time since they move from one survey to another with little time to devote to analysis beyond what is required for the publication of the final report.

With the assistance of ICF, we were able to identify 25 scientific publications from 2013 to 2018 using CDHS data. Of these 25, the vast majority are comparative studies that include Senegal. Only four focus on Senegal. Moreover, Senegalese researchers are practically absent since they are only involved in two of these publications. The complete list is provided in Annex VI.

**Question 3: Has the Government of Senegal gradually taken ownership of SCS over time?**

We considered the ownership of the SCS from two angles: technical and financial.

At the technical level, the GoS has housed the survey within ANSD, which is the government organization responsible for producing national statistics. Great progress has been noted in the technical ownership of the SCS within ANSD, which now has qualified technical staff able to carry out most of the operations required by the CDHS and CSPA. It is evident that ANSD is able to perpetuate SCS with relatively light assistance from ICF.

They do the data there [at ICF]. There are several experts there, the expertise is not here. In every field there is an expert. We don’t have that here. We can do all the processes from start to finish. But we send [the data] in for verification. All the programs are here. [ANSD]

All of this capacity has been built, start cascading it . . . First there’s the organizational capacity, which we can’t touch; this is the government, and it’s not within our mandate. But if we build [at the] individual level . . . the only way you can institutionalize is for those people to go back and teach [other] people . . . People we train should be training others. That sort of commitment we finally got in this last year. [ICF]
However, the GoS has so far contributed little to the costs of the two surveys (e.g., 7% for the SCS of 2012–13 and 2% for the SCS of 2015). Several interviewees told us that this is understandable since the funding of the five waves of surveys was secured through the support of partners, and USAID in particular.

_if USAID pays, we can use money for other things. [Partner]_

_Senegal is still a relatively poor country; I don't know if the expectation is right to say that they should assume all costs or, again, as a development partner, it should be that they assume a majority of costs or some sort of large portion of costs. Something that again shows there's an intention, that the government believes in this data source and wants to support it regardless of what donors do. [USAID]_

The 2018 survey, currently underway, has been about 75 percent financed by the GoS with support from the World Bank. Many maintain that the SCS budget is well within the government’s reach but that a belief in the importance of CDHS and CSPA at the highest levels of government has been missing.

According to most of our interviewees, the solution lies in setting up a specific budget line for independent financing of the SCS. However, there are differences in opinion as to the location of this budget line. Several interviewees thought it should be placed in the MSAS budget, while many others lean toward locating it in the ANSD budget.

CDHS and CSPA are among the flagship activities deemed “necessary to inform PSE steering” that are included in the National Statistical Development Strategy 2014–2019 (ANSD, 2014; p.48).

_There is a national strategy for statistical development and this strategy is accompanied by an action plan and a financing plan. It is within this framework that the activities of the DHS must be included. [ANSD]_

The director general (DG) of ANSD mentioned the ongoing efforts within the National Statistics Council (Le Conseil National de la Statistique or CNS) to establish a Statistics Development Fund. The NSC recommended not only the establishment of the fund, but also how it should be financed (i.e., devoting 30 percent of the existing statistical tax to it). According to the DG, the decree has been drafted and awaits the signature of the highest authority. That the prime minister heads the CNS — which made the recommendation and issued the directive of the president of the republic asking the “government to accelerate the process of setting up a Statistics Development Fund” in his speech of July 12, 2018 — suggests that, unless there is a dramatic reversal, the fund should be available in the short term. The fund would be devoted to supporting the statistical system as a whole, including surveys such as the SCS.

**Question 4: What are the requirements of a sustainable SCS that can guide the steering of public policies and the Emergent Senegal Plan (Plan Sénégal Emergent or PSE)?**

Results-based financing, a practice that ties the continued funding of programs to their proven positive results, is now the norm in Senegal, thus making program monitoring and evaluation essential. CDHS

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2 The statistical tax is levied on products imported from third countries and released for consumption, including those exempted from customs duty. An exception of goods imported under diplomatic exemptions and those acquired under financing granted by foreign partners is subject to an express exemption clause. It represents 1 percent of the value of eligible imports (https://www.douanes.sn/fr/node/722).
and CSPA are the primary data sources for health system performance indicators. They are essential for monitoring the PSE and sectoral policies.

They are equally indispensable to the technical and financial partners as they are an important source of data on which they can currently rely. These partners all agree that a country-led survey such as CDHS is the most efficient approach, rather than multiple parallel surveys by donors that would need to be conducted in their absence.

All our respondents wish to see both the CDHS and the CSPA continue. No one questioned that ANSD, the institution responsible for producing national statistics, should continue to implement the SCS. They have the capacity to conduct surveys but also to coordinate the large number of partners with their multiple needs in a functional steering committee.

However, the question everyone asks is: in what form? and the answers to this question are widely divergent.

Differences in response reflect differences in the needs of various stakeholders, but also that even a continuous survey cannot satisfy all the data needs of all stakeholders.

Each annual wave of the CSPA is based on a representative sample of all health structures across the country but also at the level of each individual region. This is not the case for CDHS, which is the most widely used source and is based on a representative sample at the national level but not at the regional level. No single CDHS wave can provide regionally valid information (except for 2017); two-year rolling averages have been needed to provide regional estimates. This is a major limitation: first, because two-year averages seem to be problematic for policymakers to interpret; and second, because the results by groups of regions (or axes) are not useful for programming, which is essentially done at the regional and medical district levels. All the partners we interviewed have programs focused on a region or a limited number of regions where the problems they aim to solve are most salient. Furthermore, the “nobody left behind” principle of the Sustainable Development Goals requires that policies and programs take regional inequalities into account. Even the MEFP, which often uses national indicators to monitor the economy, needs data by region.

Moreover, due to the small sample size, even national estimates can fluctuate from year to year in the absence of significant changes in indicators. This poses a problem for policymakers who do not have a good understanding of the variability of estimates.

We saw that when we follow neonatal mortality, it goes up and down from one year to the next. But we know it’s an artifact, a sampling problem. One year is too short to assess the impact of a program. [GOS]

Giving us a series close in time is good. But today we have difficulties with the level of indicators. I’ll take the mortality rate. Not long ago, the Director General came to worry that the rate was moving in sawtooth fashion. You know, to capture rare phenomena, you need a large sample or a longer observation time. [GOS]

The ideal would therefore be to have a representative sample at the level of the 14 regions of Senegal each year, but this would potentially require significantly higher costs. This is the path chosen by Peru, which has been financing its own survey since 2009.
Many of our interviewees said that dissemination should take place as soon as possible after reports are available, at least every time that new results are available and that ANSD should strive to cover all regions.

We recorded several suggestions on how to conduct the surveys while balancing costs and data needs.

The first is to continue with the light surveys that provide annually usable data at the national level and to conduct a survey every three years capable of informing programs at the regional level.

[ANSD has] a plan to do a smaller survey every year, and a larger survey every 3 [years]. [USAID]

[The DHS] is needed every year. Maybe there are some indicators that are not needed every year, like mortality. [Partner]

I prefer that it be every 2/3 years but with more precision. [GoS]

Big DHS every three years. . . . The partners told us we can wait three years. Every three years, we’ll have regional data. [ANSD]

If the indicators don’t change, we don’t need to collect every year. If there are indicators we need, we can do small surveys every year, every three years we can do a big survey. [ANSD]

The second is to alternate the DHS and SPA and conduct a representative survey at the regional level in the fourth year.

The DHS would be every two years. One year it will be the DHS, the next year it will be the SPA; alternate them. It really has the advantage of going beyond what the DHS alone can do. [ANSD]

I think we should alternate the SPA and the DHS if the means are there. Otherwise, every two years. If we can do it. [Partner]

Whichever approach is chosen, it will be important to secure key SCS staff who are still on contract. The current situation is worrying because the departure of these personnel would be a blow to the enterprise and its sustainability.

Currently, there is no solution in sight for the availability of valid data for the 76 health districts that carry out most of the health work. Senegal’s health system comprises 14 medical regions divided into 76 health districts. So far, the discussion has been focused on the availability of data and indicators at the regional level. The importance of having data specific to health districts was rarely raised in our exchanges at the central level in Dakar. Each health district is an operational area with at least one health center and a network of health posts close to the communities. The district chief medical officer (Médecin Chef de District or MCD) needs data as much as the regional chief medical officer and other partners for planning and monitoring their activities, but also for measuring their impact on the health status of populations.

There are two aspects to consider. There is the need for strategic decisions and the need for information at the operational level. . . . It is the district [that needs regular data most]. . . . The district is the operational unit. [GoS]
In their planning, MCDs are obliged to use regional data despite the disparities among districts, which can be enormous, calling into question the fundamental principle of equity underlying the system. Malaria prevalence is a good example where there is virtually no information on the health status of populations at the local level nor its evolution over time. And it is clear that the SCS, as it currently stands, is unable to solve this problem.

MCDs are seriously wondering what they can do to have regular measurements of the health status of populations in their district.

**Simple Data Quality Check of CDHS**

It is assumed that with a continuous survey, the quality of the data should improve over time because the interviewers are continually learning about the work. But in the case of the continuous survey in Peru, it was found that there were one or two indicators of data quality that showed deterioration in quality over time. Perhaps the interviewers “learned the job too well” (e.g., they found ways to minimize work by coding filter questions so that entire sections of the questionnaire could be skipped; see Tables C1 and C2 in the External Evaluation of Peru Continuous Survey Report, 2007).

We therefore decided to examine the quality of the data in Senegal’s CDHS. With the help of ICF, we chose two indicators: 1) the proportion of women whose age was recorded incompletely (normally it was the month of birth missing) and 2) the transfer of ages from 15 to 14 years (if a woman is 14, no interview is done). These are indicators that can show improvement or deterioration in data quality over time. We specifically examined data from the group together with nine surveyors who have been working for CDHS since 2012 and who completed approximately 75 percent of the interviews each year. The results are shown in Figure 1. The transfer index shows a trend of improvement in quality over time. But the incomplete age index shows no improvement, even if there is not a clear decline. Continued monitoring of these indicators is warranted.

**Figure 1. Mean percentage of women with age incomplete and with age shifted (15 to 14) for 9 interviewers in Senegal CDHS by year of survey**
Data Quality Check of DHIS-2

CSPA data are only representative at the regional or national level but the 76 health districts have data needs as well. For this reason, we explored the possibility of DHIS-2 data collected at that level but were told that the DHIS-2 data had quite serious data quality limitations.

USAID made available to us the data from DHIS-2. One check of data quality is described in Annex VII. The evaluation team’s general finding is that DHIS-2 could be useful for district-level estimation but only when relatively high completeness can be assured.
V. RECOMMENDATIONS

These recommendations were written upon completion of our interviews in Dakar. Later, both the findings and these recommendations were presented and considered in a workshop to which all the interviewees were invited. The results of that workshop vis-à-vis these recommendations are presented in Annex VIII. Our recommendations are categorized under the following seven headings: Financing, Next Steps, Technical Assistance, Frequency and Level of Representativeness of the SCS, Dissemination, In-depth Analyses, and Collection of Reliable Data at the District Level.

FINANCING

1. Advocate with the prime minister and, if necessary, the president of the republic to ensure the conclusion of the process of setting up the statistics fund that they already initiated.

2. Encourage the participation of interested partners both in the financing and in the steering committee of the SCS. Their funding could complement that from the government’s statistics fund.

NEXT STEPS

1. Continue with ANSD.

2. Find ways to mitigate the impact of conflicts (of time commitments of ANSD staff) with other data collection operations on the timeliness of data availability.

3. Ensure that the professional contract staff are made permanent by the end of 2018.

TECHNICAL ASSISTANCE

Continue the relationship with ICF as long as necessary to ensure quality in technical aspects that ANSD has not yet mastered.

FREQUENCY AND LEVEL OF REPRESENTATIVENESS OF THE SCS

1. Ideally, the CDHS and the CSPA should continue to be conducted each year with a sample size sufficient to provide reliable estimates at the regional level. This is what Peru did at the end of the first five years and it now has a sample of 25,000–30,000 households each year. (In Peru, this was only for CDHS as they did not implement a CSPA.) It would be reasonable to encourage all interested partners to contribute to the funding of the SCS by complementing the funding from the Statistics Fund.

2. If, for whatever reason, the funds are not sufficient to carry out the ideal survey, there are several alternatives that would reduce costs:

   a) Conduct the CSPA and DHS annually on a small scale to provide estimates at the national level and, every three years, a household survey on a larger scale to provide stable estimates at the regional level.

   b) Alternate the two surveys to have a DHS every two years (sample size to be determined) and a SPA in the other years. The fourth year DHS is based on a larger sample allowing reliable estimates for each region.
c) Conduct an annual survey in half of the regions with regional representation and a similar survey in the other half the following year.

d) Conduct a household survey every two or three years (and also concurrently the SPA survey) on a larger scale, which would allow stable estimates at the regional level.

Out of these four possibilities, we recommend (d). Our rationale is as follows: Regarding option a) there is little change in levels of nearly all measures between two adjacent years. Additionally, standard errors are large for smaller samples. The latter makes estimates bounce around leading to inappropriate worries of policymakers when a national estimate (e.g., vaccine coverage) goes down from one year to the next (but not a significant change). Though the option of including confidence intervals around estimates was discussed, quite a few policymakers lack a clear understanding of what they mean; Regarding option (b), a problem is that the estimates from the two surveys will not be for the same time so interpretation of the two together would be problematic; Regarding option (c) if only half of the regions are done in a given year, combining them with the next year’s data for the remaining regions will pose a problem of reference period for the combined estimate.

However, we must note that at the Findings and Recommendations Workshop, there was no consensus among participants on this recommendation. The differences are laid out in the workshop matrix included with the workshop report as Annex VIII.3

**DISSEMINATION**

ANSD has started to disseminate the results of the SCS at the regional level. They are encouraged to continue this effort and to ensure that all regions are covered. They should take the opportunity of these dissemination events to educate their audiences on issues and challenges that could be addressed by the SCS beyond the results presented.

Dissemination should also be of high quality and well-publicized to increase visibility. It should be sponsored by the governor who would invite all stakeholders in the region, starting with the administration and local elected officials.

Reports should be widely shared well in advance of dissemination to ensure that at least all regional and district medical officers have received so that they may actively participate in dissemination. It would simply be a matter of sharing the link to the site containing the report.

**IN-DEPTH ANALYSES**

To advance the science and understanding of population and health interrelations in Senegal, in-depth analyses of this large body of data are essential.

1. As our interviews revealed, the ANSD technical staff involved in the surveys are overworked and clearly do not have the time to make in-depth analyses beyond the final reports. We recommend exploration of the possibility of broadening participation beyond the team directly involved in the surveys, for example by involving expertise at the National School of Statistics and Applied

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3 ANSD explained their wish to continue with option (a) by the fact that not conducting a survey every year would make it difficult to keep their employees and equipment. The instability of national-level estimates will continue to confuse policymakers in such a case.
Economics, which is housed in the same building. This would require a substantial expansion of training activities.

2. Partners interested in such analyses (such as the World Bank) could consider setting up a competitive fund with calls for proposals where all local experts (Senegalese or other) could compete. Selection criteria should include not only scientific quality but also potential contribution to national policy dialogue aimed at improving the health of populations. A special effort should be made to involve academics as well as policy dialogue expertise within the government and particularly within the Direction de la Prévision et des Études Économiques.

**COLLECTION OF RELIABLE DATA AT THE DISTRICT LEVEL**

MCDs recommended that consideration be given to having regional surveys that could collect meaningful data at the district level. The regional statistics branch should work hand-in-hand with the medical region to conduct such surveys, which do not need to be done annually.

Another alternative is to take advantage of the huge investments aimed at developing an efficient health information system. The usefulness of DHIS-2 can be maximized by improving and making optimal use of the data collected at the time of delivery, simply by better organizing the data collection made at the time of delivery in the facility or at first contact with the health service after delivery at home.

There is even a way to estimate infant and child mortality with routine data. The approach requires the following information: date of delivery, sex and weight of the newborn, age of the mother, and parity and survival of the previous birth for those who have already had a child. The proportion of previous children who died is a good estimate of the probability of dying before age 2.4 This indicator and birth weight can be used as objective and continuous measures of the health status of the population in the district.

However, for these indicators to be useful, the proportion of deliveries covered should be sufficiently high (e.g., above 90 percent). The CDHS data clearly show that the proportion delivering in a health facility is increasing everywhere, rising from 60.3 percent and 92.0 percent in 2012 to 65.2 percent and 94.2 percent in 2016 in rural and urban areas, respectively. This coverage, which only increases over time, could even be significantly improved by ensuring that the same data are collected when women who give birth at home subsequently go to a health facility, as is very often the case. Post-natal visits also provide an additional opportunity to improve the quality of the data collected.

It is clear, however, that a significant improvement in the quality of routine data requires hard and sustained work to develop an information culture among all service providers. A first step is to ensure that they are aware of the great usefulness of the data they collect by organizing regular sessions to share the analyses made from these data. The system will also need to be protected from health worker strikes and subsequent data withholding.

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ANNEX I. SCOPE OF WORK

Assignment #: 549 [assigned by GH Pro]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: March 2, 2018
Last update: 5/7/18
Amendment #1

I. TITLE: Final Evaluation of the Senegal Continuous Survey Experiment

II. Requester / Client
☑ USAID/Washington
Office/Division: GH/PRH/PEC

☑ USAID Country or Regional Mission
Mission/Division: Senegal / ____________

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☑ 3.1.1 HIV
☑ 3.1.2 TB
☑ 3.1.3 Malaria
☑ 3.1.4 PIOET
☑ 3.1.5 Other public health threats
☑ 3.1.6 MCH
☑ 3.1.7 FP/RH
☑ 3.1.8 WSSH
☑ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: Note: GH Pro will provide a cost estimate based on this SOW

V. Performance Period
Expected Start Date (on or about): April 13, 2018
Anticipated End Date (on or about): September 30, 2018

VI. Location(s) of Assignment: (Indicate where work will be performed)
Metro Washington, DC; TDY to Senegal

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:
☑ Performance Evaluation (Check timing of data collection)
☐ Midterm ☐ Endline ☐ Other (specify):
Performance evaluations encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making.

☐ Impact Evaluation (Check timing(s) of data collection)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the
Intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

**OTHER ANALYTIC ACTIVITIES**

☐ Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

---

**PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)**

**Note:** If PEPFA-funded, check the box for type of evaluation

☐ **Process Evaluation** *(Check timing of data collection)*

- [ ] Midterm
- [ ] Endline
- [ ] Other (specify): ________________

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** *(Check timing(s) of data collection)*

- [ ] Baseline
- [ ] Midterm
- [ ] Endline
- [ ] Other (specify): ________________

Impact Evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** *(PEPFAR)*

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

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**VII. BACKGROUND**

If an evaluation, Project/Program being evaluated:

<table>
<thead>
<tr>
<th>Project/Activity Title:</th>
<th>The Demographic and Health Surveys Program (DHS-7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Award/Contract Number:</td>
<td>OAA-C- 13-00095</td>
</tr>
</tbody>
</table>
Background of project/program/intervention (Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis)

The purpose of this endline performance evaluation is to assess how well the Senegal Continuous Survey (SCS) achieved its aims of: 1) Increasing data use for policy and program decision-making; 2) Strengthening national capacities, particularly as related to survey planning, implementation, and results dissemination; and 3) Fostering host country ownership of the survey. Background on the overall DHS Program and SCS is provided herein. Details on the scope of the evaluation are provided in section IX.

USAID places a high premium on the collection, analysis, dissemination, and use of timely, quality, nationally representative health data for the purposes of program planning, monitoring, evaluation, and policy making. As a result, USAID has been the steadfast leader of the Demographic and Health Surveys (DHS) Program since launching it in 1984. In its 34 years, The DHS Program has provided technical assistance in the implementation of over 320 surveys in 90 countries. It is the largest and longest enduring program of its type. Thanks to a standardized methodology and approach, the surveys are comparable across time and place. And thanks to a long-standing open data approach, DHS data are freely available for download and widely used. Over time, the DHS Program has taken an increasingly larger role in strengthening local capacities, fostering data access, and facilitating data use. The current iteration of the Program, DHS-7, aims “to improve the collection, analysis, and presentation of population, health, and nutrition data and to facilitate the use of these data for planning, policy-making and program management to promote evidence-based decision-making.”

The technical support that The DHS Program provides generally relates to a specific set of surveys and their related activities. Surveys in The Program includes several household surveys: standard Demographic and Health Survey (DHS); AIDS Indicator Survey (AIS), which collects data for monitoring and evaluating HIV/AIDS programs; and Malaria Indicator Survey (MIS), which collects data used for monitoring the performance of malaria programs. In addition, The Program also includes Service Provision Assessment (SPA) surveys, which collect health facility-level data on service availability, facility readiness to provide essential health services, the quality of those services, and the satisfaction of clients and providers alike.

In addition to this suite of surveys, there have been two experiments with a continuous DHS in lieu of a once-in-five-years standard DHS. The first was in Peru starting in 2004, and the second, a five-year program in Senegal, which started in 2012 and included both a continuous DHS and continuous SPA. Further information regarding the Senegal Continuous Survey (SCS) is provided below as it is the focus of this endline evaluation.

DHS-7 is managed by USAID’s Global Health Bureau via a cost-plus award fee contract. It is implemented by ICF International in partnership with Johns Hopkins Center for Communication Programs, PATH, Avenir Health, Vysnova, Blue Raster, Kimetrica, and EnCompass.

The Senegal Continuous Survey

Background
USAID’s first continuous survey began in 2004 in Peru and continues today. The new, continuous approach was taken in response to countries’ and donors’ push: 1) to have DHS-type data more frequently than the standard five-year interval and; 2) to better institutionalize local capacity to conduct large-scale surveys. The Peru continuous survey provides key data on population, health, and nutrition every year. And within approximately five years of the continuous survey’s start, the Government of
Peru had institutionalized it, providing the lion’s share of funding and further expanding the survey sample to allow for annual estimates at the subnational level.5

Following the successful Peruvian experience, USAID became interested in expanding the continuous approach to sub-Saharan Africa. Increasingly recognizing the benefits of having population- and facility-based data collected contemporaneously, USAID also became interested in implementing a continuous survey that would incorporate both DHS and SPA data collection activities. As a result, in 2010-11, USAID began exploring a second continuous survey experiment, with both DHS and SPA elements, to be tested in a country of sub-Saharan Africa. Soon thereafter, thanks to Mission and host country government interest, Senegal was chosen to become the site of the second continuous survey, which would be framed as an experiment with formal baseline, midterm, and endline assessment.

One of the benefits of experimenting with the CS approach in Senegal was its long history of DHS Program survey implementation. Prior to the start of the SCS, Senegal had six rounds of the standard DHS (1986, 1992-93, 1997, 1999, 2005, and 2010-11) and two Malaria Indicator Surveys (MIS) (2006 and 2008-09). During more recent survey rounds, there had been concurrent survey activity at different stages – planning, fieldwork, or analysis – which, among other factors, made Senegal an appropriate location for conducting a continuous survey experiment.

In addition to its long history with the DHS Program, one of the prime reasons for Senegal’s interest in implementing the continuous survey experiment was the national data strike, which began in 2010. During the strike, health providers withheld data. Important health information and results were either unavailable or unreported to the Government of Senegal (GoS), which negatively impacted public health information systems and negatively affected various stakeholders. In response, GoS established the SCS in 2012 to monitor and ensure progress toward the achievement of the Millennium Development goals (MDGs) and other health program objectives. In an effort to maintain a continuous data flow to better inform policy, the SCS replaced the standard Demographic and Health Survey (DHS) model that supported household data collection approximately once every five years.

**SCS Objectives**

The SCS was formulated with two main objectives:

1) Meet ongoing needs for data to plan, monitor, and evaluate health programs and populations
2) Build capacity within Senegalese institutions to collect, process, analyze, disseminate, and use data.

In addition to these two main objectives, there were other hypothesized benefits. First, in the case of the CSPA, a frequent assessment of health data and availability of client services in health care facilities and facility readiness to provide services would allow swift programmatic improvements through a faster feedback loop. Second- the maintenance of a central office and field staff over time would reduce costs and would lead to institutionalization of the DHS process, which would bring benefits outside the scope of a cross-sectional DHS. Both enhanced staff capacity and the institutionalization of DHS processes were expected to result in improved data quality and a reduced need for technical assistance, ultimately allowing for a greater degree of survey ownership by the Government of Senegal. Additionally, the SCS design would allow for greater flexibility and responsiveness to country data needs as survey rounds would be tailored to address special topics that would be difficult in a standard DHS operation that occurs every five years.

This evaluation will identify whether these planned benefits were realized, including successes and challenges encountered.

**SCS Methodology and Structure**

The SCS methodology is described in detail elsewhere (see background materials). In short, the Senegal Continuous Survey built from lessons learned from the Peruvian experience, particularly with regard to attention to several issues, including sample size and its relationship to yearly reporting. Specifically,
similar to the original sampling design for Peru, the Continuous DHS (CDHS) component of the SCS does not produce estimates that are representative at the regional level each year. Data from two consecutive phases must be pooled in order to yield indicators representative for each of Senegal’s 14 regions. In contrast, the Continuous Service Provision Assessment (CSPA) is able to provide regional estimates for each phase of data collection.

Phase 1 of the SCS was conducted in 2012-13, followed by Phase 2 in 2014, Phase 3 in 2015, and Phase 4 in 2016. At the time of this writing in 2018, fieldwork for Phase 5 has just been completed (December 2017). Regarding the CDHS, the core elements of the DHS remained the same across the five phases, but other elements changed during the process as a result of initial plans or of necessary adaptations. For example, the sample size was fixed at 200 clusters and approximately 4,000 households for the first four phases, but increased to 400 clusters in the fifth phase, because of the inclusion of HIV testing and maternal mortality measurement. Women age 15-49 were surveyed in each phase, but men age 15-59 were surveyed from Phase 2 onward. Each phase included anthropometry, anemia testing, and malaria testing for children, while Phase 5 included anemia and HIV testing for men and women in the sample. Each phase used an abridged standard DHS questionnaire and included a special questionnaire module according to national priorities.

Like CDHS, CSPA was also designed to have five phases with certain elements remaining the same across the five phases, while others changing from one phase to the next. The indicators for each of the five phases were representative by facility type, managing authority, and Senegal’s 14 regions. During each phase, 50% of Senegal’s hospitals and health centers were surveyed, as well as 20% of health posts and a sample of their associated health huts. In the third, fourth, and fifth phases, 10% of the facilities surveyed in the previous phase were re-surveyed. The CSPA used four data collection methods for each phase: inventories, interviews with health care providers, consultation observations, interviews with health facility clients, and in some years- a special questionnaire for health huts. During each phase the themes for the consultation observations were the same as the themes for the interviews with health facility clients. However, the topics of these themes changed between phases. For example, during Phase 1 the themes were family planning and curative care for children, while in Phase 2 the themes were antenatal care and curative care for children.

**SCS Stakeholders and Funding**

Since the beginning, the SCS has been conducted in compliance with the action program of the National Agency of Statistics and Demography (Agence Nationale de la Statistique et de la Démographie [ANSD]) in close collaboration with the Ministry of Health and Social Action (Ministere de la Santé et de l’Action Sociale [MSAS]), with technical assistance from ICF International, and funding provided by the Government of Senegal, Global Fund, USAID, UNICEF, UNFPA, World Bank, PMI, and Nutrition International -formerly Micronutrient Initiative (see Table 1 below).

**TABLE 1. SCS Funding by Survey Round and Funding Source**

<table>
<thead>
<tr>
<th>Survey</th>
<th>USAID funding</th>
<th>Non-USAID funding by source</th>
<th>Total non-USAID funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>UNICEF</td>
<td>UNFPA</td>
</tr>
<tr>
<td>DHS 2012-13</td>
<td>$1,346,000</td>
<td>$100,000</td>
<td>$22,000</td>
</tr>
<tr>
<td>DHS 2014</td>
<td>$471,295</td>
<td>$81,141</td>
<td>$37,188</td>
</tr>
<tr>
<td>DHS 2015</td>
<td>$1,723,828</td>
<td>$41,333</td>
<td>$41,333</td>
</tr>
<tr>
<td>DHS 2016</td>
<td>$757,800</td>
<td>$32,223</td>
<td>$67,500</td>
</tr>
</tbody>
</table>
The DHS Program has five key results and six guiding principles to help achieve these results. It also has a robust internal system for monitoring these results.

**Results Framework**

**Activity Objective:** To improve the collection, analysis, and presentation of population, health and nutrition data and to facilitate use of these data for planning, policy-making, and program management.

**Result 1:** Improved tools, partnerships, and technical guidance to collect quality population, health and nutrition data.

**Result 2:** Increased in-country individual and instructional capacity for identification of data needs and for survey design and management, data collection, data analysis, and information communication to meet those needs.

**Result 3:** Improved availability of data and information.

**Result 4:** Advanced analysis and synthesis of DHS data.

**Result 5:** Improved facilitation of DHS data use among global and country-level stakeholders.

**Guiding Principles**

1. Align all activities with the ultimate goal of DHS data informing population, health, and nutrition program and policy decision-making.
2. Foster host-country ownership.
3. Strengthen, utilize, and facilitate South-to-South technical exchange.
4. Recognize DHS stakeholder needs while maximizing quality at minimal costs.
5. Coordinate and collaborate strategically with host country and international stakeholders to focus resources and reduce duplication of efforts.
6. Respect individuals, families, and communities who participate in the Program’s work.

Internal Monitoring and Evaluation Mechanisms
Data to monitor and evaluate results are available through the DHS Program’s:

- Performance Monitoring Plan (PMP)
- Annual Award Fee Reports and Review

Additional information of relevance is available through trip reports, a regularly updated survey tracking list, and yearly work plans.

The DHS Program’s prime implementer, ICF, reports in its PMP on a set of indicators developed in consultation with the USAID DHS management team to monitor progress across each of the five result areas. Indicators specifically related to the SCS include:

- Number of surveys with fieldwork started within the reporting period
- Percentage of country survey activities that have been completed within one month of the time specified in the final survey timeline agreed upon with the country
- Number of applications where advanced technologies are used to improve survey implementation
- Amount of non-USAID funds that have been leveraged to support the implementation of DHS-7 surveys (including non-USAID funded surveys)
- Number of countries that have conducted a rapid participatory capacity assessment (CAT)
- Percentage of DHS countries that have developed a capacity strengthening plan two months after completing the CAT
- Number of individuals (and percentage female) trained to implement DHS-7 surveys, including interviewers, other field staff, and individuals trained in survey dissemination activities
- Percentage of trainees who showed improved scores between pre- and post-tests during survey pretest training, training-of-trainers (TOT), and/or regional workshops
- Number of individuals (and percentage female) participating in special training (e.g. apart from routine survey training) for: DHS further analysis; sampling; data processing; data tabulation
- Number of surveys/activities in which South-to-South consultants were used to provide TA
- Number of trainings/activities that are supported by in-country funds beyond routine survey activities
- Number of DHS-7 reports and dissemination materials produced and available online
- Number of dissemination meetings facilitated in country by survey cycle
- Number of conference presentations/papers in peer-reviewed journals using DHS data authored by analysis workshop participants
- Number of users who have downloaded at least one standard recode file from the Senegal datasets
- Number of SCS standard recode file downloads
- List of analytic reports that have used SCS data (internal to the DHS Program and external using data compiled in the DHS Program Journal database)

In addition to the PMP, the DHS Program’s annual Award Fee performance evaluation provides important information of relevance to overall project management and evaluation, including information pertinent to the proposed evaluation. The USAID DHS Performance Evaluation Board works each year with the DHS implementer to define a set of criteria related to the five performance assessment areas—management, quality, results, cost-control, and timeliness. The yearly award fee process allows USAID to evaluate both actual performance and the conditions under which results are achieved.
To address the two main objectives of the SCS, a Monitoring and Evaluation (M&E) plan was established in 2012, and a Capacity Assessment Tool (CAT) was implemented in 2014. The M&E plan provided baseline measures for key indicators which supported an assessment of key evaluation questions. It also provided quantitative and qualitative measures of progress during the first year of the project, which focused on initial capacity building efforts. In keeping with the explicit focus on capacity building as a key objective of the SCS, the DHS Program utilized the DHS CAT to help DHS and key survey implementing partners: identify the specific gaps and weaknesses in implementing agencies’ capacity to implement the various activities along the entire spectrum of DHS survey related activities from planning, designing and implementing the surveys to dissemination and use of data; develop a plan that is tailored to address country-specific capacity gaps; and document progress over time in capacity built. Finally, the USAID DHS Program Management team holds biweekly meetings with ICF to provide technical input and monitor the contractor’s performance. Given that the DHS Program is a cost-plus award fee contract and the performance of the contract is monitored annually through a rigorous measurement process that evaluates progress towards and achievement of established performance benchmarks, USAID’s Bureau for Global Health and the DHS Program Management team are interested in focusing closely on one particular area of the project’s portfolio for the mid-term evaluation. This independent performance evaluation will focus on evaluating and documenting the performance of the SCS.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Senegal

VIII. Purpose, Audience & Application

A. Purpose: Why is this evaluation/assessment being conducted (purpose of analytic activity)?

Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this endline performance evaluation is to assess how well the Senegal Continuous Survey (SCS) achieved its aims of: 1) Increasing data use for policy and program decision-making; 2) Strengthening national capacities, particularly as related to survey planning, implementation, and results dissemination; and 3) Fostering host country ownership of the survey. The evaluation will address both technical and management considerations to elucidate a clearer understanding of the challenges and successes of implementing a continuous survey.

B. Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

This evaluation will serve at least various groups of stakeholders: relevant ministries of the Government of Senegal, USAID/Senegal, other donors supporting the Ministry of Health and ANSD, and program managers of USAID Washington.

C. Applications and use: How will the findings be used? What future decisions will be made based on these findings?

- The Government of Senegal’s Ministry of Health (MSAS) will potentially use evaluation data to inform future data collection activities, including potential future investment in the SCS. Additionally, since the SCS is designed to be led by the country, the ANSD will be able to gauge the burden of inheriting the CS – from budgets to process to strengthening capacity- and whether the benefits outweigh the costs.
- For the USAID Mission in Senegal, the main purpose of the evaluation would be to assess data use for decision making and sustainability of the CS model. Mission staff would be interested in gauging the quality of coordination and management of resources, quality of supervision
between the central technical team and the collection teams, level of contribution of the Government of Senegal, level of use of the survey data (both of DHS and SPA data) by various entities of the government, NGOs and other users globally, and specific achievements in capacity building.

- For USAID Washington, the SCS is one of the major innovations being implemented under the DHS-7 contract cycle. Therefore, it is necessary to assess the model and understand more about the processes, including the supporting and inhibiting factors for a continuous survey and the benefits of having a CS. The evaluation should consider whether the anticipated benefits were realized and what technical, logistical, or other challenges were created by this approach. The pressure for obtaining frequent data from countries and donors has not diminished, so assessing whether there is a benefit in collecting data through a continuous approach versus every few years will be valuable.

IX. Evaluation/Analytic Questions & Matrix:

- Questions should be: a) aligned with the evaluation/assessment purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/assessment questions. USAID Evaluation Policy recommends 1 to 5 evaluation questions.

- State the method and/or data source and describe the data elements needed to answer the evaluation questions

<table>
<thead>
<tr>
<th>SCS Objectives</th>
<th>Evaluation Question</th>
<th>Suggested methods</th>
<th>Sampling Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Increasing data use for policy and program decision-making</td>
<td>How have SCS data been used by various stakeholders in order to plan, monitor, and evaluate health programs? Include the following when answering this question: • Stakeholders perception regarding the SCS meeting data needs for decision-making • Stakeholders' perceptions regarding the value of the SCS related to other health data, including regular health management information system (HMIS) data</td>
<td>Document review; key informant interviews</td>
<td>Purposive sampling of key informants based on initial suggestions from USAID and ICF and expanded through snowball sampling. Review of program documents provided by USAID and ICF</td>
</tr>
<tr>
<td>1b Increasing data use for policy and program decision-making</td>
<td>Is it useful for various stakeholders to implement the CSPA and CDHS in conjunction? How so? And for whom?</td>
<td>Key informant interviews; program document review; literature review</td>
<td>Purposive sampling described above Review of program documents provided by USAID and ICF</td>
</tr>
<tr>
<td>2 Strengthening national capacities, particularly as</td>
<td>What were some achievements and challenges in capacity building from the beginning to end of the SCS? Include the following when answering this question:</td>
<td>Capacity Assessment Tool (CAT) findings review; key informant</td>
<td>Purposive sampling described above Review of program documents provided</td>
</tr>
<tr>
<td>SCS Objectives</td>
<td>Evaluation Question</td>
<td>Suggested methods</td>
<td>Sampling Frame</td>
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</table>
| related to survey planning, implementation, and results dissemination | • Individual and organizational technical capacity strengthening  
• Changes in technical assistance requirements over time | interviews; program document review; literature review | by USAID and ICF, specifically data and reports on capacity strengthening and the capacity assessment tool pilot results. |
| 3 Fostering host country ownership of the survey. | Has the Government of Senegal taken increasing ownership of the SCS over time?  
*Include the following when answering this question:*  
• Challenges, successes, and opportunities related to Government of Senegal financial contribution to the SCS (monetary and in-kind)  
• Ways that the management structure for SCS within ANSD and MSAS changed over time, and the relationship of these changes towards institutionalization of the SCS  
• Ways that the Government of Senegal integrated SCS data into planning and decision-making  
• Assumptions about the ways that costs associated with the SCS could decrease over time as capacity increases and the Government of Senegal contribution escalates | Key informant interviews; program document review; literature review | Purposive sampling described above |

Other Questions [OPTIONAL]  
(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

**X. Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/assessment questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

*General Comments related to Methods:* The evaluator will work collaboratively with the USAID DHS management team to develop a detailed work plan and data collection strategy including data collection instruments. Methods include but not limited to: document/literature review, and key informant interviews. Data collection approaches and sources are described in more detail herein.

- **Document and Data Review** (list of documents and data recommended for review)  
  This desk review will be used to provide background information on the project/program, and will also
provide data for analysis for this evaluation. Documents and data to be reviewed include:
This desk review will be used to provide background information on the project/program, and will also
provide data for analysis for this evaluation. Documents and data to be reviewed include:

1. Senegal Continuous Survey DHS Final Reports and dissemination materials
   - 2012-2013 (English and French)
   - 2012-2014
   - 2014
   - 2015
   - 2016 (includes regional estimates 2015-2016)
   - 2017 (when available)

Senegal Continuous Survey SPA Final Reports and dissemination materials
   - 2012-2013 (English and French)
   - 2014
   - 2015
   - 2016
   - 2017 (when available)

Report on Capacity Strengthening activities in Senegal (Award Fee Report Year 3)
MEASURE DHS Award Fee Performance Criteria (Year 5 Report): SCS Baseline and year 1 monitoring report
Report on the development and piloting of the capacity assessment tool (Award Fee Report Year 1)
External evaluation of the Peru continuous survey experiment- December 2007
MEASURE DHS Project Concept Paper: Implementing a Continuous Survey in Africa
SCS Agreements and MOUs
External Evaluation of the CS 2012-2017 conducted by Mr. Salif Ndiaye (Senegal)
External Evaluation of the CS 2012-2013 conducted by Mr. Abdou Salam Fall

<table>
<thead>
<tr>
<th>Key Informant Interviews</th>
<th>(list categories of key informants, and purpose of inquiry)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In DC area</strong></td>
<td></td>
</tr>
<tr>
<td>1. ICF International</td>
<td></td>
</tr>
<tr>
<td>• Sunita Kishor</td>
<td></td>
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<tr>
<td>• Bernard Barrere</td>
<td></td>
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<tr>
<td>• Jose Miguel Guzman</td>
<td></td>
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<tr>
<td>• Abibata Handley</td>
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<tr>
<td>• Sarah Balian</td>
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<tr>
<td>• Ruilin Ren</td>
<td></td>
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<tr>
<td>• Key Purvis</td>
<td></td>
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<tr>
<td>• Albert Themme</td>
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<tr>
<td>USAID Washington</td>
<td></td>
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<tr>
<td>• Misun Choi</td>
<td></td>
</tr>
<tr>
<td>• Jacob Adetunji</td>
<td></td>
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<tr>
<td>• Madeleine Short Fabic</td>
<td></td>
</tr>
<tr>
<td>• YJ Choi (formerly of USAID/Washington)</td>
<td></td>
</tr>
<tr>
<td>• Noah Bartlett</td>
<td></td>
</tr>
</tbody>
</table>

| **In Senegal**           |                                                          |
| 1. USAID Senegal         |                                                          |
|   • Moussa Diakhate      |                                                          |
|   • Khadidiatou AW       |                                                          |
|   • Ibrahima Top         |                                                          |
|   • Ramatoulaye Dioume   |                                                          |
|   • Laura Campbell       |                                                          |
XI. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB.** The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
XII. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program’s achievements against its objectives and/or targets.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist using in-depth interviews with key informants.

Use of multiple methods that are quantitative and qualitative, as well as existing data will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation.

XIII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include The Demographic and Health Surveys contract, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as SCS final reports, monitoring & evaluation report, and capacity strengthening report. This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A one-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:
- Review and clarify any questions on the evaluation SOW
- 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 finalize evaluation questions
- Review and finalize the assignment timeline
- Review and clarify any logistical and administrative procedures for the assignment

Draft Work Plan – Within five work days following the In-Brief with USAID Washington, at the end of the TPM, the evaluation team will develop and submit to the USAID DHS management team a draft work plan that will include the following elements:
- Description of each team member’s roles and responsibilities
- List of final evaluation questions and/or guidelines for questionnaires
- Data collection instruments (to be included in the appendices)
- Draft outline of the final report
- Dissemination plan of key findings
- Assignment timeline
- Deliverables deadline
Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.

- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.

- **Work plan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.

- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

- The Team Lead (TL) will brief the USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

- **Exit debrief in Senegal** may be requested by USAID/Senegal. If so, it will be held in French with key counterparts before departing Senegal to highlight immediate findings and conclusions. This discussion may aid the evaluation team in structuring and fine-tuning their final report.

- **Recommendations Workshop in Senegal** will be held in French with key counterparts after the evaluation team has analyzed the data and produced key findings (following submission of the first draft of the report or later). This workshop will bring key Stakeholders together to discuss findings and workshop recommendations. The Evaluation Team will prepare a PowerPoint presentation for the workshop and will not include any information that may be procurement deemed procurement sensitive or not suitable for distribution to a large audience. The Team will also facilitate a group discussion about recommendations for the way forward based on the findings shared.

- A **final debrief** between the Evaluation Team and USAID will be held after the Team conducts all data collection activities and has reached consensus on the preliminary conclusions and recommendations, but before the draft report is submitted. This debrief will be broken into two parts: the first part of the meeting the Team will present preliminary findings to the USAID DHS Management Team and DHS Program senior leadership at ICF, including a summary of the data along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a PowerPoint Presentation of the key findings, issues, and recommendations. The Team will not discuss information that may be procurement-sensitive with ICF. This sensitive information will be presented during the second part of this debrief as a smaller discussion with USAID only on such issues/recommendations. The evaluation team shall incorporate comments received during the debrief from USAID and ICF in the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

- **IP and Stakeholders’ debrief/workshop** will be held with a larger USAID audience and ICF several days after the draft report has been submitted to the USAID DHS Management Team. The Evaluation Team will prepare a PowerPoint presentation for the debriefing, and will not include any information that may be deemed procurement sensitive or not suitable for distribution to a large audience.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits in Senegal for data collection. Selection of sites within Senegal will be finalized during TPM in consultation with
USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

**Evaluation/Analytic Report** – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

**Data Submission** – Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

---

### XIV. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Launch briefing (call)</strong></td>
<td>April 13, 2018</td>
</tr>
<tr>
<td><strong>In-brief with USAID</strong></td>
<td>May 9, 2018</td>
</tr>
<tr>
<td><strong>In-brief with ICF</strong></td>
<td>May 2018</td>
</tr>
<tr>
<td><strong>Workplan &amp; methodology briefing with USAID</strong></td>
<td>May 2018</td>
</tr>
<tr>
<td><strong>Workplan with timeline submitted</strong></td>
<td>May 17, 2018</td>
</tr>
<tr>
<td><strong>Analytic protocol with data collection tools completed</strong></td>
<td>May 25, 2018</td>
</tr>
<tr>
<td><strong>Routine briefings</strong></td>
<td>Weekly, and as needed</td>
</tr>
<tr>
<td><strong>In-brief with USAID/Senegal</strong></td>
<td>July 2, 2018</td>
</tr>
<tr>
<td><strong>Data collection (post-Ramadan)</strong></td>
<td>July 2 – July 27, 2018</td>
</tr>
<tr>
<td><strong>Out-brief with USAID/Senegal (if requested)</strong></td>
<td>Week of July 23</td>
</tr>
<tr>
<td><strong>Out-brief with USAID/W with Power Point presentation</strong></td>
<td>August 2018</td>
</tr>
<tr>
<td><strong>IP &amp; Stakeholder debrief in DC</strong></td>
<td>August 2018</td>
</tr>
<tr>
<td><strong>Findings review workshop with stakeholders in Senegal with Power Point presentation</strong></td>
<td>September 2018</td>
</tr>
<tr>
<td><strong>Recommendations workshop with</strong></td>
<td>September 2018</td>
</tr>
</tbody>
</table>

*Note: Scheduled work in Senegal has been adjusted to accommodate Ramadan. The Team will revise the schedule, as needed, following the launch of this evaluation, in consultation with USAID.*
XV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team:
Two evaluators are proposed to conduct all evaluation, analysis and writing of the report. One of these individuals should be a Senegalese national based in-country. Final team size and composition will be discussed with the evaluators.

Required qualifications for Team Lead:
- Longstanding experience and technical expertise in survey operations in developing country contexts; particularly in West Africa/ Francophone countries
- Demonstrated experience using qualitative evaluation methodologies and triangulating multiple data sources; experience in French preferred
- Familiarity with national surveys and data analysis; DHS preferred
- Adequate quantitative statistical skill and understanding of sampling
- Fluency in French
- Excellent skills in project management
- Excellent analytic and writing skills

Required qualifications for in-country evaluator:
- Experience using qualitative evaluation methodologies in French
- Familiarity with national surveys and data analysis; DHS preferred
- Adequate quantitative statistical skill
- Fluency in French
- Excellent analytic and writing skills

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

**USAID** will provide a **Program Assistant** to join the evaluation team to provide logistics and administrative support for this evaluation. Working under the guidance of the evaluator, s/he will arrange meetings and appointments, assist with managing with web-based survey, and other tasks as assigned and ensure the processes moves forward smoothly.

**Local Logistics/Program Assistant** will support the evaluator for country site visits. The Logistics/Program Assistant will support the evaluator with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and French. S/He will have knowledge of key actors in the health sector and their locations, including MOH, donors and other stakeholders. To support the evaluator, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the evaluator to make preparations, arrange meetings and appointments, including assisting booking interviews. S/he will conduct programmatic administrative and support tasks as assigned and ensure the
processes moves forward smoothly. S/He may also be asked to assist with note taking at interviews and meetings, as well as with translation of data collection tools and transcripts.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or assessment activity.

☑ Full member of the Evaluation Team (including planning, data collection, analysis and report development) – If yes, specify who: Catherine (Olivia) Padis
☐ Some Involvement anticipated – If yes, specify who:
☐ No

**Staffing Level of Effort (LOE) Matrix:**

**Level of Effort in days** for each Evaluation Team member: **87** for the Team Lead, **61** for the Local Evaluator in Senegal.

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Evaluation/Analytic Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Team Lead</td>
</tr>
<tr>
<td>1 Meet USAID DHS management team for launch</td>
<td>0.5</td>
</tr>
<tr>
<td>3 Desk review</td>
<td>5</td>
</tr>
<tr>
<td>4 HTSOS Training</td>
<td>1</td>
</tr>
<tr>
<td>5 Meet USAID DHS management team for in-brief (TL in person; Local Eval by phone)</td>
<td>1</td>
</tr>
<tr>
<td>6 Develop work plan and travel plan</td>
<td>4</td>
</tr>
<tr>
<td>7 Workplan and methodology briefing with USAID with prep</td>
<td>1</td>
</tr>
<tr>
<td>8 Submit work plan, timeline, travel plan, and data collection tools to USAID DHS management team for approval</td>
<td>1</td>
</tr>
<tr>
<td>9 In-brief with the IP, ICF Int'l, with prep</td>
<td>1</td>
</tr>
<tr>
<td>10 Plan in-country meetings &amp; logistics</td>
<td>1</td>
</tr>
<tr>
<td>11 Conduct key informant interviews and telephone interviews in Washington, DC</td>
<td>5</td>
</tr>
<tr>
<td>12 Travel to country (data collection)</td>
<td>2</td>
</tr>
<tr>
<td>13 In-brief USAID/Mission staff and coordinate key stakeholder meetings</td>
<td>2</td>
</tr>
<tr>
<td>14 Conduct meetings and interviews with in-country key stakeholders (post-Ramadan)</td>
<td>24</td>
</tr>
<tr>
<td>15 Debrief with Mission and prep</td>
<td>1</td>
</tr>
<tr>
<td>16 In-Country Stakeholder debrief workshop with prep (in French)</td>
<td>1</td>
</tr>
<tr>
<td>17 Depart country (after data collection)</td>
<td>2</td>
</tr>
<tr>
<td>18 Analyze and synthesize information</td>
<td>10</td>
</tr>
<tr>
<td>19 Draft report</td>
<td>5</td>
</tr>
<tr>
<td>20 GH Pro Report QC Review &amp; Formatting</td>
<td></td>
</tr>
<tr>
<td>21 Submission of draft report(s) to USAID</td>
<td></td>
</tr>
<tr>
<td>22 USAID Report Review</td>
<td></td>
</tr>
<tr>
<td>23 Oral debriefing and PPT presentation to USAID DHS management team and ICF with prep</td>
<td>1.5</td>
</tr>
<tr>
<td>24 Submit full draft report to USAID DHS management team and ICF</td>
<td>1</td>
</tr>
<tr>
<td>25 Revise PPT presentation</td>
<td>1</td>
</tr>
<tr>
<td>26 Present draft findings at USAID</td>
<td>1</td>
</tr>
<tr>
<td>27 IP (ICF) and Stakeholder debrief, including prep</td>
<td>1.5</td>
</tr>
<tr>
<td>28 Revise the full draft report</td>
<td>5</td>
</tr>
</tbody>
</table>
### Activity / Deliverable

<table>
<thead>
<tr>
<th>Activity / Deliverable</th>
<th>Team</th>
<th>Senegal Local Evaluator</th>
<th>Local Logistics Coord</th>
<th>USAID/SENI Logistics Coord</th>
<th>USAID/W Eval Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 Edit and finalize report by all team members</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Recommendations Workshop in Senegal, including prep &amp; travel to/from Senegal</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31 Submit the final report</td>
<td>1</td>
<td></td>
<td></td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>32 GH Pro Report QC Review &amp; Formatting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33 Submission of draft report(s) to USAID</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>34 USAID Approves Report</td>
<td></td>
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<tr>
<td>35 Final copy editing and formatting</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>36 508 Compliance editing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37 Eval Report(s) posted to the DEC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total LOE</strong></td>
<td><strong>87</strong></td>
<td><strong>67</strong></td>
<td><strong>20</strong></td>
<td><strong>13</strong></td>
<td><strong>72</strong></td>
</tr>
</tbody>
</table>

If overseas, is a 6-day workweek permitted □ Yes □ No

**Travel anticipated:** List international and local travel anticipated by what team members.

The In-brief with USAID will occur in Arlington, VA while key meetings with ICF staff will take place in Rockville, MD. A majority of the interviews will take place in Senegal.

### LOGISTICS

**Visa Requirements**

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

**Senegal:** The Team will convene in Senegal prior to Ramadan (May 15) to initiate the fieldwork, and then return to Senegal after Eid (June 15). The Team Lead will then return to Senegal for the Recommendations Workshop after the report is drafted. Therefore, **multi-entry visa** is requested.

List recommended/required type of Visa for entry into counties where consultant(s) will work

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senegal</td>
<td>☐ Tourist</td>
</tr>
<tr>
<td></td>
<td>☐ Tourist</td>
</tr>
<tr>
<td></td>
<td>☐ Tourist</td>
</tr>
<tr>
<td></td>
<td>☐ Tourist</td>
</tr>
</tbody>
</table>

**Clearances & Other Requirements**

**Note:** Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant’s behalf.

GH Pro can obtain **Facility Access (FA)** and transfer existing **Secret Security Clearance** for our consultants, but please note these requests, processed through AMS at USAID/GH (Washington, DC), can take 4-6 months to be granted. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. FAs for non-US citizens or Green Card holders must be obtained through the RSO. If FA or Security Clearance is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

**If Electronic Country Clearance (eCC) is required prior to the consultant’s travel, the consultant is**
also required to complete the High Threat Security Overseas Seminar (HTSOS). HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week Foreign Affairs Counter Threat (FACT) course offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access:

☐ Electronic County Clearance (ECC) (International travelers only)

☐ High Threat Security Overseas Seminar (HTSOS) (required in most countries with ECC)

☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
Specify who will require workspace at GH Pro:

☐ Travel -other than posting (specify):

☐ Other (specify):

XVI. GH PRO ROLES AND RESPONSIBILITIES
GH Pro will coordinate and manage the evaluation/assessment team and provide quality assurance oversight, including:

• Review SOW and recommend revisions as needed
• Provide technical assistance on methodology, as needed
• Develop budget for analytic activity
• Recruit and hire the evaluation/assessment team, with USAID POC approval
• Arrange international travel and lodging for international consultants
• Request for country clearance and/or facility access (if needed)
• Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
• Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
</tbody>
</table>

EVALUATION OF THE CONTINUOUS DEMOGRAPHIC AND HEALTH SURVEY IN SENEGAL 2012-2017 / 39
Before Field Work
- **SOW.**
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- **Consultant Conflict of Interest (COI).** To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV’s for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- **Documents.** Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- **Local Consultants.** Assist with identification of potential local consultants, including contact information.
- **Site Visit Preparations.** Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- **Lodgings and Travel.** Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work
- **Mission Point of Contact.** Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team’s work.
- **Meeting Space.** Provide guidance on the team’s selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- **Meeting Arrangements.** Assist the team in arranging and coordinating meetings with stakeholders.
- **Facilitate Contact with Implementing Partners.** Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team’s arrival and/or anticipated meetings.

After Field Work
- **Timely Reviews.** Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT
Provide any desired guidance or specifications for Final Report. (See How-To Note: Preparing Evaluation Reports)

<table>
<thead>
<tr>
<th>The Evaluation/Analytic Final Report must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).</th>
</tr>
</thead>
<tbody>
<tr>
<td>The report should be no longer than 35 pages (excluding executive summary, table of contents, acronym list and annexes).</td>
</tr>
<tr>
<td>The structure of the report should follow the Evaluation Report template, including branding found <a href="#">here</a> or <a href="#">here</a>.</td>
</tr>
<tr>
<td>Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.</td>
</tr>
<tr>
<td>For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing</td>
</tr>
</tbody>
</table>
Evaluation Draft Reports found [here](#).

- The Report, including annexes, will be in English and French.

**USAID Criteria to Ensure the Quality of the Evaluation Report** *(USAID ADS 201)*:

- Evaluation reports should be readily understood and should identify key points clearly, distinctly, and succinctly.

- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.

- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.

- Evaluation methodology should be explained in detail and sources of information properly identified.

- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).

- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people’s opinions.

- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.

- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.

- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

**Reporting Guidelines:** The draft report should be a comprehensive analytical evidence-based evaluation/assessment report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. *The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.*

The findings from the evaluation/assessment will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- **Abstract:** briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)

- **Executive Summary:** summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)

- **Table of Contents** (1 page)

- **Acronyms**

- **Evaluation/Analytic Purpose and Evaluation/Analytic Questions:** state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)

- **Project [or Program] Background:** describe the project/program and the background, including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)

- **Evaluation/Analytic Methods and Limitations:** data collection, sampling, data analysis and limitations (1-3 pages)

- **Findings** (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data

- **Conclusions**
• Recommendations
• Annexes
  o Annex I: Evaluation Statement of Work
  o Annex II: Evaluation Methods and Limitations (if not described in full in the main body of the evaluation report)
  o Annex III: Data Collection Instruments
  o Annex IV: Sources of Information
    ▪ List of types and numbers of persons interviewed (without breeching confidentiality, a list of names of those contacted and interviewed will be provided to USAID in a memo, not to be posted in the DEC or public version of the report.)
    ▪ Sites visited
    ▪ Bibliography of Documents Reviewed
    ▪ Databases
    ▪ [etc.]
  o Annex V: Statement of Differences (if applicable)
  o Annex VI: Disclosure of Any Conflicts of Interest
  o Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

--------------------------------
The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

--------------------------------
All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID CONTACTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Primary Contact</th>
<th>Alternate Contact 1</th>
<th>Alternate Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID Office/Mission</td>
<td>Demography and Health Technical Advisor</td>
<td>Public Health Advisor</td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:ajadhav@usaid.gov">ajadhav@usaid.gov</a></td>
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<tr>
<td>Telephone</td>
<td>571-551-7045</td>
<td>571-551-7047</td>
<td></td>
</tr>
<tr>
<td>Cell Phone</td>
<td>571-225-6970</td>
<td>202-679-4703</td>
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EVALUATION OF THE CONTINUOUS DEMOGRAPHIC AND HEALTH SURVEY IN SENEGAL 2012-2017 / 42
List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

<table>
<thead>
<tr>
<th>Technical Support Contact 1</th>
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<tbody>
<tr>
<td>Name: Amani Selim</td>
<td></td>
</tr>
<tr>
<td>Title: Evaluation Advisor</td>
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<table>
<thead>
<tr>
<th>USAID/Senegal Contact 1</th>
<th>USAID/Senegal Contact 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Khadidiatou Aw</td>
<td>Laura Campbell</td>
</tr>
<tr>
<td>Title:</td>
<td>USAID/Senegal Health Office</td>
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<tr>
<td>USAID Office/Mission: USAID/Senegal Health Office</td>
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<tr>
<td>Telephone:</td>
<td>XX. XXI.</td>
</tr>
<tr>
<td>Cell Phone:</td>
<td>ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (To be completed after Assignment Implementation by GH Pro)</td>
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ANNEX II. DATA COLLECTION INSTRUMENTS

Questions pour l’évaluation de l’EDS-Continue
Gouvernement du Sénégal

EDSC = Enquête Démographique et de Santé Continue
CSPA = Enquête sur le suivie de la performance des services de santé

1.0 Quel a été votre rôle ou votre participation à l’EDSC ou CSPA.

1.10 Pensez-vous que la disponibilité accrue de l’EDSC et du CSPA a aidé à guider la prise de décision au Sénégal dans le domaine de la santé ? Pourriez-vous décrire comment les données ont été utilisées et par qui ?

1.2 Avez-vous utilisé les données régionales de l’EDSC ? Si oui, dans quel but ? Si non, pourquoi pas ?

1.21 Avez-vous utilisé les données du CSPA ? Si oui, dans quel but ? Si non, pourquoi pas ?

1.3 Comment accédez-vous aux données ? Sonde: à partir de fichiers informatiques ou de données agrégées, à partir des rapports ?

1.4 Avez-vous utilisé l’EDSC ou CSPA pour planifier ou évaluer un programme de santé bien spécifique ? Si oui, quels programmes ? Y avait-il des lacunes dans les données qui n’ont pas permis une planification ou une évaluation adéquate ?

1.5 Qui ou quel bureau du gouvernement du Sénégal est grand utilisateur des données de l’EDSC et à quelles fins ? Pourriez-vous décrire comment ils utilisent ou ont utilisé ces données ?

1.6 Qui ou quel bureau du gouvernement du Sénégal est grand utilisateur des données du CSPA et à quelles fins ? Pourriez-vous décrire comment ils utilisent ou ont utilisé ces données ?

1.7 Quelle est la valeur ajoutée de l’EDSC et du CSPA par rapport à d’autres sources de données existantes telles que l’état civil et le Système d’Information sanitaire du Ministère de la Santé ?

1.7b Dans quelle mesure est-il utile de mettre en œuvre le CSPA et l’EDSC simultanément ? Pour qui est-ce utile et pour qui ne l’est-il pas ? Pourquoi ?

1.8 Y a-t-il d’autres données qu’il serait utile d’avoir ? Si oui, quelles données ?

1.90 Quels sont les avantages et les lacunes des enquêtes continues par rapport aux enquêtes répétées à intervalles réguliers, par exemple tous les cinq ans ?

1.91 Pensez-vous que l’EDSC et le CSPA devraient continuer ? Pourquoi ou pourquoi pas ? Si les enquêtes doivent continuer, qu’est-ce que vous changeriez ?

2.3 Quels ont été les succès de l’institutionnalisation de ces enquêtes ?

2.4 Quels ont été les défis de leur institutionnalisation ?

3.01 De quelles manières le gouvernement du Sénégal s’est-il approprié l’EDSC et le CSPA ?
3.02 Y a-t-il eu des opportunités manquées où le gouvernement du Sénégal aurait pu s'approprier davantage les 2 enquêtes ?

3.1 Quelle est votre impression sur le niveau de la contribution financière du gouvernement du Sénégal ?
Le niveau de soutien a-t-il été adéquat ? Pourquoi ou pourquoi pas ?

3.3 Que faudrait-il pour que le gouvernement du Sénégal augmente sa contribution financière à plus de 50% des coûts des deux opérations ?

3.4 Y a-t-il des problèmes d'avoir plusieurs bailleurs pour les deux enquêtes ? Si oui, quelles sont-ils ?

3.51 Comment la structure organisationnelle de l'ANSD au cours des cinq dernières années a-t-elle contribué à la conduite des enquêtes ? Sonde : Y a-t-il eu des changements qui ont été utiles ?

3.52 Comment la structure organisationnelle de l'ANSD au cours des cinq dernières années a-t-elle entravé la conduite des enquêtes ? Sonde : Y a-t-il eu des changements qui ont entravé le travail ?

3.61 Y a-t-il eu des changements dans le personnel de l'ANSD au cours des cinq dernières années qui ont facilité le travail ?

3.61 Y a-t-il eu des changements dans le personnel de l'ANSD au cours des cinq dernières années qui ont entravé le travail ?

4 Comment compareriez-vous les données recueillies par le CSPA avec les données recueillies dans le (Système d'information Sanitaire (SIS) ? Y a-t-il des redondances ou des complémentarités ? Comment les données de chacun sont-elles utilisées pour éclairer la prise de décision et/ou les politiques de santé ?

5 Que faudrait-il faire différemment si le EDSC et le CSPA devaient continuer ?

6. Quelle est votre opinion sur la question de savoir si l'EDSC et/ou CSPA devrait continuer compte tenu des coûts ?

7. Avez-vous d'autres commentaires sur EDSC ou CSPA ?
Questions pour l’évaluation de l’EDS-Continue

ANSD

EDSC = Enquête Démographique et de Santé Continue

CSPA = Enquête sur le suivi de la performance des services de santé

1.0 Quel a été votre rôle ou votre participation à l’EDSC et au CSPA ?

1.10 Pensez-vous que la disponibilité accrue de l’EDSC et du CSPA a aidé à guider la prise de décision au Sénégal dans le domaine de la santé ? Pourriez-vous décrire comment les données ont été utilisées et en quoi le fait d’avoir des données continues a aidé ?

1.5 Qui ou quel bureau du gouvernement du Sénégal est un grand utilisateur de l’EDSC et à quelles fins ? Connaissez-vous d’autres utilisateurs ou des analyses secondaires des données de l’EDSC ?

1.6 Qui ou quel bureau du gouvernement du Sénégal est un grand utilisateur du CSPA et à quelles fins ? Connaissez-vous d’autres utilisateurs ou des analyses secondaires des données du CSPA ?

1.8 Quelle est la valeur ajoutée de l’EDSC et du CSPA par rapport à d’autres sources de données existantes telles que l’état civil et le DHIS2 ?

2.1 Quels ont été les principaux défis en matière de renforcement des capacités au sein de l’ANSD ?

2.2 Quels ont été les principaux succès en matière de renforcement des capacités à l’ANSD ?

2.3 Quels ont été les succès de l’institutionnalisation des 2 enquêtes ?

2.4 Quels ont été les défis de l’institutionnalisation des enquêtes ?

2.5 Dans quel domaine de l’EDSC ou du CSPA l’ANSD a-t-elle encore besoin de l’assistance technique de l’ICF ou d’autres experts ? Quelles formes d’assistance sont mieux fournies par ICF, et pourquoi ?

3.01 De quelles manières le gouvernement du Sénégal s’est-il approprié l’EDSC et le CSPA ?

3.02 Y a-t-il eu des opportunités manquées où le gouvernement du Sénégal aurait pu s’approprier davantage l’EDSC et le CSPA ?

3.03. Que devrait-il se passer pour que le Sénégal assume les coûts de l’EDSC et du CSPA ?

3.05. Quand pensez-vous que le Sénégal sera en mesure d’assumer tous les coûts des 2 enquêtes ?

3.1 Quelle est votre impression sur les raisons pour lesquelles le gouvernement du Sénégal n’a pas contribué davantage aux coûts de l’EDS ?

3.3. Que faudrait-il pour que le gouvernement du Sénégal augmente sa contribution financière à plus de 50% des coûts des 2 enquêtes ?

3.4 Le fait d’avoir plusieurs bailleurs pour les deux enquêtes pose-t-il des problèmes ? Si oui, lesquels ?

3.51 Comment la structure organisationnelle de l’ANSD au cours des cinq dernières années a-t-elle contribué à la bonne conduite des enquêtes ? Sonde : Y a-t-il eu des changements qui ont été utiles ?
3.52 Comment la structure organisationnelle de l’ANSD au cours des cinq dernières années a-t-elle entravé la conduite des enquêtes ? Sonde : Y a-t-il eu des changements qui ont entravé le travail ?

3.61 Comment les changements survenus au sein du personnel de l’ANSD au cours des cinq dernières années ont-ils facilité la conduite des deux enquêtes ? Veuillez décrire les changements.

3.62 Comment les changements survenus au sein du personnel de l’ANSD au cours des cinq dernières années ont-ils entravé le travail des enquêtes ? Veuillez décrire ces changements.

3.7 Comment comparez-vous la collecte de données du CSPA avec la collecte de données dans le Système d’information Sanitaire (SIS) ?

3.8 Connaissez-vous un rapport rédigé par le personnel de l’ANSD utilisant les enquêtes au-delà du rapport final ? Veuillez décrire/donnez les titres ?

3.9 Connaissez-vous quelqu'un à l'ANSD qui a publié un article utilisant les données des enquêtes ? Veuillez décrire/donnez les titres ?

4 Voyez-vous un avantage à ce que les données soient recueillies chaque année ? Si non, quels intervalles recommanderiez-vous ?

5 Que faudrait-il faire différemment si l'EDSC et CSPA devaient continuer ?

6 Avez-vous d'autres commentaires sur les deux enquêtes ?
Questions pour l’évaluation de l’EDS-Continue

Partenaires

EDSC = Enquête Démographique et de Santé Continue
CSPA = Enquête sur le suivi de la performance des services de santé

1.0 Pourriez-vous décrire brièvement les activités de votre organisation au Sénégal ?
1.01 Quel a été votre rôle ou votre participation à l’EDSC et au CSPA ?
1.10 Pensez-vous que la disponibilité accrue de l’EDSC et du CSPA a aidé à guider la prise de décision au Sénégal dans le domaine de la santé ? Pourriez-vous décrire comment les données ont été utilisées ?
1.2 Avez-vous utilisé les données régionales de l’EDSC ? Si oui, dans quel but ?
1.31 Avez-vous utilisé les données du CSPA ? Si oui, dans quel but ?
1.4 Avez-vous utilisé l’EDSC à des fins de planification ou d’évaluation d’un programme de santé spécifique ?
1.11 Utilisez-vous les données annuelles des fichiers informatiques ou seulement les données agrégées des rapports ?
1.5 Qui ou quel bureau du gouvernement du Sénégal est un grand utilisateur des données de l’EDSC et dans quel but ? Pourriez-vous décrire comment ils ont utilisé ces données ?
1.6 Qui ou quel bureau du gouvernement du Sénégal est un grand utilisateur des données du CSPA et dans quel but ? Pourriez-vous décrire comment ils ont utilisé ces données ?
1.7 Y a-t-il d’autres données qu’il serait utile d’avoir ? Si oui, quelles données ?
1.8 Quelle est la valeur ajoutée de l’EDS par rapport à d’autres sources de données existantes telles que le DHIS2 et l’état civil ?

3.01 De quelles manières le gouvernement du Sénégal s’est-il approprié l’EDSC et le CSPA ?
3.02 Y a-t-il eu des opportunités manquées où le gouvernement du Sénégal aurait pu s’approprier davantage de l’EDSC et du CSPA ?
3.03. Pourriez-vous décrire ce qui doit se passer pour que le Sénégal prenne en charge les coûts de l’EDSC et du CSPA ?
3.04 Quand pensez-vous que le Sénégal sera en mesure d’assumer tous les coûts de EDSC et du CSPA ?
3.1 Quelle est votre impression sur les raisons pour lesquelles le gouvernement du Sénégal n’a pas contribué davantage aux coûts des 2 enquêtes ?
3.3 Que faudrait-il pour que le gouvernement du Sénégal augmente sa contribution financière à plus de 50% des coûts de deux enquêtes ?
3.4 Le fait d’avoir plusieurs bailleurs pour les deux enquêtes pose-t-il des problèmes ? Si oui, lesquels ?
4 Que faudrait-il faire différemment si les enquêtes devaient continuer ?
5 Avez-vous d’autres commentaires sur les deux enquêtes ?
Questions for the CDHS Evaluation

USAID

1.0 What has your role/involvement been with the SCS?

1.10 Do you think the increased availability of CDHS and CSPA have helped guide decision-making in Senegal in the area of health? Could you please describe how the data were used?

1.11 How do you access SCS data? Probe: Do you use the yearly data from computer files or only aggregate data from reports?

1.2 Have you used regional CDHS data? If so, for what purpose?

1.31 Have you used the CSPA data? If so, for what purpose?

1.4 Have you, others in your Office, or USAID more broadly used CDHS for the purpose of planning or evaluating any specific health program?

1.51 Who or what office in the Government of Senegal has utilized the CDHS the most, and for what purpose? Could you describe how they’ve used these data?

1.52 Other than the Government of Senegal, are there other users for the CDHS data? Could you describe how they’ve used these data?

1.61 Who or what office in the Government of Senegal has utilized the CSPA the most, and for what purpose? Could you describe how they’ve used these data?

1.62 Other than the Government of Senegal, are there other users for the CSPA data? Could you describe how they’ve used these data?

1.7 Are there other data that would be useful to have? If so, what data?

1.8 What is the additional value of CDHS vis a vis other existing data sources such as civil registration and DHIS2?

2.3 What successes have there been in “institutionalizing” the CDHS and/or CSPA?

2.4 What challenges have there been in “institutionalizing” the CDHS and/or CSPA?

3.01 In what ways has the Government of Senegal taken ownership of the CDHS and CSPA?

3.02 Were there missed opportunities where the Government of Senegal could have taken more ownership of CDHS and CSPA?

3.03. Could you please describe what needs to happen for Senegal to take on the costs of the CDHS and CSPA?

3.04 When do you think Senegal will be able to assume all costs for CDHS and CSPA?

3.1 What is your impression of why the Government of Senegal has not contributed more to the costs of CDHS?

3.3 What would be required for the Government of Senegal to increase its financial contribution to over 50% of the costs of CDHS and CSPA?
3.4 Are there any problems of having multiple donors who contribute to CDHS and CSPA? If so, what are they?

3.51 How has the organizational structure of ANSD over the five years helped with the work of CDHS and CSPA? Probe: Have there been changes that have been helpful?

3.52 How has the organizational structure of ANSD over the five years hindered the work of CDHS and CSPA? Probe: Have there been changes that have hindered work?

3.61 How have changes in personnel at ANSD over the five years helped the work of CDHS and CSPA? Please describe the changes.

3.62 How have changes in personnel at ANSD over the five years hindered the work of CDHS and CSPA? Please describe the changes.

4 How would you compare the data collection in CSPA with the data collection in DHIS2?

5 What would need to be done differently if the CDHS and CSPA were to continue?

6 Do you have other comments about CDHS or CSPA?
Questions for the CDHS Evaluation

ICF

1.09 What has your role/involvement been with the SCS?

1.10 Do you think the increased availability of CDHS and CSPA data have helped guide decision-making in Senegal in the area of health? Could you please describe how the data were used.

1.5 Who or what office in Government of Senegal or other organizations have utilized the CDHS the most? Could you describe how they’ve used these data.

1.6 Who or what office in Government of Senegal or other organizations have utilized the CSPA the most? Could you describe how they’ve used these data.

2.1 What were major challenges in capacity-building at ANSD?

2.2 What were major successes in capacity-building at ANSD?

2.3 What successes have there been in “institutionalizing” the CDHS and/or CSPA?

2.4 What challenges have there been in “institutionalizing” the CDHS and/or CSPA?

2.5 In what area of the CDHS or CSPA does ANSD still need TA from ICF or from local experts?

2.55 Which of these are best provided by ICF and why?

3.01 In what ways has the Government of Senegal taken ownership of the CDHS and CSPA?

3.02 Are there missed opportunities where the Government of Senegal could have taken more ownership of CDHS and CSPA?

3.1 What is your impression of why the Government of Senegal has not contributed more to the costs of CDHS and CSPA?

3.3 What would be required for Government of Senegal to increase its financial contribution to over 50% of the costs of CDHS and CSPA?

3.31 Could you please describe what needs to happen for Senegal to take on the full costs of CDHS and CSPA?

3.32 When do you think Senegal will be able to assume the costs of CDHS and CSPA?

3.4 Are there any problems of having multiple donors who contribute to CDHS and CSPA? If so, what are they?

3.51 What changes in organizational structure of ANSD over the five years have helped with the work of CDHS and CSPA?

3.52 What changes in organizational structure of ANSD over the five years have hurt the work of CDHS and CSPA?

3.61 What changes in personnel at ANSD over the five years have helped with the work of CDHS and CSPA?
3.62 What changes in personnel at ANSD over the five years have hurt the work of CDHS and CSPA?

6 What would need to be done differently if the CDHS and CSPA were to continue in Senegal? Elsewhere?

7 Do you have other comments about CDHS or CSPA?
### ANNEX III. KEY INFORMANTS INTERVIEWED

#### Key Informants in Washington

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunita Kishor</td>
<td>Project Director</td>
<td>ICF</td>
</tr>
<tr>
<td>Bernard Barrere</td>
<td>Operations Deputy Director</td>
<td>ICF</td>
</tr>
<tr>
<td>Sarah Balian</td>
<td>Dissemination Specialist</td>
<td>ICF</td>
</tr>
<tr>
<td>Abibata Handley</td>
<td>Senior Advisor for Capacity Strengthening</td>
<td>ICF</td>
</tr>
<tr>
<td>Michelle Winner</td>
<td>SPA Survey Specialist</td>
<td>ICF</td>
</tr>
<tr>
<td>Albert Themme</td>
<td>Data Processing Deputy Chief</td>
<td>ICF</td>
</tr>
<tr>
<td>Ruilin Ren</td>
<td>Sampling Coordinator</td>
<td>ICF</td>
</tr>
<tr>
<td>Jose Miguel Guzman</td>
<td>Regional Coordinator</td>
<td>ICF</td>
</tr>
<tr>
<td>Tom Pullum</td>
<td>Senior Advisor for Research and Analysis</td>
<td>ICF</td>
</tr>
<tr>
<td>Keith Purvis</td>
<td>Data Processing Specialist</td>
<td>ICF</td>
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<td>Madeleine Short Fabic</td>
<td>COR DHS-7</td>
<td>USAID Washington</td>
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<tr>
<td>Jacob Adetunji</td>
<td>Demographer, COR DHS-6</td>
<td>USAID Washington</td>
</tr>
<tr>
<td>Noah Bartlett</td>
<td>HIV/AIDS Technical Advisor, DHS Management Team</td>
<td>USAID Washington</td>
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<tr>
<td>Misun Choi</td>
<td>PMI/Malaria Technical Advisor, DHS Management Team</td>
<td>USAID Washington</td>
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<tr>
<td>YJ Choi</td>
<td>FP/RH Technical Advisor, DHS Management Team</td>
<td>USAID Washington</td>
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</table>
### Key Informants in Senegal

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>Laura Campbell</td>
<td>Office Director</td>
<td>USAID Senegal</td>
</tr>
<tr>
<td>Amy Diallo</td>
<td>Deputy Office Director</td>
<td>USAID Senegal</td>
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<tr>
<td>Babacar Lo</td>
<td>HSSPD Advisor</td>
<td>USAID Senegal</td>
</tr>
<tr>
<td>Oumar Sagna</td>
<td>Health G2G Advisor</td>
<td>USAID Senegal</td>
</tr>
<tr>
<td>Mame Birame Diouf</td>
<td>PMI Advisor</td>
<td>USAID Senegal</td>
</tr>
<tr>
<td>Dr. Fatou Ndiaye</td>
<td>MCH/FP Specialist</td>
<td>USAID Senegal</td>
</tr>
<tr>
<td>Dr. Hassane Yaradou</td>
<td>MCH/FP/RH Specialist</td>
<td>USAID Senegal</td>
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<td>Papa Ibrahima Simang Sène</td>
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<tr>
<td>Papa Mabèye Diop</td>
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<td>Dr. Ibou Guissé</td>
<td>CSPA Coordinator</td>
<td>ANSD, Direction des Statistiques Démographiques et Sociales</td>
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<tr>
<td>Ndéye Yague Sy Gueye</td>
<td>ARCH Project Coordinator</td>
<td>Hellen Keller International</td>
</tr>
<tr>
<td>Nafissatou Ba Lo</td>
<td>Feed the Future Senegal-Kawolor</td>
<td>Hellen Keller International</td>
</tr>
<tr>
<td>Médoüne Diop</td>
<td>Country Director</td>
<td>Hellen Keller International</td>
</tr>
<tr>
<td>Siaka Coulibaly</td>
<td>Former Director of DSIS</td>
<td>Ministère de la Santé et de l'Action Sociale</td>
</tr>
<tr>
<td>Dr. Balla Moussa Diédhiou</td>
<td>Sahel Director</td>
<td>Nutrition International</td>
</tr>
<tr>
<td>Mamadou Diouf</td>
<td>Senior Program Officer, Child Health &amp; Nutrition</td>
<td>Nutrition International</td>
</tr>
<tr>
<td>Mouhammadou Fall</td>
<td>Spécialiste en Politiques Sociales/Expert données</td>
<td>UNICEF</td>
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ANNEX IV. KEY INFORMANT CONSENT FORM

Introduction
Thank you for making the time to talk with me today.

USAID has asked our team to evaluate the Continuous DHS in Senegal. You were suggested as a key person to inform this activity and we greatly appreciate your perspective, experiences and views on the successes, challenges, barriers and lessons learned regarding the Continuous DHS in Senegal.

We would like to record this interview to ensure that we do not miss any important points. Please know that anything you say during the interview will be kept confidential within our team, and that in our report, though we plan to use some quotes, we will not be attributing specific comments to any specific individual but only to institutions. Is it ok if we record or you prefer that we not record to refresh our memories later?

We estimate that the interview will take about 45-60 minutes

Do we have your permission to begin?

Before we begin, do you have any questions about this interview?
Consentement éclairé

Introduction

Merci d'avoir pris le temps de parler avec moi aujourd'hui.

USAID a demandé à notre équipe d'évaluer l'EDS continue au Sénégal. Vous avez été suggéré en tant que personne clé pour informer cette activité et nous apprécions grandement votre opinion, vos expériences et vos points de vue sur les succès, les défis, les obstacles et les enseignements tirés de l'EDS continu au Sénégal.

Nous aimerions enregistrer cette interview pour nous assurer de ne manquer aucun point important. Sachez que tout ce que vous dites pendant l'entrevue restera confidentiel au sein de notre équipe et que, dans notre rapport, bien que nous prévoyions d'utiliser des citations, nous n'attribuerons aucun commentaire spécifique à une personne en particulier, mais uniquement aux institutions. Est-ce que vous êtes d'accord si nous enregistrons, ou préférez-vous que nous n'enregistrions pas pour rafraîchir nos souvenirs plus tard ?

Nous estimons que l'interview durera environ 45 à 60 minutes

Avons-nous votre permission pour commencer ?

Avant de commencer, avez-vous des questions sur cette interview ?
## ANNEX V. DOCUMENTS REVIEWED

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<td>2012-2013 Senegal DHS Final Report</td>
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<td>Evaluation A Mi-Parcours de l’Enquête Continue du Sénégal (Mai 2015)</td>
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<td>DHS-7 Year 1 Award Fee Report (Capacity Assessment Tool pages only)</td>
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<tr>
<td>DHS-7 Year 3 Award Fee Report (Household Survey Listing and Capacity Strengthening pages only)</td>
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<td>DHS-7 Year 5 Award Fee Report (Baseline Data Collection pages only)</td>
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<td>The Peru Continuous DHS Experience, DHS Occasional Paper</td>
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## ANNEX VI. PUBLICATIONS CITING SENEGAL CONTINUOUS SURVEY DATA

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<td>Association between infrastructure and observed quality of care in 4 healthcare services: A cross-sectional study of 4,300 facilities in 8 countries.</td>
<td>Leslie HH, Sun Z, Kruk ME</td>
<td>PLoS Med 14(12): e1002464. <a href="https://doi.org/10.1371/journal.pmed.1002464">https://doi.org/10.1371/journal.pmed.1002464</a></td>
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<td>children aged 12-23 months in West Africa: Analysis of the interaction effects of maternal education.</td>
<td>Ajaero.</td>
<td>(Supp. 2), 2017. DOI: <a href="http://dx.doi.org/10.11564/31-1-1028">http://dx.doi.org/10.11564/31-1-1028</a></td>
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<td>Environmental conditions in health care facilities in low- and medium income countries</td>
<td>Ryan Cronk, Jamie Bartram.</td>
<td>International Journal of Hygiene and Environmental Health</td>
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<td>middle-income countries: Coverage and inequalities.</td>
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<td>Environmental Health Volume 221, Issue 3, April 2018, Pages 409-422. <a href="https://doi.org/10.1016/j.ijheh.2018.01.004">Link</a></td>
<td>2018</td>
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ANNEX VII. DISTRICT HEALTH INFORMATION SOFTWARE 2 (DHIS2) QUALITY TRENDS

This analysis tries to add substance to our recommendations already in the report. We have focused on one indicator, the proportion of deliveries assisted by qualified personnel, to gauge the quality of the DHIS2 and its evolution over time. Given all the concern we heard about the quality of DHIS-2 data, it is necessary to see to what extent the DHIS2 can be made to work as we are recommending using it to get data at the district level. The analysis below suggests that the DHIS2 continued to improve after its scaling up in 2016 until around end of 2017 when quality started deteriorating. The effect of data retention that was launched in April just aggravated a trend of deterioration that started in the last months of 2017.

The proportion of deliveries assisted by qualified personnel can be defined as $Q(t)=\frac{N(t)}{D(t)}$ where $N(t)$, the numerator, is equal to the number of assisted deliveries at time $t$. $D(t)$, the denominator, is the estimated number of deliveries, which comes from demographic projections. $Q$ is very interesting as a gauge of the quality of the DHIS2 particularly because its two components, $N$ and $D$, are affected by completely independent factors. $D$ is affected by the quality of demographic projections, while $N$ depends mainly on the number of assisted deliveries effectively recorded by the system. If we assume that the errors in the demographic projections are similar for all $t$, then $Q(t)$ is mainly affected by the completeness of recording of assisted deliveries in the system.

Thus variations in $Q(t)$ provide a good proxy for trends in data quality and will be mainly affected by errors in the number of deliveries recorded in the system.
Fig. 1 shows an overall percentage of 68.5 deliveries by qualified personnel in 2017 (60% in 2016). The very high figures in the last months of that year suggest that measurement improved throughout 2017 to reach a peak of 86.5% in October. The negative impact of data retention launched in April is clearly visible, but quality deterioration started beginning in December 2017.

The message here is that the DHIS2 can indeed be made to work and provide good data when the required efforts are invested in it. However, in order to sustain quality, it has to be shielded from employee strikes and subsequent data retention. Sustaining data of high quality will require, as we heard from our interviewees, the development of a culture of information among the health personnel and an understanding of how important this data is for the health system.
ANNEX VIII. EVALUATION FINDINGS AND RECOMMENDATIONS WORKSHOP REPORT

Report of the Final Evaluation Workshop on the Senegal Continuous Survey

Presented by:

Mr. Amadou Hassane SYLLA, Ms. Marthe J. KADIMPE

WORKSHOP SUMMARY

The co-construction workshop on findings and recommendations of the Senegal Continuous Survey (DHS) evaluation was held on Wednesday, October 3, 2018 at the King Fahd Palace Hotel.

Workshop objective

The objective is to share the preliminary results of the evaluation and proposed recommendations in order to develop practical recommendations with all the project’s stakeholders and to identify major actions to be undertaken for the effective implementation of selected recommendations.

Organizations represented

USAID, GHSC/TA, CDC (PMI), PNLP, General Directorate for Social Action (Direction Générale de l’action sociale) (DGAS), ANSD, UNFPA, Laboratories Directorate (Direction des Laboratoires), Cellule de Lutte contre la Malnutrition (CLM), World Bank, UNICEF, ICF/ JHU, Pop Council, Division for the Fight Against AIDS and STIs (Division de la lutte contre le Sida et les IST), OMS, Department of Planning, Research and Statistics (Direction de la Planification de la Recherche et des Statistiques) (DPRS), Abt/RSS+, Micronutrient Initiative (MI), SenEval, OMS, UNFPA.

Opening

The opening ceremony began at 10 a.m. The moderator, Mr. Amadou Hassane SYLLA, took the floor to fist thank all the organizations represented at the workshop. He then gave the floor to the representatives of USAID-Health, the Ministry of Health and Social Action (MSAS), and the National Agency of Statistics and Demography (ANSD).

In their respective speeches, while commending the Senegal Continuous Survey (DHS) project, they all emphasized the availability of the data and the partnership between the various institutions that implemented it. They hoped that the workshop would find answers regarding the future of continuous surveys: format, type, frequency, financing, project management, etc.

Subsequently, the participants introduced themselves. While introducing the first presentation, the moderator noted that the presence of all these institutions is clear proof of interest in DHS.
Presentation of methodology and findings

Mr. Cheikh MBACKE, a member of the evaluation team, gave an overview of the preliminary findings followed by a general discussion before presenting the proposed recommendations and conclusions of the evaluation. The following aspects were emphasized:

- Study context
- Evaluation question
- Methodology
- Preliminary findings

The interventions focused on:

- The need to expand the DHS for monitoring selected performance indicators.
- The need to align this project with PSE for consistency. To illustrate this need, the monitoring of PSE’s Axis III can be noted as resulting from the continuous DHS.
- The need for capacity building by expanding the targets (go beyond tools).
- How to reduce the costs of the continuous DHS?
- The major challenge is the lack of data at the decentralized level (departments, health districts); the policy of decentralization is to be taken into account.
- The instability of the indicators (what explains this phenomenon?).
- The involvement in and ownership of this information system by public authorities.
- How to explain the delay or slowness in the dissemination of results.
- Recognition of the existence of a conflict in ANSD between the various data collection activities.
  This finding was clarified by the ANSD representative who attributes it to a problem of management and delegation of tasks. Even if ANSD were required to conduct several data collection activities at the same time, a better delegation of tasks would prevent this conflict. Consequently, it is up to ANSD to become better organized.
- The discussions returned to the problem of implementing the two surveys: is it necessary to alternate or not? If so, how should they be alternated to reduce costs? In view of the very short time frame, some make the case that it would not be realistic to evaluate the indicators at the end of each year. Errors cause results to fluctuate, which explains instability.
- The representativeness of the surveys is faced with the problem of costs. It should be noted that for the financing of surveys, there is a draft order in place for the establishment of a statistics development fund,
- At the regional level, the District Chief Medical Officers who need detailed data for their planning, use data from the region that may not reflect the situation in their area of responsibility.
- During this evaluation, not all the users of the system were questioned (researchers, regional level etc.).
- It is also important to note that it is not enough to simply disseminate the data; users must also be given the time to understand and analyze the results,

After this session, there was a 15-minute coffee break.

Presentation of the proposed recommendations
Work resumed at 12 noon with a presentation by Mr. Cheikh MBACKE on the proposed recommendations. Representatives of ICF and ANSD each responded to the presentation by focusing on:

- The fact that ANSD now has the capacity to continue the process.
- Updating data and report production times is a very tedious job and will remain a continuing challenge (producing tables, checking numbers, writing and editing reports). In addition, indicators should be prioritized by identifying those that should be studied each year. In regards to decentralization, especially for districts, there is not only the problem of financing but also of the quality of the data.
- ANSD consists primarily of contract workers.
- ICF should assist ANSD to prevent and correct any errors that may occur.
- Dissemination had been carried out but not in all regions.
- It is recommended to take the time to analyze and act on the results obtained. Also, is it reasonable to do the DHS every two or three years and to strengthen DHIS2 for the production of indicators at the district level?
- The methodology could be reviewed and the survey decentralized in the districts.

**BREAKOUT SESSIONS**

The breakout sessions began at 12:45 p.m. Participants worked on the following three principal themes:

- Presentation and use of data: what is needed for an efficient use of data
- Approach to rationalizing and optimal use of resources
- Mechanisms for better ownership of the processes (by the stakeholders) and sustainability

Participants were divided into the following four groups:

- Presentation and use of data
- Capacity-building
- Rationalizing resources
- Ownership and next steps

The requested work is as follows:

- Each group should reflect further on the chosen theme.
- Propose recommendations relevant to improving the subject of the theme.
- Finally, present the group report in plenary.

The lunch break began at 1:15 p.m. and finished at 2:15 p.m., at which time the breakout sessions resumed. The presentations of the breakout sessions began at 3:30 p.m. Each group had 10 minutes to present the results of its work. The consolidated matrix is attached.

**Recommendations from the workshop and next steps**

The interventions that followed the presentations enabled the participants to make recommendations and identify the following next steps:

- The USAID-HEALTH Director made it clear that for the next steps, it will be necessary to be strategic as support resources will certainly be reduced.
Some representatives of USAID and UNFPA emphasized that from the beginning of the project, it was not clear that USAID could continue funding. As a result, funding would have to be found for the surveys. Donors will only support the project. It takes political will from the Senegalese government to support statistics.

A meeting could be planned, in collaboration with UNFPA, to ensure that the levy on the statistical tax can benefit ANSD.

As the state financed the census at 95%, why couldn’t it do that for the continuous survey? It has been estimated that the statistical tax generates 14 billion CFA francs per year and that the 30% proposed for the development of the national statistical system would correspond to 4.2 billion CFA francs per year.

Under the management of Abt Associates, a memorandum of understanding and an implementation plan between MSAS and ANSD have been approved and they should be shared with all stakeholders.

In regard to sustainability:

- It is easy to raise the awareness of partners and others on the importance of continuous SCS since most of the indicators of the ODD, PSE etc. are supplied by SCS.
- It would be necessary to diversify publications and have them appear regularly at the Ministry of Health level.
- The human resources situation of ANSD must be reviewed to ensure the sustainability of the DHS.

In regard to dissemination:

- Activities should be implemented around the regional statistical offices.
- It is also important to understand that the survey is merely a report; qualitative research is what helps to improve understanding. Additional analysis of the data is very important.
- The ICF is studying the ways and means to better use data during the next phase.
- The involvement of health programs in the development of DHS questionnaires is paramount.

Capacity must be built first of all at the central level.

Data must be made available to medical regions.

Regional representativeness is very important although it is expensive.

The quality of the surveys must be the first priority in the next steps.

The evolution of the epidemiological realities of the country must be taken into account in the SCS. It should consider the new priorities in health.

Concerning the frequency of continuous DHS, which is up for debate, ANSD had opted for every 2 or 3 years, but, according to the participants, the National Statistics Council preferred that the survey be done each year because of high demand. Institutions regularly request that data of interest to them be made available. In addition, conducting the survey every 2 or 3 years would result in ANSD losing its human resources, expertise, and logistics, which goes against the original idea of a continuous DHS.

Moreover, there are other surveys conducted by ANSD that need the support of ICF and partners, especially in regards to continuous capacity building.

It came out of the discussions that quality surveys are needed in order to have stable indicators; ensuring the quality of the survey is essential, even though it is expensive.
The reliability of the data must be ensured; the computer scientist must work closely with the demographer and the statistician in order to have stable and reliable data. In addition, an audit of data quality should be considered.

Next steps

The USAID-Health director:
- Pointed out that all USAID programs were systematically consistent with state policies.
- Insisted on the fact that the support of the TFP must be a collective effort.
- Proposed that ANSD organize a meeting with all the TFP to discuss the collective support, that is, of each stakeholder.

The ANSD representative:
- Emphasized the fact that the continuous DHS was a pilot project.
- Called attention to the need to consider the ways and means to sustain the continuous SCS, as the USAID director noted.
- Stressed that measures are being taken for data quality (see how to alternate modules, reduce the size of the questionnaire, etc.)

According to the ICF representative, that organization remains available to support ANSD.

Closure of the workshop

At the end of the workshop at 5:45 p.m., the moderator thanked all the participants and focused his remarks on the importance of this continuous DHS evaluation workshop in Senegal. Finally, he noted that the comments of the various speakers would be taken into account during the finalization of the document, which would be shared later with all the stakeholders. He ended his remarks by declaring the workshop closed.
### Synthèse des travaux de groupes

**Evaluation de l’Enquête Continue du Sénégal : Matrice des recommandations et actions à mener**

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<td>Comment les données de l’Enquête Continue du Sénégal (ECS) ont-elles été utilisées par diverses parties prenantes pour planifier, suivre et évaluer les programmes de santé ?</td>
<td>Les données de l’ECS sont beaucoup utilisées aussi bien par les différentes composantes du gouvernement que par les partenaires, pour la planification et l’évaluation de leurs activités dans le pays.</td>
<td>Dissémination : Elaborer un plan de partage et de dissémination (format, contenu, cible, policy brief…)</td>
<td>ANSD</td>
<td>DG ANSD</td>
<td></td>
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<tr>
<td>Faible niveau d’utilisation des données au niveau décentralisé</td>
<td>Faire le partage et la dissémination des résultats dans toutes les régions du Sénégal aussitôt que les résultats sont disponibles selon le plan adopté.</td>
<td></td>
<td>ANSD</td>
<td>DG ANSD</td>
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<tr>
<td>Peu d’analyses des données débouchant sur une publication scientifique ont été</td>
<td>Orienter les acteurs sur les techniques d’utilisation des données lors des disséminations régionales</td>
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<td>ANSD</td>
<td>DG ANSD</td>
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<td>Gouvernement</td>
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**ANSD**

**DG ANSD**
## Findings

Les données de l'ECPSS ne sont pas disponibles dans StatCompiler.

## Recommendations

- Analyses approfondies : Mettre en place un fonds compétitif avec des appels à proposition où tous les chercheurs/experts pourraient compétir.
- Impliquer les universités et les institutions de recherche dans les sessions de partage et de dissémination des résultats des enquêtes.
- Appuyer la mise en œuvre du plan d’action du mémorandum entre ANSD et le MSAS (qui intègre un volet sur la publication scientifique basée sur les analyses approfondies).
- Faire des analyses secondaires thématiques au niveau sectoriel.
- Ajouter le volet ECPSS dans StatCompiler.

## Question 2 : Utilisation des données

La mise en œuvre concomitante de l'EDSC et l'ECPSS est-elle utile ? Dans quel sens ? Et pour quelles parties prenantes ?

- Le principal utilisateur de l'ECPSS est le MSAS. Pour le staff du MSAS, le fait d’avoir les deux enquêtes faites en même temps leur permet de corréler la performance des services.
- Impliquer les différents programmes du MSAS dans la conception des questionnaires pour prendre en compte les priorités sanitaires actuelles (Hépatique B, maladies non transmissibles …).
<table>
<thead>
<tr>
<th>Findings/Constatations</th>
<th>Recommendations/Recommandations</th>
<th>Comments/Commentaires</th>
<th>Responsibility</th>
<th>When</th>
<th>Priority</th>
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<tr>
<td>de santé avec les données collectées au niveau des ménages. Il faut noter que l'ECPSS est la seule source sur l'appréciation de la qualité des services de santé par les populations.</td>
<td>L'analyse conjointe des données des deux enquêtes est très complexe. ICF devrait aider au développement de méthodes d'analyse appropriées.</td>
<td>ICF</td>
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<td>Question 3 : Renforcement de capacité</td>
<td>Quelles ont été les réalisations et les défis dans le renforcement des capacités depuis le début de l'ECS ?</td>
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<tr>
<td>Au fil du temps, ICF a réussi à renforcer les capacités du personnel technique de l'ANSD dans presque tous les aspects liés à la conduite des enquêtes. L'ANSD est actuellement capable de continuer l'ECS avec une assistance minimale d'ICF.</td>
<td>Renforcer les capacités des experts de l'ANSD pour qu'ils puissent conduire tout le processus de l'enquête sans avoir besoin de faire recours ICF à aucune étape de l'opération.</td>
<td>ANSD/ MEFP</td>
<td>Premier trimestre 2019</td>
<td>2</td>
<td></td>
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<td></td>
<td>Formation à l'analyse des données: Continuer et élargir les ateliers de formation sur l'analyse des données actuellement conduits par ICF.</td>
<td>ICF et ANSD</td>
<td>Premier trimestre 2020</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renforcer les capacités des acteurs sectoriels dans l'utilisation des données produites</td>
<td>ANSD</td>
<td>Janvier 2019</td>
<td>1</td>
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<td></td>
<td>S'assurer que la titularisation des contractuels professionnels impliqués dans l'ECS est effective d'ici la fin de l'année 2018.</td>
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<td></td>
<td>Le mémorandum signé entre l'ANSD et le MSAS prévoit le renforcement de capacité des agents du MSAS en matière de collecte et d'analyse des données, y compris le personnel de santé des autres ministères</td>
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<tr>
<td><strong>Constatations</strong></td>
<td><strong>Recommandations</strong></td>
<td><strong>Commentaires</strong></td>
<td><strong>Org</strong></td>
<td><strong>Lead Person</strong></td>
<td><strong>Quand</strong></td>
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<tr>
<td><strong>Question 4 : Appropriation de l’ECS</strong></td>
<td>Le gouvernement du Sénégal s’est-il progressivement approprié l’ECS au fil du temps ?</td>
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<tr>
<td>Sur le plan technique, le gouvernement a institutionalisé l’enquête au sein de l’ANSD qui est l’organisation gouvernementale responsable de la production des statistiques nationales.</td>
<td>Faire le plaidoyer auprès du Premier ministre et, si nécessaire, du Président de la République afin qu’ils puissent voir à son terme le processus de mise en place du fonds de la statistique qu’ils ont déjà initié.</td>
<td>EDS est reconnue comme faisant partie intégrante de l’agenda des enquêtes nationales.</td>
<td>Conseil national de la statistique</td>
<td>Court moyen terme</td>
<td>1</td>
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<tr>
<td>Le gouvernement du Sénégal n’a pas beaucoup contribué à la prise en charge des coûts des deux enquêtes durant les 5 premières années.</td>
<td>S’assurer que l’ECS est bien positionnée dans la stratégie nationale de développement de la statistique et qu’elle est bien prise en compte dans ce fonds.</td>
<td>A partir de 2016 la contribution de l’Etat s’est considérablement améliorée à travers le PFSN et les PTF dont la contribution avoisine les 90% et ce jusqu’en 2019</td>
<td>Conseil national de la statistique</td>
<td>DG ANSD</td>
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<td>Mettre en place un plan de transition pour le financement des EDS en attendant la mise en place du fonds de financement</td>
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<td></td>
<td>Faire le plaidoyer pour le respect des engagements pris</td>
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</table>
**Question 5 : Quel futur pour l’ECS ?**

Quelles sont les exigences d’une ECS pérenne et apte à guider le pilotage des politiques publiques et du PSE ?

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<thead>
<tr>
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<th>When Quand</th>
<th>Priority</th>
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<tr>
<td></td>
<td>par les ministères sectoriels (MSAS, MEF)</td>
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<td>ANSD</td>
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<td></td>
<td>Continuer le plaidoyer auprès des autres partenaires</td>
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<td>DG ANSD</td>
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**ANSD**

**DG ANSD**
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<th>Priority</th>
</tr>
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<tbody>
<tr>
<td>Constatations</td>
<td>Développer un plan de renforcement de capacités pour les sectoriels et le niveau opérationnel et un plan de diffusion pour le niveau opérationnel. ANSD reste maître d’œuvre et continue la relation avec ICF aussi longtemps que nécessaire afin d’assurer la qualité dans les aspects techniques que l’ANSD n’a pas encore maîtrisés.</td>
<td>ANSD/MSAS</td>
<td>DG ANSD</td>
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ANNEX IX. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

<table>
<thead>
<tr>
<th>USAID Non-Disclosure and Conflicts Agreement: Global Health Program Cycle Improvement Project</th>
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<tbody>
<tr>
<td>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, &quot;sensitive but unclassified information,&quot; procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.</td>
</tr>
<tr>
<td>Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:</td>
</tr>
<tr>
<td>1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.</td>
</tr>
<tr>
<td>2. Before disclosing Sensitive Data, I must determine the recipient's &quot;need to know&quot; or &quot;need to access&quot; Sensitive Data for USAID purposes.</td>
</tr>
<tr>
<td>3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.</td>
</tr>
<tr>
<td>4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.</td>
</tr>
<tr>
<td>5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.</td>
</tr>
<tr>
<td>6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.</td>
</tr>
<tr>
<td>7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).</td>
</tr>
</tbody>
</table>
| 8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that:
(i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[Signature]
Name: [Name]
Title: [Title]
Date: [Date]

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PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature: C. Mbacké
Date: 03/20/2018

Name: Cheikh Seydil Moctar Mbacké
Title: Doctor
ANNEX X. SHORT BIOS OF EVALUATION TEAM MEMBERS

Stan Becker is a professor in the Department of Population, Family and Reproductive Health at Johns Hopkins University. He obtained his BA in Public Affairs and MA in Demography at the University of Chicago and doctorate in demography at the Population Dynamics Department of Johns Hopkins University.

He then worked overseas—three years at the International Centre for Diarrheal Disease Research, Bangladesh, one year at L’Institut National d’etudes Demographiques in Paris and 3 years at the Vrije Universiteit Brussel in Belgium, all as a demographer. In Bangladesh he helped with the Demographic Surveillance System in Matlab and did studies of subcomponents of the birth interval, of seasonality of births and of deaths and did two validation studies, one of birth histories (backward versus forward) and one of pregnancy histories versus birth histories using the accurate registers of births and deaths in Matlab.

He teaches a course, Population Health and Development to undergraduates. He also teaches the course “Couples and Reproductive Health” at the Johns Hopkins School of Public Health and helps in the demographic methods sequence in which he taught for many years. He is current head of the Population and Health faculty group in the department. His research interests are interventions with couples in reproductive health and estimation of fertility and mortality in developing countries.

Cheikh Seydil Moctar Mbacké is Senior Fellow at the Center for Research on Applied Economics and Finance of Thiès (CREFAT), University of Thiès, Senegal. As senior fellow, he helps mobilize resources to strengthen and sustain the center and provides mentoring to staff and students at this young research center.

Dr. Mbacké is an acknowledged advisor in population and health research and training in sub-Saharan Africa. His advisory work serves diverse organizations in Africa and the United States. He serves in the boards of many institutions where he brings his 30-year experience in building individual and institutional research capacity.

Previously, Dr. Mbacké spent 6 years at the Sahel Population and Development Research Center in Bamako, Mali and fourteen years at the Rockefeller Foundation where he headed the Foundation’s program for Africa and served as Vice President for Administration and Regional Programs until 2006.

Dr. Mbacké, a statistician and population scientist by training, holds a BSc in Statistics from the Institute of Statistics and Applied Economics in Paris, an MSc in Demography from the Demographic Training and Research Institute in Yaoundé, Cameroon and a PhD in demography from the University of Pennsylvania in Philadelphia.

Olivia Padis is a Program Assistant in USAID’s Bureau for Global Health in the Office of Population and Reproductive Health. Ms. Padis holds a BA in French and Francophone Studies from Virginia Polytechnic Institute and State University.
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