



Africare

**AFRICARE SENEGAL
Tambacounda Healthy Start Program (THSP)**

FINAL EVALUATION REPORT

Cooperative Agreement No.: GHS-A-00-03-00002-00

October 2003-September 2008

Submitted by:

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Submitted to:

United States Agency for International Development
Bureau for Global Health
Office of Health, Infectious Disease and Nutrition
Washington, D.C.

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December, 2008

LIST OF ACRONYMS

ANC	Antenatal Care
BCC	Behavior Change Communication
CBD	Community Based Distribution
CBO	Community Based Organization
CDD	Control of Diarrheal Diseases
CHW	Community Health Worker (community-based volunteer)
C-IMCI	Community-based Integrated Management of Childhood Illnesses
CM	Community Mobilization
CS	Child survival
DIP	Detailed Implementation Plan
EPI	Expanded Program of Immunization
FE	Final Evaluation
GOS	Government of Senegal
HIS	Health Information System
IEC	Information Education Communication
IPT	Intermittent Preventive Treatment (of malaria)
ITN	Insecticide Treated Nets
JICA	Japanese International Cooperation Agency
KPC	Knowledge Practice and Coverage (survey)
MCH	Maternal and Child Health
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Non-government Organization
NIDs	National Immunization Days
ORS	Oral Rehydration Solution
PMI	President's Malaria Initiative
RH	Reproductive Health
TBA	Trained Birth Attendant
TH	Traditional Healer
THSP	Tambacounda Healthy Start Program
TOT	Training of Trainers
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

A. Summary

Program Goal and Objectives: The goal of the THSP was to decrease the morbidity and mortality rates of pregnant women and children under one year of age in the Tambacounda Region by improving community based health care services, increasing community access to health information, and strengthening community linkages with the health care system. The THSP had five objectives:

- 1) Increase the access to, demand for, and use of quality maternal and child health services, including emergency care;
- 2) Improve case management of malaria for pregnant women and children under five at the community and health post levels;
- 3) Improve nutrition of pregnant women and newborns, including promoting vitamin A supplementation and the practice of exclusive breastfeeding;
- 4) Improve diarrhea recognition and management at community and household levels;
- 5) Improve the capacity of local partners to plan, implement, monitor and evaluate child survival interventions at the community and district levels, with an emphasis on capacity in maternal and newborn health, malaria, nutrition, and breastfeeding.

Key strategies to attain these objectives included:

- Building capacity at the health posts and community levels by training 70 health personnel and 200 Traditional Birth Attendants (TBAs);
- Assisting communities to establish functioning referral and transport systems in collaboration with the MOH and community health committees;
- Educating and mobilizing communities by training 400 CHWs drawn from among the members of local women's groups;
- Organizing pregnant women, care givers, and grandmothers into maternal care groups;
- Designing and carrying out a social marketing campaign to increase access to and use of ITNs, ORS, safe birthing/hygiene kits, and iron pills.

The primary interventions and levels of effort for the THSP were divided as follows: Maternal and Newborn Care – 50%; Nutrition/Exclusive Breastfeeding – 20%; Malaria – 20%; Diarrhea – 10%.

Main accomplishments

1. Mobilization of 150 communities, most with functioning village health committees, approximately 311 CHWs, 53 TBAs, and 277 Maternal Care Groups.
2. Capacity building of community resource persons;
3. Increased health knowledge and progress in the area of behavior change;
4. The development of an efficient referral and counter referral system between the community and health post level;
5. Strengthened linkages between communities and the MOH health structures;

6. Increased use of health services by the populations in the project villages, including ANC, delivery, postnatal care, EPI, and GM.
7. Reduced incidence of malaria, diarrhea, and illness during pregnancy as noted by mothers, community leaders, CHWs and health providers;
8. Project support and collaboration with districts partners for the implementation of child survival campaigns, outreach activities and EPI.

Constraints

- The Child Survival project budget was very limited (\$2,006,478 including match), with respect to supporting the implementation of an ambitious project for a duration of 5 years.
- The dramatic devaluation of the US dollar over the life of the program (from 700 CFA/US\$1 at the time of proposal development to 400 during the last year of the project) had a devastating impact on the program budget. It greatly reduced the amount of money actually available for program implementation after the currency exchange.
- The large size of intervention area including the Tambacounda, Koupendoum and Maka districts consisting of over 400 villages and distances of up to 162 kilometers, made coverage and logistics difficult. Many villages are also inaccessible during the rainy season. The project had to limit their work to 150 villages.
- Low levels of education of community health volunteers and resource persons require special efforts for capacity building, and in the area of data collection and reporting.

The THSP did well overall with respect to results on project indicators. The project achieved 12 of a total of 17 indicators. Only five indicators did not reach their target. There is also a clear increase in Africare Senegal organizational capacity in community health and development as a result of this project. They now have a big team of field staff who has learned lessons in community mobilization and BCC, and contributed to the THSP achievements. All staff has been transferred to new projects and is in a very good position to replicate these results and have even more impact in other parts of the country. There is no doubt that the project has greatly increased community capacity and responsibility for health, in addition to increasing community demand and improving health practices.

The potential for the sustainability of certain aspects of the project such as referrals and counter referrals, increased use of maternal and child health services and coverage, community mobilization for sanitation and hygiene, outreach and EPI, and the affiliation with a Care group where they were developed, is also very good. Africare very much intends to replicate some of these experiences as they continue to implement community health programming elsewhere. They also hope to get more funding to scale up the THSP to other villages and districts in the Tambacounda region.

Recommendations for stakeholders

1. Integrate the supervision of CHWs with the existing outreach activities currently conducted by health post nurses.
2. Ensure that community health information is transferred to the health posts either by the CHW or that it is collected by the health post nurse during outreach activities.
3. Advocate for the remuneration of community health volunteers by the health committees at the health post level (soon to be established as community development organizations).
4. The health post nurses and their committees should plan and budget for the refresher training and continued capacity building of CHWs in their catchment areas.
5. The health post nurses should ensure the sustainability of the referral and counter referral system by maintaining the supply of the existing referral forms used for this purpose at the community level.
6. The THSP staff who continue to work in certain communities under the new malaria project should serve as resource persons and advisers to CHWs trained by the project.
7. Organizations intervening in the program area, including Africare, should avoid the creation of multiple different forms for CHWs to report community health information.
8. Africare should continue and strengthen its efforts to replicate and scale up the successful Maternal Care Group approach across Senegal. Africare should also make an effort to document this experience, share it on their website, and present it in other forums as well.

B. Assessment of Results and Impact of the Project

1. Results: Summary Chart

Baseline, midterm and final KPC data for project indicators.

Indicator	Baseline	MTE	Final	Target
Nutrition /Micronutrients				
Percentage of mothers practicing exclusive breastfeeding for six months	24	80	88	60
Percentage of mothers taking vitamin A forty-two days after delivery	11	60	59	60
Percentage of children 6-23 months of age receiving vitamin A supplementation in the previous six months	40	72	100	80
Percentage of households using iodized salt	49	59	83	70
Control of diarrhea				
Percentage of children aged 0-23 with diarrhea in the last two	52	27	27 *	65

weeks who received ORS and/or recommended home fluids.				
Percentage of children aged 0-23 with diarrhea in the last two weeks who were offered more fluids during the illness.	48	57	58	60
Percentage of children aged 0-23 with diarrhea in the last two weeks who were offered the same amount or more foods during the illness.	48	39	48	60
Percentage of mothers who know the signs of diarrhea needing treatment	43	87	73	70
Percentage of mothers who usually wash their hands with soap before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	7	14	78	50
Control of Malaria				
Percentage of pregnant women with access to IPT	2	89	79	60
Percentage of caregivers recognizing severe danger signs of malaria and seeking appropriate care within 24 hours	48	40	62	60
Percentage use of ITNs among pregnant women	18	83	93	50
Percentage use of ITNs among children under age two	21	94	80	50
Maternal and Newborn Care				
Percentage of women making at least three antenatal care visits	33	60	70	60
Percentage of deliveries attended by skilled birth attendants	45	55	51	60
Percentage of newborns breastfed during the first hour after birth	20	33	60	30
Percentage of women using at least one modern method of Contraception	10	21	20	13

*Note that the KPC final (and most likely MTE) omitted to include home fluids in the calculation. This explains the poor result for this indicator.

2. Results: Technical Approach

a. Project overview

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Interventions: The primary interventions and levels of effort for the THSP are divided as follows: Maternal and Newborn Health – 50%; Nutrition/Exclusive Breastfeeding – 20%; Malaria – 20%; Diarrhea – 10%.

b. Progress report by intervention area

i. Results and Outcomes.

The THSP did well overall. It achieved 12 of a total of 17 project indicators. Only five indicators were not achieved and two of those were very close to the target. The projects undertook a KPC baseline, midterm, and final survey. This allowed them to monitor progress on these indicators through the life of the program. It should be noted that 5 of the 17 indicators stayed more or less the same from the time of the midterm, while 3 others dropped dramatically, rather than progressing after the MTE. For ITN use, this is explained by the fact that it is seasonal so the coverage will change depending on when the survey is conducted. And although health providers interviewed said that they had no supply issues, this might not have been the case everywhere, per the results for ORS, SP, and post delivery Vitamin A. The CDD results are difficult to explain as although the project had limited funding for activities in the second half, IEC/BCC continued to be supported by project supervisors and trained CHWs and TBAs. It is not clear whether or not this reflects poor data collection during one or more of the surveys, or that there was in fact, not much progress made in certain areas during the last couple years of the project.

Nutrition/Micronutrients: The project did very well on its Nutrition/Micronutrients indicators. Three of four indicators were achieved, and the fourth came close to being achieved. This includes exclusive breast-feeding (88% as compared to the 60% target); Vitamin A coverage for postnatal mothers (59%, close to the 60% target); Vitamin A coverage for six to 59-month-olds (100%, far surpassing the 80% target) and the percentage of households using iodized salt (83%, again surpassing the 70% target). These final evaluation results showed a marked improvement from the time of the baseline KPC, as can be seen in the table above.

Control of Diarrhea: The project did not do as well in for the control of diarrhea. Of the five indicators identified by the project, only two achieved their targets; a third was fairly close. The project did exceptionally well as it relates to hand washing with soap, reaching a high 78% from a low 7% (the target was 50%). This is an indicator that many CS projects in Africa have not been doing so well in. When it came to the percentage of mothers who recognized signs of diarrhea that required treatment, they achieved 73%, compared to the baseline 43%, and 70% target. But remarkably enough, this was an indicator that had reached a high 87% at the time of the MTE. So this leaves an unanswered question. With regard to the use ORS and/or recommended home fluids, the project only reached 27% at the final, falling short of the 65% target. Again, this is explained by the omission during the final (and likely MTE) KPC to include home fluids in this calculation. The baseline was a high 52%, which includes both ORS and home fluids. With regards to children being offered more liquids during episodes of diarrhea, the project went from 48% at the baseline to 58% at the final. But it fell a little short of the 60% target. In the area of feeding during episodes of diarrhea the project did not make any progress from the baseline 48% at all. The final was also 48%; short of the 60% targeted.

The reduced use of ORS or recommended home remedies is difficult to explain because even with the lack of ORS packets at the community level (due to the fact that stocks don't move fast, there is a reluctance to purchase them), home remedies are always available to the household. There is the possibility though, that with the reduced severity of diarrhea cases as reported by mothers in project communities, and concurrent increased access to health huts and community-based distribution of medicines, children do not have diarrhea for prolonged periods of time, and they also receive antibiotic treatment very quickly (care seeking has reportedly increased dramatically). These two factors could influence mothers not to expend a lot of effort on the preparation of home remedies. Certainly, per the data, they have been increasing the consumption of fluids during diarrhea episodes, if not ORS.

Malaria Control: The Tambacounda Child survival project did very well in the malaria component. They succeeded in achieving all of the objectives, including a dramatic increase in IPT coverage, which went from an extremely low 2% coverage at the start of the project, and went to 79%. Recognition of danger signs requiring treatment within 24 hours went from 48% to 62%; and the percentage of pregnant women and children under two sleeping under insecticide treated nets increased from 18 to 93% and 21 to 80% respectively. All project targets were met and surpassed by large margins, with the

exception of recognition of danger signs, whose target was close to what the project achieved (60% target, with 62% achieved). The decreased percentage of children under two years of age sleeping under nets from 94% at the time of the MTE, to 80% of the final is explained by the fact that the use of these nets is seasonal (dependent on the strong presence of mosquitoes during the rainy season). The use of nets decreases during the dry season, reflected in the above difference. The project also reached very high IPT coverage at the MTE (89%), which they did not maintain at the final (79%). This is something that is hard to explain as SP is provided free of charge and providers say that in general they have not had stock out problems.

Maternal and Newborn Care: The project achieved 3 out of 4 indicators under the maternal and newborn care component. There was a dramatic increase in the number of women making at least three antenatal care visits. This went from 33% at baseline to 70% at the final, surpassing the 60% target. The number of newborns breast-fed during the first hour after birth went from 20% to 60%, also surpassing the 30% target by a large margin. The percentage of women using a method of contraception went from 10% at the baseline to 20% at the final. Although the project reportedly did not end up expending a good amount of effort towards the achievement of this indicator, they did surpass the target 13%. The only indicator not achieved, is that of deliveries attended by skilled birth attendants. This was 45% at the time of the baseline, and went up to 51% at the final. The latter did not meet the project target of 60%. The majority of deliveries in rural Senegal are attended by TBAs who have been trained by the project and the MOH. Because of distances, an effort to go to the health post is made only in the case of complications

ii. Factors affecting achievement

The community capacity building and community mobilization approach of the project, and the resulting community ownership, participation and organization around maternal and child health, were clearly the biggest factors influencing the achievement of project objectives. Per interviews conducted in a sample of the project communities, community-based health education activities and home visits were regularly conducted by community health workers and traditional midwives. The successful organization and mobilization of womens associations generally present in each village, into smaller Care groups (neighborhood or otherwise), enabled and facilitated the prior-mentioned, and provided a peer support and mentoring mechanism for continued learning, exchange and behavior change in targeted child survival areas. Thus the presence of trained CHWs and TBAs, the development of community-based distribution system, the support of health huts in some cases, and the identification and support of village health committees, all provided an enabling environment for the THSP to achieve good results. As previously mentioned for the most part, where project indicators did not achieve the targets such as was the case with the control of diarrhea, it is not altogether clear why this happened. The major problem seems to have been in the area of diarrhea case management in the home, as well as recognition of signs of diarrhea. It is difficult to know if this is due to the fact that health behaviors are not always consistent, and mothers may forget health information

and good practices if they don't hear the message for a while. This is a surprising though, in a context where care seeking has been improved (both according to the KPC data and qualitative interviews), and CHWs are readily available and in regular communication with the women and the Care groups. The majority of project villages did establish and have functioning Care groups.

iii. Main Successes and Lessons Learned

Successes

- The strong collaboration of the project with the Ministry of Health in the implementation of its bi-annual child survival activities and NIDs strengthened the outcome of the Vitamin A coverage (and systematic de-worming) in the project area. The provision of Vitamin A by UNICEF, the logistical and financial support of the THSP, and community participation to mobilize target groups contributed to the success of this activity.
- The successful adoption of the Maternal Care Group strategy, which organizes women and women's associations into medium-size support groups, facilitated a peer support and mentoring mechanism for increased knowledge and behavior change in the project intervention areas, most notably maternal health. This strategy also contributed to increased access to MCH services as members were asked to make monthly contributions towards the development of an emergency fund available for members to borrow in times of need.
- The capacity building and mobilization of community resource persons (CHWs and TBAs) was extremely successful under the THSP due to the fact that the project supervisors provided consistent support and encouragement to the latter, and that these individuals are stable community members who are very happy and proud of the important service that they are able to provide to their communities.
- The establishment of a referral and counter referral system between community resource persons and the health post has been a great success, and is something that is looked upon very positively by both the health post nurses in charge as well as clients at the community level. Clients who have been referred by the CHW to the health posts are given priority by the head nurse. A counter referral is sent back with the client and enables the community health worker to follow up on the case and provide any support needed in terms of instructions regarding the medication or treatment. With this system, the CHW is also able to ensure that the client does not miss the next appointment.
- The project support for and implementation of quarterly coordination meetings at each health post with the participation of approximately 20 CHWs from the catchment area was very successful in strengthening linkages between community volunteers and the MOH health system. These coordination meetings served as forum for reporting and information exchange, data analysis, joint planning and

decision-making. All of this supported the continued capacity building of community health workers, helped to motivate them and improve community-based activities, including health hut and CBD services.

- A performance by some local actors in the project village of Koussanar, led the THSP to encourage them to develop a Theatre Troupe. The project provided them with training in the key child survival areas (mainly maternal health and malaria control), and this troupe traveled and performed across the program area. The performances given by this talented group of actors is said to have had a strong impact; which included getting male involvement, stimulating and encouraging dialogue and communication in the household, as well as educating and sensitizing large groups of community audiences around the importance of key health practices, behaviors and attitudes. The Koussanar Theatre Troupe has attracted the attention of other NGOs and is also a resource for other projects across the region of Tambacounda.
- Community hygiene and sanitation days are activities that communities across the program area speak about. These initiatives were encouraged by THSP supervisors and have really taken off. The hygiene and sanitation days typically mobilize all community members once a week for a few hours, and includes clearing up animal droppings, cutting brush and tall grass growing close to households, removing stagnant water, maintaining cleanliness around wells (including keeping the animals away), and general cleanup within the community and households. Community members say that this has greatly contributed to reducing malaria-causing mosquitoes and unhygienic conditions leading to food and waterborne diseases.
- The ability of Africare to leverage funding for additional programming in Tambacounda, very much contributed to the success of the child survival project in that it provided complementary and matching funds for acute respiratory infection and malaria programs (which supported the C-IMCI approach). Via different funding, Africare was able to hire additional program supervisors as well as support community-based distribution of drugs, including ACT and cotrimoxazole.

Lessons Learned

- The positive community response to special community behavior change communication days implemented with loudspeakers, skilled educators and facilitators or the theatre troupe makes it important to prioritize these activities when planning community health programming, because the potential impact and influence is often more notable than community response to routine health education sessions conducted by volunteers who do not always have the level of skill and expertise to facilitate discussion and dialogue. CHWs are not always able to provide stimulating and entertaining activities that draw interest and attention.

- The project's focus for capacity building was essentially CHWs, who received manuals that served as reference material to help them in their volunteer work. Although village health committees were not trained in the health areas, and key messages, staff subsequently realized that providing them with a copy of the manual changed their attitudes with regards to their participation and support of these volunteers. Many had not been actively involved because they felt that they did not know the content. This changed after they received their own copy of the manual.

iv. Special outcomes, unexpected successes, constraints.

The project had to deal with the number of constraints. The most notable of these was the THSP budget which was exacerbated by 1) the devaluation of the US dollar from approximately 700 Central African Franc at the time of the original proposal budget (650 at the time of the DIP), to as low as 400 CFA per US dollar during the last year or two of the program. As the source of the project funding was coming in US dollars, converting that into CFA for project implementation meant that Africare had in fact, much less money for project implementation than originally envisaged. Although at the time of the proposal design, Africare expected the project to cover the entire district of Tambacounda (including 400 plus villages), it was clear at project start-up that this was not realistic considering the extensive geographical area that made up the eventual three districts (up to 162 km from the regional capitol to the furthest village of Kanouma in Maka district, with terrible road conditions). The team had to modify this and dramatically reduce their coverage, bringing it down to approximately 150 villages.

An additional complication that presented itself during the first year of the project was the subdivision of the Tambacounda district into two, and subsequently three districts. This meant that the project needed to work and collaborate with two additional district teams; teams that were in development, and only getting established well into the life of the program.

v. Application of lessons learned to future activities.

Although the project is not continuing, Africare continues to implement community health programming in Senegal. The lessons learned and experiences (along with the transfer of THSP staff to new projects) will benefit other Africare and collaborating NGO programming.

vi. Potential for scale-up/expansion

Africare has been the biggest community-based partner in the Tambacounda, Koumpendoum and Maka districts. Africare is currently involved in the implementation of the President Malaria Program (PMI) and networking for additional funding.

According to interviews with the Africare leadership, additional funding would be used for ‘graduating’ communities where activities are well-established, and scaling up to expand program impact in new intervention areas within the existing partner districts, and potentially in other districts of the Tambacounda region.

c. New tools/approaches

Amongst the tools that the project developed were reporting forms to be used by the community health worker, traditional birth attendant, the health hut aide, and the village health committee. In addition to this the project encouraged each health hut to maintain simple registers to record daily activities, along with an IEC book to document the number of health education sessions and home visits undertaken. Some health huts displayed monthly activity calendars as well; also something that was supported by the project. Last, but certainly not least, was THSP’s support of two-sided referral forms to be used by CHWs for referral, and health post nurses for counter referral.

Based on the various interviews conducted during the final evaluation activity, it is clear that the referral forms are extremely popular. This mechanism has strengthened the linkages between the community health worker and the health post; providing the CHWs with a clear support system, and increasing client satisfaction with the care and services that they receive. The health providers have been more than happy to work with CHWs on this. When clients are referred by the latter they are usually given priority, and this is very encouraging to the CHW and the clients. This referral system is something that they expect to continue after the end of the project. They did not see that it would be a problem to use a piece of paper if they run out of referral forms at any given point in time.

Unfortunately, when it comes to the community-based health information data forms mentioned above, although reports continue to be produced by the aforementioned community resource persons, it is doubtful that these tools can be maintained without the continued support of the project. These forms are quite extensive (consisting of 3 to 4 pages for each type of community volunteer) and just making these forms available at the community level will be an issue - not to speak of the data collection, which during the life of the program was being conducted by Africare with copies given to the health post. The community based HIS is not a part of the health information collected and reported on in the MOH health system. Thus currently, there is nothing to drive the health post nurses to collect and use that information.

3. Results: Cross-cutting approaches

a. Community Mobilization

i. Effectiveness of CM approach

The strategy for community mobilization undertaken by Africare in the THSP was extremely effective. This included an approach that has been tried and true (albeit with

its problems, as it relates to sustainability): the mobilization and capacity building of community health workers or *relais*, and the organization of village health committees. The buy-in demonstrated by the number of activities being undertaken at the community level, and the frequent contact and close relationship between these individuals and mothers in the community speak to the success of this CM activity. The village health committee role tends to revolve around the management of health huts (including revenues and drug purchases), and CBD activities in some communities where there are no health huts. These committees have each identified a president, treasurer and secretary, and for the most part, as reported during the evaluation interviews, meet on a regular basis and take their job quite seriously.

An innovative community mobilization approach used by the project, and mentioned earlier in the report, is that of establishing Maternal Care groups. This approach was initially piloted in an earlier Africare program, and was refined and implemented in the Tambacounda child survival project. The Care group strategy was very effective because it gave women concrete ideas about how to support each other, and learn and improve their health coverage through their participation in the group. Most of the 150 THSP villages did go ahead and develop two to four Care groups consisting of approximately 25 women either living in the same neighborhood or with another type of association. (333 Care groups were established and approximately 277 are functional). The main objective of these organizations was to be able to pool financial resources, and develop a group fund that would be available to any member with a health emergency or health cost on loan. This idea gave women a very strong motive and incentive to participate in the Maternal Care group. Bringing groups of women together in this manner was also an opportunity for women to give each other support through pregnancy, delivery and infant care. Some groups even initiated a ‘godmother’ practice whereby a more experienced older woman would be paired up with a newly pregnant woman to be able to provide her with special support and attention during this period.

ii. Achievement of CM objectives

Although the THSP community mobilization approach and activities saw great success, when referring to the DIP work plan, there were several objectives that were not achieved. At the time of the midterm, Africare re-evaluated their capacity, and realized that they had to reduce their coverage and expectations. The project came down from an original 400 plus communities, to approximately 150 of the most populated and most inaccessible communities (as identified by health post nurses). With this change, also came the reduction of the number of CHWs and TBAs to be trained. These numbers were reduced from the original 400 and 200 to 311 and 53 respectively. But on the positive side, the project was able to get the communities to identify reliable CHWs (many of whom had been *relais* in these communities for a long time, but had been left without continued support and training) and obviously dedicated TBAs, already serving their communities. The health hut aides collaborating with the project were also found to be very dedicated individuals who were well-respected in the communities. The latter also received training from the project and make up part of the 311 total CHWs collaborating

with the project. A total of 191 and 120 of these community resource persons were trained in C-IMCI and maternal health respectively, and the project was able to procure 83 hygiene kits for safe and clean births (53 of which were distributed to the 53 trained TBAs) and the rest will be provided to the districts for future needs. The division of labor (child health and maternal health) is a strategy that has made it possible for CHWs to master health information and key messages in one of the two areas, enabled them to be more focused and have greater impact.

When it came to the training of village health committees, project resources became a problem. Only 18 of approximately 150 village health committees formed were able to participate in a formal training activity. The other health committees had to receive on-the-job support from the project supervisor. Most of the health committees felt that this was inadequate, and are still hoping that they will benefit from a special training one day. Again based on the DIP work plan, several of the other activities that the project was not able to implement include the distribution of iron to pregnant women at the household level and the procurement of an initial stock of iron and Vitamin A for the community level. It should be noted that there are some very valid reasons for which some of the latter CM objectives were not implemented. When it came to the distribution of iron at the household level, it no longer made sense as CHWs pushed women to attend the ANC clinics at the health post. They could thus receive their supply of iron from there and also be checked for anemia and provided with higher doses of IFA to treat this. Per the MOH policy, mothers were also encouraged to deliver in health facilities and to seek postnatal care after delivery. These are two opportunities for postpartum women to receive Vitamin A. But nevertheless, since many women are still delivering at home because of the issue of access, it would have been ideal for the project to encourage its partners to support the administration of Vitamin A at the community level by TBAs assisting with home deliveries.

With complementary and match funding (shown in a table in the Financial Management section of the report), the project was able to implement several different community based activities. But due to the cost and efforts required, these were not able to be implemented across all 150 project communities, e.g. they initiated growth monitoring activities in 27 communities; CBD initiatives (not linked to the existence of a health hut) were started in 40 communities; the community-based malaria program funded by the PMI was initiated in 37 villages (the criteria being that this activity needed the presence of a health hut); Nutrition Hearth activities were initiated in two pilot villages; and the ARI project activities were implemented in 28 health huts.

It is important to note that the THSP also benefited from the support of five Peace Corps volunteers (PCVs). They were spread across two of the three project districts: three in Tambacounda, and two in Koumpentoum. A total of nine project villages received the support of these volunteers who collaborated with the project, received project training, participated in health post coordination meetings etc. The PCVs provided substantial support with community health education and training activities, as well as mobilizing community members for routine vaccination, hygiene and sanitation days, and child survival campaigns, among other things.

Among the community mobilization activities undertaken in this project was also a small effort to link with traditional healers. The project organized a one-day workshop, and working with the leadership of the Association of Traditional Healers based in the district of Tambacounda, they were able to organize for the invitation of important traditional healers in the program area. The workshop included the participation of 37 THs and 245 community leaders. It gave the project an opportunity to advocate for increased collaboration with the THs, have a dialogue around early treatment and care-seeking for malaria in particular, and educate participants on danger signs and the importance of referral.

iii. Lessons learned

A lesson learned in recognizing program limitations when one has a very tight budget and other important components (such as the maternal and neonatal health) came when the THSP attempted to undertake community mobilization for nutrition Health activities. This activity did not take off, as although preparations for this activity were undertaken with women and community members in two pilot villages, the project did not have the resources to proceed. Thus the project ended up in a position of raising community expectations and not following through.

iv. Community demand

Community demand for health services, and support by CHWs has clearly been established by the child survival project. Women both in the Care groups and those who are not part of a Care group interviewed during the final evaluation visits, spoke about the fact that they more actively seek advice and services now than they did before because of the trained CHWs, and the referral system established with the health posts. They spoke about disease prevention and consultation during pregnancy. During visits, it was clear that women in communities are close to the trained TBA, and view the project trained volunteers as important resource persons. Women interviewed reported having attended health education sessions, and village chiefs and the health committees also spoke about how important these activities are to them as community leaders. Based on the interviews conducted at the community level, there is unanimous agreement that the THSP-initiated activities are very much appreciated. Participating communities have seen great benefits and as a consequence they expect to continue putting their knowledge to practice.

The project had various ways of measuring this community demand. The primary evidence can be seen through a review of the community-based health information being collected and report on by the community resource persons. The data from the community includes references for antenatal care, delivery, postnatal care, and danger signs during pregnancy, the post partum period, and childhood illness amongst other things. In addition, as mentioned above, the community health workers also report the number of health education sessions and home visits that they have conducted. This enables the project supervisors to monitor the level of community mobilization both in terms of volunteer motivation and community interests. Both staff and community

partners interviewed confirmed that community demand has been well established, with reduced activities only visible during the planting and harvest period when everyone is very busy in the fields.

v. Plans for sustaining activities

The project design was based on increasing community capacity and mobilizing communities to take more ownership and responsibility for health. Again the project went beyond the traditional strategy of training community health workers and village health committees, to encouraging women to also participate in the management of their own health and organizing themselves into support or 'Care groups'. The THSP also saw the need to strengthen the linkages between these project communities and the health structure in place. This began by working in close collaboration with the MOH at the district level, and included the orientation (and Training of Trainers), planning and implementation of training activities. The first group of individuals to be trained was the health post nurses. Health post nurses subsequently worked with project supervisors to take on the training of the aforementioned community resource persons. These project-supported training activities helped to establish the relationship between the community level and the health post level. To strengthen this relationship, the project subsequently initiated health post level quarterly coordination meetings whereby the approximately 20 CHWs working in each health post catchment area were able to meet, share and discuss community health activities, and plan together. And as has already been discussed, the project also established a very successful referral and counter referral system. With these at committees, the THSP paved the way for community-based activities to be sustained.

But although many CHWs may continue to be motivated because of their status in the community, and are likely to remain resource persons to mothers seeking health advice and referrals to the health post. Based on the final evaluation interviews, it is clear that certain aspects of what was put in place by THSP will not be sustained. Examples of this include the quarterly coordination meetings held at the health posts, and the relatively extensive reporting currently being done by community health workers. Both of these activities require financial support; something that could eventually come from the health committees managing the health posts, but is not currently envisaged. The evaluation visits in project villages confirm the fact that CHWs see these as Africare reports and not reports that could be transferred to the health posts. This is also related to the fact that the MOH does not currently collect and report on community-based health information, and when health providers are in villages for vaccination or other committees they generally have a lot to do, and do not ask to see the community data, reports or register kept by the health huts.

The collaboration between the community volunteers and the health posts is established however, and health post nurses interviewed report that the capacity building of CHWs has made their work easier, has enabled them to increase their coverage, they have seen the increased use of services, and are very happy with what they consider to be the very positive impact of the THSP.

Any potential sustainability planning activities that the project could have undertaken in its last year were not able to come to fruition due to the fact that the USAID Washington funding ran out by the end of Year four, in a five-year project. It is in fact to Africare's credit that they were able to bring in a reserve of funding to continue to pay project staff and support essential activities through half of Year five of the project.

Although the project experienced a serious handicap as it relates to the development and implementation of a sustainability plan, the Africare leadership and national program team is dedicated to continuing its efforts at resource mobilization. They hope to be able to continue to support community health in the region of Tambacounda in the years to come.

b. Communication for Behavior Change

i. Effectiveness of BCC approach

The behavior change communication approach used by the project was clearly effective, as can be seen through the achievement of the majority of project indicators discussed previously in the report. Focus group discussions with women in various communities selected during the final evaluation revealed that there is a good level of knowledge of key health messages, as well as good health practices taking hold. Again, as discussed above, the capacity building of community resource persons was effective in that these individuals, as confirmed by community women interviewed, were very accessible to women and families in the community. CHWs and TBAs tended to organize health education sessions and discussions once a week, or two to three times a month with the different Care groups. Some of the CHWs, and certainly all of the TBAs, conducted home visits as well. So according to the sources, there was frequent contact between these volunteers and community members. The traditional birth attendants were found to have very close relationships with mothers, and with the Care group; thus increasing their capacity and knowledge, and improving their skills was certainly a worthwhile BCC approach to use. In fact, the latter were very happy to be collaborating and referring cases to the health post level, despite the fact that most women not residing close to a health post continue to prefer home deliveries. The availability of health huts in some villages made delivery in a health hut an additional option. But it should be noted that health huts are not typically equipped for delivery and the health system still encourages women to deliver at health posts.

As mentioned before, another effective BCC approach was the development and use of a local theater troupe. The 40 theatre performances undertaken across the program area during 2006 and 2007 proved to be extremely popular and thus very effective in capturing people's attention, promoting dialogue and discussion and most notably, getting male involvement. The project also managed to organize special BCC/community mobilization events. This came about as a result of the fact that some communities did not seem to be progressing as well as others???? (per community data collected). Community response to special BCC activities was very positive and according to program staff, being able to implement these activities was an extra boost in promoting

behavior change. People found these special activities stimulating, entertaining, and a nice addition to the routine health education sessions implemented by CHWs. The project was able to implement a total of 70 of these social mobilization activities; 45 community talk shows with the use of loudspeakers; and 15 radio programs, in addition to supporting the districts with biannual child survival campaigns, and initiating the development of community hygiene and sanitation days.

Another BCC tool used by the project that is important to mention is a game called the *Wure, Wer, Werle* (W3). W3 is a communication strategy for behavior change that was developed by the Maternal Health/Family Planning Project in Thies, Senegal, and funded by USAID. The W3 game is based on a traditional game called *Wure* in Wolof, and is used specifically for maternal health as a learning tool to increase knowledge and recognition of danger signs and risk factors in pregnancy and the postpartum period, and what to do. The game, consisting of 81 cards highlighting the above, was developed for low literacy audiences and has reportedly been very successful as it is entertaining and competitive. Thirty eight communities were trained in the W3 card game. Staff report that they only purchased and distributed 10 games. The W3 card game is rather expensive (31,750 CFA or US\$79).

ii. BCC objectives

Specific BCC indicators were discussed under the results section. Again the project did very well in the area of behavior change for maternal and newborn care, the control of malaria and nutrition/micronutrients interventions. Per the KPC, they did not do so well with the control of diarrhea behavior change indicators. With respect to the general objectives of the BCC strategy, the project did very well. The efforts undertaken by trained CHWs and TBAs with the support of project supervisors, focused on establishing an enabling environment whereby good health practices could be seen as a social norm; supported by both older and younger women through the Care group, men, community leaders and representatives in the village health committee, as well as community volunteers.

The success of this effort was very clear during final evaluation visits to some sample project communities in the three target districts. Village chiefs interviewed were very aware of project activities and had, for the most part, had periodic contact with project supervisors, and participated in important community meetings related to health activities. Village health committee members spoke about how the project had brought about improvements in their community: be it that women and children had better access to advice and health care; that they now had drugs available in the community; pregnant women and children had received insecticide treated nets; the community is cleaner as a result of hygiene and sanitation days; and/or women have a savings fund which they can use in times of need or emergencies.

Mothers interviewed (both members of Care groups and non members) spoke about how they are experiencing less cases of malaria and diarrhea as a result of putting to practice the health information that they have learned through the project. They spoke about hand

washing with soap, and hygiene with food and utensils as behaviors that help to keep their children free from illness. With regard to health practices, as a general rule it was found that community members do not sleep under ITNs during the dry season when there are fewer mosquitoes. When asked if this was the advice that they received from the CHWs, they said no. But mothers did insist that all pregnant women and young children sleep under nets year-round. Another area that came out as a challenge (this from health providers) is that women still do not tend to go for antenatal care (ANC) checkups early in the pregnancy. A big effort by the TBAs and CHWs has been put into encouraging women to attend prenatal care so that they can receive iron folic acid, intermittent malaria treatment, check on their general condition, identify cases that might be high risk, and begin planning and preparing for delivery. A few Care groups have reportedly taken the initiative of finding ways to help members communicate that they are pregnant. For example, a pregnant woman will wear an earring only in one ear for a certain period of time as a way of letting the other women know that she is pregnant. In another group, a pregnant woman will wear a certain color dress in order to make this announcement. Some groups have developed a 'godmother' strategy so that pregnant women get the support they need, and everyone can be sure that she is attending prenatal care, etc. But many groups interviewed said that women in the group do not tend to tell them that they are pregnant. They can usually tell over time, based on physical changes taking place.

Achieving assisted delivery by a qualified MOH provider continues to be a challenge, as can be seen by the fact that the project did not achieve its objective for this indicator. But they did see some improvement, and it is clear that as a result of the project and the organization of women into these groups, there is great awareness of the care that needs to be taken during pregnancy, delivery and post partum period. Based on interviews with mothers and TBAs, one can see that women are ready to follow any advice coming from the TBAs and health workers as well. Health providers attest to the fact that TBAs are very conscientious now, and promptly refer all cases that they are concerned about. Support from men in this regard does not seem to be a problem. Likewise, as a result of the project CM and behavior change communication events, men report that they are very supportive of their wives participation in health activities and encourage good health practices in the household.

iii. Lessons learned

Please refer to previously outlined lesson on the importance of budgeting and organizing for special BCC events.

iv. Sustaining behaviors.

During the life of the program, the THSP established the mechanisms for sustaining behavior change. This, as discussed above, includes the assistance of active community resource persons and functioning peer support groups (the Maternal Care groups). Women interviewed spoke about how if a pregnant group member is not attending prenatal care, they would pressure her to do so. Village health committees spoke with pride about the hygiene and sanitation days that everybody has to participate in. TBAs

and community health workers ensure that pregnant women and children are the ones targeted to receive insecticide treated nets when they are available. One village chief interviewed spoke about how he and his assistant personally ensure that mothers are participating in health education activities and vaccination campaigns. The latter are examples that show that these mechanisms are working.

It is important to note that due to the financial problems encountered by the project, seven of the nine THSP supervisors were transferred out to other Africare project areas at the beginning of February 2008. Based on the fact that the project stopped collecting community health information after November 2007, it is clear that there are many project communities that have not had an Africare presence since the end of 2007. The final evaluation team made a specific effort to visit some of these communities during this July 2008 evaluation. Those visits confirmed that despite the precipitous withdrawal of Africare staff, CHWs are still active and many are still preparing monthly reports even though they have not been collected by anyone. Many mothers interviewed said that now that they have learned new health information and behaviors, it is not possible to go back and do things in the old ways. This included such things as exclusive breast-feeding practices that appear to have been increasing progressively as mothers following the practice remark that their children are healthier. These mothers also serve as examples for women preparing for the arrival of a new baby.

v. Measurement of impact

In addition to the midterm and final KPC, the impact of the BBC interventions was measured in two ways. The first way was through the community health information reports coming from CHWs. As was previously mentioned, these reports showed progress and trends in terms of clinic attendance, referrals and care seeking behavior. The other way in which the project was able to evaluate the success of the BCC activities is the fact that community members, and leaders and volunteers were responsive. They actively participated and led program activities, including such strategies as the Care group. These activities are documented in the IEC books and reported by project supervisors every month.

c. Capacity Building Approach

i. Strengthening the Grantee Organization

Africare as an organization has had extensive experience with the child survival program. But with staff turnover over the years, the more recent technical backstop persons working with the child survival grants program for the first time have had the opportunity to gain capacity in health and child survival through their participation in the THSP. Headquarters participated in the DIP development, the development of annual reports and attending CORE group workshops and meetings. The Africare Senegal team that helped with the design and development of this project did have prior experience with community health programming. But this grant was certainly an opportunity for them to

strengthen their experience in child survival and health, and to develop a much larger team of people with strong capability in CS program implementation. As a result of their experience, Africare Senegal was well-positioned to get President's Malaria Initiative (PMI), and Pfizer Foundation funding for Acute Respiratory Infection activities. The THSP has greatly contributed to Africare Senegal's portfolio and established capacity in community health. The country office is making the most of the expertise that they have developed, by using staff from the Tambacounda child survival project for new projects. Thus staff who developed strong skills have been transferred to new programs and continue to support program design and development as funding opportunities present themselves. With the completion of the MTE and the FE, Africare program staff has been able to, and will continue to take the lessons and experiences to new programming. Examples of positive experiences in the THSP that will be replicated in new programming includes the women's Care groups, the theater troupe strategy, communication events to the degree that funding allows this, and project support of coordination meetings that bring in CHWs to share, discuss, and plan with health posts.

ii. Strengthening Local Partner Organizations

It is important to note that the focus of the THSP was on the strengthening of community-based capacity. District partner strengthening and health facility strengthening were not focus areas in this project. So the project did not conduct any assessments of the organizational capacity of the local partners. They did, however, work with the district health teams as well as health facility staff in the planning, orientation, preparation and implementation of training activities. As such, the MOH partner at these two levels did benefit from technical capacity building. Eight district team members participated in TOTs, and subsequently 35 health post nurses received training at the beginning of the project. These, in turn, assisted project supervisors with the training of community health workers and TBAs. The training organized by the project included basic emergency obstetric and neonatal care, maternal health, contraceptive technology, and C-IMCI. It is important to mention though, that there was a misconception of the project by the health districts who, right from the start, expected that some funding would be allocated to the procurement of ambulances and other material to support the districts and health centers. This caused some discussion and frustration on their part.

The project contributed to the development of two training modules: one for maternal health and one for communication. Other contributions from the CSP that can be used by the local partners in the future include a guide for growth monitoring that was adapted by the project, and reporting tools for community volunteers to use in the collection of community health information. The project has also produced a guide for the development of Maternal Care Groups for use by local partners and stakeholders.

District health staff interviewed view the greatest impact of the project as being the capacity building of community resource persons; as was the project's intention. They recognized that the project has played a very strong role in revitalizing the CHW role in Tambacounda, Koumpendoum and Maka districts, and establishing linkages with the

health post level. The health post staff interviewed were very enthusiastic about the project's efforts. They emphasized that through their partnership with the project, they have been able to work very closely with CHWs. Head nurses report that the project has made a big difference in terms of increasing community capacity and that with this new team of community volunteers, health posts are able to do a lot more in the way of population coverage and service provision than they were before.

As highlighted above, the major capacity building efforts, and subsequent changes in capacity as a result of this project are with the community partner. The project focused on community organization for health, beginning with the development of village health committees, which were non-existent in Tambacounda at the time of the project design and start-up. Unfortunately, as discussed previously, the THSP did not end up having enough funding to provide formal training to most of the village health committees that they helped to establish (only 18 out of 150 participate in a formal training). But these structures are in place now, and interviews during the final evaluation process revealed that for the most part, these community leaders have a commitment to supporting health and development activities in the community. A total of 36 health huts managed by community volunteers across the project area also received the support of the THSP. This included 24 in the Tambacounda district, 6 in Koupendoum, and 6 in Maka. In addition to this, CHWs have been revitalized and are taking the lead in the implementation of education and information activities. With the training of TBAs as well, these valuable resource persons have gained added respects, and are working very closely with the health system. And again, to highlight what the project has become most popular for: the 'best practice' Maternal Care Group strategy has very clearly led to the organization of women, and their increased capacity to take responsibility for their health and that of their young infants and children.

Lesson learned:

One challenge the project encountered was the fact that although they were working to strengthen community capacity and participation in health, the local government partners at the district level also expected the project to support the districts. In the context of limited funding and the necessity to prioritize, Africare learned that to the degree that NGOs can mobilize other donors and partners to complement their own efforts, i.e. provide support where they cannot, government partners become more receptive to their efforts at the other levels.

iii. Health Facilities Strengthening

The THSP did not specifically target the improved management and services of health facilities. As previously mentioned, they worked with the districts and health providers to strengthen community-based capacity, and establish linkages between the health posts and the community in order to increase access to services. Nevertheless, the training of health providers in IMCI was an opportunity for them to improve their skills in case management. So one can assume that there was some benefit as it relates to improving

services. Again 35 health post nurses participated in project training. In total, 19 health posts collaborated with the project including 11 out of 13 health posts in the Tambacounda district; 4 out of 8 in the Koupendoum district; and 4 out of 6 in the Maka district.

One could argue too that the strengthened linkages resulting first from the health posts nurses participation in the training of CHWs and TBAs, and secondly from the implementation of health posts level coordination meetings, has also contributed to improved services. As reported by both CHWs and health posts nurses, when a client comes in with a reference from the CHW, they are given priority. Clients are very happy with this new system, and once they have a referral form in hand, they say that are given immediate attention and special treatment. Clients are being referred for ANC, delivery, postnatal care, and signs and symptoms of serious illness (per the C-IMCI training). Health post nurses interviewed said that there is more use of services as a result of the capacity building and developing the linkages with the community level. Service providers are also better able to reach their targets in terms of vaccination coverage as well, because they now collaborate very closely with CHWs in terms of planning for these outreach and/or campaign activities (CHWs mobilize communities and ensure that those in the target group, or due for immunizations are present).

One health provider interviewed discussed the fact that the mobilization of CHWs was something that he valued greatly and he continued benefiting from their services. He felt it was important to conduct weekly trainings for them at his health post. In this particular case, the provider has taken the initiative to continue strengthening this relationship and maximize the impact of the collaboration with community volunteers. As he is based in urban Tambacounda, transportation and distance from communities may not be such an issue. When asked, he did admit that most of his colleagues across the THSP Tambacounda district have not followed his example. And without budgetary support to cover transportation and food costs of CHWs coming in for such activities, he admits that this will always be a challenge.

iv. Training

The training strategy used by the project was very effective. They used a cascade approach, beginning with TOTs of the district health team, training of the health post nurses, and subsequently the training of the target group, i.e. community resource persons, by the health posts. As mentioned before, the project had expected to train a larger number of CHWs and TBAs than they ended up doing. This was due to a reduction in the intervention area from the original 400 plus villages to 150.

Based on meetings at the community level, there is a lot of evidence that suggests that the training resulted in new activities and increased knowledge and skills of the trainees. CHWs and TBAs spoke about how happy and proud they are to have participated in the project training. They said that the training helped them provide health advice and information to mothers in the community (mainly through education sessions and home

visits). As a result of the training and subsequent quarterly coordination meetings with the health posts, these community-based volunteers now have a direct relationship with health post nurses. This new relationship has greatly facilitated CHWs knowledge of health post services, and awareness when it comes to referrals for those services, and when they need to refer.

When mothers were asked about their knowledge and practices related to the health intervention areas of the project, they were able to speak of this new knowledge and practices obtained from the CHWs and TBAs. Thus this confirmed that the new knowledge and information acquired by CHWs and TBAs has been transferred to mothers.

Although not unexpected, the strategy the project used (cascade training within the health system so that's health post nurses were responsible for the training of community level workers) was extremely effective and helped to establish the relationship between health posts and the communities in Tambacounda.

For plans on sustaining training activities please refer to previous discussion highlighting that the majority of health post nurses have not taken the initiative to continue the training of CHWs and TBAs. Continuing capacity building through the health post coordination meetings will also be a problem once these meetings are not financed by the project.

d. Sustainability Strategy

Although the THSP did not specifically list sustainability goals and objectives in the DIP, the program capacity building approach was aimed at achieving sustainable improved health, access and community-based services. Based on observations during the final evaluation reports coming from communities, it is clear that the project did indeed achieve their capacity building objectives and there are very positive indications that basic capacity and services will be sustained. As previously mentioned, CHWs and TBAs who have not been in contact with project staff in several months still appear to be quite active and clearly continue to be resource persons to mothers and the community. The Care group approach has also facilitated the sustainability of improved health practices and care seeking behavior.

The project did not develop a sustainability plan (largely due to the fact that they ran out of money in Year 4 of the project). But encouraging the Care groups to collect and save money which would then be available to members for maternal and other emergencies, linking them with micro-finance associations such as the Credit Fund of Senegal, and establishing and strengthening the linkages with the health posts through the training strategy and coordination meetings are all strategies that have contributed to sustainability. Africare is making efforts to identify new funding. Continuing technical and management assistance is dependent on the success of this endeavor. Africare continues to work in Tambacounda, but the new project is limited to malaria control.

An activity that the project expected to be key to the success of the Care groups was to support them with a micro-finance initiative that would assist groups in generating income, and most importantly to address issues of access with regard to maternal emergencies and evacuation needs. Unfortunately due to various reasons, this complementary effort did not really take off. In the second half of the project though, Africare program staff from the country office did develop guidelines for THSP staff to use to get this component started. One project supervisor with prior experience in the area was able to link 14 Care groups with credit from the above-mentioned institution. Unfortunately, these were the only groups that benefited from this opportunity. Other staff mentioned challenges such as groups not wanting to open a bank account which is a basic requirement prior to obtaining credit; expectation that this credit would come directly from Africare; and that the time required to sensitize and educate community members on these issues limited further achievement when the project started running out of money in Year four. It should be noted that the project was also plagued by delays in budget disbursements from USAID. This periodically delayed the implementation of project activities.

As discussed earlier in the report the project's community capacity building and community mobilization organization strategy built community demand for services. Women are attending ANC, postnatal services, children are getting vaccinated and participating in monitoring, and sick children are being referred. Community resource persons are in regular communication with health service providers and are very engaged. Their dedication to their work has already influence health post nurses to recognize their value and give them credit for the increased use of services that they are seeing and increased coverage. CHWs participating in quarterly coordination meetings engaged in joint planning for outreach and vaccination activities. Their contribution to these activities are key, and it would not be surprising to see health posts open to their suggestions on issues of service delivery.

C. 4. Project Management

1. Planning

Africare Senegal implemented a DIP workshop and ensured that stakeholders within the Tambacounda region and district actively participated in program planning. Although this facilitated the implementation of the program over the years, it should be noted that the teams in Tambacounda and Koumpendoum most particularly, would have liked to see more direct material and other support to the districts. The district team members interviewed mentioned that they had not benefited from support and would have wanted to participate in more joint supervision visits as well. Needless to say, as a community-based capacity building project, it would have been difficult for the CS project to dedicate more resources to capacity and institution building of the Ministry of Health system and structures.

The DIP work plan was practical in that it focused on the most essential capacity building and community mobilization activities in order to begin to see increased knowledge and improved practices. The project also had some great strategies and approaches to stimulate community organization and dialogue around health. One area where Africare could have been more careful though was in the budgeting for this project. In the DIP they grossly underestimated the staff and financial requirements to cover villages in the entire district. It is clear that even if the project had not been afflicted with problems related to the devaluation of the US dollar, they would still have had to deal with the fact that they could not hire enough staff to cover 400 plus villages. Thus the project DIP was too ambitious with regard to geographical coverage.

The obvious gap in the THSP project was the fact that Africare did not outline a clear phase-out plan either at the time of the DIP, or after the MTE. The team was clearly more preoccupied with program implementation; also having gotten off to a late start. They only started to think about planning for sustainability in the last year of the project when there was not enough money to undertake any major activities. Part of what could have gone into a phase-out plan was advocacy to community stakeholders, health posts and the MOH about sustaining certain key initiatives that the project had put into place.

One important project activity that is expected to be lost as a result of this is the quarterly coordination meetings at the health posts. These meetings have been opportunities to strengthen linkages between communities and health facilities, and they served to continue the education and capacity building of community resource persons. In addition to the latter, these meetings certainly helped to maintain volunteer motivation. In view of the unanimous appreciation that everyone involved has for these meetings, and the unquestionable added value and contribution that this activity brought to the project, it would have made sense for the project to advocate for the continuation of these meetings beyond the life of the project. Health posts health committees and village health committees consist of community representatives who generally have a small budget available to them. This comes from health service fees and drugs. These committees can also fund-raise when the need arises. Thus it is not inconceivable that these stakeholders might have agreed to do whatever they can to support these quarterly meetings. But this question was never put to them.

Other areas where advocacy was needed include: ensuring that the referral system put in place does not disintegrate with, for example, the absence of referral forms once the project is not there to make sure that there is an ample supply of them; and the need for the supervision of CHWs by health posts staff during outreach and other activities.

2. Staff Training

Training provided to project staff was essentially the same training that health post nurses received (they participated in the same training workshops). Thus project staff was able to learn about the health guidance and protocols being followed by the Ministry of Health. This included maternal health, and C-IMCI. Project staff say that these trainings

strengthened their skills in those areas. In addition to this, they report that this job experience has also increased their competence in various other areas. This includes skills in leadership and management of community-based organizations, supervision and organization of community resource persons, problem identification, problem solving. They also added that they now have a lot of experience working under pressure and working with limited resources.

In addition to the above trainings, project staff has a meeting every month which is an opportunity for more orientation in one area or another as needed. All staff was provided with technical guidelines to refer to as they go about the job of supporting community health workers, community mobilization, education, information and communication. The field supervisors interviewed during the final evaluation said that being coupled with health post nurses for their training allowed them to develop some camaraderie of sorts. The latter helped to initiate the good collaboration that exists between project staff and the MOH health structure, and subsequently the extension of this to project communities.

Project supervisors interviewed said that although they received adequate basic training, they would have liked to attend outside trainings and workshops as well. They mentioned that exchange visits to other projects, for example, would have been very useful and interesting to them. At the beginning of the project, the project coordination team did undertake an exchange visit to a Christian Children's Fund area of intervention to have a first look at the implementation of a CSP. Again, with a limited project budget, it is clear that staff development opportunities are going to be limited.

Lessons Learned

Project supervisors, whose entire task revolved around community capacity building, community mobilization, support of community health promotion and strengthening linkages between communities and the MOH health system, found that their task was facilitated when the project organized for their training to be combined with the training of health post nurses who were to be their partners on the ground. This was an excellent strategy to bring together the MOH and project team who needed to work towards the same goal.

3. Supervision of Project Staff

Again, the project was plagued with a limited budget and the fact that it covered a very large geographical area. As a result of this, the senior project staff mentioned that they were not able to supervise each field staff every quarter as they had planned for. But during the supervision visits that they did undertake, they prioritized their efforts on observing what was going on with communities, and whether or not progress was being made, rather than observing the actual competence of the supervisors while they worked. They mentioned that monthly staff meetings with the participation and reports from the field supervisors were also opportunities for supervision in that it gave them a chance to talk about work and to observe their level of competence. Senior staff often visited

communities when the supervisors were not present. This methodology, they said, focused on potential weaknesses and gaps at the community level, which is also a reflection of whether or not the supervisors are doing their job, and in addition to this, allows project staff to monitor where program effort need to go.

Although the district health staff were able to team up with project staff on the few joint supervision visits, these were relatively limited (6 with the Tambacounda district coordinator for maternal health). There is no evidence that the project’s approach for supervision had any influence on the district or anyone else’s supervisory system.

4. Human Resources and Staff Management

Essential personnel policies and procedures of the grantee and partner organizations are in place. The morale of the staff appeared to be relatively good. Working relationships of the project personnel are strong. They report that they enjoyed working together on the project and this had a very positive impact on implementation. Different team members continue to work together on new projects.

The level of staff turnover for the project was very limited. The expatriate project coordinator left the project in early 2007 and was replaced by a national hire. There were no other THSP staff changes, although Africare Senegal did have a change in Country Director in 2007 also, soon after the departure of the project coordinator. As previously mentioned, Africare has already transferred 7 of the project supervisors to other geographical areas to implement new projects activities. They plan to make full use of this very competent project personnel. The remaining two supervisors in Tambacounda are in fact working on the new PMI project. Senior THSP staff is also attached to the new PMI activities, i.e. the Maternal Health and IEC/BCC specialists.

9. Financial Management

Child Survival Matching funds raised by Africare

Project Name	Project Number	Project period	US \$equivalent
Cash Match	26.35.0011	April 2006-july 2006	\$6,479
Community Health Promotion (Japanese funding)	26.35.2301	Oct 2003-March 2005	\$87,030
Acute Respiratory Infection Project (PFIZER funding)	26.35.2304	February 2006-April 2007	\$141,048
Africare Guarantee Fund (Africare unrestricted funds match)	26.35.4507	April 2008 – September 2008	\$64,163
PARINS Nutrition and Health Project (World Bank and GoS)	26.35.5306	August 2003 – June 2006	\$207,760
TOTAL			\$506,480

It is important to note that Africare, most particularly the Senegal country team, was very successful in securing CS matching funds that were relevant and contributed to great synergy and complementarity.

The THSP has an administrator in the Tambacounda field office responsible for all administrative and financial transactions. Project staff develop quarterly budget and submit these to Dakar. The team admits that they have had a lot of problems getting disbursements on a timely basis; sometimes delaying community training and other activities by several months or canceling them altogether, e.g. two sites were identified for Nutrition Hearth activities, but the materials for implementation were never purchased.

Although Africare Senegal has staff in the country office capable and responsible for the financial management of budgets, and a Country Director accountable for project finances and budgeting, this project had to deal with a few issues. The first was related to the devaluation of the US dollar as mentioned above. It went from approximately 700 CFA/\$1 US during the program design, to 400CFA/\$1 in 2008. This left the project with a huge reduction in local currency available for project implementation. It is also important to note that with the start up of this project came a new Africare Senegal Country Director who made the decision to hire an expatriate project coordinator, rather than continue with the recruitment and hire of a national public health doctor as had been foreseen in the THSP budget. In view of the challenges the project was already beginning to grapple with (the implementation of project with a budget too tight for the 5 year duration, and trying to work in a geographical area that was much bigger than its resources), this was not only a bad decision, but clearly an irresponsible one as well. The latter not only contributed to the project running out of money before the end of Year 4, but was totally unnecessary in view of the fact that there is a large pool of qualified, experienced candidates in the country, who also have the necessary language and cultural know-how to manage the sometimes difficult relationships and demands of the regional and district partners.

With the recent change in country leadership, in addition to this recent experience with the devastating effects of the changing value of the US dollar, the country office is now much more careful with budget development and budget management.

Africare and partners have not made any specific plans or put in place resources to finance operations or any project activities (please refer to discussion under sustainability). They are though, working on obtaining follow-on funding to continue to support community health in the Tambacounda region.

10. Logistics

Project staff did mention that the supervision of field supervisors every month was not always able to be undertaken because there was only one vehicle available to the project

in the first couple of years (in addition to the limited budget for supervision). Procurement for the most part, was not an issue because fortunately, the project was not involved in much of this. But as mentioned before, they did experience some delays and cancellations, as was the case with the nutrition Hearth materials and TBA kits. The MOH, along with its partners such as UNICEF, manage to ensure the supply of drugs and micronutrients.

With the project procurement of the Pfizer funding for ARI, Africare was not only able to hire additional staff to benefit the THSP (as all project were integrated into the overall CSP strategy), but they were also able to procure motorbikes for this staff to support field activities. Without this, the THSP would not have been able to cover the 3 health districts.

11. Information Management

The project established an elaborate collection of monthly reporting forms to be used by traditional birth attendants, community health workers, health hut aides and village health committees. This was the system that they used to measure progress towards project objectives. The report forms were collected by project supervisors every month, shared with health post nurses, and analyzed by the project team during their monthly meetings. Although health providers were reportedly very interested in these reports, the data did not go beyond the health post. As has been mentioned, community health information has not yet been integrated into the MOH information system. Africare reports that this is something currently under discussion by NGO stakeholders and the MOH, and will hopefully be changed soon. Again, in the case of the THSP, this data consisted of referrals made from the community level to the health post, including ANC, postnatal care (and Vitamin A supplementation), as well as for danger signs related to maternal health and childhood illnesses.

The community data collected by the project shows an upward trend in referrals and increased referrals for malaria during the rainy season as well. The Community reports concur with reports from health post nurses, i.e. they have seen a big increase in the use of services and referrals as a result of the collaboration with the project-trained CHWs and TBAs. Reports from the community level also reflected the number of activities undertaken by CHWs and TBAs. This enabled project supervisors to monitor the degree of community mobilization. Also included in the reports were Care group activities, including money collected for the emergency fund. Project staff was able to know when Care group's decreased or increased the collections, and when they stopped altogether (as was the case with some groups who were discouraged when they do not benefit from a microfinance activity, or stopped collections because of financial constraints).

In addition to the above, the project conducted the midterm KPC survey which allowed them to see how well they were doing with the project indicators. An example given by project staff of how data was used for decision-making is how the team ended up organizing special IEC/BCC events in communities that were not as active, and where the data was not as good. Another example given is how when the staff realized that they

were not getting data from TBAs because many of them are illiterate, they took steps to ensure that these TBAs received assistance from other people so that the data would not be lost.

The project did not conduct any special assessments to solve problems or test new approaches. As this was not a health system strengthening project, the THSP did not work with the MOH or other data collection system. Per interviews and discussions during the final evaluation, it is clear that participating Africare staff at the different levels, health post and community partners, agree on, and have a clear understanding of what the project has achieved. The project's monitoring and impact data has been shared through reports sent to the USAID mission in-country and shared at Africare headquarters.

12. Technical and Administrative Support

In view of the fact that Africare Senegal already had several years of experience with the implementation of a community health project, and had a public health doctor on staff, they did not see the need to obtain additional external technical assistance. External consultants were only used to help conduct the baseline, midterm, and final KPC surveys as well as the MTE and FE evaluations.

There is no evidence that the project needed assistance that was not available to them in-house. The country program team consists of a Senior Program and MIS officer with extensive experience in program development and management, and the project also received the support of the Admin and Projects Manager as well. The THSP also received support from the first headquarters Technical Advisor with the DIP development, but she did not travel out to the project again during four years of implementation. This was partly due to the budgetary constraints of the project. The main support from headquarters has been with the editing and finalization of the project annual reports. The relatively new HQ advisor who replaced the first one was able to visit the project in November 2007, and returned in July to participate in the final evaluation. She worked with the external consultant and assisted with all the interviews.

13. Mission Collaboration

The FE team's debriefing with the USAID mission in Senegal confirmed the fact that they were aware of the project and very much appreciate Africare's efforts in the Tambacounda region. They did reiterate the fact that the Tambacounda region is not one of USAID's priority regions, but that they are very happy to see NGOs able to expand USAID's reach by covering parts of the country that do not benefit from their direct support. The THSP program goals and activities are very similar to that of the mission's and thus contribute to the strategy for health at the country level. The mission has been receiving Africare, annual reports every year, and has been kept abreast of program achievements through periodic contact. Africare also receives USAID mission-funding for PMI activities in Tambacounda and other regions.

14. Management Lessons Learned

- The biggest lesson learned for the project in terms of budgeting is that for future projects, they have to think in terms of a potential range or upper limit of currency equivalence when budgeting in a currency other than the one that they are using to implement the project (especially US dollar). They need to ensure that budgets have an extra margin so that they can deal with unexpected fluctuations, or depreciations that may occur over the life of a multi-year program.
- In terms of project planning, because of the THSP experience with staff and logistical limitations in terms of geographical coverage, including the initial planning for 400 communities and subsequent reduction to 150, Africare is now better able to gauge how many villages and the geographical coverage projects can realistically cover when considering the budget, staff and distances involved.

For other lessons please refer to previous sections.

Describe how the grantee organization (HQ and field management) will share and internalize these lessons. Nene and country office

C. Conclusions and Recommendations

Main accomplishments

1. Mobilization of 150 communities, most with functioning village health committees, approximately 311 CHWs, 53 TBAs, and 277 Maternal Care Groups.
2. Capacity building of community resource persons;
3. Increased health knowledge and progress in the area behavior change;
4. The development of an efficient referral and counter referral system between the community and health post level;
5. Strengthened linkages between communities and the MOH health structures;
6. Increase use of health services by the populations and the project villages, including ANC, delivery, postnatal care, EPI, and GM.
7. Reduced incidence of malaria, diarrhea, and illness during pregnancy as noted by mothers, community leaders, CHWs and health providers;
8. Project support and collaboration with districts partners for the implementation of child survival campaigns, outreach activities and EPI.

The THSP did well overall with respect to results on project indicators. The project achieved 12 of a total of 17 indicators. Only five indicators did not reach their target. There is also a clear increase in Africare Senegal organizational capacity in community health and development as a result of this project. They now have a big team of field staff who has learned lessons in community mobilization and BCC, and contributed to the THSP achievements. All staff has been transferred to new projects and is in a very good position to replicate these results for even more impact in other parts of the country. There is no doubt that the project has greatly increased community capacity and

responsibility for health, in addition to increasing community demand and improving health practices.

The potential for the sustainability of certain aspects of the project such as referrals and counter referrals, increased use of maternal and child health services and coverage, community mobilization for sanitation and hygiene, outreach and EPI, and the affiliation with a Care group where they were developed, is very good. There is also tremendous potential for scale up and expansion. The successes of the THSP are notable. Based on both the qualitative and quantitative project data, it is clear that the Maternal Care Group strategy, among other things discussed in the report, has had an enormous impact on behavior change and use of services. Africare is taking some of these experiences to their other community health programs (such as the region of Ziguinchor), and they hope to secure more funding to scale up the THSP experience in the other villages and districts in the Tambacounda region.

Constraints

- The Child Survival project budget was very limited ((\$2,006,478 including match), with respect to supporting the implementation of an ambitious project for a duration of 5 years.
- The dramatic devaluation of the US dollar over the life of the program (from 700 CFA/US\$1 at the time of proposal development to 400 during the last year of the project) had a devastating impact on the program budget. It greatly reduced the amount of money actually available for program implementation after the currency exchange.
- The large size of intervention area including the Tambacounda, Koupendoum and Maka districts consisting of over 400 villages and distances of up to 162 kilometers, made coverage and logistics difficult. Many villages are also inaccessible during the rainy season. The project had to limit their work to 150 villages.
- Low levels of education of community health volunteers and resource persons require special efforts for capacity building, and in the area of data collection and reporting.

Lesson learned: Consolidated Programmatic and Management

- The positive community response to special BCC/community mobilization days implemented with loudspeakers, skilled educators and facilitators or the theatre troupe theatre makes it important to prioritize these activities when planning community health programming, because the potential impact and influence is often more notable than community response to routine health education sessions conducted by volunteers who do not always have the level of skill and expertise to facilitate discussion and dialogue; nor are they always able to provide stimulating and entertaining activities that draw interest and attention.

- The project's focus for capacity building was essentially CHWs, who received manuals that served as reference material to help them in their volunteer work. Although village health committees were not trained in the health areas and key messages, staff subsequently realized that providing them with a copy of the manual changed their attitudes with regards to their participation and support of these volunteers. Many had not been actively involved because they felt that they did not know the content. This changed after they received their own copy of the manual.
- One challenge the project encountered was the fact that although they were working to strengthen community capacity and participation in health, the local government partners at the district level also expected the project to support the districts. In the context of limited funding and the necessity to prioritize, Africare learned that to the degree that NGOs can mobilize other donors and partners to complement their own efforts, i.e. provide support where they cannot, government partners become more receptive to their efforts at the other levels.
- Project supervisors, whose entire task revolved around community capacity building, community mobilization, support of community health promotion and strengthening linkages between the community and the MOH health system, found that their task was facilitated when the project organized for their training to take place, not as a separate activity, but rather as part of the training of an MOH and project team who would work towards the same goal. This strategy helped to forge a partnership between the MOH health post nurses and THSP field supervisors.
- The biggest lesson learned for the project in terms of budgeting is that for future projects, they have to think in terms of a potential range or upper limit of currency equivalence when budgeting in a currency other than the one that they are using to implement the project (especially US dollar). They need to ensure that budgets have an extra margin so that they can deal with unexpected fluctuations, or depreciations that may occur over the life of a multi-year program.
- In terms of project planning, because of the THSP experience with staff and logistical limitations in terms of geographical coverage, including the initial planning for 400 communities and subsequent reduction to 150, Africare is now better able to gauge how many villages and the geographical coverage projects can realistically cover when considering the budget, staff and distances involved.

Promising/Best Practice

- The Maternal Care Group strategy, which organizes women and women's associations into medium-size support groups, facilitated a peer support and mentoring mechanism for increased knowledge and behavior change in the project intervention areas, most notably maternal health. This strategy also contributed to increased access to MCH services as members were asked to make

monthly contributions towards the development of an emergency fund available for members to borrow in times of need.

- The establishment of a referral and counter referral system between community resource persons and the health post has been a great success, and is something that is looked upon very positively by both the health post nurses in charge as well as clients at the community level. Clients who have been referred by the CHW to the health posts are given priority by the head nurse. A counter referral is sent back with the client and enables the community health worker to follow up on the case and provide any support needed in terms of instructions regarding the medication or treatment, as well as ensuring that the client does not miss the next appointment.
- The project support for and implementation of quarterly coordination meetings at each health post with the participation of approximately 20 CHWs from the catchment area, was very successful in strengthening linkages between community volunteers and the MOH health system. These coordination meetings served as forum for reporting and information exchange, data analysis, joint planning and decision-making. All of this supported the continued capacity building of community health workers, helped to motivate them and improved community-based activities, including health hut and CBD services.
- Africare will share lessons learned and best practices from this project with CORE Group members and the global health community through public presentations or various websites. For broader dissemination, abstracts of key project experiences will be submitted for international public health conferences. Copies of the final evaluation report will be provided to the Senegal Ministry of Health and to the Tambacounda regional health department. Africare intends to apply the lessons learned to its future projects in Senegal and other African countries.

Recommendations for Stakeholders

1. Integrate the supervision of CHWs with the existing outreach activities currently conducted by health post nurses.
2. Ensure that community health information is transferred to the health posts either by the CHW or that it is collected by the health post nurse during outreach activities.
3. Advocate for the remuneration of community health volunteers by the health committees at the health posts level (soon to be established as community development organizations).
4. The health post nurses and their committees should plan and budget for the refresher training and continued capacity building of CHWs in their catchment areas.

5. The health post nurses should ensure the sustainability of the referral and counter referral system by maintaining the supply of the existing forms used for this purpose at the community level.
6. The THSP staff who continue to work in certain communities under the new malaria project should continue to serve as resource persons and advisers to CHWs trained by the project.
7. Organizations intervening in the program area, including Africare, should avoid the creation of multiple different forms for CHWs to report community health information.
8. Africare should continue and strengthen its efforts to replicate and scale up the successful Care group approach across Senegal. Africare should also make an effort to document this experience, share it on their website, and present it in other forums as well.

F. Results Highlight

During the project design, maternal and child morbidity and mortality in the Tambacounda region were reported to be among the worst in Senegal. This was linked to poor health practices and care seeking behavior in the area of childhood illnesses and maternal health including the 4 delays, i.e. recognition of danger signs, decision-making, reaching services, and receiving treatment. The THSP initiated the development of Maternal Care Groups as a community mobilization strategy to address many of these problems. The project was able to work with Women's Association, which are well established in most communities. They proposed that these Women's Associations sub-divide into smaller, 25-member Care groups. More often than not, these smaller groups can be formed around the various village neighborhoods or sections. Once community leaders such as the village chief and the President of the Women's Associations have bought into the idea of the Care groups, all women of reproductive age, along with grandmother caretakers in the community are invited to join a group. This is irregardless of whether or not they are members of the larger Women's Association (Community Based Organization). The two criteria to become a member are to give a monthly financial contribution and to participate in IEC/BCC activities. Each village ends up with a maximum of four to five Maternal Care groups. When the membership is established, each of the groups elects a governing board consisting of a coordinator, treasurer and accountant.

The Maternal Care groups provide a forum for education and information sharing. This strategy has facilitated peer support, solidarity and a mentoring mechanism for increased knowledge and behavior change in maternal as well as child health. In the Care group strategy, an older, more experienced woman becomes a 'godmother' or mentor and helps to monitor and support a pregnant woman in the group. The godmother is responsible for ensuring that the pregnant group member attends all her prenatal care sessions, takes her iron folic acid or medicines as prescribed, respects appointments, and follows the project-trained TBA's and/or CHW's advice. TBAs and CHW are responsible for health education and mobilization for health activities conducted with the group. TBAs have the specific responsibility to help expectant families draw up a birth plan. They follow up and check on these clients regularly, and refer cases or assist with home deliveries as needed.

Being part of these Care groups has also contributed to increased access to MCH services as member's monthly contributions go towards the development of a savings or 'solidarity' fund available for members to borrow in times of need. All members abiding by the criteria are eligible to borrow from the emergency fund to cover health related costs. They can also participate in whatever income generation activities the group might take on. Maternal Care group members usually contribute a monthly minimum of 100 Francs CFA (approximately US\$0.20 cents) to the cashbox for the purpose of assisting pregnant women who may need pregnancy-related financial assistance. Some have reduced this to 50F CFA due to hardship. For the most part, the groups developed under the THSP have not highlighted serious problems with member reimbursement. The Maternal Care group intervention directly benefits 8,310 participating mothers (30 in each of 277 functional groups), in addition to their infants and young children. This constitutes approximately 18% of the population of WRAs. Another 56 groups (a total of 333 groups were formed) are not functional. Other women are reached through the other community outreach and education activities of the THSP. As confirmed by health post nurses and community stakeholders, the MCG intervention has been a leading factor in the increased use of health services including antenatal care, delivery, postnatal care and child health services, as well as behavior change such as exclusive breastfeeding, improved hand washing, and use of bednets, as seen in the KPC results.

G. ATTACHMENTS:

A. Evaluation Team Members and their titles

1. Marguerite Joseph, Consultant
2. Dr. Nene Diallo, Africare HQ technical backstop
3. Mactar Sy, Translator
4. Ladj Dabo, Translator

B. Final KPC report (attached)

C. Evaluation Assessment methodology

The evaluation was led by an external consultant. The Africare headquarters technical backstop accompanied the consultant, and two translators assisted with the community level interviews. Group and individual interviews were conducted with the MOH in the 3 districts and with health facility staff. FGDs and interviews were organized in several project communities. This included mothers and Care group members, village health committees, CHWs, TBAs and village chiefs. The criteria for the choice of sites for interviews was the following: accessible and less accessible; distant and close to regional center; with and without presence of a health hut and health post; with and without presence of a women's Care group; population reportedly engaged, and not so engaged; and health post with good collaboration and average level of collaboration.

Evaluation Work Plan

Dates	# Days	Principal activities
Mon. -Tues. June 30 - Jul 1	2	Document Review/Travel to Dakar, Senegal
Wednesday July 2	1	Planning prior to travel to Tambacounda; Interview with Africare country office staff
Thursday July 3	1	Travel to Tambacounda
Friday July 4	1	CS Team Planning Meeting: selection of sites and development of interview schedule Courtesy visits to local authorities. Preparation of interview guides (Consultant and HQ representative)
Saturday July 5	1	Interviews with CS project staff
Sun – Thurs. July 6 - 10	5	Site visits: Key Informant Interviews and Focus Group Discussions with district health officials, health post staff, and project communities
Friday July 11	1	Presentation of preliminary findings to Africare Tambacounda and local partners; Data analysis continued

Dates	# Days	Principal activities
Saturday Jul. 12	1	Data analysis continued/clarification of pending questions etc
Sunday July 13	1	Travel from Tambacounda to Dakar
Monday July 14	0.5	De-briefing presentation with USAID Senegal
Tuesday July 15	0.5	De-brief meeting with Africare Country office team
Wednesday July 16		Travel to US
Mon. -Wed July 21 – 30	7	Report writing
Thursday July 31		Submission of first draft to Africare
Total	22	

Site Visit Schedule – MTE CSP Tambacounda

Date	Location	District Chief; Regional Ministries; Steering Committee	Nurse in Charge Health Post	Community Health Agents/ Workers; 1 Theatre troupe	Village Health Committee	Care group or women	Village Chief (and/or other male leaders)
<u>Sunday</u> <u>6th July</u>	1. Koupentoum District Center 2. Village of Diokoul 3. Village of Maleme Niani^	X	X	X	X	X	X
<u>Monday</u> <u>7th July</u>	1. Village of Botu 2. Village of Sare Barka * ^			X X	X X	X X	X X
<u>Tuesday</u> <u>8th July</u>	1. Maka District Center 2. Village of Colibatam* # ^ 3. Village of Okere # 4. Koussana (Tamba)	X		X X X X		X	X
<u>Wednesday</u> <u>9th July</u>	1. Village of Dar Salam 2. Village of Laboya* ^			X X	X X	X X	X X

<u>Thursday</u> <u>10th July</u>	1. Tambacounda District Center; Villages of: Bohe, Tessan, Neteboulou,	X X X	X X X X				
<u>Total</u> <u>interviews</u> <u>with</u> <u>project</u> <u>partners/</u> <u>Participants</u>	35	5	4	9	5	6	6

* No health Hut

No Care group

^ No current Africare presence

D. List of persons interviewed and contacted

Africare Project and support Staff

1. Mr. Saboye Diagne – IEC Advisor
2. Mrs. Kany Sall Diop – Maternal Health Advisor
3. Ms. Yacine Gueye – Field Supervisor
4. Mr. Amadou Bassrou Diawara – Field Supervisor
5. Mr. Nor Talla Toure - Field Supervisor
6. Mr. Ousseynou Samb – Assistant Program Manager, Country Office
7. Mr. Gorgui Diallo - Senior Program and MIS office, Country Office
8. Dr. Bonaventure Traore, Country Director

MOH Partners

9. Dr. Mamadou Ndiaye – Koumpendoum District Medical Officer
10. Dr. Papa Abdoulaye Seck – Maka District Medical Officer
11. Mr. Thierno Seye – Supervisor for Primary health Care (Nurse), Tambacounda District
12. Mr. Papa Saboye Mbaye- In Charge of Health Education, Tambacounda District
13. Mrs. Seynabou Ndiaye Thioub – Coordinatrice Sante de Reproduction
14. Mr. Oussman Coulibali – Head Nurse Health Post Maleme Niani
15. Mr. Amadou Doukoure – Head Nurse health Post Sare Guilele
16. Mr. Alioune Seck – Head Nurse Tessan
17. Mr. Diomaye Sarr – Head Nurse Bohe
18. Mr. Diname Thir – Head Nurse Bira
19. Mr. Lamine Diop – Head Nurse Netteboulou

E. Diskette or CD with electronic copy of the report in MS WORD 2000

F. Project Data Sheet form – updated version