



FOR DI PIKIN DEM WEL BODI (THE HEALTH OF THE CHILD)

Community-based health initiatives implemented through social cohesion strategies in Koinadugu District, Sierra Leone

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BFV	Blue Flag Volunteer
CA	USAID Cooperating Agencies
CARE	Cooperative for Assistance and Relief Everywhere, Inc.
CARE-SL	CARE Sierra Leone Mission
CB	Capacity Building
CBO	Community-Based Organization
CBP	Community-Based Provider
CCF	Christian Children's Fund
CES	Christian Extension Services
CHC	Community Health Club
Chiefdom	Third level administrative unit in Sierra Leone, under the District.
CHW	Community Health Worker (include TBA, CBP, BFV, etc.)
C-IMCI	Community-Based Integrated Management of Childhood Illnesses
CO	Country Office (CARE Sierra Leone)
CRS	Catholic Relief Services
CS	Child Survival
CSO	Central Statistics Office, Ministry of Development and Planning, GOSL
DFID	Department for International Development, Government of England
DHMT	District Health Management Team
DHO	District Health Office
DIP	Detailed Implementation Plan
District	Second level administrative unit in SL, under the Region and above the Chiefdom
DMO	District Medical Officer, in charge of DHO
DOSA	Discussion-Oriented Organizational Self-Assessment
EBF	Exclusive Breastfeeding
EMC	Emergency Management Committee
FA	Facility Assessment
GDP	Gross Domestic Product
GOSL	Government of Sierra Leone
HBLSS	Home-Based Life Saving Skills
HH	Household
HMIS	Health Management Information Systems
HIV	Human Immune Deficiency Virus
HLS	Household Livelihood Security
HQ	Headquarter
IDP	Internally Displaced Persons
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPC	Interpersonal Communication
ITN	Insecticide Treated Mosquito Net

KPC	Knowledge, Practice and Coverage
LNGO	Local Non-Governmental Organization
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MELO	Monitoring and Evaluation Liaison Officer
MICS2	Multiple Indicator Cluster Survey – Round 2
MMR	Maternal Mortality Rate
MNC	Maternal and Newborn Care
MOHS	Ministry of Health and Sanitation, Government of Sierra Leone
MSFB	Medecins Sans Frontieres Belgium
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
NSL	Norway-Sierra Leone Health Project
OFDA	The Office of US Foreign Disaster Assistance
ORS	Oral Rehydration Solution
PHU	Peripheral Health Unit
PLA	Participatory Learning & Action
PM	Program Manager
PVO	Private Voluntary Organization
QA	Quality Assurance
QOC	Quality of Care
Region	The largest administrative unit at the sub-national level; there are four regions in SL.
Reproductive age	In this proposal, refers to women aged 15-49 years
RH	Reproductive health
SCM	Standard Case Management
SL	Sierra Leone
SO	Strategic Objective
SP	Security Plan
TA	Technical Assistance
TBA	Traditional Birth Attendant
TD	Talking Drum Studios
TT	Tetanus Toxoid
UNDP	United Nations Development Program
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VA	Vitamin A
WHO	World Health Organization
WRA	Women of Reproductive Age

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A. Executive Summary

CARE Sierra Leone (CARE-SL) and the Ministry of Health and Sanitation (MOHS) present the Detailed Implementation Plan for CARE's Child Survival XIX Project under the standard category in Koinadugu district in the Northern Region of Sierra Leone. The project dates are October 1, 2003 through September 30, 2008. This project seeks to improve the health status of children under 5 and women of reproductive age in a remote district in a former rebel stronghold through innovative strategies that build partnerships between communities and government.

Infant and child mortality rates in Sierra Leone are 170 and 286 deaths per 1,000 live births, respectively¹. The maternal mortality ratio is estimated to be 1,800 deaths per 100,000 live births². The Koinadugu District Knowledge, Practice and Coverage Survey (KPC) found vaccination rates in Koinadugu district as 45.7% of children 12-23 months fully vaccinated before their first birthday. Just over 69% of these children received a measles vaccine and 47.2% of mothers received at least two tetanus toxoid injections (TT) before the birth of their youngest child aged 0-23 months. Underweight (< 2 SD) among children 0-23 months in the KPC survey was found to be 26.5%. Malaria is the most frequent cause of death in children under five at Koinadugu Hospital, accounting for 40 percent (53/132) of child deaths in 2001-02³. Less than 1% of children with a febrile episode in the last two weeks had slept under an insecticide treated bednet the preceding night. The population of Koinadugu is dispersed in small villages with limited access to haphazardly staffed peripheral care units (PHUs).

CARE will work in all eleven chiefdoms of Koinadugu to strengthen the MOH health system, and conduct intensive project activities in five of them including Dembelia Sinkunia, Follasaba Dembelia, Neini, Sengbe, and Wara Wara Yagala, focusing on the most crucial partner in Koinadugu: the community. In these five chiefdoms, CARE in partnership with PHU will implement interventions in immunization (EPI), nutrition, malaria and maternal and newborn care (MNC) through a grassroots, civil-society building variation of the overarching Community Integrated Management of Childhood Illness (C-IMCI) approach. The CARE approach promotes voluntary participation in "community health clubs" (CHCs) for any community member who wishes to join. The CHCs will disseminate health information, promote healthy practices and spearhead community support for the formal health system. They will also focus on mobilizing community members for EPI outreach, community-based growth promotion and birth preparedness. The Project will collaborate with the Ministry of Health and Sanitation (MOHS) in district-wide activities to train PHU staff in IMCI, expand and improve services, and plan a Behavior Change Communication (BCC) campaign to improve family and community practices.

The CARE capacity-building strategy will work through a partnership structure, with local organizations such as CHCs, Radio Bintumani (with the assistance of Talking Drum Studios) the MOHS and Christian Extension Services (CES). The CHCs will be responsible for implementing health promotion activities at community level and supporting government health services. Radio Bintumani will work with CARE and MOHS through support from Talking Drum Studios to design and broadcast key health messages, while CES will work through inter-

¹ Survey Report on the Status of Women and Children in Sierra Leone at the End of the Decade. GOSL, November 2000.

² Source: Unpublished analysis. MICS2 database. UNICEF and Central Statistics Office, MODEP, GOSL.

³ Source: MSFB/DHO Database, Koinadugu District Hospital, Kabala, Koinadugu.

sectoral collaboration at the community level for health promotion. The MOHS at all levels will be involved in setting policy, managing the health system, providing health services and promoting improved health practices. This approach builds local capacity and sustainability and allows the Project to maintain continuity of project activities if security declines.

Direct beneficiaries of the Project include an estimated 48,630 children under five and 51,491 women aged 15-49 years. Secondary beneficiaries include direct beneficiaries of Health Units from the remaining six chiefdoms. The goal of the Project is to improve the health status of children under five and women of reproductive age in Koinadugu district through the achievement of three principal objectives:

1. Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to prevent, recognize and manage common diseases;
2. Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms; and,
3. Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services.

The Project will implement the following four interventions through the C-IMCI strategy:

The **EPI intervention (15%)** will focus on raising vaccination coverage of children and pregnant women from current low levels. CARE will work with communities and MOHS to promote EPI outreach through the CHCs. The second prong of the CARE strategy is to support CHCs to use appropriate BCC strategies to increase demand for and utilization of EPI services.

The **nutrition intervention (20%)** will work through CHCs and other community-based organizations (CBOs) to promote the early initiation of breastfeeding, exclusive breastfeeding (EBF), complementary feeding and improved Vitamin A (VA)/iron intake for women and children. CARE has complementary multi-sectoral activities that support improved nutrition such as water and sanitation in Koinadugu District.

The **malaria intervention (35%)** will confront the high prevalence of malaria and self-treatment by training PHU staff in recognition of malaria and standard case management, educating community members about malaria and its treatment, promoting intermittent treatment of malaria amongst pregnant women, and promoting and selling insecticide treated mosquito nets (ITNs) through social marketing.

The **MNC intervention (30%)** will focus on improving access to information and basic maternal health care by providing educational sessions on danger signs recognition, birth preparedness at the community and household level, promoting TT vaccination and iron supplementation for pregnant women and VA supplementation for postpartum women, and training PHU staff in intermittent prophylaxis of malaria in pregnant women.

The Detailed Implementation Plan is a collaborative effort with USAID Sierra Leone and incorporates the feedback of Ms. Kathy Jacquart, Reproductive Health Advisor, USAID Sierra Leone. Other organizations consulted in the development of this program include WHO, UNICEF and IRC. The total budget is \$2,013,054 with \$1,488,582 from USAID and \$524,472 from CARE. Principal authors of the DIP were Namita Kukreja from CARE HQ and Boiketho Matshalaga and Vandy Kamara from CARE Sierra Leone. The contact person for the proposed CS program is Namita Kukreja at CARE HQ.

B. CSHGP Data Form

Please see attached CSHGP data form in Annex 2. Based on another review of the Rapid CATCH indicators for measles coverage, the data form may need updating. The form will be resubmitted during the 1st Annual Report.

C. Description of DIP Preparation Process

The Child Survival Project in Koinadugu District, Sierra Leone, has been active in regular project start-up activities and preparation for the DIP. Since October 2003, all project staff have been hired. The Assistant Project Manager position has been modified to include administrative/financial operations of the program as well as coordination of IMCI, for the purpose of building their capacity on both technical and operations aspects of the project. The project did identify and place a Project Manager by the start of the project, however, she submitted her resignation in late November due to her own discomfort in carrying out Project Manager responsibilities effectively. The country office immediately began the search for a replacement. The new Project Manager, Boiketho Matshalaga Murima came on board March 1, 2004 after completing commitments with CARE Zimbabwe. Please find her CV in Annex 5. In the absence of the Project Manager, the Child Survival Assistant Project Manager and the Project Manager of the sister Watershed Project in the district carried out responsibilities for project start-up. An updated organizational chart for the Project is included in Annex 7.

Office space is now available and procurement of project supplies and equipment, including motorcycles and vehicles, were completed during this time. Specific villages for project implementation were identified through an in-depth assessment. Memorandums of Understanding (MOU) and project management committees were established in all participating communities. Health clubs have been established in 92 communities. Examples of community MOUs can be found in Annex 4. Project staff have held several meetings to identify specific areas of collaboration with the District Health Management Team, Talking Drum Studios, Radio Bintumani and other NGOs (Medecins Sans Frontieres, Christian Children's Fund, Christian Extension Services, Catholic Relief Services) working in the district and in the health sector. Staff have also been trained in initial health club session topics and introduced to CARE's Household Livelihood Security and Rights-based concepts.

Also during this time, rapid and in-depth assessments of 48 communities were also conducted to familiarize project staff with the project area. These assessments included accessibility to the rest of the community, population, topography and the presence/absence of a Peripheral Health Unit (PHU). A PHU assessment was also completed to identify existing PHUs in the intense project area and their capacity related to staffing, equipment, etc. Additionally, the Knowledge, Practices, Coverage (KPC) survey was conducted using 30-cluster sampling. Some basic qualitative research was conducted to complement the KPC. Copies of all of these assessments are included in Annex 3. More in-depth qualitative research is planned in addition to a more structured Health Facilities Assessment (HFA) in partnership with UNICEF and the World Bank planned before the end of 2004. The project team is in the process of identifying a partner capacity assessment tool to be conducted in the coming months.

This project, along with the International Rescue Committee (IRC) Child Survival Project in Kono District, was selected for Technical Assistance (TA) from the Child Survival Technical Support Project (CSTS+) on the Child Survival Sustainability Assessment evaluation methodology. The CARE Child Survival Project team along with representatives from the DHMT held a visioning exercise in preparation for the Sustainability TA. A joint visioning exercise between CARE and IRC was conducted on March 10th, 2004 in Kabala (Koinadugu District capital). Staff from the two projects along with their respective district health staff came together for a three-day Working Group meeting held March 29-31, 2004 in Freetown. The draft report of this meeting and list of participants is included in Annex 8.

Prior to the Sustainability Working Group meeting, CARE Sierra Leone conducted a Country Office-wide program review. A major focus of this meeting was to review the current and upcoming activities in the Koinadugu District. Koinadugu is in the Northern Region, historically the poorest and least developed in the country. The most remote district in Sierra Leone, Koinadugu has only one paved road in the entire district and has received limited attention in the initial post-conflict humanitarian efforts. CARE is becoming extremely active in the District with other activities and recent proposals funded. CARE Sierra Leone has taken a deliberate interest in the District and planned new projects with a program approach. Each new project is complementary to existing projects and works within the existing program infrastructure. The new initiatives within the District are described in the Intervention Specific Approach section based on their relevance to the Child Survival activities.

After these activities, a Stakeholder Planning Workshop was held in Koinadugu April 7th and 8th, 2004. Those in attendance included staff from the DHMT, Christian Extension Services (CES), a Chief's representative, two community representatives (who are literate) and staff from the Child Survival and Watershed projects. The full list of participants and agenda for this meeting is included in Annex 9. The two-day meeting included a review of baseline data, BCC strategy, M&E plan and a draft workplan. The HQ backstop, Namita Kukreja, was in-country through the end of the Sustainability meeting to support the meeting and hold appropriate discussions as part of DIP preparation. After the Sustainability and Stakeholder meetings, DIP writing continued with regular communication between the project staff and the HQ backstop to refine activities and plans. After the completion of the draft DIP, an additional stakeholder debriefing meeting has been planned.

D. Revisions (from the original application)

The main change from the original application is related to the distribution of interventions. The new distribution is as follows: Immunization (15%), Nutrition (20%), Malaria (35%) and MNC (30%). The change after year 2 has no longer been kept. The original purpose for this was to allow for strong focus in certain important interventions at the beginning of the project and a later shift to MNC. Given the integrated approach to this project through C-IMCI and the health clubs, the stakeholders decided to begin all interventions at once. The change in level of effort of each intervention is related to results from the KPC survey and the activities of other actors in the district (i.e. UNICEF and the World Bank) as well as new programs being initiated in the district by CARE Sierra Leone.

An additional change is related to the partners. Norway Sierra Leone (NSL) was anticipated to support the Project's efforts at the community level. Unfortunately, for reasons unknown to CARE, the Sierra Leonean government has deregistered NSL. The Project is actively searching for a new partner, however, at this time, only the relationships with Radio Bintumani and CES have been well established.

No changes have been made to the project site or number of beneficiaries which would contribute to changes in the budget. While the interventions have been shifted slightly, this has not impacted any specific plan of activities and, therefore, the budget items relating to this are also unaffected.

However, some changes have been made to staffing. The position earlier written in as Assistant Project Manager (APM) has been modified to include IMCI training. This is the position expected to take over Project Manager responsibilities after Year 3.

The only significant changes to the budget are related to the NICRA. Since the proposal was written, the NICRA changed from 7.722% to 8.88%. The original budget requested an amount of \$1,488,582 from USAID. Cost savings related to delayed recruitment of staff and no consultant-led qualitative research has allowed for the change in the NICRA to be made without significant effect on the program budget. A revised budget including SF 424 and 424A is included in Annex 10.

E. Detailed Implementation Plan

1. Summary of Baseline and Other Assessments

In order to inform project activities and provide a basis for monitoring and evaluating project progress, the project conducted several assessments. The key baseline assessment conducted was the KPC survey. This survey was conducted using the KPC 2000+ instrument. The standard 30-cluster sampling was used for the exercise. Lot Quality Assurance Sampling (LQAS) was originally anticipated as the preferred method for the survey. The country office staff decided that since there was a lack of knowledge on the methodology by the project team and that the new training would delay the survey, it would be best to utilize the standard cluster sampling. The original plan had been to conduct surveys in Kono (IRC) and Koinadugu (CARE) together so as to have additional relevant enumerators and to assist CARE in learning the LQAS methodology, however, due to the delay in having project managers in place for both organizations, the coordination on this was difficult. Additionally, given that very little health data are available in Koinadugu district, as it has been neglected for quite some time, cluster sampling seemed to be the best methodology to allow for larger representation.

Koinadugu District is broken into 11 chiefdoms, of which the Child Survival Project is working directly in five. The chiefdoms represent a demarcation of traditional land by Paramount Chiefs. Sections are a further smaller administrative classification where again land has been demarcated by local chiefs/traditional authorities. Each section can have any number of villages ranging in size from 20 to well over 1000 inhabitants. Project and DHMT staff were involved in conducting the survey in 394 villages with a population of 87,341. The sample size was 14

households per cluster for a total of 420 mother child pairs. Households with a child 0-23 months of age were considered for a survey household. Instead of using the recommended child survival sample size of 300 or 10 households per cluster (30 clusters), the sample size was increased to 14 households per cluster. In Sierra Leone, it is customary for a number of families to live under one roof. Typically, the population of a village might be high, but the number of households minimal. In an effort to guard against homogeneity within the clusters, more households per cluster were added. The 30 clusters were identified using the population proportionate to size (PPS) method. However, due to severe inaccessibility (as well time and logistical constraints) one of the selected village clusters (three day walk in and three days out) was replaced with another randomly chosen village from the same section.

Five teams with four enumerators and one supervisor were further divided into 2 sub-teams. These sub-teams were trained to begin the survey at the nearest house to one of the two randomly selected entry points for each cluster. Upon completion of this initial household survey the teams were then instructed to proceed to the next closest house until the required number of questionnaires were administered. Only households with a child less than 24 months were included in this survey. A total of 45 days was required to collect data from the 30 designated clusters. With five teams, this required 9 days of data collection per team, including travel to cluster sites. Data collection took place from 24 January 2004 to 3 February 2004. Field supervisors checked the questionnaires for completion before departing the survey cluster. If errors were found they were corrected on the spot. All teams were able to communicate via radios with the local survey coordinator. The local survey coordinator visited each team regularly in the field to ensure quality of data control of survey procedures.

The data collection process was challenging. Some of the villages visited were located so far into the bush that the CARE survey teams were the first visitors to some of the villages in the previous six years. Given the poor quality of the roads, more often than not villages were reached by foot. Traveling to several of the more remote sites required the survey teams to walk as far as 8 miles each way across mountainous and forested terrain. Data were entered using EpiInfo 2002. CARE staff performed the data entry as well as taking responsibility for data cleaning. All data entry and cleaning was undertaken in Freetown, supervised by the survey consultant.

The total sample size was 420 mother child pairs, however, during the analysis five children were found to be older than the criteria of less than 24 months. Thus, a sample of 415 mother child pairs is included in the analysis.

Qualitative research was conducted following the KPC survey. The research included focus group discussions and key informant interviews in four out of the five targeted chiefdoms. The remaining Neini chiefdom was inaccessible to vehicles and motorbikes due to road maintenance/rehabilitation. Research communities were randomly selected from each of the four chiefdoms and the CARE field supervisors facilitated the discussions. Key informant interviews in each chiefdom were done with TBAs, teachers or community leaders. Two focus group discussions and two key informant interviews were done per chiefdom.

The main source of comparison data comes from the 2000 Sierra Leone Multi-Indicator Cluster Survey-2 (MICS2). It is a nationally representative survey of households, women and children.

The main objectives of the MICS2 were to provide up-to-date information for assessing the situation of children and women in Sierra Leone at the end of the decade (1990 –2000) and to furnish data on which future MOHS activities could be prioritized. Data from the MICS2 estimates that the infant mortality rate for Sierra Leone is 170 per 1000 live births and the under-five mortality is 286 per 1000 live births in 1998.

There is additional information available at the district level based on government data. The Koinadugu District Recovery Committee (DRC) conducted their second data collection exercise in 2003. The report is based on a set of monitoring forms developed under the Technical Committee of the National Recovery Committee. There is an additional “Who What Where” data report to complement the DRC data to provide a list of implemented projects within the sector by international agencies and organizations. The purpose of these data collection exercises is to establish a set of reliable data to be used for national planning and monitoring. This is referred to as the Koinadugu District Data Pack.

According to the Data Pack, priority actions for the Koinadugu District Health Program are: rehabilitation and reconstruction of health facilities, extension of primary health care to the community and provision of trained staff, equipment and supplies to all health facilities. The District Data Pack mentions that malaria ranks as the top cause of morbidity in the district.

Socio-demographic characteristics

Koinadugu district is known for its diversity in the number of tribes that live throughout the district. However, even with the diversity of tribes, languages and conflict, the socio-demographic data did not find significant differences among the KPC survey population in the five project chiefdoms.

A household in Koinadugu district is defined as one breadwinner within a house who takes care of his/her family. House structures can hold several households. If a particular ‘house’ or ‘hut’ has four breadwinners, then that ‘house’ would equal four households. According to this definition, household sizes ranged from two, the mother and the survey child, to 30 member households. Most households (44.6%) have between 7-10 members. Just over 41% have six or fewer members and 10.5% have between 11-15 members. Most households had only one under five in the house (51%). Just over 29% had two under fives and only 19.3% had more than two.

Mothers in the survey were asked how many live births they have had. Live births ranged from one to more than 10. Sadly, about half of all live births have ended in death with no significance by gender of child, age at marriage or level of education. The highest recorded number of deaths to any one woman was seven. Of the entire survey population (n=415) 78.9% reported no formal schooling. It is important to note that many women were unaware of their age at marriage.

The qualitative research showed that “house and kitchen activities are meant for girls and that they should be raised to bear children and take care of their husbands and kids at home.” Some respondents indicated that some parents had good intentions of sending their girl children to school but their economic status was not favorable at the time in question. Schools were viewed

as institutions of prostitution where girls were taught the arts of defying their husbands and going in search of several lovers.

In the KPC survey, about 50% of mothers who had an older child besides the one in the survey, did not have a birth card to confirm the child’s date of birth. According to the MICS2 report, 47% of births of children under the age of five have been registered. In the North (where Koinadugu District is located), this number is only 27%. In this region, “didn’t know it should be registered” and “don’t know where to register” were cited by caretakers as the reasons why registration is so low.

KPC 2000+ Rapid CATCH compared with Sierra Leone MICS2

During analysis of the KPC data, some errors in indicator calculation were noted based on the way the survey questionnaire was designed. Every effort will be made to gather correct information for the indicator during LQAS monitoring. It is the opinion of project staff, however, that the information provided is still reflective of current practice in the District.

Below is a table with results from the KPC survey done in the project area compared to similar indicators from the MICS2 where possible:

Rapid CATCH Indicator	Koinadugu District data	MICS2 data (national level, measured for 0-59 months)
1. Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	26.5%	27%
2. Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	95.1%	-
3. Percentage of children age 0-23 months whose births were attended by skilled health personnel	15.1%	42%
4. Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	47.2%	58% (received either 2 TT in last 3 years, 3 TT in last 5 years, 5 TT in lifetime)
5. Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	8.3%	2% (less than four months according to mother/caretaker report)
6. Percentage of infants age 6-9 months receiving breastmilk and complementary foods	69.8%	52%
7. Percentage of children age 12-23 months who are fully vaccinated (against the five	45.7%	39%

vaccine-preventable diseases) before their first birthday		
8. Percentage of children age 12-23 months who received a measles vaccine	40.9%	62% (documentation or guardian's report)
9. Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0.57% (febrile episode in past 2 weeks as denominator)	2% (febrile episode in past 2 weeks as denominator)
10. Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	79%	77%
11. Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks * Denominator is children with diarrhea	48.7%	30% (numerator as 'ate slightly less, same or more')
12. Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	3.8%	21% (three known ways)
13. Percentage of mothers of children 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated *Numerator is mother who wash hands with soap before eating	2.7%	-

Immunization

More than half (54.7%) of the respondents of the KPC baseline survey had vaccination cards available for their youngest child. Of the 229 with card, 105 were in the 12-23 months group. One hundred eighty-one children were in the 12-23 months age group overall. The measles coverage indicator is for those confirmed by card. This indicator will be reassessed to include mother's recall and will be included in the 1st Annual Report. The following table shows the key indicators for immunization as confirmed by the vaccination card:

	Frequency	Percent
EPI Access, age 12-23 (n=105) (Percent of children aged 12-23 months who received DPT1)	99	94.3%
Measles Vaccination Coverage, age 12-23 (n=181) (Percent of children aged 12-23 months who received measles vaccine)	74	40.9%
EPI Coverage I, age 12-23 (n=105) (Percent of children aged 12-23 months who received BCG, DPT3, OPV3, and measles vaccines)	48	45.7%
EPI Coverage II, age 12-23 (n=105) (Percent of children aged 12-23 months who received DPT3)	60	57.1%
Drop Out Rate	99-60/99	39.39%

(Percent of drop-outs between DPT1 and DPT3)		
Vitamin A Coverage, age 6-23 (n=175) (Percent of children aged 6-23 months who received a Vitamin A dose in the last 12 months)	126	72%

The target for national Vitamin A coverage is 85%, with the baseline information showing 68.2%. The percent of children 6-23 months who received de-worming medicine in the last six months before the survey was low at 15.9% (45).

It is important to note that there was a National Immunization Day (NID) approximately two months before the KPC survey was conducted. The higher immunization coverage may be biased based on this, however, it is also a recognition of the success of the NIDs.

According to the qualitative research, not all mothers take their children for immunization because of the prohibitive distance from health facilities, financial constraints, lack of decision-making authority at the household level and poor attitude of health care providers at PHUs.

In the MICS2 survey, mothers were asked to provide a vaccination card for children under the age of five. If the child did not have a card, the mother was asked to recall whether or not the child had received each of the vaccinations. This method of calculating coverage may yield an estimate of coverage that is higher than the true coverage level, if some caretakers exhibit faulty recall. However, it is still considered accurate.

According to the MICS2 survey, the percentage of caretakers able to show the vaccination card for the child were as follows: 28% in the North, 35% in the East, 43% in the South and 50% in the West. The percent of children who received measles vaccination was 62%. Children 12-23 months who received DPT 3 was 46% - both of these figures represent national level coverage. As for Vitamin A coverage, children aged 6-59 months receiving Vitamin A supplement in the last six months was 58% nationally.

Infant Feeding and Nutrition

According to the KPC baseline survey in Koinadugu District, all mothers (100%) had breastfed their youngest child (the survey child). However, only 19.5% (81) initiated breastfeeding immediately (within the first hour after delivery), with 77.1% initiating breastfeeding after one hour or more. Of the 132 children in the 0-5 months age group, all were breastfed in the 24 hours preceding the survey. However, all but 11 were also given other liquids besides breast milk in the 24 hours preceding the survey as well. Of the 132 children in the 0-5 months age group, 90.9% gave water in addition to breastmilk the day before.

From the above information it is clear that very few mothers practice exclusive breastfeeding. This was further investigated during the qualitative research when the mothers explained that newborns are given “hot water to clear their digestive tract and to wake up the baby.” Additionally, the colostrums is expressed and discarded to provide “clean milk or food for the baby.” Interestingly, the community members frowned at women that do not breastfeed their babies. Respondents suggested that it would be feasible to establish a growth monitoring system

in the communities by way of involving parents and community leaders and training community based growth promoters backed by health education campaigns.

In the MICS2 survey, the exclusive breastfeeding rate is measured as the children aged less than 4 months exclusively breastfed according to mother/caretaker's report. At the national level, this was measured at 2%. For those aged 12-15 months, breastfeeding was continued for 52% and for those aged 20-23 months, it was continued for 51%.

As for complementary feeding, if mothers in the KPC survey did not give semi-solid food or solid food in the past 24 hours and also responded 'no' to sometimes giving the child semi-solid food then they were not included in the numerator, due to the skip pattern. Hence, the total of 298 children are in the denominator. Clearly, as the following table reveals, children in Koinadugu District are introduced to solid foods too early as well as too late.

Complementary feeding (N=298)

How old was (name) when you started giving additional food?	Number	% Yes
0-4 months	103	34.6%
5-6 months	100	33.6%
7-9 months	80	26.8%
> 10 months	15	5.0%
Total	298	100%

According to the MICS2 survey, timely complementary feeding was measured as children aged 6-9 months who received breastmilk *and* complementary food according to mother's/caretaker's report. In this case, 52% of children aged 6-9 months are receiving both solid or semi-solid foods and breastmilk.

In both the KPC and MICS2 surveys, underweight children are measured at -2 SD from the median weight-for-age, according to the WHO/NCHS reference population. The KPC measured this for children aged 0-23 months whereas the MICS2 does so for those aged 0-59 months. The KPC found 26.5% of the children surveyed in Koinadugu District as underweight. The MICS2 found 27% underweight prevalence nationally.

Malaria

In the two-week period preceding the KPC survey, febrile episodes were reported in 41.9% (174) of children. Of the 174 children with a febrile episode, 52.3% sought treatment. However, only 45% of those who sought treatment did so from a health facility. The remaining 50 (54.9%) mothers went to a traditional or spiritual healer as well as drug peddlers.

Thirty-one of the 113 children or 27.4%, who had a fever that ended during the two weeks preceding the survey sought treatment from a health facility within 48 hours and were treated

with an effective anti-malarial. An effective anti-malarial includes Chloroquine and Halfan. Even though Chloroquine is the first line of treatment for malaria according to the official health policy, recent studies indicate over 60% resistance to this drug.

Mothers' knowledge on malaria was very low. Only 7 respondents mentioned mosquito bites as the cause of malaria. Of the 174 children who had a febrile episode in the preceding two weeks of the survey, only 12 or 6.7% of the respondents stated they had bed nets, and 11 out of the 12 had the child sleep under the bed net the preceding night. However, of the 12 respondents who have bed nets, only one had the bed net dipped or soaked with a mosquito repellent.

According to the MICS2 report, 46% of under-five children were ill with fever in the two weeks prior to the survey. Fifty percent of those interviewed in the North had experienced a febrile episode in the two weeks prior to the survey. Approximately 66% of children with a fever in the two weeks prior to the MICS2 interview were given Paracetamol to treat the fever and 60% were given Chloroquine while only 4% were given Fansidar. A relatively large percentage of children, 43%, were given some other medicine. Fifteen percent of under-five children slept under a bed net the night before the survey interview. However, only 6.7% used bed nets of which only about 10% of the bed nets used were impregnated with insecticide.

Maternal and Newborn Care

In the Koinadugu District KPC survey, about 71.6% of the mothers stated they saw 'someone' for antenatal care while they were pregnant. However, only 30.8% were able to produce a maternal health card, with an additional 26% stating they had a card, but were not able to locate it at the time of the survey. About 64.1% (196) of the mothers who received antenatal care reported having received at least one tetanus toxoid before giving birth to the youngest child. Of these mothers 49.6% received an injection at least twice and 24.1% received an injection more than twice.

A skilled birth attendant was defined as the delivery being assisted with a doctor, nurse or maternal child health assistant (MCH). Deliveries performed by Traditional Birth Attendants (TBAs) or family members were not included as a skilled birth attendant. A total of 63 births or 15.1% of respondents had a skilled birth attendant assist them with the delivery of their youngest child. Interestingly, if a woman needs to go to a health facility, over 68% stated that the husband would decide if the woman should go. Only 26% of respondents indicated they themselves would make the decision. About 75.9% of the deliveries used a new razor blade to cut the navel cord, 10.8% did not know what was used, 8.2% said scissors was used.

According to the qualitative research, decisions for where to deliver were primarily made by the husband and not until the onset of labor. Participants frowned upon vaccination during pregnancy as it made the pregnant woman sick and prevented her from doing chores. There is also no identified transport for emergency obstetric care but the community was willing to set up one.

Just over 40% of mothers were able to state at least two symptoms that would indicate the need to seek referral for emergency obstetric care. Only 7.4% were able to report at least two known neonatal danger signs.

In the MICS2 report, approximately 68% of pregnant women receive antenatal care from skilled personnel. Women are more likely to receive antenatal care from a physician if she lives in the Western Area (38%) compared to 8% in the Northern Province. Fifty-eight percent of mothers who gave birth in Sierra Leone in the 12 months prior to the MICS2 survey received two doses of tetanus toxoid to protect their children against neo-natal tetanus. A woman's educational level is associated with the status of her protection against tetanus.

Skilled personnel, defined as a doctor, nurse, midwife or auxiliary midwife, attended approximately 42% of births in Sierra Leone in the year prior to the MICS2 survey. Only 22% of the births in the Northern region were attended by skilled personnel. Traditional Birth Attendants (TBAs) assisted 38% of births nationally, widest in the North at 44%.

IMCI-related interventions

The qualitative research indicated low knowledge of the most prevalent communicable diseases. In the Koinadugu District KPC survey, mothers were asked about signs of illness in their child that would indicate to them the need to seek treatment. The table below is a summary of the responses from mothers. The mothers were allowed to name as many as they felt needed to be mentioned.

**Signs of illness that would cause the mother to seek treatment
(N=415)**

Sign of Illness	Number of responses
High fever	357
Persistent crying	168
Vomits everything	88
Not eating	65
Loose stools	62
Coughing	44
Looks unwell	43
Paleness	26
Cold skin	22
Distended abdomen	18
Sleeplessness	18
Fast or difficult breathing	11
Difficult to pass feces	7
Difficult to wake	4

About 79% of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment. According to the MICS2, correct care-seeking knowledge was found in 77% of caretakers interviewed nationally.

Of the children (117) who had diarrhea in the two weeks preceding the survey, 49 or 41.9% of the mothers sought treatment for their child. More than half of the mothers sought treatment at a clinic and 12 went to a traditional healer for treatment. Of the women (49) who did seek treatment, 22 of them stated that their husbands decided they should seek treatment and 20 of them stated they themselves decided. Those children 0-23 months with diarrhea in the past two weeks, 48.7% received increased fluids and continued feeding.

Just over 58% of mothers stated that they never wash their hands with soap before eating, and 31.5% stated that they rarely practice washing their hands with soap before eating. Only 2.7% said they always wash their hands with soap before eating. Qualitative research indicated the belief that diarrhea in children is caused by “mothers having sexual intercourse whilst breastfeeding.”

The prevalence of diarrhea reported by caretakers in the MICS2 survey was high (25%). The diarrhea season in Sierra Leone begins with the rainy season in May and June, at which time diarrhea prevalence rates can reach in excess of 30% (MICS2 was conducted in April). Approximately 56% of children with diarrhea received increased fluids during their episode of diarrhea. However, considering the hot and humid climate in Sierra Leone, inadequate levels of fluid intake put children at substantial risk of dehydration due to diarrhea.

Acute respiratory infection (ARI) symptoms during the two weeks preceding the survey were reported in 173 (41.7%) of the children. Of these, health care was sought for 91 (52.6%) of the children. However, only 26% (45) sought health care from a health facility/provider. Seventy-five of the children received care or some sort of treatment (this includes traditional healers, drug peddlers) within the first three days of onset of illness. Health care was sought mainly from the clinic, traditional healers, drug peddlers, and pharmacy and district hospital. Based on the qualitative analysis, the first point of contact for treating sick children is the traditional healer followed by the clinic.

Only 9% of under-five children had an ARI infection in the two weeks prior to the MICS2 survey. Of these, 17% were taken to a hospital for treatment and 22% were taken to a health center. Overall, 50% of children with ARI were taken to an appropriate health provider. Children in the north endure the highest prevalence of ARI in the country (11% in the north versus 4.9% in other regions); they are the least likely to be treated by an appropriate health provider (40% in the north versus 53-68% in other regions).

HIV/AIDS

The Koinadugu District KPC survey found that just over 53% (221) of the mothers had heard of HIV/AIDS. Only 23.1% have ever seen a condom and just over 1% stated they have actually used a condom. Only 3.8% of mothers of children aged 0-23 months could cite at least two known ways of reducing the risk of HIV infection. The MICS2 survey found that 21% of women 15-49 years of age could correctly state the three main ways of avoiding HIV infection. In the Northern Province, only 2% knew all three ways. The vast majority of women of childbearing age in Sierra Leone have never heard of HIV/AIDS during the MICS2 survey. Only 54% of women had heard of AIDS.

Peripheral Health Unit (PHU) assessment

The objective of the PHU assessment was to confirm the number, type and cadre of staff in the PHUs in the operational area and for staff to familiarize themselves with the same PHUs. A question guide was developed for administration to all existing facilities within the project intensive area. The main activities and the expected outcomes are explained below:

Activity	Outcome
Assessment of PHUs in the five operational chiefdoms.	<ul style="list-style-type: none">• Statistics on the number, type, location and staffing of PHUs.• Catchment populations per PHU and views for health staff on the most prevalent diseases.• Familiarization of staff with the location of operational villages.
Compilation of assessment statistics	<ul style="list-style-type: none">• A master sheet of all functional and non-functional PHUs developed.• Recommendations for changes in health topics currently on the subject list.

Broadly, the assessment dwelt on general information, issues of supervision, monitoring by PHUs, training, referral information, cold chain systems, growth monitoring and the relationship between existing PHUs and the community. It was focused only on the five chiefdoms (Follosaba Dembelia, Wara Wara Yagala, Sengbeh, Dembelia Sinkunia, Neini) that comprise the intensive project area. Data collection was conducted over a period of a month due to the difficulties experienced in accessing some of the PHUs.

There is conflicting information regarding pre-war district and intensive project site (five selected chiefdoms) populations. According to a 1985 census for Koinadugu District provided by the Central Statistics Office, there was a total population of 183,286 in the district with a combined population of 88,382 in the 5 chiefdoms that comprise the intensive project area. As of 1990, according to the District Hospital records, the total population for the five chiefdoms was 54,741.

There were forty operational peripheral healthcare units (PHUs) servicing the district in 1990. Within the intensive project site there were fourteen PHUs, with no chiefdom having more than three PHUs, irrespective of geographic area, population or type of services offered. These facilities were in mainly the same locations as present. Three were designated as community health centers, two were community health posts, and nine were maternal child health (MCH) posts. The endemic diseases in direct relation to the project were malaria, measles, water and bloody diarrhea, neonatal tetanus, TB, and AIDS/STIs. Respiratory and skin infections and waterborne diseases rounded out the list.

A peripheral healthcare unit (PHU) is an all-encompassing term referring to any health care facility provided by the Ministry of Health and Sanitation (MOHS) through to the district hospital. There is a gradation in service and level of training of staff. All of these facilities refer complicated and emergency cases to the district hospital. The following are the standard types found within the districts at village level:

- **Community Health Centers** are the most comprehensive in services and staffing, after the district hospital. They are located in the chiefdom headquarter town. The in-charge is a Community Health Officer with the equivalent training of a physician's assistant. General medical services and simple procedures are provided, but all complicated and emergency cases are referred to the district hospital, as there are not adequate staff, equipment or supplies to run an operating room. Essential drugs are available and dispensed from these sites. At least one MCH aide is on staff providing basic MCH services.
- **Community Health Posts** are located within a chiefdom, but generally not at the headquarter town. The in-charge is a dispenser, who has had basic training geared toward use and distribution of essential drugs. They are not trained to the level of a physician's assistant. General medical services are performed and prescriptions dispensed as needed. An MCH aide is on staff for MCH services. (Note: Community Health Officers generally refuse to serve in rural areas and, therefore, Community Health Posts, though manned by dispensers, are referred to as CHCs by PHU and district health staff and patients alike.)
- **Maternal Child Health Posts** are in villages throughout the chiefdoms. The in-charge is a maternal child health aide. MCH aides have received an 18-month training course offered by the MOHS through the district hospital. They perform maternal and child health care, Under 5's clinics, ante- and postnatal care, deliveries, and general services. There are essential drugs available at site, provided by the MOHS on a cost recovery basis.

According to the PHU assessment, there are 14 functioning PHUs within the project site. Of these, four refer to themselves as Community Health Centers but are effectively Community Health Posts having only a dispenser as senior staff on site, and not a Community Health Officer as an in-charge. Two PHUs are listed as CHCs but lack dispensers, and one of these has a lab technician though not a dispenser on staff. Both have only an MCH aide performing MCH duties and therefore, are effectively MCH posts. Eight are Maternal Child Health Posts with MCH aides, trained by the MOHS, as the in-charge. The PHUs are generally understaffed. The Koinadugu District Data Pack reports 145 MOHS staff operating in the district with only 2 medical doctors. All provide basic maternal/child health services.

MSF-B is actively supporting 3 community health centers. This support includes drugs, supplies, supervision, monthly monetary incentives and free transport for referral patients. All is free of charge. Only two MCH aides interviewed have been exposed to IMCI. One was trained by the MOHS and one began training through MSF-B that was cancelled by the MOHS.

Cold chains exist in all the posts, including those not yet staffed. Nine are solar-powered fridges supplied by CCF, UNICEF or directly by the MOHS. Only one dispenser received training for repairs, with basic maintenance training provided to the other facilities.

The MCH aides, dispensers and vaccinators at the PHUs and during outreach clinics administer the five vaccine preventable disease immunizations included in the national EPI. These are tracked in registers, tally books, and growth chart cards. Certain diseases, including malaria, are also tracked. These figures are reported monthly to the District Health Management Team (DHMT) or MSF-B, in the case of the posts under its leadership.

Community participation with PHUs exists mainly in the form of maintenance, water fetching, and announcements. Village Development Committees (VDCs) do exist but have not taken a proactive approach in PHU management.

The PHU assessment conducted by CARE is available in Annex 3d.

Rapid and In-depth Assessments

CARE Child Survival and Watershed Project staff carried out rapid and in-depth assessments in order to assess accessibility to operational communities, estimate population for the operational area, assess sanitation needs (for the purpose of the Watershed sister project to the Child Survival project), design community health education training practices and assess other NGO activity in the District. These assessments were conducted in the first two months after the start of the project. A survey questionnaire was developed and administered by trained field staff to randomly selected households. In the initial rapid assessment, 77 villages were randomly selected. The in-depth assessment was conducted with 324 community members across the social spectrum in an effort to receive feedback from a wide range of respondents.

As for accessibility, the rapid assessment found that 71.4% of the villages were accessible by a 10-ton truck, while light vehicles could reach the remaining. The in-depth assessment found that 58.7% of the 324 households interviewed use unprotected communal wells as their sources of drinking water. Seventy-two of the 77 villages assessed in the rapid assessment reported existence of latrines, however, most had no superstructure and no proper covering of squat holes. Fifty-three of the 77 villages have to cover a distance of 6 kilometers or more to reach a PHU of any form. Approximately 65% of villages stated that they had VDCs. About half of the villages (51.9%) had an absence of any NGOs.

Traditional Birth Attendants (TBAs) information was collected from the District Health Office. Eighty were found to be trained, while 153 were untrained within the project intensive site area. The dates for trainings ranged from 1982 to 2003.

The reports from these assessments are included in Annex 3d.

Koinadugu Health NGO assessment

CARE convened a collaboration group of NGOs working in health in Koinadugu. Meetings are held monthly with rotating host responsibility. The following bullets are highlights of the activities that the NGOs are involved in based on updates from these meetings.

Catholic Relief Services (CRS)

- Construction of 8 PHUs in nine communities
- Conduct baseline survey using parts of CARE's KPC questionnaire in May 2004
- Work with VDCs' health subcommittee to select TBAs who will also work as village health workers. They will also train/support training of MCH Aides (TOT) and (250) TBAs in

Neini, Diang and Mongor chiefdoms to be conducted between April and May 2004. Kits are to be given to TBAs upon completion of training.

MSF Belgium

- Exit from Kabala effective 1 May 2004 due to funding problems.
- Before their impending exit they had plans to build 4 additional PHUs and pilot test the use of Artesinate Combination Therapy (ACT) against Malaria. They have left a 3 months supply of essential drugs in the PHUs which they support.

SLRCS (Sierra Leone Red Cross Society)

- School health clinic has been established (in their office in Kabala).
- 150 war affected children and mothers have benefited from their assistance.
- Ministry of Health and Sanitation staff make regular visits to the center to monitor the use of chloroquine among under fives.
- Community health posts will be constructed for women and children (and will operate on a cost recovery system). The targeted chiefdoms are yet to be determined.
- They aim to establish first aid posts and to train 30 community first aiders.
- 41 disaster preparedness volunteers have been trained in March 2004.
- First aid training was conducted in Kakonkobo on the 7th of March 2004 after the fire disaster.

Christian Extension Services (CES)

- Health education (on basic communicable diseases) is on-going.
- Following up VVF (reproductive health conditions) patients.
- Plans to conduct a research in the district to identify VVF patients.
- Secured USD 10,000 from a US donor for footing medical costs of VVF patients.

Other Donors/NGOs (who do not have regular attendance for district collaboration meetings)

UNICEF

UNICEF will be providing support for Koinadugu district health management team. There is a draft plan for 2004 and promises for a revised one.

World Bank

Have plans to rehabilitate the district referral hospital and construction of three PHUs (community health centers).

Helen Keller International

HKI will be supporting nutrition-related programming for the DRP and the Child Survival Project with specific emphasis on improving Vitamin A status through supplementation, dietary diversification and home gardens.

Meetings are held regularly with other health actors in the District in order to coordinate activities. The group of NGOs listed above, with CARE, meet together on a recurring basis. Information on UNICEF and World Bank activities are sometimes hard to capture, however, the DHMT serves as a good information and coordination source.

National Level Coordination

At national level, CARE is involved in the Nutrition Working Group, the Roll Back Malaria (RBM) Task Force and the MOHS Task Force—convened by the NGO/donor liaison officer. Additionally, IRC is implementing a Child Survival Project in the neighboring Kono District of Sierra Leone. Collaborative linkages have been developed between the implementing teams of the Child Survival Projects in Kono and Koinadugu. The two NGOs have participated in joint health visioning exercises towards the formation of the Sustainability Working Group. The Working Group plans to meet routinely so as to reflect on the progress of the two projects towards sustainability. The two NGOs will explore further collaboration in areas such as training curricula, Health Management Information Systems (HMIS) and quality assurance standards. In addition, cross-visits will be arranged between key stakeholders from the two districts to share efforts and achievements.

Health policies in Sierra Leone are also difficult to locate. Few policies seem to exist and those which do are constantly in “draft form” and not circulated. For this reason, CARE has worked and will continue working closely with the DHMT in order to ensure consistency with health policies as they understand them.

Constraints to Achieving Program Objectives

Several sources of risk have been identified at all levels of implementation. The following table identifies the different areas which could present a challenge for successful project implementation. These issues have been taken into consideration in planning activities and developing the timeline.

Constraints to Achieving Objectives			
Level of Risk	Effect on Behavior Change	Effect on Quality	Effect on Access to Services and Health Products
Environmental	Disease epidemics (malaria, cholera, dysentery, AIDS) due to poor practices and conditions. Recurring environmental shocks.	Inaccessibility of the project area and of health facilities due to excessive rainfall or other weather conditions.	Inaccessibility of the project area and of health facilities due to excessive rainfall. Prohibitive costs of health care limiting use of skilled health workers.
State/District	Conflict destroying social infrastructure and imposing mobility restrictions. Policies regarding disease control e.g. malaria policy on protocol for prevention and control may not necessarily be appropriate.	Declining public health expenditures, user charges, declining education expenditures. Privatization of social services reduces community's utilization of state owned/run facilities.	Deterioration or poor remuneration and working conditions of health staff leading to low staffing. Reduction in labor opportunities. Rapid inflation increasing costs of health care for communities.
Community	Breakdown in community cohesion and social support networks. Poor participation in interventions.	Deteriorating or poor quality of health care causing a breakdown in community support of social services.	Low uptake of health services from facilities resulting in poor utilization of services.
Household	Poor Awareness, knowledge, attitude and practice towards health care by chief decision-makers reduces households' chance of positive behavior change.	Poor quality of care for sick children and household members can lead to increased morbidity or mortality.	Mistrust by the household of health caregivers can lead to low uptake of services rendered by the facilities.

Intervention Selection

The four interventions chosen for the Koinadugu District were done so in conjunction with the DHMT and in consultation with other local actors. Based on the KPC data, the selection of interventions is confirmed, with slight alteration in the level of effort for each. Given that an infrastructure is in place for stronger Immunization coverage, previous and future existence of support for this activity by other agencies such as UNICEF, the Christian Children's Fund (CCF) and MSF-B and the high levels of coverage reported in the KPC survey, the emphasis on this intervention has been reduced. Regular monitoring of immunization coverage will be necessary as the high coverage may be closely linked to the recent NID. Malaria prevention, on the other hand, has been identified as a critical activity for the project area. KPC data show frequent self-treatment of fever and poor insecticide treated bed net use. Additionally, national policy for malaria treatment was recently changed and the responsibility of NGOs to help implement will be high. The level of effort for the nutrition intervention has been reduced given the focus of CARE's Nutrition Support Project (NSP) and Title II Development Relief Program (DRP) on community-based growth promotion and positive deviance. The projects will work together in this effort to improve local nutrition practices. The maternal and newborn care intervention remains essentially the same as district statistics support the need to focus on skilled assistance during deliveries and appropriate newborn care.

While the baseline survey found low levels of knowledge regarding HIV/AIDS, the Child Survival Project will not directly address the intervention. The Community Health Clubs do include HIV/AIDS prevention as one of their topic areas, however, other CARE projects in the area will complement with a heavier emphasis. The DRP, funded by Food for Peace, and a component of the CARE Condom Social Marketing Project will be implemented in Koinadugu District to support other HIV/AIDS activities. The Watershed Project will implement Stepping Stones, a communication training package that focuses on reproductive health and HIV/AIDS working through peer groups of old and young men and women. In addition, CARE will work specifically through their Sexuality and Youth (SAY) Project with out of school youth on reproductive health and sexuality issues. SAY will be implemented in collaboration with UNICEF and the Ministry of Education, Science and Technology (MEST).

2. Program Description by Objective, Intervention and Activities

The goal of *For Di Pikin Dem Wel Bodi* is to improve the health status of children under five and women of reproductive age in Koinadugu district through the achievement of three principal objectives:

1. Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to prevent, recognize and manage common diseases;
2. Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms; and,
3. Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services.

The Project will implement four interventions: EPI (15%), Nutrition (20%), and Malaria (35%) and MNC (30%) based on the following strategies:

1. *Capacity-building of institutions and partners* through training, organizational diagnosis activities and subsequent action on areas of need.
2. *Behavior change communication (BCC)* activities will be used to promote physical health, prevent disease, improve home management of disease, promote appropriate care-seeking practices among caretakers and household members, and improve practices of health care providers.
3. *Quality assurance initiatives* will include the development of protocols and instruments that will guide an innovative system of creating opportunities for peer feedback.
4. *Health system strengthening* will be addressed by CARE in support of IMCI.

The objectives, strategies and interventions listed above contribute well to each of the CSHGP's Intermediate Results. CSHGP's IR1 relates to increased quality of programs implemented by PVOs and their partners. The Child Survival Project uses a community-centered approach in close partnership with the Koinadugu DHMT to have the greatest impact on child health. There is specific focus on quality assurance for safe and sustainable practices. Intermediate Result 2 focuses on sustainability of programs which is supported by this Child Survival Project by the inclusion of Community Health Clubs (CHCs) to support community level behavior change. This activity allows for capacity-building at the community level for sustainable change. The project has also teamed up with the IRC in Sierra Leone to develop indicators for monitoring and evaluating sustainability. The final IR on the testing and application of child health program strategies, tools and approaches is once again supported by the Child Survival Project's focus on CHCs and through the use of Child Survival tools such as C-IMCI, the CSSA and the BEHAVE framework.

Given that the objectives of the Project are cross-cutting for all interventions, the approach to achieving them is covered within each intervention's description. The strategies described above and those specified in the DIP guidelines of Behavior Change Communication, Quality Assurance and Access are also cross-cutting. Key overarching aspects are covered here with more details provided in each of the intervention sections.

2a. Intervention Specific Approach

Behavior Change Communication

Based on the baseline and qualitative assessments, the practice of healthy behaviors in the Koinadugu District is in need of improvement. The development of a more intensive BCC strategy is planned in the coming months for the Child Survival Project partners in the district. An initial draft was created during the stakeholder meeting held in April focusing on key messages and key activities for the interventions. This is presented within the details of the interventions. The key family/household practices of the C-IMCI strategy will be promoted through the BCC strategy. To contribute further to the strategy, additional qualitative research will be conducted. There are some general activities to be conducted across all interventions with regards to behavior change. In order to define key messages and key behaviors, the project

has used the BEHAVE framework for program planning. Examples of this are under each specific intervention section. These will be refined during behavior change strategy meetings with the DHMT in the third quarter of the first year.

Household/Community

The project's key approach to behavior change at the household and community level is through the community health clubs (CHCs). These clubs are designed to disseminate health information, promote healthy practices and spearhead community support for the formal health system. The CHCs work closely with the PHUs to ensure that key messages are consistent and activities are complementary. The participation and training of other local health workers such as Blue Flag Volunteers, Traditional Birth Attendants, traditional/spiritual healers and drug peddlers will enhance communities' capacity to initiate, support and sustain health initiatives. Regardless of the health worker entry point, i.e. TBA or CHC, all workers and their activities will be monitored and coordinated by the PHUs.

Ninety-two Community Health Clubs have already been established in collaboration with other CARE projects in the District. Working closely with other CARE health projects ensures consistency of approaches and messages to target beneficiaries. Membership is not limited. Men and women above 15 years of age are included in this activity. These clubs have weekly health education sessions and are managed by an executive committee. CARE's Child Health mobilizers based in the communities currently facilitate the sessions. It is anticipated that this will eventually be turned over to the community health workers and PHU staff in the community. These clubs established a community map for the way their communities looked in the past (before the war) and how they are now and what they dream for the future. Other topics have included/will include nutrition education, diarrhea management using ORS/SSS, child rights, HIV/AIDS, etc. Approximately 25 topics have been established thus far. These topics relate to health issues beyond child health. There will also be an emphasis on girl child education as the KPC quantitative and qualitative surveys found low levels of education and little importance given to this area by community members. This allows the clubs to continue on as community-based organizations sustainable with their own capacity. Club members are expected to attend at least 80% of the 25 health education sessions. Once all topics have been covered, a special graduation ceremony is arranged. All of those members who qualified by attending at least 80% of the sessions will receive a glossy certificate. For most villagers, it will be the very first time in their lives that some recognition is given to their attainment of an intellectual pursuit.

Upon completion of these topics (expected by the end of the Project's first year), the clubs will take over responsibility for subjects and activities by seeking guidance from PHU staff and CARE Child Health Mobilizers. Community-based growth promotion (CBGP) volunteers will be selected from CHC 'graduates'. Based on the CBGP data, the need for the Hearth methodology will be assessed. Birth preparedness with regards to emergency transport will also be a key component of CHCs after the initial round of health education topics.

The DRP will also be mobilizing CHCs throughout the several of the same chiefdoms. The Child Health mobilizers will be involved in conducting another batch of 25 health education sessions starting early in the Year 2 of the Child Survival Project.

One-on-one communication between PHU staff and mothers/caretakers is another anticipated form of behavior change communication through the project. With village level health workers being better supported with key health information, they will have increased capacity to deliver more effective training to their respective community members. When a caretaker visits the PHU, health personnel will provide additional information regarding appropriate health, hygiene and nutrition practices to improve the health of the child.

Radio spots will be used to disseminate other key messages for community members. While Talking Drum is currently building the organizational capacity of Radio Bintumani, CARE will work together with MOHS and Radio Bintumani to help create appropriate health messages and dramas for the communities. Radio Bintumani, a local station in Koinadugu District, has agreed to work with CARE and Talking Drum on this endeavor, in exchange for further capacity building regarding radio-led health education. A further assessment of usage of radios in the communities will still be necessary in order to initiate this activity. During the KPC, it was found that 10.4% of community members own radios and 27.4% own recorders. Wind-up, solar powered radios (as per UNICEF's suggestion) will be provided to communities based on the assessment. Kabala theatre groups will also be involved in the capacity building of Radio Bintumani to provide another forum for message dissemination.

Health Facility

At the health facility level, as mentioned above, PHU staff will play a central role in ensuring the consistency of key messages (through active supervision) in the BCC strategy across health workers at community level. PHU staff will also collaborate closely with NGOs working in Koinadugu to develop appropriate and culturally relevant messages that are easily understood by low-literacy audiences.

District

In order to ensure consistency of messages and appropriate health education techniques, Child Survival Project staff will be trained in collaboration with the Ministry of Health and Sanitation regarding the key messages of public health concern in the areas of EPI, nutrition, malaria and maternal and newborn care as well as other key messages currently being utilized by the Ministry. Child Survival Project and Ministry of Health and Sanitation staff will also be trained on how to deliver participatory health education sessions to increase the retention and internalization of lessons by the beneficiaries or the target group.

The Project's health education officer will focus together with the Ministry of Health and Sanitation, on the articulation of messages and development of appropriate Information, Education and Communication (IEC) materials for implementation of recommended interventions. The Monitoring and Evaluation Liaison Officer will routinely collect data reflecting progress towards anticipated behavior changes.

Quality

The project had initially planned to conduct a health facility assessment to evaluate quality of care in the facilities. UNICEF is now planning to conduct the WHO health facility assessment in the coming months in Koinadugu District and, therefore, it seems redundant for the project to do

a separate one. CARE staff, along with the DHMT, will be partnering with UNICEF on this endeavor and will be involved in finalizing the tool and carrying out the assessment. This will provide the appropriate information for understanding the level of quality of care provided in the PHUs. Based on the current situation, the project will include quality of care components in the core IMCI training curriculum prepared for PHU staff. While the project focuses on specific intervention areas, the broader IMCI/C-IMCI approach will be an important piece of the technical skills to be acquired by district health staff. In preparation for this training, provider-friendly written materials will be adapted or possibly produced to assist PHU staff in conducting appropriate health services. This includes following intervention-specific protocols as well as ensuring client satisfaction.

At the start of Year 2 of the project, CARE staff will work with the District Health Management Team to utilize the COPE (Client-Oriented Provider-Efficient) manual with special focus on the COPE for Child Health model. EngenderHealth, in conjunction with the Columbia University Mailman School of Public Health Averting Maternal Death & Disability Project (AMDD), of which CARE has been heavily involved in, has recently produced a Quality Improvement for Emergency Obstetric Care Leadership Manual as an adaptation of COPE. These two tools will be used in a COPE assessment with the DHMT.

Including the DHMT from the start allows them to assess their ability to utilize the tools and process on a regular basis for supervision as well as planning future action steps. These tools allow for self-assessment at facility level as well as two-way discussion for supervision. Other supervision activities include review of records and joint patient examining and treatment. This also allows for strengthened forms and record-keeping to contribute to a smoother Health Management Information System (HMIS).

Quality Assurance standards will be set at District level in conjunction with CARE staff and DHMT staff. These will include the focus on client perspective and needs, viewing work in terms of systems and processes, using data-based decisions and teamwork. Data-based decision-making will be key to the project activities as this is an area of weakness in Koinadugu District. Very little data are analyzed at the district level and/or fed back to the PHU level. This is an important part of health systems strengthening in the project, however, the contribution and importance of data-based decision-making will support quality assurance at health facility and district level. As quality issues arise, as part of joint supervision, facility and district level health staff will work together to identify and analyze problems, develop, test and implement changes to improve the quality of services in the facilities.

Access: (1) Services; (2) Health-Related Products (Availability of Drugs, Vaccines, Micronutrients, Equipment, etc.)

PHUs are scattered around the chiefdoms. One PHU is likely to be responsible for anywhere between 10-50 villages. Given this, a number of NGOs are currently rehabilitating or constructing new PHUs in a number of chiefdoms. However, even with the construction and/or rehabilitation of these PHUs, they will still need to be staffed, and this will take time given the current capacity of the MOHS. Once staffed appropriately, CARE will work closely with these new PHUs as well as existing ones.

Community Health Clubs have been established in all communities in the project's intensive area. The active promotion of immunization outreach services, Vitamin A distribution and community-based growth promotion, form a major focus of these clubs. In this way, communities will gain an appreciation for the benefits of preventive health education and services available within their communities and at the PHUs.

The CHCs will also provide a link between the community and PHU with regards to health education. Project facilitated improvements in the improving quality of services at the facility level, is expected to increase community acceptance and utilization of the same. Awareness on the availability of free medical services, such as immunization, should improve the community uptake of the services.

The Sierra Leone Ministry of Health and Sanitation is currently in the preliminary stages of decentralization of the administration of health services to the District levels. A Health Facilities Assessment to be conducted by UNICEF and World Bank will help to identify the capacity of the District to oversee its health interventions as well as the availability of drugs, vaccines, etc. at the facility level. Thus far, there has been no obvious noting of unavailability of supplies. Insecticide-treated bednets (ITNs), however, are not easily accessible in Koinadugu District. UNICEF holds many nets at this time and is currently in conversations with CARE and the Koinadugu District Health Management Team on how to distribute these nets. Given the current high supply of these nets and the need in Koinadugu, the organizations are interested in distributing these nets appropriately and as soon as possible. DHMT and CARE will develop a social marketing plan that is in compliance with the Ministry of Health policy on bednets to affect the sale and distribution of the ITNs.

IMCI and C-IMCI

There are three key **components** to the IMCI approach:

1. Improving case management skills of the health-care staff – By the end of Year 1 of the Child Survival Project, it is anticipated that the Sierra Leone MOHS will have defined the implementation process for IMCI in the country. Included in this will be adapted guidelines for IMCI training for PHU staff. This will form the basis for CARE to develop a plan to train PHU staff in Koinadugu District on IMCI case management protocols and counseling techniques in partnership with the DHMT.
2. Improving the overall health system – CARE, working together with UNICEF and World Bank will establish an effective cost recovery mechanism for the IMCI essential drug list. The Child Survival Project will use the COPE for Child Health module will be used to assess quality of services at facility level and develop/modify supervision tools for DHMT staff.
3. Improving family and community health care practices - Community Health Clubs serve as the focus for community interventions aimed at improving household health, hygiene and nutrition practices. Participation of both men and women is largely encouraged to increase considering the significant role of men in the decision-making

CARE's approach to C-IMCI will focus on each of the **elements** described below:

Element 1: Improving collaboration and partnerships between the PHU staff and CHCs.

Element 2: CBGP volunteers and TBAs will provide appropriate and accessible care and information to community members.

Element 3: Positive family health practices are promoted through CHCs, radio spots, theatre, mass campaigns and one-on-one interaction between PHU staff/health workers and their clients.

Immunization (15%)

Behavior Change Communication

Key health objectives for EPI have been refocused in behavioral terms here:

Objectives	Behavior Change
Increased percentage of women of childbearing age who receive at least two Tetanus Toxoid vaccines before pregnancy or delivery.	- Women of childbearing age going for Tetanus Toxoid vaccination at least two times.
Increased percentage of mothers with children within the age 0-9 months attending EPI sessions.	- Women taking initiative to take their children for immunizations - Women ensure that immunization cards for their children are kept clean and safe at all times.
Ensure the availability of EPI services/facilities at PHU level.	- Personnel at national level to ensure the supply of EPI facilities free of cost. - Service providers at PHU level to deliver services free.

The following is the BEHAVE framework as used for the Immunization intervention. Proposed interventions are further classified based on whether the level of influence is at policy (**P**), institutional (**IS**), community (**C**), household (**H**) or individual (**I**) level:

Who?	What?	Factors	Intervention
Women of Child Bearing age. Bread-winners of the family	Women of Childbearing age go for TT at least two times before pregnancy/delivery.	-increased awareness on the side effects of TT vaccination - create awareness on the importance of TT vaccination to women of child-bearing age and other community members - change of attitude by EPI service providers - strengthen the logistics base to carry out immunization activities.	Mass campaigns (I, C, H, IS) Radio Spots (I, H) Theatre Groups (I, H) Full immunization at PHUs (P, IS) Increased number of outreach centers (P, IS) Provision of regular supplies for EPI services (P, IS).
Caregivers of Children 0-59 months	Mothers taking the initiative to take their children for immunization	-increased awareness on the side effects of TT immunization. - create awareness on the importance of TT immunization to women of child-bearing age and other community members - change of attitude by EPI service	Mass campaigns (I,C,H) Radio Spots (I,H) Theatre Groups (I,H) Full immunization at PHUs. P, IS) Increased number of outreach centers (IS)

		providers - strengthen the logistics base to carry out immunization activities.	Provision of regular supplies for EPI services. (P, IS)
Caregivers of Children 0-59 months	Women ensure good immunization record keeping (road to health/growth cards/TT cards)	- increased availability of cards to mothers - good recording of vaccines administered - emphasize on the clean and safekeeping of children's cards by mothers and caregivers.	Outreach activities for EPI (IS)

Quality and Access

Household/Community

With respect to quality of immunization activities at the community level, surveillance will be an important responsibility within the CHCs. While the community health monitoring boards are not yet fully established, it will be the responsibility of community members to monitor the children under five in their village who have received all immunizations. The child growth cards will be used by the CBGP volunteers to monitor child health immunization when they come for growth promotion activities. They will also work with PHU staff for organizing outreach services for immunizations for those communities located further from the PHU. CHCs will ensure that PHU workers are not charging for immunization services which will help to keep the communities closely linked with the health services provided. Generally, immunization coverage, as reported in the KPC survey, is high. The focus of the project is that the communities and PHUs work together to maintain this.

Health facility/District

Quality assurance within the Health System refers to quality of care issues as noted in IMCI training. This includes ensuring that vaccines are kept under proper conditions. Also included are monitoring that health facility workers are screening for immunization status, providing proper counseling and proper administration of vaccines. Additionally, guaranteeing the provision of vaccination cards and indication of vaccines given at the time of visit. Health facility staff are responsible for providing quality services while the District Health Management Team will be responsible for appropriate training and supervision, to be conducted jointly with CARE Child Health mobilizers.

Cross-cutting activities

Household/Community

Activities for improved immunization coverage at the household level include health education sessions during the Community Health Clubs promoting immunization. The Community Health Clubs will also assist in mobilizing support for EPI outreach activities to be conducted by PHU workers. The Community Health Clubs will also be involved in helping to monitor immunization coverage at the community level through their new community health monitoring boards. This will help in identifying children who have not received full immunizations and to encourage greater participation in regular immunization campaigns and outreach activities.

The radio spots and dramas planned in the district will also impact at community level to increase knowledge and awareness of free immunization services. This will promote transparency between health facilities and community members.

While the Child Survival proposal had mentioned working with volunteer vaccinators, they will now be included as community health workers to be trained on mobilizing support for immunization outreach activities. UNICEF is planning training for these community members, for which CARE will provide support as needed.

Health Facility

Health staff based at the health facility will be responsible for accurate record-keeping to track EPI coverage. The project will not be responsible for providing vehicles for outreach activities, however, PHU staff will be involved in conducting outreach visits at the community level with the support of the community health clubs, support structures at that village level (such as VDCs) and CARE.

These outreach sessions will be done through planning with the CHCs and coordination with CHC growth promotion sessions. Recommendations from the UNICEF Health Facility Assessment to be conducted will contribute to improve the cold chain and other possible problems inhibiting strong immunization coverage. The assessment will help to identify equipment needs for which assistance may be needed in identifying any necessary procurement. There will also be a review of materials to identify gaps in health education resources for PHU workers to use. CARE will assist in the design and production of these materials. There will also be sensitization to make sure that facility workers are providing free immunization services.

Given the high immunization coverage noted in the baseline survey, there are noticeable health practices with regards to immunization in the project area. PHU workers and CARE Child Health Mobilizers will work closely on identifying those families who practice these healthy behaviors for the improved health of their children.

District

The District Health Management Team will be responsible for collection, analysis and feedback on immunization data from the chiefdoms. This will help in monitoring coverage in the District and establishing a feedback mechanism. CARE will provide training to the District level Monitoring and Evaluation Officer to establish a system for keeping and analyzing the data electronically.

In order to ensure appropriate supply of vaccinations, the systems and communication will be set up with UNICEF. UNICEF is involved in provision of refrigerators and facilitates other cold chain logistics. Based on the health facility assessment, the need for improved cold chain activities will be reported.

District level staff will also be involved in supervision of PHU-level health workers on their EPI activities. CARE will assist to establish or modify checklists to assess cold chain, supply and correct administration.

Nutrition (20%)

As part of CARE's Household Livelihood Security approach, several complimentary projects to the Child Survival Project will soon be starting in Koinadugu District. Of these, several have nutrition components. This is one reason for the reduction in level of effort directly from this project, as the activities will be shared and overlapping with the other CARE projects.

The key CARE projects contributing to the improved nutritional status of the Koinadugu communities are the Nutrition Security Project (NSP) funded by Jersey Overseas Aid and the Title II DRP. The NSP includes the following focus: Improved nutrition will be achieved by 1) improving access to, and use of, potable water, 2) improving production, processing and consumption rates of nutrient-rich foods and by 3) delivery of an intensive health, hygiene and nutrition education program to increase understanding of waterborne disease transmission, the importance of dietary diversification and healthy nutrition practices (e.g. breastfeeding) and improving personal hygiene practices. The nutritional focus in the TAP will be on the involvement of community members in the CBGP. Both projects include supportive nutrition activities focusing on nutrition gardens and farmer field schools.

Behavior Change Communication

Key health objectives for Nutrition have been refocused in behavioral terms here:

OBJECTIVES	Behavior Change
To increase the number of mothers practicing exclusive breast-feeding.	- initiate mother and child contact immediately after birth. - commence breast-feeding within the first hour after birth. - give breast-milk on demand including at night.
To promote good nutritional practices for women and children including appropriate complementary feeding.	- pregnant women and children eating nutritious food (e.g. fish, eggs, meat etc). - introduction of supplementary foods at the appropriate time - continued feeding of children during illness especially during diarrhoea.
To increase the use of Vitamin A supplements for both children and women (post-natal care) as well as iron for pregnant women.	- full immunization of children. - encourage clinic attendance by mothers.

The following is the BEHAVE framework as used for the Nutrition intervention:

Who?	What?	Key Factors	Intervention and Level of Influence
Lactating mothers and pregnant women. Mothers in law as well as peer pressure groups.	- initiate mother and child contact immediately after birth - give colostrum within the first hour after birth - give breast-milk on demand and continue until the child is 18 months old.	- reflect on cultural beliefs discouraging breast-feeding e.g. devil takes away the children. Colostrum contains worm, breast-feeding immediately after birth causes mother to experience stomach ache, sexual intercourse while breast-feeding poisons the milk. - emphasizing the importance	CHC talks (I, H, C) Workshops (C) Theatre groups (C) Radio spots (I, H, C) PHU Health talks (I, C) Ante or post-natal clinics (I, C) Posters on breast-feeding (I) TBA training (IS)

		of colostrum.	
Pregnant and Lactating women.	Full immunization of children. Regular clinic attendance by mothers	-Emphasis on the importance of immunization and Vitamin A and Iron supplements for pregnant women. -Emphasis on the fact that immunization is free. Increased awareness on the side effects of immunization. -Emphasis on the benefits of deworming for children 6-59 months.	CHC talks (I,H,C) Workshops (e) Theatre groups (C) Radio spots (I,H,C) Ante or post-natal clinics (I,C) Posters on breast-feeding (I)
Pregnant and Lactating women.	Initiation of complementary feeding after 6 months Appropriate complementary feeding for children.	-Stressing on the importance of the correct timing for initiation of complementary feeding. -The importance of continued breast-feeding with the introduction of complementary feeding -Emphasis on the importance of balanced diet for children. -Stressing the importance of continued feeding during child illness. -The correct preparation of ORS -Emphasis on hand-washing (with soap or ash) before eating	Group Demonstrations - (Hearth model) (I, H) CHC talks (I,H,C) Radio spots (I, H,C) Posters on breast-feeding (I)

Quality/Access

It will be imperative for appropriate supervision to be done by PHU workers as well as DHMT on the CBGP activities. Access to Vitamin A will be facilitated by HKI and by UNICEF for deworming medication. Scales are to be procured through UNICEF.

Cross-cutting

Household/Community

As part of the CHC activities, community-based growth promotion (CBGP) will be done on a regular basis. Graduates from the CHCs will be trained in this activity. The training will help the volunteers to conduct monthly growth monitoring and promotion, nutrition counseling, follow-up home visits for under five children with faltering growth, referrals, etc. Scales will be purchased from UNICEF. A quote has already been received for the price of the scales. The ownership of the CBGP program will be with the CHCs, which will in turn allow for ownership of the child's health. These sessions will begin once the initial 25 sessions are completed. Before that time, CARE Child Health Mobilizers will conduct training for the CBGP volunteers. CARE will facilitate child registration and issuing of birth certificates procured from the MOHS followed by the growth card for CBGP. As mentioned in the Immunization section, this will be

held in conjunction with the outreach immunization campaigns. This activity will also combine Vitamin A distribution as well through the support of Helen Keller International. As growth monitoring is conducted, PHU workers will supervise overall compliance with MOHS protocols regarding appropriate counseling and designing an action plan for follow-up of malnourished children.

The radio spots and dramas through Radio Bintumani and the Kabala theatre groups will include messages on the importance of exclusive breastfeeding, timely complementary feeding and local options to ensure balanced diets for young children.

The CHCs are already using flash cards for health education in the sessions. These cards include messages on exclusive breastfeeding, complementary feeding practice, promotion of locally available foods, interfamilial distribution of food, etc. These cards have been adapted from the Zimbabwean Health NGO Zimbabwe AHEAD (Applied Health Education and Development). Even though the pictures are of rural Africa, they will need to be adapted into the Sierra Leonean context. Some adjustments may be made in the future and additional cards created to address common practices related to nutrition including children not eating eggs or bananas and no fish/meat in front of elders. There is also a problem with group eating in poor sanitary conditions, which will be addressed in health education messages.

To support exclusive breastfeeding practices, the CHCs will serve as mother-to-mother support groups as needed to encourage successful breastfeeding practices. The Mommy queens in these groups will be targeted in order to encourage this type of atmosphere within their community due to their position of influence.

Deworming will also be a component of the nutrition intervention, but only as one of support. UNICEF will be taking the lead by providing deworming medication free. The CHCs will support UNICEF and PHU deworming activities by conducting health education and awareness raising for the medication.

During the third year, it is anticipated that the Hearth model will be put into place. This will include the CHCs to involve mothers, families, and neighborhoods in rehabilitating their own malnourished children by using local foods and knowledge. This will help to reduce the prevalence of childhood malnutrition in the community and to energize the mothers and community to take broader, sustained action against malnutrition and poor health. Based on data from the CBGP sessions, specific communities will be targeted for where the need for nutrition counseling is most.

Health Facility

All areas promoted at the community level will be supported by the health facilities. The facility staff will also be educating on the benefits of exclusive breastfeeding, timely and appropriate complementary feeding, locally available foods, Vitamin A and Iron Folic Acid (IFA). There will be a direct connection with the CHCs in order to help with health education and counseling for malnutrition.

With regard to appropriate breastfeeding practices, PHUs will be expected to follow the WHO/UNICEF “Ten Steps for Successful Breastfeeding”:

- 1) Have a written breastfeeding policy that is routinely communicated to all health care staff,
- 2) Train all health care staff in skills necessary to implement this policy,
- 3) Inform all pregnant women about the benefits and management of breastfeeding,
- 4) Help mothers initiate breastfeeding within an hour of birth,
- 5) Show mothers how to breastfeed, and how to maintain lactation even if they are separated from their infants,
- 6) Give newborn infants no food or drink other than breast milk, unless medically indicated,
- 7) Practice rooming-in (allowing mothers and infants to remain together 24 hours a day),
- 8) Encourage breastfeeding on demand,
- 9) Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants, and
- 10) Foster the establishment of breastfeeding support groups and referring mothers to these support groups on discharge from the hospital or clinic.

Nutrition assessment and counseling is part of the IMCI strategy. Health workers will be trained and supervised to improve their ability to conduct nutrition counseling on such as aspects as the preparation of locally available foods high in nutritional value and beneficial to children under 5. There is a plan for monthly coordination at PHU level between PHU staff and community-based health volunteers (including CBGP volunteers) to follow-up and troubleshooting with regards to particular cases of malnutrition.

Health staff will also provide oversight and supervision of CBGP activities. Additionally, they PHU staff will be responsible for collecting data from CBGP sessions as well as for those in their own facility. These data will be locally analyzed as well as sent up to the district level for further analysis and feedback. CARE will train/refresh PHU staff on analysis and interpretation of PHU level data.

District

At the District level, DHMT members will be responsible for managing these data and providing feedback to their PHU representatives. They will also be involved in other NGO and international agency programs in the planning and coordination of health activities and communication messages.

National/Policy

In planning meetings between several INGOs and Helen Keller International, there was concern that information on nutritional assessments by the government and policy on nutrition issues are lacking. HKI is expected to assist the MOHS on this front with the advice and involvement of the other NGOs. Behavior change strategies and the assessment tools are being circulated between these organizations. HKI will be working closely with CARE in deciding a plan for Vitamin A distribution, recommended to be free by the MOHS. For now, the Vitamin A policy to be used will be that established by the WHO:

Target Group	Dose
Infants < 6 months of age, only if not breastfed. (Breastfeeding infants should be protected by post-	50,000 IU orally, one dose

partum dosing of mothers)	
Infants 6-12 months of age	100,000 IU orally, every 4-6 months
Children > 12 months of age to 5 years	200,000 IU orally, every 4-6 months
Mothers (post-partum, lactating mothers)	200,000 IU orally within 6 wk. of delivery, one dose. Note: This should be given during the first post-partum visit, ensuring that the woman is not pregnant at that time.

CARE will also pay close attention to align health education messages with policies to be defined/developed regarding exclusive breastfeeding and infant and young child feeding. These are part of HKIs current workplan.

Malaria (35%)

Behavior Change Communication

Key health objectives for Malaria have been refocused into behavioral terms here:

Objective	Behavioral Change
Increased use of ITNs	<ul style="list-style-type: none"> - vulnerable target groups sleeping under ITNs - routine re-dipping of ITNs practiced (if 5-year long-lasting bednets are not available) - target groups buying ITNs
Increased treatment of children aged 0-59 months and pregnant women with an effective anti-malarial drug.	<ul style="list-style-type: none"> - children and pregnant women with fever going to the PHU for treatment - standard case management of all malarial cases by PHU staff - target groups using effective anti-malarial drugs - adherence of target groups to prescribed treatment
Increased use of intermitten preventive treatment (IPT) with anti-malarials for pregnant women.	<ul style="list-style-type: none"> - pregnant women and caregivers with under fives routinely attend PHUs for well clinics - pregnant women utilizing anti-malarials - early detection of danger signs and symptoms by Pregnant women and mothers with under fives - household participatory decision making on ante and post-natal care - pregnant women and mothers with under fives seeking advice from TBAs and other community based auxiliary staff.

The following is the BEHAVE framework as used for the Malaria intervention:

Who?	What?	Key Factors	Interventions
Mothers of Under-fives and pregnant women. Fathers, caretakers and breadwinners.	Pregnant women and Under fives sleeping under ITNs.	<p>Women undertake income generating activities to enhance the self-procurement of ITNs</p> <p>Increase knowledge on the merits of ITNs use as compared to other nets.</p> <p>Emphasis on why pregnant women and children under five are most vulnerable to Malaria.</p>	<p>PHU health talks (I, C)</p> <p>Posters (I)</p> <p>CHC sessions (I, H, C)</p> <p>Weighing days (I, H, C)</p> <p>Film shows (I, C)</p>
Mothers with children 0-23 months and pregnant women.	Pregnant women and mothers with children 0-23 months being treated with	<p>Knowledge by PHU staff of Standard Case Management of Malaria.</p> <p>Availability of health care delivery system.</p>	<p>PHU health talks (I, H, IS)</p> <p>CHC sessions (I, H)</p> <p>Radio spots (I, H, C)</p> <p>Outreach days (IS,</p>

	effective anti-malarial drug.	Effective utilization of health services.	I, C)
Pregnant women, women 15-49 years of age, women with children 0-23 months.	Ante and post-natal services as well as under five well baby clinics effectively utilized by target groups.	Participatory decision-making on health issues (husband and wife etc) Importance of post and antenatal health care understood and appreciated by all parties (husband and wife etc). Importance of anti-malarial medication for pregnant women.	CHC sessions (I, H, C) Outreach Days (IS, I, C) Posters (I) Radio (I, H) Community Theatre (H,C) Home visits (IS, I) Mid-wife talks (C) T-shirts (I)

Quality

Quality with respect to the malaria intervention will include ensuring appropriate standard case management at the facility level through the IMCI training. Given that a high percentage of patients seen at the PHU are due to malaria, quality of care in relation to client-worker interaction and standard case management may be lacking. A new policy is in the process of being put in place for the use of ACT for malaria treatment; however, it will likely take some time for the old practices to disappear. It will be important that supervision activities include close monitoring on this issue as the resistance to treatment such as chloroquine is high.

Access

Drug availability, especially given the new protocols, may be difficult for many of the PHUs. ITNs will be provided by UNICEF. Pilot testing the sale of nets will assess the accessibility in relation to cost. The project, in collaboration with UNICEF and the DHMT, is in the process of defining the social marketing component in terms of type of nets, storage, treatment and partner roles. Based on the results, adjustments will be made to ensure that these nets are accessible to the entire community. Before and after nets are distributed (or sold), health education with CHCs and the broader community will take place to ensure appropriate use of nets and access by all family members.

Cross-cutting

Household/Community

Malaria related activities at the community-level will include health education on the topics of insecticide-treated bed nets, recognition of danger signs and appropriate environmental sanitation practices. A consumer education approach will be used with the CHCs to train on modes of transmission, recognition of disease, prevention and treatment options and recognition of serious illness which requires referral. The health promoters from Christian Extension Services will also be involved in these field-based activities and will follow-up to make sure that the learnings are being applied. UNICEF has a great quantity of ITNs that they are interested in distributing within Koinadugu through the Child Survival Project's assistance. The CHCs will be used as

intermediaries to sell ITNs on a cost recovery basis. This will likely be initiated through pilot-testing of social marketing of the nets.

Given that many mothers sought treatment for their children's fever from traditional healers and drug peddlers, these groups will also be targeted for recognition of serious illness and seeking treatment. Given the change in policy for treatment with ACT, these groups of people may not be able to carry the appropriate drugs. The focus on them, therefore, will be on encouraging appropriate referral.

Radio spots will include dramas based on the messages mentioned above. There will also be strong promotion of ITN use through the radio spots. Given the additional focus in the District by other CARE projects on water and sanitation programs, emphasis on breeding grounds will also be highlighted.

Health Facility

PHU workers will be trained in IMCI standard case management for malaria. The algorithm will be provided to assist the workers in assessment, classification, treatment, referral for severely ill children, recognition of treatment failure, use of second-line anti-malarials and counseling. Health workers will also promote the use of ITNs by all for prevention of malaria.

The Koinadugu Hospital in Kabala is in the process of becoming a tertiary facility. This is currently the only place in the District for severe malaria cases to be seen. IMCI training will also be conducted for staff at this level. Given the distance to this facility from many villages, the PHU workers may be targeted for how to manage these kinds of cases. CARE and the DHMT will assess this together in designing the IMCI training.

Those at the PHU level will be responsible for carrying out the new policies put in place for combination therapy treatment of malaria. Chloroquine has been the treatment used most commonly, however, efficacy studies now show a 60% resistance to chloroquine, and therefore, chloroquine will no longer be used as a treatment for malaria.

Imported test kits (rapid diagnostic tests, RDT) will also be used to help health workers identify cases of malaria more quickly. Laboratory testing is a lengthy process and often community members do not return to find out the results. The concern is that it will take some time for the new treatment drugs to be available which may make the in-house malaria testing a possibly questionable activity. The use of these kits will be part of the project's operations research as it will initially be pilot tested in certain communities.

The project will encourage the provision of intermittent preventive therapy during pregnancy. It is recommended that all pregnant women receive at least 2 doses of the recommended anti-malarial drug. Case management of malaria during pregnancy will also be a part of the training package for PHU workers.

Health workers will be trained in appropriate techniques track malaria cases in order to direct health education at the PHU level and within the CHCs.

District

The district level will take the responsibility of monitoring data from the PHUs. The District Health Management Team will actively be involved in analysis of data to measure prevalence of malaria for the district. They will also be helping to establish and carry out protocols for IMCI which will include malaria diagnosis and treatment.

The new changes in treatment protocol will also involve the district. The DHMT will be responsible for training the rural health workers on the new protocols for treatment and with the supply for this. ITN distribution will be worked on at the district level to devise a strategy for cost recovery and equitable distribution.

These drugs and ITNs will be available in the district medical store. CARE will help the DHMT to revive the store as part of project activities. During the partnership assessment, the Koinadugu MOHS capacity will be assessed for their needs in terms of the systems to support the cost of the new drugs and ITNs. The logistics of moving insecticides for the purpose of retreatment of nets, is an issue to be assessed at the district level. As of yet, this has not been discussed as UNICEF also needs to be a part of this discussion.

National/Policy

MOHS Sierra Leone is actively involved in Roll Back Malaria. This includes home recognition of malaria as well as seeking treatment. This is an important piece of G-IMCI. As part of the RBM strategy, the National Malaria Control Program (NMCP) in collaboration with WHO conducted a study of drug resistance on chloroquine, sulphadoxime-pyrimethamine and Amodiaquine in selected districts.

Efficacy study results indicate that Chloroquine (CQ), Sulfadoxine-pyrimethane (SP) and Amodiaquine (AQ) resistance (treatment failure) is high throughout the country.

- Freetown: CQ 60.7%; SP 17.6%; AQ 7.4%
- Makeni: CQ 70.0%; SP 24.0%; AQ 5.4%
- Kabala: CQ 39.5%; SP 23.2%; AQ 18.2%
- Kailahun: CQ 78.8%; SP 46.1%; AQ 29.8%

Thus far, only 11.5% of health workers in the country were trained in malaria case management within the past two years. Apart from the core group, no other health workers have been exposed to IMCI. The new policy (still in draft form), suggests that Sierra Leone will soon join 13 other African countries, including Liberia, that are in the process of changing their national first-line malaria treatment policies away from mono-therapies, such as Chloroquine and Fansidar, which are now virtually useless due to resistance, to proven Artemisinin-based combination therapy--known as ACTs. This change in policy will affect the drug supply and protocol supervision for malaria treatment. ACT treatments cost on average ten times more than the traditional chloroquine treatment. CARE will remain actively involved in the further progress of this policy and overall RBM implementation to ensure consistency with trainings in Koinadugu district.

Maternal and Newborn Care (30%)

Behavior Change Communication

Key health objectives for Maternal and Newborn Care have been refocused into behavioral terms here:

Objective	Behavioral Change
Regular ANC visits by pregnant women.	- pregnant women making regular visits to the PHU for ANC.
Early reporting of danger signs associated with pregnancy.	- women can recognize danger signs associated with pregnancy.
Joint and timely household decision making on ante-and pre-natal care issues.	- women and men both participate in making timely decisions regarding pregnancy, delivery and breast-feeding.
Increased knowledge of women on HIV/AIDS	- women know about HIV/AIDS and can state at least two modes of transmission.
To increase deliveries conducted by skilled personnel	- mothers delivering their babies at the local PHU.

The following is the BEHAVE framework as used for the Maternal and Newborn Care intervention:

Who?	What?	Key Factors	Interventions
All pregnant women Husbands Caretakers e.g. mothers-in-law Mommy Queens	Regular ANC visits.	Messages to address the importance of; -nutrition (IFA, locally available foods) -immunization (TT) -personal hygiene -use of ITNs -environmental sanitation -clean and safe delivery -early recognition of risks in pregnancy.	PHU health talks (I) CHC sessions (I, H, C) Radio spots (I, C) Posters (I, H) Songs (C) Campaigns (C) Outreach Clinic (IS, I)
Women of Child Bearing Age Lactating mothers Husbands Caretakers	Early reporting of danger signs associated with pregnancy e.g. fever Early referral mechanism set up and operating.	Increasing knowledge about the benefits of early reporting of neonatal danger signs. Early treatment of ailments.	PHU health talks (I, IS) Songs (C) Campaigns (C)

Women (15-49 years), husbands, caretakers	Husbands and wives make joint decisions on health related issues.	Importance of joint participation in decision-making. Importance on planning ahead for delivery before the onset of labor.	Campaigns (C) Role plays (I,H,C) Posters (I,H)
Women of child bearing age Husbands	Husbands and wives are aware of HIV/AIDS and the modes of transmission and prevention.	Stressing of the main modes of transmission of HIV. Emphasis on the disease progression of HIV/AIDS Details on ways of preventing spread of the disease Information on what to do when one is HIV positive.	Posters (I, H) Role Plays (H, C) Campaigns (C) Pamphlets (I, H)
Women of Child Bearing Age Husbands Mothers in Law	Mothers delivering their babies at the local PHU.	Emphasis on the benefits of delivery at the PHU assisted by skilled personnel. Emphasis on the quality of care provided at the PHU during delivery of children.	Mother in law talk sessions. (I, C) Role Plays (H, C) Theatre groups (H, C) PHU Health talks. (I, IS)

Quality

Quality assurance will be a key component in the MNC intervention especially in the area of Emergency Obstetric Care. The DHMT will use the COPE Quality Improvement for Emergency Obstetric Services manual to identify key areas to focus quality of care activities for the PHU and Kabala Hospital staff. These will be used during regular quality of care supervision visits. As mentioned in previous interventions, the same quality assurance techniques will also be present for conducting TT vaccination, Vitamin A distribution as well as intermittent presumptive treatment. Quality of care for the newborn will also be an important aspect of training. The Healthy Newborn manual produced through CARE will contribute to this activity. The manual focuses on ensuring an essential newborn care package. The package includes training in skills for neonatal resuscitation; the clean chain (clean hands, clean services, clean blade to cut cord, clean cord tie, clean cloth); the warm chain (dry baby, warm room, warm mother, wrap up, use hat); breastfeeding; cord, eye and skin care; immunization; and Vitamin K for low birth weight. This will be included in the training curricula for PHU staff and TBAs in the District.

Access

A large problem with Emergency Obstetric Care is access to a facility and in the case of very dangerous cases, to a facility that has the ability to assist. To address this, the project will focus on birth preparedness. This is to help communities focus on planning for where to deliver in advance and what to do in an emergency. CHCs will be involved in assessing potential modes of transport to the PHU for normal deliveries and/or Kabala Hospital in the case of an emergency.

Communities will discuss options for allocating an area for mothers to wait for several days before onset of labor. In addition, as noted from baseline information, decision-making about where to deliver usually lies with the husband and does not happen until the woman is in labor. Through the CHCs, emphasis will be placed on early and joint decision-making. This also addresses CARE's focus on rights-based approaches.

Household/Community

To support Maternal and Newborn Care activities in the district, the project will work in the CHCs to promote key messages such as improved nutrition for the pregnant mother, prevention of and treatment seeking for infections and birth preparedness and complication readiness by the entire community. Iron/folate tablets will also be distributed during outreach activities organized by the PHUs and CHCs.

Birth preparedness includes promotion of skilled attendance during delivery. The inclusion of TBAs is important given the high usage of them in Sierra Leone. If a skilled attendant will not be present, promotion of a birth preparedness plan developed jointly by the family and the TBA should be done. In this situation, early post-partum care, especially within the first 24 hours through outreach visits from the PHU staff will be promoted. Given that so many births are still likely to occur in the home, community members will be trained to ensure a safe and clean delivery and immediate newborn care. Immediate newborn care includes immediate warming, drying, stimulation of crying, ensuring the baby's airway is clear, clean umbilical cord care, immediate and exclusive breastfeeding and reduction of unsafe practices. Recognition of danger signs will also be key to immediate newborn care. UNICEF and CRS already have plans for training TBAs in the District. CARE will work with UNICEF and the DHMT in developing this training to ensure that it is of good quality, suitable for low-literacy target groups and checks for learning.

CARE will provide Home-Based Life Saving Skills (LSS) training in CHCs for full community involvement and understanding of need for and means of preventing maternal and neonatal deaths. Home Based LSS represent a critical re-thinking of conventional community-based approaches. First, Home Based LSS takes into account the social context of childbirth, focusing on the pregnant woman, her family caregivers and home birth attendant. Secondly, it addresses the challenges inherent in responding to unpredictable life threatening complications, including problem recognition, first aid care, referral decision-making and health care seeking. Last, Home Based LSS works to enhance, rather than replace, existing care practices, negotiating safe, feasible and acceptable actions that will be taken in the home setting when life-threatening complications occur. This activity complements the focus on improving EOC at the health facility and will shape the TBA training. CARE will work with the DHMT to modify this training for the CHCs and to link it in with general TBA training.

The CHCs will also be educated on the importance of setting up a referral system based on the recognition of common danger signs for referral. The activities will include birth preparedness. The common practice is for the husbands to decide on where to deliver *while* the wife is in labor. The focus of messages will be on advanced decision-making.

Health Facility

PHU staff will be responsible for encouraging regular antenatal check-ups and screening for potential complications. Key antenatal care conditions will include deworming, IPT for malaria, TT, IFA distribution and screening for infections. Screening should be done with potential solutions available as well. Many of the PHUs will not have interventions available to address all complications, however, they will be trained to help identify options for the mother. It will be the responsibility of these health facility workers to monitor utilization rates for antenatal visits. As the HMIS system improves, so will the workers' ability to use the data to monitor health utilization in their catchment area.

Clean and safe delivery and immediate newborn care will be key components of training for health workers. IMCI training will include algorithms for care management of infants two weeks of age or younger. The IMCI approach assesses, classifies, treats and refers neonates when necessary, and ensures that mothers are appropriately counseled in breastfeeding, nutrition and home care.

The UNICEF Health Facilities Assessment should help to identify the ability of the facility to provide even basic Essential Obstetric Care as defined by WHO. Quality of obstetric care will also be the focus of activities at the PHU level. As mentioned before, training for PHU workers on quality obstetric care will be taken from the COPE model on Quality Improvement of Emergency Obstetric Care (EmOC). While the main focus will be only on EOC and appropriate referral linkages, the manual will be used as a guide.

The PHU health workers will partner with CARE staff in training the TBAs and other community members on Home-Based LSS. This will provide the linkage to the facility in case of referral.

District

The District Health Sister (DHS), who focuses heavily on public health in the district, will be involved with UNICEF and CRS in planning for TBA training in the district. There are several actors in the district that are involved in this type of training who will join together to devise a plan for targeting all TBAs in the district with consistent training and no duplication. The Home-Based LSS component will also be key to the TBA training curriculum here.

With the expected restoration of the District Medical Store, supply of essential drugs should be addressed. Based on the Health Facilities Assessment to be conducted by UNICEF, any need for better logistics will be discussed between CARE and the DHMT and a plan will be devised to ensure timely delivery to PHUs.

When a maternal or neonatal death occurs in a particular village, verbal autopsy will be used to understand why it occurred. This will involve the community through the CHC, the local PHU worker, the local CARE Child Health Mobilizer and a member of the DHMT. In this way, awareness will be created on how to prevent one from happening again.

It is the responsibility of the DHMT to supervise PHU workers on antenatal care and to be involved in training for appropriate antenatal, delivery and postpartum services. It is also

important for the DHMT to be responsible for monitoring data on antenatal coverage. CARE will conduct training and supervision jointly with the DHMT.

3. Program Monitoring and Evaluation Plan

Koinadugu District is known nationally for poor reporting with regards to health as well as all sectors. Basic data are collected at the health facility level through registers, tally sheets and growth cards for coverage of key health services. These data are sent to the DHMT, however little analysis is done. This is a problem recognized by even the DHMT.

The MOHS health information system includes:

1. The collection of raw data in the form of records, reports and registers from hospitals and Peripheral Health Units (PHUs).
2. The collation, analysis and interpretation of the information at:
 - Chiefdom (community) level
 - District Level
 - Provincial Level
 - National Level
3. The feedback of information in analyzed, condensed form to:
 - Provincial Level
 - District Level
 - Chiefdom (community) level
 - International Agencies concerned with health (e.g. WHO, UNICEF and World Bank)

The following illustrates the collection of health information from the district:

Level	Points of Patient Contact with Health Service	Forms
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Village Development Committee	<i>Village Registration</i>	Village Register
Peripheral Health Posts	<i>Community MCH Post</i>	Posts register of mothers/neonates UFC register General Clinic Register Tally sheet
Chiefdom Community HC	<i>Community Health Center</i>	Posts register of mothers/neonates UFC register General Clinic Register Tally sheet

Information is recorded at the points of patient contact above, on registers and forwarded to District headquarters on tally sheets

District PHC Monitoring and Evaluation Unit

1. General Register new and follow-up children over 5 yrs and adults.
2. Diseases of children under five years.
3. Nutritional status of U5s
4. Antenatals and at risk
5. Deliveries
6. Mothers' puerperal record and Neonate's condition.
7. Immunization of women and children.
8. Referrals
9. Tally sheets

Child Survival Project staff, in looking for information on TBAs, visited the DHO for records on TBAs in the district as well as their level of training. There was no central database for this type of information, instead the Project staff was instructed to go through stacks of individual names so as to collect the locations, names, training and if trained, when they were trained. The Koinadugu Data Pack mentioned in Section E1 mentions data gathering exercises to try to improve this area, however, the health information is still lacking. There were large differences between the data reported in the Data Pack and that collected by Child Survival Project staff directly.

Given that several PHUs have been supported by NGOs such as Christian Children's Fund and MSF-B, data collection has been two-fold in their facilities. There are forms for the NGOs and separate forms for the District Health Office. Now that most PHUs have now been handed back to the District MOHS, data collection will need to be standardized.

Data collection at PHU level relevant to Child Survival includes registers for under fives, antenatal check-ups and deliveries and tally sheets for immunizations. Few PHUs are able to provide statistics for their specific catchment area. VDCs will be encouraged to carry out and maintain a village level census that will provide catchment data for PHUs and will be routinely updated through a community-based system.

The project will conduct a partner capacity assessment in which they will be able to assess the strengths and weaknesses of the M&E system of the DHO. This is expected to happen by the end of quarter three of the first year.

UNICEF has donated a computer for the Koinadugu DHMT. The Child Survival Project, through CARE, is planning to assist in the purchase of a printer for the DHMT's use. The difficulty is, however, that few in the DHMT have computer skills. The Child Survival Project is working to identify an intern from an MPH program who will be able to assist during the fourth quarter of Year 1 on providing basic computer training for the DHMT M&E coordinator. The intern will also work with the M&E coordinator to establish a simple database for tracking all information coming in from PHUs in the district.

At the community level, there is currently no data collected in relation to health activities. Village Development Committees will be formed and/or revitalized through the mobilization of CHCs by CARE Child Health mobilizers and will be closely linked in collecting data at the community level. In other experiences with CHCs, community health monitoring boards were established for community level monitoring. During the final evaluation of another project utilizing CHCs, these boards were considered to be too much and sometimes irrelevant information. They were not designed to allow for community surveillance. The other difficulty was related to the literacy of the community members. Illnesses were *written* on the board, which made it more difficult to understand for the general community members. They were not created through a participatory process. During the fourth quarter of Year 1, when the rainy season is in full effect, the Project will use a participatory process of identifying the key diseases in the community and their major causes. Pictures will be developed as part of the participatory process to identify a common understanding of the diseases visually. This participatory process will also allow for further qualitative information to be collected on key diseases such as malaria

and maternal and newborn care. One thing to also include on the board will be deaths of mothers and neonates.

The surveillance board will take some time to fully be incorporated as a monitoring tool; however, the involvement of the community on this will contribute to the ownership to be held by community members. CHCs will identify an active member to keep the board updated. These data will be collected monthly by the CARE Child Health Mobilizer and provided to the relevant PHU as part of their catchment data. CARE at Kabala will gather the data together to assess health status for the five intensive chiefdoms. They will be able to assess village level morbidity and mortality through the information provided.

CHCs are also used for monitoring Child Survival activity. Registers are kept to keep track of club membership and attendance. As attendance seems to decrease, the Child Health Mobilizer will work with current members to identify reasons for this and try to mobilize community members to remain active. Each member of the CHC also holds a membership card. Each card includes the following information: Name, Health club (name), CDP (CARE Child Health Mobilizer), Village, Section, Chiefdom, District, Date enrolled and Date completed. In addition, there is a list of 25 topics to be covered by the CARE Child Health Mobilizer with the date and signature indicating completion and attendance. There is also a list of 25 items for practical homework in relation to the topics previously covered.

As part of monitoring and management for program impact, LQAS methodology is planned for use every six months. This approach using small random samples will allow the project and DHMT staff to measure whether or not progress is being made towards pre-determined standards. The first of these will be conducted in the 1st quarter of Year 2. This will be done in conjunction with DHMT staff and serve as a trial, to assess whether this can be done as frequent as twice a year. Where questions from the KPC survey were posed in slight error, the LQAS assessment, will look carefully at the questionnaire to ensure that this is corrected. It is hoped that this will be used as a management tool and help to reaffirm or reshape activities in the 5 target chiefdoms.

As mentioned earlier, the COPE methodology will be used to monitor quality assurance at the facility level. CARE and DHMT staff will work together to modify and test tools based on the UNICEF assessment and COPE guidelines. CARE will assist in producing additional copies of tools. This focus on quality assurance will allow for two-way discussion between workers and supervisors in devising ways of improving health worker performance and quality of service delivery.

In the third year of the project, a midterm evaluation will be conducted using an external consultant. The evaluation will be primarily qualitative, however, based on the successful use of the LQAS methodology, this will also be included. At the end of the project, an external consultant will also conduct a final evaluation. The KPC survey will be repeated at this time and IRC will be invited to participate in these evaluations as well.

As part of efforts aimed at the improvement in the DHO HMIS, the M&E coordinator and intern in collaboration with CARE, DHMT and PHU workers, will create a method for feedback of the

data reported to the District level. This will provide appropriate analysis of the data by the M&E coordinator and a systematic method of feedback for health workers. Data analysis will also be shared with other NGO actors in the district and with IRC who is implementing a Child Survival Project in the neighboring Kono District. During the design of a streamlined HMIS system, IRC and the Kono DHMT will be closely involved so as to share possible ideas for consistency.

DHMT members were involved in the KPC survey and will continue to be involved in LQAS surveys. They have been trained in conducting the surveys and supervising enumerators. A comprehensive field guide was provided during the KPC survey, which allowed for increased capacity. Their continued ability in years 3-5 to conduct these assessments without the assistance of CARE will be a measurement of their strengthened capacity.

Sustainability

In March 2004, CARE and IRC received TA from CSTS+ on Sustainability. The outcome of this TA was a set of indicators for each project to use in measuring sustainability in their District. As part of the process, the two organizations conducted visioning exercises in preparation for the TA. The Technical Assistance included a three-day working group meeting. The objectives of this meeting were to:

- Introduce the Child Survival Sustainability Assessment (CSSA) framework,
- Review and refine the vision,
- Develop indicators for sustainability in the Child Survival projects and activities and
- Define the next steps and identify responsibilities.

The vision created during the joint visioning exercise was presented for refinement. The new vision included several components. The following was the vision:

- More girls are staying in school longer, with positive consequences, including later marriage, greater capacity to follow their children's health.
- Most children are well nourished.
- Both women and men take equal responsibility in ensuring the health of their children.
- Health facilities are well equipped, accessible and well attended for both curative and preventive service with trained and motivated staff.
- Communities openly discuss, participate and come up with solutions in addressing their own health problems.
- National and community leaders, as well as local and international organizations, are accountable and transparent.

The dimensions of the CSSA were introduced. These include: Dimension One-Health and Health Services, Dimension Two-Organizational Capacity and Viability and Dimension Three-Community and Social Ecological Environment. Goals for each of these were identified as common for both organizations and Districts. The dimensions were further broken down into their components in the separate District groups. Elements for each of these components were identified to lead into the development of indicators.

Twelve indicators were established within the Koinadugu District. These indicators were refined during the stakeholder workshop following the Sustainability working group meeting. The

stakeholders agreed to work on the eleven listed in the M&E matrix and logframe below. While eleven still seems to be a large number in addition to the other set indicators, several are not necessarily collected directly through Project activities and can be analyzed using secondary data. The project will use the first year to assess whether these are feasible indicators to monitor.

Operations Research includes social marketing of ITNs for increased access to communities. Additional operations research includes the effectiveness of the Hearth Nutrition model. The methodology will be documented for insights into process, measurement of results and possibility for replicability. This will be shared with the MOHS and the aid community within Sierra Leone.

M&E matrix

The M&E matrix includes the indicators, data required, tool/source of information, whether the information is qualitative or quantitative, who collects the data, who analyzes the data, frequency of reporting and circulation. These indicators will be assessed using the LQAS methodology twice a year and especially during the midterm and final evaluations. The M&E matrix for the project can be found below:

Project M&E matrix							
Indicators	Data Required	Tool/Source of Information	Quantitative/Q ualitative	Who collects the data?	Who analyses data?	Frequency of Reporting	Circulation
Objective 1: Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviours to improve maternal and child health and prevent, recognize and manage common diseases.							
Nutrition							
Percent of children aged 0-23 months who were breastfed within the first hour after birth.	# of children 0-23 months and recall of breastfeeding within the first hour after birth	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of children aged 0-5 months who were exclusively breastfed during the last 24 hours.	# of children aged 0-5 months and 24-hr recall of exclusive breast-feeding	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of children aged 6-9 months who received breast-milk and complementary foods during the last 24 hours.	# of children aged 6-9 months and # of children who received complementary foods during the last 24 hours.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
Malaria							
% of children aged 0-23 months who slept under an ITN the previous night.	# of children aged 0-23 months and # that slept under an ITN	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of children aged 0-23 months with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug within 48 hours after the fever began.	# of children aged 0-23 months and # of children with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug within 48 hours after the fever began.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of mothers who took anti-malarial medicine to prevent malaria during	# of mothers and # who took anti-malarial medicine to prevent	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs

pregnancy.	malaria during pregnancy.						
Maternal and Newborn Care							
% of women aged 15-49 who know at least two symptoms that indicate the need to seek referral for emergency obstetric care.	# of women aged 15-49 years and # who knew at least 2 symptoms that indicate the need to seek referral for emergency obstetric care.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of mothers able to report at least two known neonatal danger signs.	# of mothers and # able to report at least two known neonatal danger signs.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
Other							
% of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment.	# of mothers of children aged 0-23 months and # that knows at least two signs of childhood illness that indicate the need for treatment.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of mothers with children aged 0 – 23 months who cite at least two known ways of reducing the risk of HIV infection.	# of mothers with children aged 0-23 months # who can cite at least two known ways of reducing the risk of HIV infection.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs

Indicators	Data Required	Tool/Source of Information	Quantitative/Qualitative	Who collects the data?	Who analyses data?	Frequency of Reporting	Circulation
Objective 2: Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services.							
EPI							
% of mothers with children aged 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child less than 24 months of age.	# of mothers with children aged 0-23 months # who received at least two tetanus toxoid injections before the birth of their youngest child less than 24 months of age.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of children aged 12 – 23 months who are fully vaccinated (against the five vaccine-preventable diseases) before first birthday.	# of children aged 12 - 23 months and vaccination status	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
% of children aged 12-23 months who received a measles vaccine.	# of children aged 12 - 23 months and vaccination status for measles	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
Nutrition							
% of children aged 6-24 months who received a high dose of Vitamin A supplement during the last six months.	# of children aged 6-24 months and # who received a high dose of Vitamin A supplement during the last six months.	KPC 2000+ survey and FGDs	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final	DHMT, CARE, Community, USAID, other NGOs
% of mothers who received/bought ≥ 90 iron supplements while pregnant with the youngest child less than 24 months of age.	# of mothers and # who received/bought ≥ 90 iron supplements while pregnant with the youngest child less than 24 months of age.	KPC 2000+ survey and FGDs	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final	DHMT, CARE, Community, USAID, other NGOs

% of mothers who received a Vitamin A dose during the first two months after delivery.	# of mothers, # who received a Vitamin A dose during the first two months after delivery.	KPC 2000+ survey and FGDs	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final	DHMT, CARE, Community, USAID, other NGOs
Maternal and Newborn Care							
% of children aged 0-23 months whose births were attended by skilled health personnel.	# of children aged 0-23 months, # of children whose births were attended by skilled health personnel.	KPC 2000+ survey and FGDs, LQAS	Qualitative and Quantitative	CHM, CHS, APM, PM	APM, PM, HSC	Baseline and Final, Biannually	DHMT, CARE, Community, USAID, other NGOs
IMCI							
% of children checked for three general danger signs.	# of children reporting sick at PHU, # checked for three general danger signs	IMCI facility assessment	Quantitative	CHS, DHMT	M&E Officer	Bi-annually	DHMT, CARE, USAID, other NGOs
Other							
% of health facilities that received at least one supervisory visit that included observation of management during the previous six months.	# of health facilities, # that received at least one supervisory visit that included observation of management during the previous six months.	DHMT supervisory reports	Quantitative and Qualitative	APM	M&E Officer	Bi-annually	DHMT, CARE, USAID, other NGOs

Indicators	Data Required	Tool/Source of Information	Quantitative/Q ualitative	Who collects the data?	Who analyses data?	Frequency of Reporting	Circulation
Objective 3: Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms.							
Number of health clubs formed that have:							
A documented set of organizational by laws.	# of health clubs formed, # of CHCs that have a signed set of organizational by-laws.	MOU, HC constitution	Qualitative	CHS, CHM	M&E Officer and APM	Bi-Annually	DHMT, CARE, USAID, other NGOs
Conduct 10 documented meetings per year.	# of CHCs, # of meetings per HC within a year.	CHM training reports, HC membership cards	Qualitative and Quantitative	CHS	M&E Officer and APM	Monthly	DHMT, CARE, other NGOs
Demonstrate documented conduct of health-related activities in the previous 3 months.	# of CHCs, # of CHCs that have carried out practical home-work from the training sessions in the previous 3 months.	HC Membership Cards, Direct observation of village	Qualitative and Quantitative	CHM	M&E Officer	Quarterly	DHMT, CARE, USAID
% of HCs with documented female membership of at least 40%.	# of CHCs, # of CHCs with female membership of at least 40%.	HC Membership Cards,	Qualitative	CHM	M&E Officer	Monthly	DHMT, CARE, USAID
# of HC members who have participated in CARE health promotion mobilization training.	# of registered CHC members, # of CHC members participating in CARE health promotion mobilisation training.	HC Membership Cards,	Quantitative	CHM	M&E Officer	Monthly	DHMT, CARE, USAID
% of respondents who state an action that was done by community or CBO to improve the health of the community.	# of respondents, # of respondents who state an action that was done by community or CBO to improve the health of the community.	Assessment interviews with village members	Qualitative	CHM	M&E Officer	Quarterly	DHMT, CARE, USAID

Sustainability Indicators							
Dimension 1 Component 2							
Percent of PHU staff following standard case management protocols.	# of PHU staff, # of PHU staff observed to be following standard case management protocols.	CARE/DHMT supervisory reports	Quantitative and Qualitative	APM, DHS	M&E Officer and PM	Quarterly	DHMT, CARE, USAID, other NGOs
Percent of households that have access to safe drinking water all year round.	# of households in project intense area, # of households getting water from a water source within 10 minutes reach.	DHMT supervisory reports	Quantitative	APM, DHS	M&E Officer	Quarterly	DHMT, CARE, USAID, other NGOs
# of PHUs receiving feedback from DHMT on the returns collected (functioning HMIS).	# of PHUs, # of PHU staff reporting feedback from DHMT on returns collected.	PHU records/reports	Quantitative	DNO, APM	PM	Quarterly	DMT, CARE, USAID, other NGOs
Dimension 2 Component 3							
% of health service provider with at least 50% knowledge in the skill area.	# of service providers for a skill area, level of knowledge of service providers.	Post-training assessments	Quantitative	CHM, CHS	M&E Officer and APM	Quarterly	DMT, CARE, USAID, other NGOs
% of HC implementing at least 4 health promotion activities per year.	# of HC, # of activities implemented by HC in the year.	HC membership cards	Qualitative	CHM, CHS	M&E Officer	Annually	DMT, CARE, USAID, other NGOs
Quality Supervision of health service cadres at least twice a month.	# of service cadres per skill area, # of service cadres who have received quality supervision as per standards within the month.	Supervisory visit reports	Quantitative/Qualitative	APM, DHS	M&E Officer	Quarterly	DMT, CARE, USAID, other NGOs
% of health related organisations attending Koinadugu Quarterly co-ordination meetings per year.	# of health related organisations in the district, # of health related organisations that are attending meetings.	Meeting minutes	Quantitative	APM/DHS	M&E Officer	Monthly	DMT, CARE, USAID, other NGOs

Dimension 2 Component 4							
Annual Revenue Generated	Amount of revenue generated in the year	DHMT financial records	Quantitative	PM/APM	M&E Officer	Annually	CARE, USAID
Dimension 3 Component 5							
Number of trained village health volunteers that actively participate in village health activities.	# of trained village health volunteers, # of village health volunteers participating in village health activities.	CHM supervisory reports	Quantitative	APM	M&E Officer	Bi-annually	DMT, CARE, USAID, other NGOs
Dimension 3 Component 6							
Percent of girls who have completed JSS	# of girls of school-going age, # of girls of school-going age who have completed JSS.	Ministry of Education	Quantitative	APM	M&E Officer	Annually	DMT, CARE, USAID, other NGOs
IMCI strategy adopted by government	# of master trainers selected and trained, # of PHUs not reporting stock-out of recommended drugs	DHMT Records	Quantitative	APM	M&E Officer	Quarterly	DMT, CARE, USAID, other NGOs

4. Workplan

As a means of creating a plan that can be easily used by Child Survival Project staff, the Project has decided to include both a logframe and a more time-based workplan. One allows for monitoring progress towards objectives based on activities, while the other focuses on a timeline of specific activities, according to objective. Please find the logframe below, followed by the workplan table.

4a. Project Logframe

Project Goal: To improve the health status of children under five and women of reproductive age in Koinadugu District, Sierra Leone.

Objectives	Indicators (baseline level: target)	Measurement Method	Major Activities
<p>Objective 1: Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to improve maternal and child health and prevent, recognize and manage common diseases.</p>	<p>Nutrition * Percent of children aged 0-23 months who were breastfed within the first hour after birth. (19.5:50) * % of children aged 0-5 months who were exclusively breastfed during the last 24 hours. (8.3:20) * % of children aged 6-9 months who received breastmilk and complementary foods during the last 24 hours. (69.8:80) Malaria * % of children aged 0-23 months who slept under an ITN the previous night. (.57:15) * % of children aged 0-23 months with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug within 48 hours after the fever began. (27.4: 40) * % of mothers who took anti-malarial medicine to prevent malaria during pregnancy. (31: 50) Maternal and Newborn Care * % of women aged 15-49 who know at least two symptoms that indicate the need to seek referral for emergency obstetric care. (37.8: 75) * % of mothers able to report at least two known neonatal danger signs. (7.4: 50) Other * % of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment. (79:95) * % of mothers with children aged 0-23 months who cite at least two known ways of reducing the risk of HIV infection (3.8% 25)</p>	<p>KPC baseline and final (KPC – B&F) KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS KPC – B&F, Biannual LQAS</p>	<ol style="list-style-type: none"> Formative research on feeding practices and food availability, health beliefs, social norms (including positive deviance behavior), perception of and management of disease, care-seeking practices, profile of community-based health providers. KPC baseline study on key family health practices including breastfeeding, weaning, child feeding, immunization, and malaria prevention and treatment. Development of BCC strategy and materials and conduct of BCC activities. Conduct training needs assessment (TNA) for community-based organizations, local partner organizations and MOHS staff. Project presentation to and initiation of dialogue within communities. Formation of health clubs (including pre-existing CBOs, as appropriate). Training of PHU staff, and health club members to implement BCC strategy to HH members of community resulting in decrease in harmful practices; increase in practice of beneficial preventive practices; improved recognition of danger signs; and increase in appropriate care-seeking behavior. Support the development of community health surveillance system through CHCs. Implementation of health promotion/education campaign through CHCs targeting HH knowledge, beliefs and practices. Key activities will include the following: <u>Nutrition</u>: Promotion and support of exclusive breastfeeding and complementary feeding; Vitamin A supplementation; Hearth Model; iron folate for pregnant women; <u>Malaria</u>: Increasing availability of ITNs; support increased availability of anti-malarial medications; promotion of treatment of malaria during pregnancy; promotion of appropriate care-seeking for treatment of malaria. <u>EPI</u>: Raise awareness of importance of vaccination and date/time/place where vaccination services are available and community demand for EPI services. <u>MNC</u>: Promotion of birth preparedness at the community and household level; promotion of tetanus toxoid vaccination and iron supplementation for pregnant women and VA supplementation for postpartum women; and training for PHU staff in appropriate presumptive treatment of malaria in pregnant women. <u>Other</u>: Promotion of basic sanitation; appropriate feeding during illness and care-seeking during illness; education of danger signs for neonates, sick children and pregnant/postpartum women; promotion of birth registration; education about HIV.

Objectives	Indicators (baseline level: target)	Measurement Method	Major Activities
<p>Objective 2: Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services</p>	<p>EPI * % of mothers with children aged 0–23 months who received at least two tetanus toxoid injections before the birth of their youngest child less than 24 months of age. (47.2:70) * % of children aged 12–23 months who are fully vaccinated (against the five vaccine-preventable diseases) before first birthday. (45.7:60) * % of children aged 12–23 months who received a measles vaccine. (69.5:80) Nutrition * % of children aged 6-59 months who received a high dose Vitamin A supplement during the last six months. (68.2: 85) * % of mothers who received/bought >= 90 iron supplements while pregnant with the youngest child less than 24 months of age. (60:80) * % of mothers who received a Vitamin A dose during the first two months after delivery. (17.8:50) Maternal and Newborn Care * % of children aged 0–23 months whose births were attended by skilled health personnel. (15.1:30) IMCI * % of children checked for three general danger signs. (0: 80) Other * % of health facilities that received at least one supervisory visit that included observation of management during the previous six months. (0; 90)</p>	<p>KPC – B&F, Biannual LQAS</p> <p>IMCI Facility Assessment (FA) FA</p> <p>DHO records</p> <p>DHO records</p>	<ol style="list-style-type: none"> 1. Promote dialogue between communities and DHO/PHUs. 2. Work with DHO to identify and prioritize problems in district health services and design and implement solutions that are based on qualitative and quantitative data. 3. Support the identification (by PHUs/communities) and training (by PHUs) of community volunteers (Vaccinators) for EPI outreach support. 4. Assess organizational development needs of MOHS in Koinadugu and support capacity-building activities. 5. Conduct training needs assessment (TNA) for community-based organizations, local partner organizations and MOHS staff. 6. Adapt/develop curricula for training of community health workers and obtain MOHS approval for training. 7. Facilitate training in supervision, training of trainers, and quality assurance for DHO/PHU staff. 8. Facilitate initial and refresher IMCI training (or, alternatively, vertical program case management trainings) for DHO/PHU staff. 9. Conduct quarterly quality assurance (QA) workshops for PHU staff. 10. Work with partners (MSFB, UNICEF, MOHS) to develop strategy/plan for ensuring supply of essential drugs in PHUs to support IMCI. 11. Work with partners (UNICEF, MOHS) to provide PHUs with basic medical equipment to support IMCI. 12. PHU staff and Vaccinators expand and improve consistency of EPI outreach services. 13. PHU staff provide quality primary care service at PHUs. 14. Build nutritional counseling and services for pregnant women into outreach services provided by PHUs and CHCs (supervised by PHUs). 15. Develop a productive interface between community surveillance systems developed through the CHCs and DHO/PHU that results in problem identification and response. 16. Conduct ongoing monitoring of CS Project results in collaboration with DHO/PHU colleagues and feed results back into project. 17. Participate in national-level processes regarding IMCI development and implementation. 18. Facilitate cross visits for DHO/community leaders from Koinadugu, Kono and Kailahun districts.

Objectives	Indicators (baseline level: target)	Measurement Method	Major Activities
Objective 3: Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms	<ol style="list-style-type: none"> 1. Number of health clubs (CHCs) formed that: * Have a documented set of organizational bylaws. (0; 59) * Conduct 10 documented meetings per year. (0:40) * Demonstrate documented conduct of health-related activities in the previous 3 months. (0:40) 2. % of CHCs with documented female membership of at least 20%. (0:90) 3. Number of villages that have designated an individual to provide information to community members about EPI outreach and assist outreach activities. (0:40) 4. # of CHC members who have participated in CARE health promotion mobilization training. (0:1000) 5. % of respondents who state an action that was done by community or CBO to improve health of community. (0:90) 	<p>CHC records PHU/CHC records CHC records CHC records</p> <p>CHC records</p> <p>CHC/CARE records</p> <p>CHC records</p> <p>KPC – B&F, Biannual LQAS</p>	<ol style="list-style-type: none"> 1. Formative research on attitudes and beliefs of community members regarding rights, civil society, community action to identify and act on communal problems, community support for GOSL health services, etc. 2. Present project to communities and begin a dialogue with all community members regarding community action, governance, health rights, etc. 3. Formation of health clubs (CHCs, including pre-existing CBOs, as appropriate). 4. Facilitate community dialogue regarding health volunteers and their roles and responsibilities both to community and to PHU. 5. Facilitate community nomination of volunteers to assist with PHU outreach activities. 6. Assist well-run CHCs to identify needs of their organization and provide TA to build their capacity. 7. Collaborate with communities in a participative evaluation of their own efforts. 8. Assist communities and CHCs to access multi-sectoral development opportunities to improve their communities. 9. Advocate with GOSL at national level to develop policies/processes that support responsibly managed community-level initiatives in remote areas where GOSL does not provide adequate services (e.g., sell GOSL-provided ITNs or essential drugs).

Objectives	Indicators (baseline level: target)	Measurement Method	Major Activities
<p>CSSA framework indicators (work in progress, to be further refined)</p>	<ol style="list-style-type: none"> 1. Percent of PHU staff following standard case management protocols. 2. Percent of households that have access to safe drinking water all year round. 3. # of PHUs receiving feedback from DHMT on the returns collected (functioning HMIS). 4. % of health service provider with at least 50% knowledge in the skill area. 5. % of CHC implementing at least 4 health promotion activities per year. 6. Quality Supervision of health service cadres at least twice a month. 7. % of health related organizations attending Koinadugu Quarterly co-ordination meetings per year. 8. Annual Revenue Generated 9. Number of trained village health volunteers that actively participate in village health activities. 10. Percent of girls who have completed JSS 11. IMCI strategy adopted by government 	<p>Quarterly supervision reports.</p> <p>Final watershed project report (Oct 04)</p> <p>Training pre and post tests</p> <p>Monthly Supervision reports</p> <p>Quarterly meeting minutes</p> <p>MOHS annual financial report</p> <p>Monthly supervision reports</p> <p>MEST Annual Enrolment statistics</p> <p>MOHS report</p>	<ol style="list-style-type: none"> 1. Training of PHU staff on standard case management. 2. Supervision of PHU staff for direct observation of standard case management. 3. Review the progress in construction by the Watershed project of 192 family wells and rehabilitation of 48 communal wells in 5 Chiefdoms of Koinadugu district. 4. Gap analysis of the current HMIS system. 5. Implementation of the recommendations for improvement of the HMIS system. 6. Training needs assessment of health service providers to evaluate knowledge levels. 7. Design/modification and implementation of follow-up training of health service providers. 8. Training of CHC members on health, hygiene and nutrition. 9. Attending quarterly co-ordination meetings. 10. Implement project activities through partners or side-by-side. 11. Review the annual financial report for the MOHS. 12. Create opportunities for partner organizations to develop inter-organizational links, access to information and assistance, and accountability. 13. Advocate for opportunities for partners to achieve or work towards financial viability. 14. Training of village health volunteers to undertake village health activities. 15. Advocacy for formal adoption and completion of IMCI strategy.

4b. Project Workplan																												
Objective 1: Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to improve maternal and child health and prevent, recognize and manage common diseases.																												
																	Year 1		Year 2		Year 3		Year 4		Year 5		Personnel	
Major Activities	Activity Focus*	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	Who at CARE	Who (Other)					
		Household																										
Formative research on feeding practices and food availability, health beliefs, social norms (including positive deviance behavior), perception of and management of disease, care-seeking practices, profile of community-based health providers.	BC			X	X	X																M&E, APM, CHS, CHM, PM						
KPC baseline study on key family health practices.	BC		X	X																		All project staff	DHMT					
Community																												
Project presentation to and initiation of dialogue within communities.	BC	X																				CHM, CHS	PHU staff					
Formation of health clubs (including pre-existing CBOs, as appropriate).	BC	X	X	X																		CHM, CHS	PHU staff					
Implementation of health promotion/education campaign through CHCs targeting HH knowledge, beliefs and practices.	BC	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	CHM, CHS	DHMT, Community					
Health Facility																												
Develop a productive interface between community surveillance systems developed through the CHCs and DNO/PHU that results in problem identification and response.	BC			X	X	X																M&E, APM, HEO	DHMT					
Communication																												
Development of BCC strategy and materials for communication.	BC			X	X	X																PM, APM, HEO	DHMT					
Conduct training needs assessment (TNA) for community-based organizations, local partner organizations and MOHS and CARE staff.	Q and A			X	X																	HSC, PM, HEO	DHMT					

<p>Training of PHU staff, and health club members to implement BCC strategy to HH members of community resulting in decrease in harmful practices; increase in practice of beneficial preventive practices; improved recognition of danger signs; and increase in appropriate care-seeking behavior.</p>	<p>Q and BC</p>					X	X	X	X	X	X	X												<p>CHS, CHM, APM, HSC, PM</p>	<p>DHMT</p>
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Objective 2: Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services															
h Facility															
Promote dialogue between communities and DHO/PHUs.	Q	X	X	X	X	X	X	X	X	X	X	X	X	CHM, CHS, APM PM	PHU staff, DMO, WC
Conduct Quality of Care assessment with MOHS and UNICEF.	Q	X	X	X										HSC, PM	PHU staff, DMO, WC
Facilitate training and implementation in supervision, training of trainers, and quality assurance for DHO/PHU staff.	Q			X	X	X	X							HSC, PM	PHU staff, DHMT
Facilitate initial and refresher IMCI training.	Q						X			X			X	PM, APM	DHMT
Conduct quarterly quality assurance (QA) workshops for PHU staff.	Q						X	X	X					PM, APM	DHMT
Build nutritional counseling and services for pregnant women into outreach services provided by PHUs and CHCs (supervised by PHUs).	Q			X	X									HEO	DHMT
ct															
Work with DHO to identify and prioritize problems in district health services (including HMIS) and design and implement solutions that are based on qualitative and quantitative data.	Q			X	X	X	X	X	X	X	X	X	X	PM, APM, M&E	DMO, DHS, M&E, PHU staff
Assess organizational development and physical needs of MOHS in Koinadugu and support capacity-building activities.	Q			X	X									HSC, PM, APM	M&E, DMO, DHS
Conduct training needs assessment (TNA) for community-based organizations, local partner organizations and MOHS staff.	Q			X	X		X			X			X	HSC, PM, APM, HEO	DHMT
Adapt/develop curricula for training of community health workers in collaboration with MOHS.	BC				X	X								PM, APM, HEO	DHMT
Development and implementation of Social Marketing Plan for the promotion of purchase and use of ITNs.	A			X	X									All Staff	DHMT
Work with partners (UNICEF, MOHS) to develop strategy/plan for ensuring supply of essential drugs in PHUs to support IMCI.	A									X	X	X	X	HSC, PM, APM	DHMT

Conduct ongoing monitoring of CS Project results in collaboration with DHO/PHU colleagues and feed results back into project including the use of LQAS.	Q	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	PM, M&E, APM, CHS, CHM, HEO	PHU staff, M&E, DHMT
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ANNEX 1

Response to Application Debriefing

CARE Sierra Leone CS XIX Response to the CSHGP debriefing packet

External Reviewer comments:

Weaknesses identified	PVO Response
<p>1. The proposal appears to lack a deep involvement of the population served as its primary stakeholders</p>	<p>Through the implementation of CARE’s rights based approach (RBA), the Child Survival project strives to ensure that project participants attain ownership of project activities as well as playing an active role in the developing solutions to their poverty and to address their health problems. The following are some of the main project activities that clearly illustrate the involvement of the target population in activities aimed at the improvement of their health situation within the Child Survival Project :</p> <ul style="list-style-type: none"> - At project initiation, community mobilization and orientation meetings conducted by CARE outline the project implementation strategies. - Community leadership is represented in routine co-ordination and collaboration meetings that focus on health initiatives within the villages. - MOUs between the Child Survival Project and Village development committees outline roles and responsibilities of each institution. - Participatory social mapping and planning with community members regarding project implementation takes into consideration the community’s views - Formation of community health clubs and implementation of community based growth promotion is through voluntary participation by all community members. - Health action plans are developed and implemented through the initiative of the community health club members. - Community is extensively involved in disease identification, surveillance and development of plans to address key issues identified.
<p>2. Although the use of LQAS was mentioned in the text of the document, no specific reference was made to its use in program monitoring in the workplan.</p>	<p>Indicators for the project will be assessed using the LQAS methodology twice a year and especially during the mid-term and final evaluations. The first of these will be conducted in the 1st quarter of Year 2.</p>
<p>3. It is unclear what are the skills and background of IMCI</p>	<p>A revision of the human resources structure has been made. The Assistant Project Manager position has been modified to include administrative/financial operations of the</p>

<p>training officer who will also be the BCC coordinator/materials developer. It is also unclear where field staff will be based- assume it will be in Koinadugu district if feasible.</p>	<p>program as well as coordination of IMCI, for the purpose of building their capacity on both technical and operations aspects of the project. Given the position's relations built with the DHMT and coordination of IMCI, the individual will be well positioned to take over this responsibility. The BCC co-ordinator (now titled the Health Education Officer, will have the sole responsibility of overseeing research, development of IEC and other training materials for interventions towards achieving behaviour change). Field staff are currently based in Koinadugu district (Kabala town) where the project is being implemented.</p>
<p>4. Dedicated staff focusing on the PHU-level interventions and implementation of IMCI might be inadequate</p>	<p>As per the project's workplan, PHU level interventions will be shared depending on the skill required between the Project Manager, the Assistant Project Manager, community health supervisors, the Health Education Officer and the Monitoring and Evaluation Officer. It is anticipated that the same DHMT staff working with the project on implementing IMCI activities will ultimately be the same staff who will be co-ordinating activities to improve capacities at PHU and district level hence the timing of these activities will be staggered so as not to overload the DHMT stakeholders.</p>

ANNEX 1a

Summary Scoresheet

**GH/HIDN Child Survival And Health Grants Program
Debriefing Summary Sheet
FY 2003**

Application Contact in GH/HIDN/CSHGP _____

Sheila Lutjens 202-712-5734

PVO: CARE
Country: Sierra Leone
Category: Standard

Categories	Entry	Mentoring	Standard	Cost Ext	Expanded
Number reviewed	8	3	32	10	11
Number funded	1	1	9	2	2
Highest score	91.16	88.00	95.09	93.87	93.85
Lowest score	37.91	80.52	57.74	65.31	58.84
Funded upward	88.00	88.00	88.00	90.00	90.00
PVO Rank			2		
PVO Score			91.26		

Individual Category Scores: (Maximum Points in Parentheses)

Budget	Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Organizational Development	P M & E	Management Plan	Collab.w USAID Missions	Total Points
(3)	(5)	(5)	(20)	(22)	(10)	(15)	(15)	(5)	(100)
2.73	5.00	4.73	18.40	20.21	8.80	13.56	13.03	4.80	91.26

USAID Internal Application Review Team:

Div/Bureau:	Number of Reviewers
GH/HIDN/CSHGP	2
GH Bureau	1
Regional Bureau	1
Mission	1
External	1

ANNEX 1b

External Reviewers' Comments

UNDO → 3126/100

PVO Applicant: CARE Country: Sierra Leone

Submission Category: Standard

2.73/3

Budget Information

STRENGTHS

Budget tables are very well laid out. Clear written budget narrative.

WEAKNESSES

5/5

Executive Summary and Overall Application

STRENGTHS

Care's application and executive summary present an exceptionally clear and comprehensive overview of the project, how and where it will be implemented and the rationale for selected strategies for severely affected district in post-conflict zone. Joint efforts by CARE, the MOH, and local organizations give the project a tremendous potential for success.

WEAKNESSES

4.73/5

Description of the PVO Applicant

STRENGTHS

This is a good presentation of CARE's strengths generally and in Sierra Leone. CARE's experience in scaling up programs in SL and other countries is clearly presented. CARE also clearly explained its vast experience implementing Child Survival programs around the world and in Sierra Leone. Its proposal to scale up the "health clubs" model offers promising results. The application also presents how the proposed project will complement CARE's country strategy.

WEAKNESSES

PVO Applicant: CARE Country: Sierra Leone

18.40/20

Submission Category: Standard
Situational Analysis

STRENGTHS

The situational analysis presented a good discussion of general health status of population and poor infrastructure due to the recent civil war, documenting tremendous need for health and development assistance. The applicant also documents process and criteria used for site selection, active involvement of partners/stakeholders and USAID in selection of interventions and site and the impact of conflict/civil war on the proposed region.

The situational analysis is realistic presenting the poor health indicators for Koinadugu province, the challenges and constraints of lack of infrastructure or functioning health system in the district. Project appears to have the full support of the MOH. USAID's input and strategic objectives are taken into account. Care received input from a variety of other stakeholders, particularly at the community level.

The proposal discusses potential synergies with NGOs, GOSL and the USAID field mission. It has clearly involved these other organizations in the design of the program and would therefore be likely to garner their continued support.

WEAKNESSES

The proposal appears to lack a deep involvement of the population served as its primary stakeholders.

PVO Applicant: CARE Country: Sierra Leone

Submission Category: Standard
Program Strategy and Interventions

2021/22

STRENGTHS

This section provides a good discussion of strategy and justification for each intervention selected - i.e. - severe child death rate due to malaria, do-ability and support for improving the immunization status of the population, severe MMR justifying MNC intervention etc. There is also a good presentation of how CARE's community dialogue/conflict mitigation strategy meshes with the C-IMCI approach being introduced in SL. It includes an explanation of strategy that begins with EPI, malaria and nutrition interventions in years 1-2 and then additionally phases in MNC in years 3-5. There is a good discussion of plans to mitigate and prevent further conflict in the area. Innovative strategies to push/assist government in F- and C-IMCI, expansion of malaria treatment protocols for resistant malaria, development of role/system for GOSL in providing drugs to health facilities are included.

Each intervention strategy is clearly outlined addressing quality and training issues etc. Integration and involvement of local partners is seminal to the design of the project. The MOHS appears to be in full agreement with planned objectives and strategies.

Care's description of its proposed interventions lays out a detailed and clear picture of activities in priority order as well as how they relate to health infrastructures at the community, PHU and district levels.

Proposal presents a well integrated four-pronged intervention through the C-IMCI strategy as well as with previously existing health services in Koinadugu. The proposal appears to have the full backing of the MOH. Program strategies and interventions generally very well thought out.

WEAKNESSES

PVO Applicant: CARE Country: Sierra Leone

8.80/10

Submission Category: Standard
Organizational Development

STRENGTHS

Application stresses the importance of capacity building and sustainability throughout the proposal as it is a clear CARE priority. Good discussion of CARE's history in building partner organizational capacity.

Strategies for sustainability and capacity building of the MOHS and local NGOs are reasonable given the circumstances under which activities will be carried out. Care's experience in other post-conflict settings will offer lessons learned and best practices.

Although there is very limited local capacity, this program proposes to build on community knowledge and create locally trained providers. Capacity building is strongly articulated.

WEAKNESSES

13.56/15

Performance Monitoring and Evaluation

STRENGTHS

This section is well presented, meets guidelines criteria and provides a good explanation of how project will build on existing MOH data systems and use CARE's experience in other areas to develop community-level data collection systems. These data will then be fed back to the communities and districe health offices for decision making.

Program will focus on community based information system that has been developed and is functional in other districts in SL. Program does not propose to collect extraneous information that will not be needed for decision making.

The M&E plan is detailed and more than adequate. The focus on strengthening data collection at the community level will complement MOHS data collection efforts that are presently weak. Sustainability indicators will be useful in ensuring that activities remain after the project ends.

KABF is highly comprehensive and needed to supplement poor MOH records. Strong emphasis on M&E.

WEAKNESSES

Although use of LQAS was mentioned in the text of the document, no specific reference was made to its use in program monitoring in the work plan.

PVO Applicant: CARE Country: Sierra Leone

Submission Category: Standard

13.03/15

Management Plan

STRENGTHS

Program management and collaboration arrangement with partners is clearly laid out in this section. Good chart describes managerial relationships and roles between implementing partners. This section clearly describes local and HQ staffing and roles. Contingency and security planning section describes potential dangers, CARE's security preparedness and alternate plans for maintaining continuity of project activity if there is unrest. This section demonstrates a significant level of involvement of C.O. staff and HQ backstoppers in project management and coordination between projects.

WEAKNESSES

It is unclear what are the skills and background of IMCI training officer who will also be the BCC coordinator/materials developer. It is also unclear where field staff will be based - assume it will be in Koinadugu district if feasible.

Dedicated staff focusing on the PHU-level interventions and the implementation of IMCI might be inadequate.

4.80/5

Collaboration with USAID Field Mission

STRENGTHS

Strong letter of support from USAID mission indicating that CARE's project strategy is congruent with the USAID country plan and strategic objectives. The letter stresses how the proposed project has chosen to work in one of USAID's priority regions and how it complements the mission's reintegration and democracy strategic objectives. Field appears to be committed to this endeavor and is eager to see a positive change that is so badly needed in this underserved area of the world.

WEAKNESSES

ANNEX 2

CSHGP data form

Child Survival Grants Program Project Summary

DIP Submission: Jun-24-2004
CARE Sierra Leone

Field Contact Information:

First Name: [REDACTED]
Last Name: [REDACTED]
Address: 35 & 35A Wilkinson Road
P.O. Box 744
City: Freetown
State/Province:
Zip/Postal Code:
Country: Sierra Leone
Telephone: 232-22-234-227
Fax: 232-22-234-280
E-mail: ketho@sl.care.org
Project Web Site:

Project Information:

	<p>Sierra Leone is ranked last among all countries on the UNDP Development Index and has the lowest GDP per capita in the world (\$490) . Infant and child mortality rates are 170 and 286 deaths per 1,000 live births, respectively . The maternal mortality ratio is estimated to be 1,800 deaths per 100,000 live births . Vaccination rates in Koinadugu district are the lowest in the country: 19 percent of eligible children are vaccinated for measles and 10 percent of pregnant women receive the second tetanus toxoid (TT) vaccination . Prevalence rates of wasting, stunting, and underweight (< 2 SD) among under-fives in Koinadugu are 9, 39 and 29 percent, respectively (MICS2). Malaria is the most frequent cause of death in children under five at Koinadugu Hospital, accounting for 40 percent (53/132) of child deaths in 2001-02 . The population of Koinadugu is dispersed in small villages with limited access to haphazardly staffed peripheral care units (PHUs). Residents generally self-treat health problems or seek treatment from traditional healers or</p>
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Project Description:	<p>untrained drug peddlers. CARE will work in all eleven chiefdoms of Koinadugu to strengthen the MOH health system, and conduct intensive project activities in five of them including Dembelia Sinkunia, Follosaba Dembelia, Neini, Sengbe, and Wara Wara Yagala, focusing on the most crucial partner in Koinadugu: the community. In these five chiefdoms, CARE in partnership with PHU will implement interventions in expanded program of immunization (EPI), nutrition, malaria and maternal and newborn care (MNC) through a grassroots, civil-society building variation of the overarching Community Integrated Management of Childhood Illness (C-IMCI) approach. The CARE approach promotes voluntary participation in “health clubs” (HCs) for any community member who wishes to join – an approach that has been successfully tested by CARE-SL in Moyamba and Tonkolili districts. The HCs will disseminate health information, promote healthy practices and spearhead community support for the formal health system. CARE will also work with community health providers – Blue Flag Volunteers (BFVs), traditional birth attendants (TBAs), traditional practitioners, and drug peddlers –or through the HCs. The Project will collaborate with the Ministry of Health and Sanitation (MOHS) in district-wide activities to train PHU staff in IMCI, expand and improve services, and plan a Behavior Change Communication (BCC) campaign to improve family and community practices. The CARE capacity-building strategy will work through a partnership structure, with local organizations such as HCs, Talking Drum (TD) and Norway-Sierra Leone Health Project (NSL). This approach builds local capacity and sustainability and allows the Project to maintain continuity of project activities if security declines. Direct beneficiaries of the Project include an estimated 48,630 children under five years and 51,491 women aged 15-49 years. Secondary beneficiaries include direct beneficiaries of Health Units from the remaining six chiefdoms. The goal of the Project is to improve the health status of children under five and women of reproductive age in Koinadugu district through the achievement of three principal objectives: 1. Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to prevent, recognize and manage common diseases; 2. Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms; and, 3. Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services.</p>
Partners:	MOHS, Radio Bintumani/Talking drum studios (TDS), Christian Extension Services
Project Location:	Northern Province, Koinadugu District, Sierra Leone

Grant Funding Information:

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USAID Funding:(US \$)	\$1,488,582	PVO match:(US \$)	\$520,725
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Target Beneficiaries:

Type	Number
0-59 month old children:	48,630
Women 15-49:	51,491

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
(No Data)	100%

General Strategies Planned:

Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey

Health Facility Assessment

Organizational Capacity Assessment with Local Partners

Lot Quality Assurance Sampling

Community-based Monitoring Techniques

Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Social Marketing

Mass Media

Interpersonal Communication

Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ CS Project	PVOs (Int'l./US) Local NGO	Traditional Healers	National MOH Dist. Health System Health Facility Staff	Health CBOs CHWs

Team			
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Interventions:

Immunizations 15 %
** IMCI Integration
** CHW Training
** HF Training
*** Classic 6 Vaccines
*** Vitamin A
*** Surveillance
*** Cold Chain Strengthening
*** Injection Safety
Malaria 35 %
** IMCI Integration
** CHW Training
** HF Training
*** Training in Malaria CM
*** Adequate Supply of Malarial Drug
*** Access to providers and drugs
*** Antenatal Prevention Treatment
*** ITN (Bednets)
*** Care Seeking, Recog., Compliance
Maternal & Newborn Care 30 %
** IMCI Integration
** CHW Training
** HF Training
*** Emerg. Obstet. Care
*** Recog. of Danger signs
*** Newborn Care
*** Post partum Care
*** Integr. with Iron & Folate
*** Normal Delivery Care
*** Birth Plans
Nutrition/Micronutrients/Vit A (Combined) 20 %
** IMCI Integration
** CHW Training

** HF Training
*** Comp. Feed. from 6 mos.
*** Hearth
*** Cont. BF up to 24 mos.
*** Growth Monitoring
*** Supplementation
*** Integrated with EPI
*** Iron Folate in Pregnancy

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	75	283	26.5	5.5
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	137	144	95.1	3.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	63	415	15.2	4.8
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	196	415	47.2	6.8
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	11	132	8.3	6.3
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	30	43	69.8	16.1
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	48	105	45.7	11.0
Percentage of children age 12-23 months who received a measles vaccine	74	181	40.9	7.4
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	1	174	0.6	1.4
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	328	415	79.0	5.6

Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	57	117	48.7	12.8
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	16	415	3.9	5.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	11	415	2.7	2.1
Comments				
A few errors were found during analysis related to the way way the questions were asked. The bednet indicator was only asked for those children who have a febrile episode in the past two weeks. The sick child indicator referred to children who had had diarrhea in the past two weeks. And the handwashing indicator only refers to mothers washing hands before eating. These were missed during survey questionnaire development. Every effort will be made to ask similar questions for baseline/final comparison but also to correct these for external comparison.				

ANNEX 3

Baseline Assessment Reports

ANNEX 3a

KPC

ANNEX 3b

Qualitative Research

Child Survival Project-Kabala

Qualitative Research.

Summary of findings from focus group discussions (FGD) and key informant (KI) interviews.

Background

The qualitative research was carried out to serve as a back up to the recently concluded quantitative baseline survey the analysis of which is currently underway. It is intended that this qualitative research using the FGD and KI techniques will further help to deeply explore the views of community members regarding community health practices and beliefs.

Methodology

The focus group discussions and key informant interviews were carried out in four out of the five operational chiefdoms. The remaining chiefdom Neini was inaccessible to vehicles and motorbikes due to road maintenance/rehabilitation.

Due to operational work over load on the field staff, the supervisors were assigned the responsibility of organizing and conducting these surveys and interviews in some of our operational communities using community health club members where applicable and other community key informants like the TBAs, teachers and other opinion leaders.

Research communities were randomly selected from each of the four chiefdoms and the field supervisors facilitated the discussions.

Attached to this report are the guidelines of the key informants and focus group discussions

Findings

Variations of the responses from respondents are not marked and it can be observed that the respondents had similar views on some if not all the topics that were discussed even though the discussions were done in different villages and Chiefdoms.

Education

Responses to the question referring to the non-attendance of school by some women, were that the cultural beliefs in the communities in particular and the Chiefdoms in general about girl child education prevented parents from sending their girl children to school. The house and kitchen activities are meant for girls and that they should be raised to bear children and take care of their husbands and kids at home, as it was indicated.

Some respondents remarked that some parents had the intentions of sending their girl children to school but their economic status was not favorable at the time in question. Schools were seen as institutions of prostitutions where girls were taught the arts of defying their husbands and going in search of several lovers. It was revealed by the respondents that girl child education serves as a conduit for girl children to break the cultural and traditional chains binding them and their communities.

Discussions revealed that most of the women do embark on traditional back yard gardening and farming for income generation and sustaining the other family members, as it is the primary role of women to provide food for the home

Decision-making and child-care giving

Decision-making process in the home lies mainly with the husband and women are not allowed to decide their actions in the absence of the husband, *"it is an offence and the woman caught doing that will be punished, we met it like that and so, it should be maintained for our children yet unborn"* as stated by an elderly woman in one of the discussion groups.

General opinion from the respondents indicated that the elderly women, commonly referred to as **"grannies"** do take care of young children when the mother is in the field working or doing other activities. The father in most of the cases is charged with the responsibility of providing the basic necessities like shelter, food and clothing for the family, strongly assisted by the mother and other outside relations.

Immunization

The importance of immunization to the mother during pregnancy and the baby as indicated by the discussion participants, is to build the body's defense mechanism to enable them fight infection but further investigations revealed that not all mothers take their children for immunizations. Reasons for non-clinic attendance was associated with distance from health facilities, financial constraints, decision-making in the home and a big emphasis on the attitudes of health care providers at PHU level. Some of the common diseases as outlined by the respondents were ARI, malaria, and diarrhea. In some communities, measles came up strongly as a killer disease but they were quick to add that it is periodic in the form of an epidemic and when it does occur, it becomes fatal and devastating. The respondents indicated that children that are not immunized live happily (as some of them doing the discussion now were never immunized but survived). It was however indicated by clinic attending mothers in the discussion groups that children that are immunized have the chance of surviving than those that are not.

Breast-feeding practices

Almost all women in the communities practice breastfeeding according to the respondents but further probing by the facilitators showed that the importance of exclusive breastfeeding is not understood by mothers and as such the first milk that is very rich in protein and other food nutrients, referred to as colostrum which also has

immunoglobulin, is squeezed out and wasted. This practice according to the respondents is meant to clean the breast and provide "*clean milk/food for the baby*". The respondents stated that breast-feeding is a family planning method and that it keeps women away from men and it is a taboo for a woman not to breastfeed her child except in certain instances of ill health of the mother with strong approval by the husband. The community members frowned at women that do not breast feed their babies.

Discussing the question as to what should be done to encourage mothers to practice exclusive breast-feeding; the responses were that women should be sensitized on the importance of exclusive breastfeeding and postnatal nutrition. The men should be empowered to provide food for the home thereby encouraging women to rest through out the breast-feeding exercise. Newly born babies are usually given hot water "*to clear their digestive tract and to wake up the baby*", this continues till the baby is 2 or 3 months old and then other foods like rice pap are introduced to the baby.

The respondents observed that breast-feeding of the baby till the baby is able to walk coupled with the woman not indulging in any sexual act whilst breast-feeding is necessary for proper growth of the child. In addition, it was revealed by the respondents that children should be cared for if they are to grow well and perform better in life. The respondents suggested that it would be easy to establish a growth monitoring system in the communities by way of involving parents and community leaders and training community based growth promoters backed by health education campaigns.

Water and Sanitation

Furthermore, the availability of adequate and safe water in the communities is a serious problem that needs urgent attention as indicated by the survey participants. The raining season is the only time they have access to portable water and the situation drastically changes when the rains stop. Water is stored in five-gallon containers/rubbers in some communities and in buckets and pots in other communities. This commodity (water) is precious during the dries and women and children spend a good number of their time in search of water for their various households. Diseases were associated to God and other factors and it was difficult to associate it to water, "*as water is there to clean people and not the other way round,*" a young lady remarked. Assistance in the provision of wells would be appreciated and would change the living standards of the community people.

Maternal and new-born care

It was further revealed from discussions that care during pregnancy is important as the life of the baby and mother depends on the care and support given to the pregnant women. Support in the form of proper health care during pregnancy like clinic attendance to facilitate immunizations, foetal growth monitoring and promotion and birth preparedness.

Decision –making on pregnancy related issues and delivery is the prerogative of the husband and it is he that decides where the woman should give birth. According to the respondents, the decision is not made until the onset of labor and this is responsible for the delays in accessing health care for safe deliveries.

Bleeding, paleness and non-movement of the fetus was indicated as some of the dangerous signs during pregnancy, coupled by others like lack of appetite, nausea and frequent and intense headache (migraine type).

The participants frowned at vaccination during pregnancy. It was unanimously agreed that vaccination during pregnancy makes the pregnant woman sick (fever) and the hand becomes heavy, thereby preventing them from carrying out other daily chores. Traditional birth attendants though untrained featured as those that perform 80% of all deliveries in their communities. Some women do seek the services of trained nurses; this is for those that live in communities with PHU or stays closer to the district head quarter town of Kabala.

Community support

Findings from the discussions revealed that there is no community emergency transportation mechanism to assist the movement of pregnant or other emergency cases to health facilities. When further asked whether it would be good to set up a system of community transport mechanism, the answer was in the affirmative and the participants opined that it would be a dream come true and would help solve the high infant and maternal mortality rates in the district. They however cautioned that it needs a lot of planning with the local authorities and corporation of the entire community members.

Infections and health seeking behaviors.

In addition, findings from the discussions revealed that knowledge on the mode of transmission, signs and symptoms and prevention and control of most communicable diseases like malaria, diarrhea and respiratory tract and other infections is very low. Few signs and symptoms about diarrhea were mentioned, running stool, loss of weight and lack of appetite, to name a few. Diarrhea in children especially suckling babies is as a result of *“mothers’ having sexual intercourse whilst breast-feeding, the sexual fluids interferes with the mothers milk”*. The respondents had a fair knowledge about the purpose of ORS but gave incorrect preparation and administration methods.

According to the respondents the first point of contact for treating children with infection are the traditional healers and later to the clinics. Some respondents living closer to health facilities stated that they normally consult the health care delivery personnel when they or their kids fall sick.

Good environmental sanitation and personal hygiene practices were highlighted as the major ways of preventing diseases in communities.

Conclusion

The respondents were very confident and proud of the answers to the discussion questions and this clearly reveals that women if given the training and capacity, are ready to play leading roles in improving their health in all communities. From the responses, it is abundantly clear that there is a very high infant and maternal mortality rates in the district and that all women of reproductive age face risk of survival throughout their

reproductive lives. Delay from the husband in deciding where a woman should give birth and who should pay for the health services, delay in referring pregnancy complicated cases, delay in facilitating the movement of emergencies and delay in treating the emergency at health facilities were indicated as factors affecting maternal health in the communities in general and the district as a whole.

During the discussions, issues surrounding early marriages, family planning and girl child education strongly emerged and was supported by all participants in the survey. It was also indicated that men should be targeted in reproductive issues at community level in order for the women to make decisions on their health matters.

ANNEX 3c

PHU Assessment

CHILD SURVIVAL PROJECT

**Assessment report on Peripheral Health Units
of the Intensive Project Site**

**Koinadugu District
November 2003**



Historical Data

There is conflicting information regarding pre-war district and intensive project site (five selected chiefdoms) populations. According to a 1985 census for Koinadugu District provided by the Central Statistics Office, there was a total population of 183,286 in the district with a combined population of 88,382 in the 5 chiefdoms that comprise the intensive project site. As of 1990, according to the District Hospital records, the total population for the five chiefdoms was 54,741.

There were forty operational peripheral healthcare units (PHUs) servicing the district in 1990. A peripheral healthcare unit (PHU) is an all-encompassing term referring to any health care facility provided by the Ministry of Health and Sanitation (MOHS) through the district hospital. There is a gradation in service and level of training of staff. Following are the standard types found within the districts at village level:

- **Community Health Centers** are the most comprehensive in services and staffing, after the district hospital. They are located in the chiefdom headquarter town. The in-charge is a Community Health Officer with the equivalent training of a physician's assistant. General medical services and simple procedures are provided, but all complicated and emergency cases are referred to the district hospital, as there are not adequate staff, equipment or supplies to run an operating room. Essential drugs are available and dispensed from these sites. At least one MCH aide is on staff providing basic mother child care services.
- **Community Health Posts** are located within a chiefdom, but generally not at the headquarter town. The in-charge is a dispenser, who has had basic training geared toward use and distribution of essential drugs. They are not trained to the level of a physician's assistant. General medical services are performed and prescriptions disbursed as needed. An MCH aide is on staff for mother child services. (NB community health officers generally refuse to serve in rural areas and therefore PHU and district health staff and patients alike refer to community health posts, though manned by dispensers, as CHCs.)
- **Maternal Child Health posts** are in villages throughout the chiefdoms. The in-charge is a maternal child health aide. MCH aides have received an 18-month training course offered by the MOHS through the district hospital. They perform mother child health care, Under 5's clinics, ante- and postnatal care, deliveries, and simple general services. There are essential drugs available at site, provided by the MOHS on a cost recovery basis.

Methodology of the Assessment

The objective of the assessment was to confirm the number, type and cadre of staff in the PHUs in the operational area and for staff to familiarize themselves with the same PHUs. A question guide was developed for administration to all existing facilities within the project intensive area. The main activities and the expected outcomes are explained below :

Activity	Outcome
Assessment of PHUs in the five operational chiefdoms.	<ul style="list-style-type: none">- statistics on the number, type and location and staffing of PHUs.- catchment populations per PHU and views for health staff on the most prevalent diseases.- Familiarization of staff with the location of operational villages.
Compilation of assessment statistics	<ul style="list-style-type: none">- a master sheet of all functional and non-functional PHUs developed.- recommendations for changes in health topics currently on the subject list.

Broadly, the assessment dwelt on general information, issues of supervision, monitoring by PHUs, training, referral information, cold chain systems, growth monitoring and the relationship between existing PHUs and the community. It was focused only on the five chiefdoms (Follosaba Dembelia, Wara Wara Yagala, Sengbeh, Dembelia Sinkunia, Neini) that comprise the intensive project area. The detailed assessment questionnaire is annexed to this report. In addition a data sheet was utilized to collect information on the PHUs (attached to this report).

Data collection was conducted over a period of a month due to the difficulties experienced in accessing some of the PHUs.

Current Data

According to a projected estimate by the Central Statistics Office, the 2001 population of Koinadugu District should have been approximately 238,408 and for the project site approximately 132,594. There are currently 33 functioning PHUs in the district and 18 sites either proposed or under construction according to the district EPI office.

Within the intensive project site there were fourteen PHUs, with no chiefdom having more than three PHUs, irrespective of geographic area, population or type of services offered. These facilities were in mainly the same locations as present. Three were designated as community health centers (CHC), two were community health posts, and nine were maternal child health (MCH) posts. The endemic diseases targeted directly by

the project were malaria, measles, water and bloody diarrhea, neonatal tetanus, Tuberculosis, and HIV/AIDS or sexually transmitted infections (STIs). Respiratory and skin infections and waterborne diseases were included on this list.

PHU staffing and General Information

Currently there are 14 functioning PHUs within the project site. Of these, four refer to themselves as community health centers but are effectively community health posts having only a dispenser as senior staff on site, and not a community health officer as an in-charge. Two PHUs are listed as CHCs but lack dispensers, and one of these has a laboratory technician though not a dispenser on staff. Both have only an MCH aide performing MCH duties and therefore, are effectively and MCH posts. Eight are maternal child health posts with MCH aides, trained by the MOHS, as the in-charge. All facilities refer complicated and emergency cases to the district hospital. In addition, there is at least one porter and one guard on staff.

The PHUs are generally understaffed. All provide basic maternal/child health services. At least one target population count listed on the following chart is from 2002. All other figures are calculated using standardized percentages per population group (4% for 0-11 mo, 17% for 12-59 mo, and 24% for females 15-49 yrs), center/post records or house-to-house counts performed by respective staff. These are not verified as accurate by the MOHS.

There are five sites either under construction or newly built that are not yet staffed. Solar panels and latrines can be witnessed on three of these properties.

MSF-B is actively supporting 3 community health centers. This support includes drugs, supplies, supervision, monthly monetary incentives, and free transport for referral patients. All services are free of charge.

Only two MCH aides interviewed have been exposed to IMCI. One was trained by the MOHS and one began training through MSF-B that was cancelled by the MOHS.

Physical Status of PHUs

Physical conditions are not hygienic at any of the posts. Nearly all the MCH posts are in private houses, of varying states of disrepair, provided by the village. There are no ceilings in the rooms or mosquito netting on the windows. Water is supplied by bucket using either a porter or a volunteer from the community. No permanent hand-washing facilities or drainage/soak away areas exist at any post. Only newly built posts have latrines. All PHUs have a pit in which sharps and other biomaterials are burnt. Two have a cement cover on their sharps pit, with a pipe extending approximately two feet above the surface for deposit. Lighting is very poor and furniture is extremely minimal.

Immunisation

Cold chains exist in all the posts, including those not yet staffed. Nine are solar-powered fridges supplied by CCF, UNICEF, or directly by the MOHS. One was currently not functioning and no estimated repair date was given. There are five gas-powered fridges

supplied by UNICEF through the MOHS. One, was not functioning with no estimated repair date given. Only one dispenser received training for repairs while all received basic maintenance training.

The MCH aides, dispensers and vaccinators at the PHUs and during outreach clinics administer the five vaccine preventable disease immunizations included in the national EPI. These are tracked in registers, tally books, and growth chart cards. Certain diseases, including malaria, are also tracked. These figures are reported monthly to the District Health Management Team (DHMT) or MSF-B, in the case of the posts under its leadership. Some aides keep handmade wall charts.

PHUs and Communities

Community participation with PHUs exists mainly in the forms of maintenance, water fetching, and announcements. Community development committees do exist but have not taken a proactive approach in PHU management. Some PHUs train vaccinators on site and oversee their performances. All blue flag volunteers (BFVs) are trained by the DHMT.

Ante-natal Care

Deliveries are performed at the PHUs if the pregnant women are able to reach the post. If not, the women are attended during delivery by a traditional birth attendant (TBA) in their homes. Patients may be kept under observation. All complicated and emergency cases are referred to the District Hospital. Usually the traditional hammock is used or one awaits a vehicle to be conveyed to the hospital.

The MCH aides conduct training and refresher courses for TBAs with materials provided by the MOHS. Some PHUs train vaccinators on site and oversee their performances. All blue flag volunteers (BFVs) are trained by the DHMT.

Pharmaceutical Drug Supply

Drugs are supplied by the District Hospital. They are sold at a minimal price for cost recovery purposes and supplies are restocked as needed.

Staff Training

Within the last year trainings and workshops in EPI, communicable disease surveillance, TB and leprosy, solar fridge, data information, motivators training, drug management, and MCH aide refresher course in EPI, were attended by members of staff or selected volunteers (TBAs and motivators) from communities. These trainings were conducted mainly by the MOHS and the longest training was estimated to have been over a period of three weeks. Staff at two PHUs stated they received no training in the last year.

Chiefdom specific information

Chiefdom specific information and considerations are listed below.

- In **Follosaba Dembelia Chiefdom**, with a population of 11,079, there are two CHCs, both receiving support from MSF-B. An opportunity presents itself to foster a working relationship with MSF-B to coordinate IMCI training efforts and find solutions to gradually wean staff from monetary incentives from MSF-B without compromising services. Strengthening of health clubs and training of the 60 untrained TBAs reported and vaccinators, none reported, could be a priority here.
- **Wara Wara Yagala Chiefdom**, with a population 21,331, has three MCH posts, all with minimal staff, and houses the district hospital. All respective catchment areas of the PHUs are relatively small and service no more than 13 villages. This lends itself to strengthening the skills of the MCH aides in quality of service and community outreach.
- **Sengbeh Chiefdom**, with a population of 22,095, has four functioning PHUs, one of them a CHC supported by MSF-B. There are 15 trained staff and 66 trained TBAs, BFVs, and vaccinators throughout the district. IMCI training could be a beginning here as the number of trained staff to support it are readily available.
- **Dembelia Sinkunia Chiefdom**, with a population of 23,952, has two PHUs one CHC and one MCH post, with a total of 5 trained staff and 42 trained village health volunteers. There is one new, unmanned MCH post. These facilities service 41 villages over a radius of at least 22 kilometers. Liaising with the MOHS to provide more staff in this area is recommended. With so few staff for a sizeable chiefdom population, strengthening of the community health clubs and strong IMCI training especially at the community serves as a good starting point.
- **Neini Chiefdom**, with a population of 54,137, is the most populous and vast chiefdom. It is also the least accessible. It houses 3 functioning PHUs and two unmanned ones with only 10 trained staff total. Eight trained village health volunteers were reported. Liaising with the MOHS for more trained staff is urgently needed here. IMCI training through community health clubs should begin as soon as possible as staff is so few. A strong referral system needs to be devised to prevent death of patients while in transit. Well-coordinated outreach services are needed to reach the vast population over the extensive distances.

Perceived areas of Improvement

The following are perceived areas of improvement as recommended by the in-charges of the PHUs during site visits.

- A concerted effort must be made with the MOHS/DHMT to conduct intensive, standardized IMCI training for its own staff at the District Hospital and for the PHU staffs in the respective chiefdoms. Intensive training in other project areas, as applicable, will necessarily include appropriate MCH staff.
- Basic hygiene practices need to be put into place and facilities need to meet a minimum required measure of sanitation.
- Enough furniture should be supplied so that the in-charge has his/her own working space as well as a storage area for stock and supplies and all records.
- Basic organizational skills such as: a tracking system for all incoming and outgoing drugs, immunizations, supplies and other inputs; recordation of all drugs sold; duty rosters and timetables; and regular feedback sessions with village representatives, are needed.
- Training and education topics should be agreed upon with the village health clubs and regular sessions scheduled. Follow-up on these sessions should be ongoing. This can also be arranged with the CARE health mobilizers. Systematic outreach services need to be scheduled, tracked and recorded.
- Sensitivity training and facilitation skills for PHU staff, to create open communication with the population served, should be considered. This, coupled with improved technical training and basic organizational skills, will facilitate all-around improved services.
- Visual aids need to be created for PHU staff to use with illiterate populations.
- Lessons in tracking and recording of services for vaccinators and BFVs should be developed. A referral system should be put into place so that illiterate TBAs can as quickly as possible notify the MCH aide of a birth or miscarriage and status of the mother. A buddy system with a literate person in the village would be helpful to accurately record all vital information immediately. Currently illiterate TBAs are provided a Salter scale that indicates only healthy/sickly weight zones, which leaves actual birth weight, when recorded, imprecise. Any information collected should be in a standardized format used by all TBAs.

CARE Sierra Leone
Child Survival Project in Koinadugu District
PHU Assessment

Chiefdom: _____ Section : _____

Village : _____ Date : _____

Name of Interviewer : _____

General Information

1. Name of In-Charge : _____

2. What is the current number of staff? _____

3. Are there enough staff in the PHU? Yes _____ No _____

4. What is the ideal number of staff for this PHU? _____

5. What is the cadre of current staff in this PHU and their level of training?

6. What types of services are provided in this PHU?

- a. Maternal/Child health care
- b. Health education
- c. General medical services
- d. Complementary/therapeutic feeding
- e. Training/supervision of VHVs
- f. Growth monitoring/nutrition education
- g. Others _____

7. Do you dispense drugs from this PHU? Yes _____ No _____

8. Are community members charged for medicines? Yes _____ No _____

9. Do you currently have a drug supply? (Observe) Yes _____ No _____

10. Who supplies the PHU with drugs? _____

11. How often do you restock your drug bank? _____

Supervision

12. Who supervises the activities of this PHU?
- a. DHMT
 - b. NGO Officials
 - c. Community Members
 - d. Others
13. How often is this supervision done?
- a. Weekly
 - b. Monthly
 - c. Quarterly
 - d. Daily
 - e. Other
- 14., Who does the general reporting of activities in this PHU?
- a. In-charge
 - b. Deputy-in charge
 - c. Other
15. To whom does he/she report?
- a. DMO
 - b. DHS
 - c. CHO
 - d. NGO officials
 - e. Community members
 - f. Others
16. How often does s/he report?
- a. Weekly
 - b. Monthly
 - c. Quarterly
 - d. Other

Monitoring

17. Do you track immunizations? Yes _____ No _____
18. If yes, what method do you use? _____
19. Do you track the cases of Malaria? Yes _____ No _____
20. How often do you report your figures? _____
21. To whom do you report your figures? _____

Training

22. Have any IMCI trainings been conducted for any staff in this PHU? Yes ___ No___
23. If yes, who conducted the training and when? _____
24. Who took part in the training? _____
25. What was the duration of the training? _____
26. Have you or any member of staff in this PHU ever benefited from any other training apart from IMCI? Yes _____ No _____
27. If yes, state the type of training _____
28. When was that training conducted, by whom, and what was the duration? _____

Referral Information

29. What is your nearest referral point?
- CHC
 - DHH
30. How far is your nearest referral point?
- 10km
 - 50km
 - 100km
 - Other
31. What type of cases do you refer?
- Emergency
 - Complicated cases
32. What means of transportation do you use for referral?
- motorbike
 - vehicle
 - hammock
 - carry on the back
 - other

Cold Chain System

33. Do you have a cold chain? Yes _____ No _____
34. How is it powered ? _____
35. Is it currently functioning? Yes _____ No _____
36. If no, when is it expected to be repaired? _____ By whom? _____
37. Is anyone trained in repair and maintenance? Yes _____ No _____
38. From whom do you get your vaccines and vaccine accessories?
- DOO
 - NGOs
 - UNICEF
 - Other agencies
39. Who performs the vaccinations?
- MCH aide
 - Vaccinator
 - CHO
 - EDC Unit assistant
 - Other
40. How often do you conduct outreach immunization services?
- Weekly
 - Bi-weekly
 - Monthly
 - Other

Growth Monitoring

41. What nutrition/growth monitoring services are provided?
- advising mothers to attend clinic regularly _____
 - complementary feeding of children _____
 - monitoring of growth chart
 - monitoring of height for age
 - monitoring of weight for age
 - Mid upper arm circumference (MUAC)
 - Nutrition education
 - Ante and post-natal feeding practices
 - Others

Community PHU relationship

42. Do community members support activities of this PHU? Yes _____ No _____

43. If yes, how?

- a. Drug restocking
- b. Assisting in referrals
- c. Provision of volunteers
- d. Incentives to PHU staff
- e. Others

44. Is there a feedback/dialogue system in place for the community members?

Yes ____ No _____

45. Are community members involved in the general management of this PHU?

Yes _____ No _____

46. If yes, how?

- a. Formation of health committees
- b. Community monitoring of PHU
- c. Facilitation of training sessions.
- d. Others

47. Do you conduct training for community members? Yes ____ No _____

48. If yes, what type of training?

- a. TBA
- b. BFV
- c. Vaccinators
- d. Others

49. How often do you conduct trainings? _____

50. Do you perform community outreach? Yes _____ No _____

51. If yes, how often? _____

N/B Write down additional information not targeted by the above questions.

Child Survival Programme

PHU assessment form for Koinadugu District (Form 2)

Village :

Section :

Chiefdom :

Date :

Type of PHU	Supported by		Number and type of staff	Catchment population		Catchment distance	Number of VHVs			Services Provided
	MOHS	NGO		U5	Over 5		TBA	BFV	Vaccinators	

**CARE - SIERRA LEONE CHILD SURVIVAL PROJECT
PHU INFORMATION CHART - OCTOBER 2003 - KOINADUGU DISTRICT**

CHIEFDOM	Section	Community	Type of PHU	Supported by		Type of trained Staff	No. of staff	Total catchment area (Villages)	Catchment Pop.		Catchment distance	No. of TBAs		No. of BFVs		No. of Vacc		SERVICES PROVIDED
				NGO	MOHS				<5yrs	15- 49 yrs Females		T	NT	T	NT	T	NT	
FOLLOSA BA DEMBELIA	Musaia	Musaia	CHC	Y	Y	Dispenser, MCH Aide	2	81	5998	7678	19.2 KM	8	50	25	0	0	0	EPI, Health & Nutrition Educarion, Complementary/Therapeutic Feeding (BP-5), Growth Monitoring, Routein Immunisation, Family Planning.
	Gbentu	Gbentu I	CHC	Y	Y	Dispenser, MCH Aide, technician	3	70	2793		17.6 KM	2	10	25	0	4	0	Ante & Post natal services, Therapeutic feeding (BP - 45) General Health Education, Outreach services.
		Hamdalai	Proposed MCH post			Not Staffed												
WARA WARA YAGALA	Heremakono	Heremakono	MCH post		Y	MCH Aide	2	12			14.4 KM	3*		20*		1*		Family Planning, Ante & Post natal services, General Health Education. NOTE: * Means training was conducted by MCH Aide.
	Yataya	Senekedugu	MCH post		Y	MCH Aide, Motivator, TBA	3	13	680		6.4 KM	1	1	0	0	0	0	Ante & Post natal services, Health Education, NOTE: Catchment Population data was collected in 2002 House to House survey.
	Yataya	Mamodaya Koroh	Proposed Mch post															
	Yagala	Yagala	MCH post		Y	MCH Aide	2	10			19.2 KM		8	25	0	0	0	Ante & Post natal services, Health Education, NOTE: Catchment Population data was collected in 2002 House to House survey.
SENGBEH	Koinadugu	Koinadugu	MCH post		Y	MCH Aide, TBAs	6	9	1155	935	11.2 KM	2	4	10	0	1	0	EPI, health, envrionmental & nutrition educarion, Growth Monitoring, Routine Immunisation, Family Planning, ANC, general treatment.
	Bendugu	Kondeya	MCH post			Not Staffed												
	Upper Kamadugu	Dankawallie	CHC	Y	Y	Dispenser, MCH Aide, TBA	2	7	452	515	16 KM	3	12	10	0	0	0	General medical services, growth monitoring, health and nutrition education, deliveries, ANC, outreach
	Heremakono	Gbenekoro	MCH post		Y	MCH Aide	1	16	992	5128	11.4 KM	2	5	14	0	0	0	General medical services, growth monitoring, health
	Lower Kamadugu	Kamadugu Sokuralla	MCH post		Y	MCH Aide, TBAs. Motivator/Vaccinator	7	10			14.4 KM	2	18	20	10	2	0	ANC, Deliveries, Home Visits, EPI, Nutrition, health Education, General Treatment, Underfives, Growth Monitoring.
DEMBELIA SINKUNIA	Sinkunia	Sinkunia	CHC		Y	MCH Aide	1	10			8 KM	7	0	10	0	0	1	Under fives clinic, Delivery, Immunisation, General Services, Growth Monitoring, Health & Nutrition Education.
	Sinkunia	Gbindi IV	CHC		Y	MCH Aide Dispenser, Vaccinator, motivator	4	31	3327	497	14 KM	4	0	20	0	1	0	Under fives clinic, Delivery, Immunisation, General Services, Growth Monitoring, Health & Nutrition Education.
	Manah	Manah I	Proposed MCH post			Not Staffed												
NEINI	Yiffin	Yiffin	MCH post		Y	MCH aides, nurse's aide, health overseer	6	34			48 KM	5	0	0	0	2	0	Health and nutrition education, general medical services, complementary/therapeutic feeding, growth monitoring, deliveries, community outreach.
	Kalian	Alikalia	CHC		Y	MCH Aide, TBA, lab technician	3	13			32 KM	1	0	0	0	0	0	General medical services, health and nutrition education, growth monitoring.
	Yiffin	Fankoya	Proposed MCH post			Not Staffed												
	Barawa	Firawa	MCH post		Y	MCH Aide												*MCH aide not at site.*
	Sumbaria	Sumbaria	Proposed MCH post			Not Staffed												
5			14 (6 CHCs & 8 MCH Posts)	3	14		42	316	15397	14753		37	108	159	10	6	5	

ANNEX 3d

Rapid and In-depth Assessments

RAPID ASSESSMENT REPORT FOR WATERSHED AND CHILD SURVIVAL PROJECT CONDUCTED IN OCTOBER 2003.

1.0 Introduction

CARE International field agents carried out this rapid assessment in October 2003 in the Koinadugu district for the joint implementation of water and sanitation and child survival projects. This assessment was carried out in five chiefdoms to provide information about the estimated population, presence of water wells and latrines, health facilities and the presence of other NGOs. A total of 77 villages were randomly selected from Wara Wara Yagala, Sengbeh, Folosaba Dembelia, Dembelia Sinkunia and Nenie chiefdoms.

2.0 Objective of the Rapid assessment

- To assess the accessibility of the intending operational communities.
- To identify 48 potential villages for CARE operations.
- To get an estimated population of the different villages.
- Assessed the need for sanitation facilities such as latrines, communal wells and those wells needing rehabilitation
- Collect information on the presence of health facilities
- To know the availability of local materials such as sand and gravel for construction work.
- Assess if other NGOs are operating in the villages and their activities undertaken.

3.0 Methodology

A survey questionnaire was developed and administered by trained field staff to the 77 randomly selected villages. A questionnaire was administered to a group of community people in each community to get information at community level.

4.0 Summary of findings

4.1 Estimated population

The analyses of the respondents indicated that 61 (79.2%) of the villages have a population of over 150, 45 (58.4%) with over 50 households and 23 (29.9%) having 21-50 households in the 77 communities. This analyses indicated that the population criteria is been met for the intervention of the project.

4.2 Accessibility

From the 77 assessed villages a total of 55 (71.4%) are accessible by 10 ton truck and 22 (28.6%) accessible by light vehicles. The analyses indicated that 72 (93.5%) of the villages are accessible throughout the year by light vehicles.

4.3 Availability of wells

A total of 50 (64.9%) communal protected and traditional water wells are available in these communities. Out of this total available water well only 37 (48.1%) of them are functional as indicated by the survey. Total wells needing rehabilitation in these assessed villages amounted to 43 (55.9%) from the survey analyses. These analyses indicated that there is need for the construction of new water wells and the rehabilitation of some non functional well to improve the sources of drinking water in the selected communities.

4.4 Sanitary facilities:

72 (93.5%) of the assessed villages said they have latrines for disposal of faeces and all 72 are traditional latrines. From observation most of these latrines have no superstructure and no proper covering of squat holes to prevent the breeding of flies. This clearly indicates the need for improved sanitary facilities such as latrines in these communities if they are selected for the project intervention.

4.5 Local materials:

A total of 59 (76.6%) of the assessed villages said local materials such as sand can be easy to source for construction work and 63 (81.8%) can easily source gravel as well. The project activities which include construction work and needing such local materials could see these communities as qualified.

4.6 Peripheral Health Units (PHUs)

The analyses indicated that 58 (75.3%) of the assessed villages have no Peripheral Health Unit. 53 (68.9%) of the villages cover a distance of 6 kilometers and above to meet a PHU for any form of medical treatment. A total of 62 (81.6%) are without PHU staff which indicates that even some of the villages with PHUs are without staff. From the analyses there is clear indication for the need for constructing PHUs in the selected villages for the project activities. Analyses indicated that Blue Flag Volunteers ((46) 59.7%) and Traditional Birth Attendance ((27) 35.1)) have been previously trained in these villages. From discussions with these trained people there is need for refresher training considering there time of training.

4.7 Presence of NGOs/CBOs

A total of 50 (64.9%) villages said they have social structures such as Village Development Committees, 27 (35.1%) said they have Working Groups. These committees when present in communities helps the smooth work of NGOs though they may need to be sometimes restructure. Absent of NGOs as indicated by the analyses was 40 (51.9%) in the assessed communities. In all the assessed communities 12 (15.6%) communities have medical activity and 1 (1.3%) having water and sanitation activity going on. From the above analyses there is clear need for NGO with water and sanitation activities in these communities in order to improve their sources of drinking water.

The topography of the land is another important factor for well construction and this was identified through observation by enumerators. A total of 40 (51.9%) and 26 (33.8%) villages were gently slopy and low land respectively as indicated by the analyses.

IN-DEPTH ASSESSMENT REPORT FOR WATERSHED AND CHILD SURVIVAL PROJECTS CONDUCTED IN OCTOBER 2003.

1.0. Introduction

CARE International field agents carried out this rapid assessment as a follow-up activity to the rapid assessment carried out November 2003. The prime objective of this assessment was to further screen the pre-selected villages from the rapid assessment by identifying through a questionnaire the most vulnerable villages for implementing a joint water, sanitation and child survival projects in Koinadugu district. This assessment which was carried out in five chiefdoms provided information about the level of community awareness of health related issues, health practices, health facilities, sanitation facilities and sources of drinking water. The 324 respondents were selected randomly from Wara Yagala, Sengbeh, Folosaba Dembelia, Dembelia Sinkunia and Nene chiefdoms.

2.0. Objective of the In-depth Assessment

The objective of the survey was;

- To assess the level of accuracy of the data collected from the Rapid Assessment.
- Further screen the initial list of potential villages for CARE operations to 48 villages
- Provide baseline information on current water and sanitation practices.
- Design implementation strategies and training content for health and hygiene lessons
- Develop strategies for facilitating the adoption of health practices
- Design community health education training packages for Koinadugu District
- Assess if other NGOs have provided training in health related topics

3.0. Methodology

A survey questionnaire was developed and administered by trained field staff to randomly selected households in short-listed villages. The questionnaire was administered to all members of the social spectrum in an effort of getting feedback from a wide range of respondents.

4.0. Summary of findings

4.1. Water sources:

The analysis of this survey indicated that 190 (58.7%) of 324 households interviewed use unprotected communal wells as their sources of drinking water. This clearly indicates that sources of drinking water for majority of the respondents are not protected, thus increase in water born disease. The distance covered by most of those sourcing water from the protected wells is relatively far as 108 (33.3%) said they cover a distance of 25 minutes and above to get water. The 48 villages selected are

those with people covering the greatest distance to get safe drinking water based on the findings of this survey.(Annex1)

4.2.Practices of appropriate hygiene:

A total of 132 (40.7%) said they normally wash their hands before handling food implying that 192(59%) of the interviewed people do not wash hands before eating food. This information shows a relatively low practice by the respondents to this health practice. All the respondents said however they sometimes wash their hands when they are dirty and 161 (49.7%) of these respondent said they use only water to wash their hands whenever they decide to wash them. The communities where respondents indicated the non-washing of hands were given top priority when finally selecting the 48 villages.(Annex2)

4.3.Sanitary Facilities

A total of 211 (65.1%) said they own and use local latrines for disposal of faeces and most of these latrines are without superstructures and no proper covering of squat holes to prevent breeding of flies (Annex3). All the latrines do not have hand-washing facilities implying that people who wash hands after using the toilet do not do it as soon as they finish using them. This finding further supports the earlier findings that people do not regularly wash their hands. The selected villages for intervention were those with no Latrines to those with the list number of traditional pit latrines. Latrine construction, use and maintenance training have been designed to address some of these findings

4.4.Water storage and food contamination:

195 (60.2%) of the respondents store water in buckets and the remaining 39.8% use other containers. 218 (67.3%) placed drinking water container on the floor. The respondents could not be probed further for other forms of water storage but the fact that only 32.7% of the respondents indicated that they use raised platform for keeping containers with drinking water indicates low levels of understanding the need for protecting the water. 213 (65.7%) of the respondents have indicated that food can be protected from faecal contamination by covering it (213 (65.7%)). The interviewers could not carry out physical inspection to assess if people actually practice this but from the survey, the majority of people are aware of the need for covering food. Analysis indicate that 204 (63.0%) of the respondents dispose of refuse in open field. (Annex4)

Hand washing, refuse disposal, latrine construction and maintenance are some of the topics that are going to be incorporated during health lessons. This survey has further affirmed the need for introducing community-managed health structures such as refuse pits and plate rakes.

4.5.Knowledge about diarrhoea and its management:

A total of 222 (68.5%) respondents indicated that the symptoms of diarrhoea disease is the passing of more than three watery stools within twenty-four hours. 129 (39.8%) of the survey respondents related the cause of diarrhoea as eating of faecally

Care International in Sierra Leone – Kabala Base

contaminated food and 71 (21.9%) related it's prevention to good eating habit with 80 (24.7%) having no idea on its prevention.. All the respondents indicated that diarrhoea leads to death if not treated. 186 (57.4%) said they go to health unit when a child has diarrhoea, others give their children native herbs and some don't have any idea on its management. Time for referring a child with diarrhoea was said to be at the time when signs of severe dehydration is eminent 164 (50.6%).

The results of this survey have further re-affirmed the need for continuing the health topic in Diarrhoea management.(annex5)

4.6.Worm infestation and its control:

88 (27.2 %) said one could become infested with worm by eating dried fish and 23% of the respondents indicated that the food worms can be obtained through eating food contaminated with worms. A total of 25.3% indicated that they did not have an idea of how one gets infected with worms. The means of prevention of worm infestation was pointed out as use of clean and safe water 69 (21.3 %), but 142 (43.8%) could not have any response to this question. Symptoms of worm infestation was highlighted as abdominal pain 77 (23.8 %) with 108 (33.4%) having no idea. 46.9% indicated that the treatment for worms could be received from health Units. (annex6)

The assessment has clearly shown the need to develop a training package for assisting the communities in addressing worm infestation.

4.7.Knowledge about STI and HIV/AIDS:

Survey respondents had some knowledge about HIV and AIDS as evidenced by a large number of 231 (71.3 %) of respondents who said they have heard about it, through various channel of communication such as, the radio discussions, health centres and workshops. A total of 107 (33.0 %) indicated that they were not familiar with the disease. 187 (57.7 %) people indicated that Aids was transmitted through unprotected sex while 126 (38.9%) were not sure of the form of transmission. 121 (37.3%) of the respondent said having one sexual partner could prevent its transmission and 126 (38.9%) of them said they have no idea on its prevention.(Annex7)

HIV/AIDS awareness training has been incorporated as one of the health education topics for these two projects as a result of this survey.

The survey was more quantitative and could not provide detailed household livelihood coping strategies. This survey was only for the purposes of selecting villages and provides basic information of the health status in the targeted villages. An in-depth training needs assessment will be carried out to further help in developing the project implementation strategies.

ANNEX 4

Example MOUs with communities

MEMORANDUM OF UNDERSTANDING

BETWEEN

Timbo Sokralla

AND

CARE INTERNATIONAL IN SIERRA LEONE WATERSHED AND CHILD SURVIVAL PROJECTS

INTRODUCTION:

CARE International in Sierra Leone is implementing WATERSHED and CHILD SURVIVAL projects in five chiefdoms namely; Neini, Wara Wara Yagala, Sengbeh, Dembelia Sinkunia and Follosaba Dembelia with the aim of increasing access to improved water and sanitation facilities, promote personal/general hygiene practices and improve on the health status of children <5 and women of reproductive age (15-49) years.

In order to ensure transparency, accountability, participation and the success of the projects for all parties involved, CARE international and the Village Development Committee & the Community Health Club Executive Committee of

Timbo Sokralla

hereby agree to the following:

(A) CARE International:

1. CARE International will facilitate the formation of community structures such as Community Health Clubs, Village Development Committees and Community Health Club Executive Committees.
2. CARE International will provide basic construction tools to communities where Ventilated Improved Pit latrines (VIP) and wells will be constructed.
3. CARE International will provide industrial construction materials for the construction of ~~ten~~ latrines, ~~four~~ new wells and ~~one~~ rehabilitated well.
4. CARE International will provide qualified technical personnel to layout sample plan of Ventilated Improved Pit Latrines and wells prior to construction.
5. Qualified Construction Technicians of CARE International will provide technical advice on construction techniques and methods in a bid to achieve maximum utilisation of materials to enhance the structural integrity of VIP latrines and well to be constructed.
6. CARE International will provide trained staff to facilitate health sessions so as to improve personal and general hygiene/environmental practices and monitored by the Community Health Clubs.

7. CARE International will build the capacity of committees such as members in the Village Development Committee, and Community Health Club Executive Committee by providing informal leadership training.
8. CARE International will work in close collaboration with Ministry of Health and Sanitation staff to raise vaccination coverage of children and pregnant women from current low levels through Health Units.
9. CARE International will work through Health Units, NGOs and Community Based Organisations to promote the early initiation of breast feeding, complimentary feeding and vitamin 'A' iron intake and de-worming of children and pregnant women.
10. CARE International will closely work with Ministry of Health and Sanitation in building the capacity through trainings of Community Based Health Groups such as Traditional Birth Attendants (TBAs), Blue Flag Volunteers (BFVs) and Vaccinators.
11. CARE International will provide trained hired Technicians for the construction of wells and latrines.
12. CARE International will train Community Based Local Technicians on basic wells and latrines construction skills.
13. CARE International will focus on information on basic Maternal Health Care by educating communities through sessions on danger signs recognition, birth preparedness at community and household level, training Health Unit staff in intermittent malaria control measures in pregnant women and promoting immunization for pregnant women.
14. CARE International will confront the high prevalence of malaria and self treatment by training Health Unit staff in recognition of malaria, educating community members about malaria and its treatment, promoting intermittent treatment of malaria amongst pregnant women and promoting and selling of Insecticide Treated Nets (ITNS) through community structures on a pilot basis.

(B) ~~TAMBO~~ Sokrolla

COMMUNITY:

D) All industrial materials supplied by CARE will be utilized accordingly.

(C) Byelaws/Sanctions policy:

1. All members of the village must take part in the village work.
2. All C H C members must attend sessions on day choosen.
3. All children within the age of 15 vaccination must taken to the Centre for vaccination.
4. All defaulters of the above must be fined a sum of Le 2000.00.
6. 1. + 1 3

and Sand.

- materials → stones
- ③ Local labour for digging of latrines and wells will be provided.
 - ④ We are going to participate fully in health sessions.
 - ⑤ We are always ready to be trained.
 - ⑥ We will nominate people to be trained whenever CARE wants them - T.B.A.s, B.F.U. etc.

Signature of Representatives from the Village Development Com.

1. Name: Mohamed S. Tallah Signature: [Signature] Date: 25/11/03

Position: Chairman

2. Name: Mohamed Tallah Signature: [Signature] Date: 25/11/03

Position: Secretary

3. Name: Fatmata Tallah Signature: [Signature] Date: 25/11/03

Position: Chairlady

Signature of Representatives from the Community Health Club Committee:

1. Name: Ramatu Samah Signature: [Signature] Date: 25/11/03

Position: Chairlady

2. Name: Mamuna Bama Signature: [Signature] Date: 25/11/03

Position: Ass. Chairlady

3. Name: Abdulai B. Tallah Signature: [Signature] Date: 25/11/03

Position: Secretary

Signature of CARE representative:

Name: Alpha I. Durbuya Signature: [Signature]

Date: 25/11/03

ANNEX 5

Boiketho Matshalaga-Project Manager

Boiketho Francisca Rugare Murima (nee Matshalaga)

P. O. Box 66132, Kopje, Harare, Zimbabwe

Work: 263-04-727986-8 Cell: 263-11 230 959

E-Mail Address: boiketho@yahoo.co.uk, boikethoma@carezimbabwe.org

Career Statement:

I aspire to continue to grow professionally through further developing and facilitating the implementation of sustainable nutrition and health interventions which both challenge and utilise my technical knowledge and managerial expertise.

EMPLOYMENT EXPERIENCE

Health/Emergency Programme Manager, 7/02-present, CARE Zimbabwe, Harare, Zimbabwe.

Developed and currently manage emergency public health portfolio (US \$ 2 million annual budget) with a focus on integrating approaches on maternal and child health, supplementary feeding and HIV/AIDS into multi-year relief programs. Presently supervise 3 Project Managers to ensure consistency in implementation strategies and ensuring contractual obligations are met at donor and field levels.

Also, facilitate the implementation of project monitoring and stock tracking systems, ensuring maximum stakeholder involvement is maintained throughout this process. Represent CARE Zimbabwe to donors and the Government of Zimbabwe. (Currently, actively participating in the exclusive breast-feeding working group, chaired by MoH).

Health & Nutrition Project Manager, 10/02-6/02, CARE Zimbabwe, Zvishavane, Zimbabwe

Provided day-to-day oversight for the implementation of a multi-year health and nutrition and intervention in remote rural communities. Project activities included integrated initiatives in maternal child health and nutrition, including: exclusive breast-feeding; diarrhea management; appropriate weaning practices; promotion and preparation traditional foods; community-based growth monitoring; as well as other health education activities (EPI, IMCI, water and sanitation) in collaboration with Ministry of Health. Responsible for a project budget of over US\$ 1.2 million and supervised project staff of 15. Facilitated the baseline, mid-term and end of project surveys. Also, developed participatory monitoring and evaluation processes to measure project activities and assisted in developing staff capacity in areas of participatory training, monitoring, evaluation, project management and strategic planning. Supervised consultant in the development of a community-based BCC component.

Assistant Health and Nutrition Project Manager, 11/98 – 10/02, CARE Zimbabwe, Zvishavane, Zimbabwe.

Trained and supervised staff in community based health activities and community group project management. Developed project database for monitoring key output level indicators in an effort to improve project delivery approaches. Supervised data collection in collaboration with government counterparts for project related feasibility studies. Facilitated the participatory skills enhancement training of project participants using learner centred approaches and social mobilisation skills. Developed and maintained rapport with Government, NGOs, women's groups and community leaders to ensure complementarity of project activities with government extension agencies on technical aspects of the programme.

Research Assistant, Triconsult Private Limited, 1/98 – 10/ 98, Harare, Zimbabwe

Conducted both quantitative and qualitative research in the form of feasibility studies, baseline surveys, needs assessment surveys. Research activities included: field and data collection, data coding, entry, cleaning, data analysis and report compilation.

Research included:

- Situational analysis for Intermediate Technology Development Group (ITDG) Rural Development Project, Chimanimani District.
- Civil society empowerment and poverty reduction in Zimbabwe: A State the Art Review for CODESRIA.
- Zimbabwe country study of post-Beijing activities: An assessment of the National Machinery and the implementation of the 'Platform for Action.'
- UNICEF Zimbabwe situation analysis for 1998, focus on child protection and identity issues.

Internship with Nutrition Unit, Harare City Health Department, 1/97-3/97, Harare, Zimbabwe.

Duties included the following:

- Presented monthly anthropometric analyses of data for school going children in the City of Harare
- Organised soup kitchens for primary school going children
- Conducted nutrition surveillance and Growth Monitoring of School going children
- Facilitated workshops on Baby Friendly hospital Initiative for health centre based staff

Internship with Provincial Medical Directorate (PMD) Matebeleland North Province, 1/96-3/93, Harare, Zimbabwe.

Duties included the following:

- Monitored child supplementary feeding programmes in the province
- Facilitated workshops on Baby Friendly hospital initiative
- Conducted Nutrition Surveillance, growth monitoring of under fives in the Province

ACADEMIC QUALIFICATIONS

Bsc Degree in Nutrition (University of Zimbabwe), 1997. Degree Class: 2.1

University Book Prize for Outstanding Academic Performance

Courses Attended

- Emergency Preparedness and Management (SCF(UK)), October 2001
- Fundraising fundamentals (Project proposal Writing), PAMOJA-USA, April 2001
- Participatory Rural Communication Appraisal (PRCA), SADC Centre for Communication, December 1999
- Participatory Health and Hygiene Education, Zimbabwe AHEAD, May 2000
- Anthropometry Level 1, Nutrition Congress, Durban, S.A., August 2000
- Gender Awareness Training, March 2000
- HIV/AIDS and Nutrition, Institute of Food, Nutrition and Family Sciences, University of Zimbabwe, June 1999

References

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FAO Regional Food and Nutrition Officer
Box 3730, Harare, Zimbabwe
E-mail : Georges.codjia@fao.org

ANNEX 6

Maps

SIERRA LEONE PLANNING MAP



Chiefdom Names
and
Geo- Codes

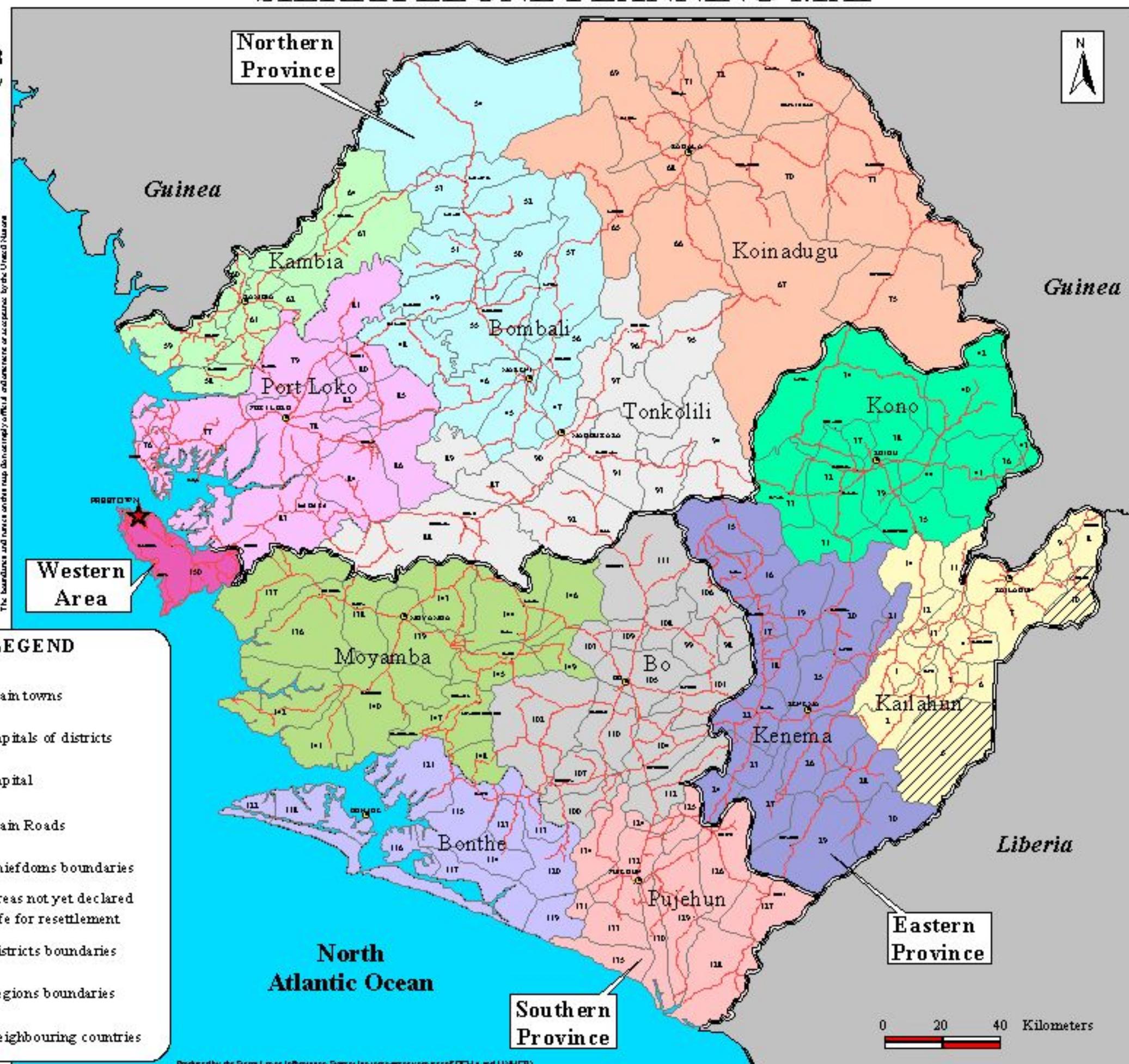
BALAHUN	PORT LOKO
1 Nalushun	76 Kaffu Bullom
2 Javie	77 Lokonama
3 Mandu	78 Mafubi
4 Upper Bembani	79 Buri (B-GV)
5 Adalewa	80 Oba
6 Da	81 Sanda Magbolon
7 Luani	82 Takungu Mafubi
8 Sam Tong	Saffoko (TWS)
9 Sam Sam	83 Koya
10 Kima Togi	84 Mawona
11 Pongu	85 Bays Ruvuru
12 Poy Woe	86 Mungu
13 Poy Bongi	
14 Yandi	
BOBIA	TONGOLILI
15 Gama Mendi	87 Kholi Mbang
16 Wandu	88 Yaw
17 Sribanu	89 Mafu Mafu
18 Sanda Loggona	90 Kholi Rovella
19 Dada	91 Tare
20 Lower Bembani	92 Gbankeken
21 Mafoghan	93 Kanki Bama
22 Small Bo	94 Kanki Sanda
23 Nawa	95 Sanda Bembani
24 Lunguwa	96 Kalamogon
25 Nonguwa	97 Kafi Sere
26 Dava	
27 Koya	
28 Gama	
29 Tunka	
30 Nawa	
BOBO	
11 Gama Kono	98 Badi
12 Nankono	99 Baga
13 Nanyana	100 Baga
14 Sando	101 Bama
15 Gbani	102 Bungeh
16 Gbani Sanda	103 Gbo
17 Kama	104 Jamba-Bongu
18 Gbani	105 Kaku
19 Tunkono	106 Kanki
20 Lodi	107 Luga
21 Saka	108 Nawa Long
22 Tali	109 Silega
23 Mafandi	110 Tikonko
24 Pava	111 Yaku
	112 Wundi
BOBOLLI	BOYIBO
5 Boboli Sere	113 Epanko Kono
6 Mafu Mafu	114 Yawbo
7 Pali Mafu	115 Jang
8 Libamoghan	116 Benda Cha
9 Sanda Tondon	117 Mungu Bullom
10 Mafubani	118 Saka
11 Gbani	119 Kama Kono
12 Sanda Loko	120 Sere
13 Sanda Loko	121 Ingon
14 Tunka	122 Dava
15 Gbandu	123 Sere
16 Saffoko Loko	124 Sawa
17 Sere	125 Poya
18 Sere	126 Sere
19 Gbandu	127 Mafu
20 Sere	128 Sere
21 Sere	129 Chikoni Pori
22 Sere	130 Kpaka
23 Sere	131 Poya Kono
24 Sere	132 Poya Kono
25 Sere	133 Yaku
26 Sere	134 Mafu
27 Sere	135 Mafu Sere
BOBOLLI	BOYIBO
58 Mafu	116 Bunge
59 Sere	117 Ribba
60 Gbandu	118 Bunge
61 Mafu	119 Kama
62 Mafu	120 Bunge
63 Tunka Loko	121 Tunka
64 Sere	122 Sere
65 Sere	123 Sere
66 Sere	124 Sere
67 Sere	125 Sere
68 Sere	126 Sere
69 Sere	127 Sere
70 Sere	128 Sere
71 Sere	129 Sere
72 Sere	130 Sere
73 Sere	131 Sere
74 Sere	132 Sere
75 Sere	133 Sere
	WESTERN AREA
	150 Fofuwa

The boundaries and names on this map do not imply official endorsement or acceptance by the United Nations

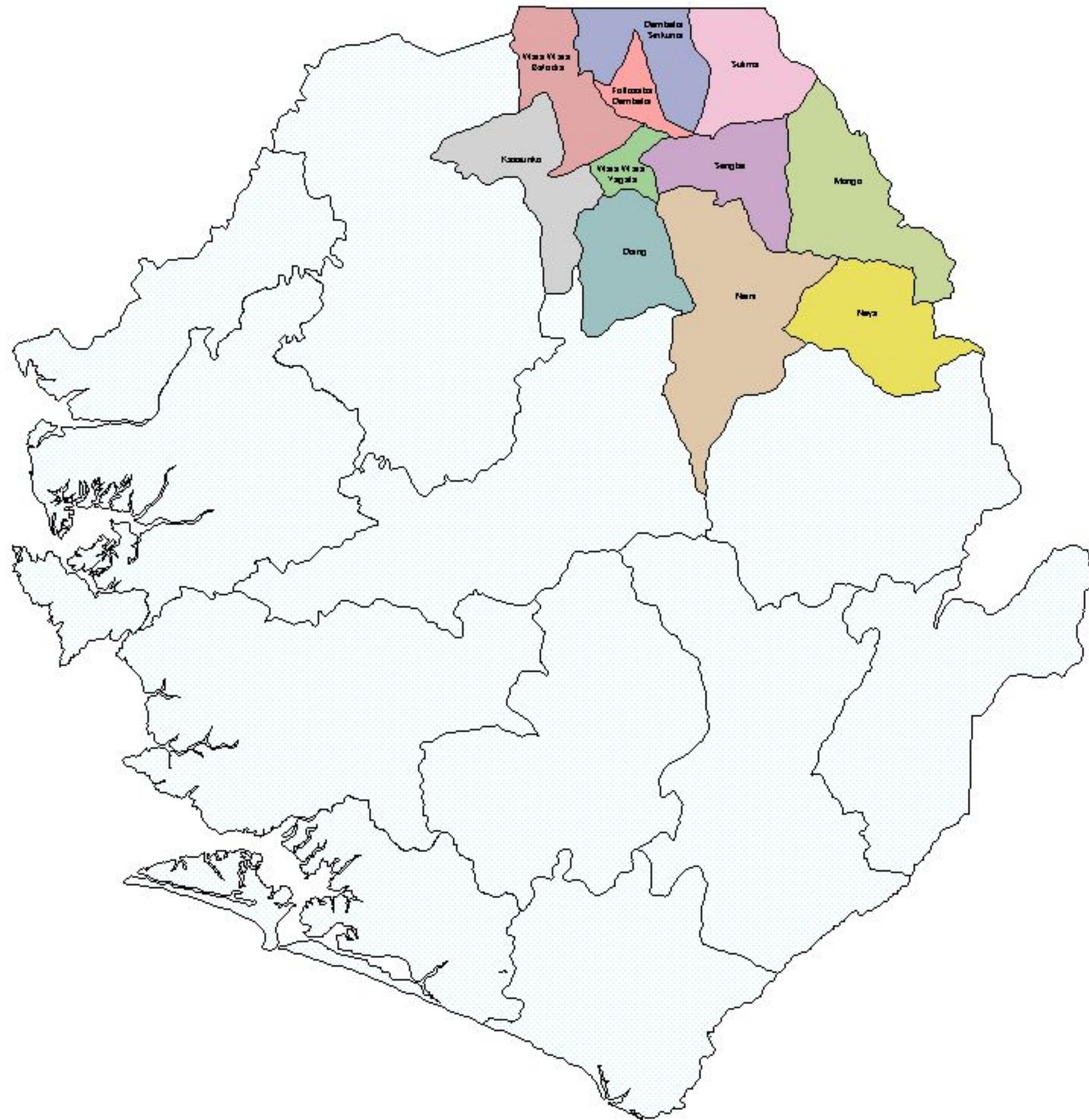
August 2002

LEGEND

- Main towns
- Capitals of districts
- Capital
- Main Roads
- Chiefdoms boundaries
- Areas not yet declared safe for resettlement
- Districts boundaries
- Regions boundaries
- Neighbouring countries



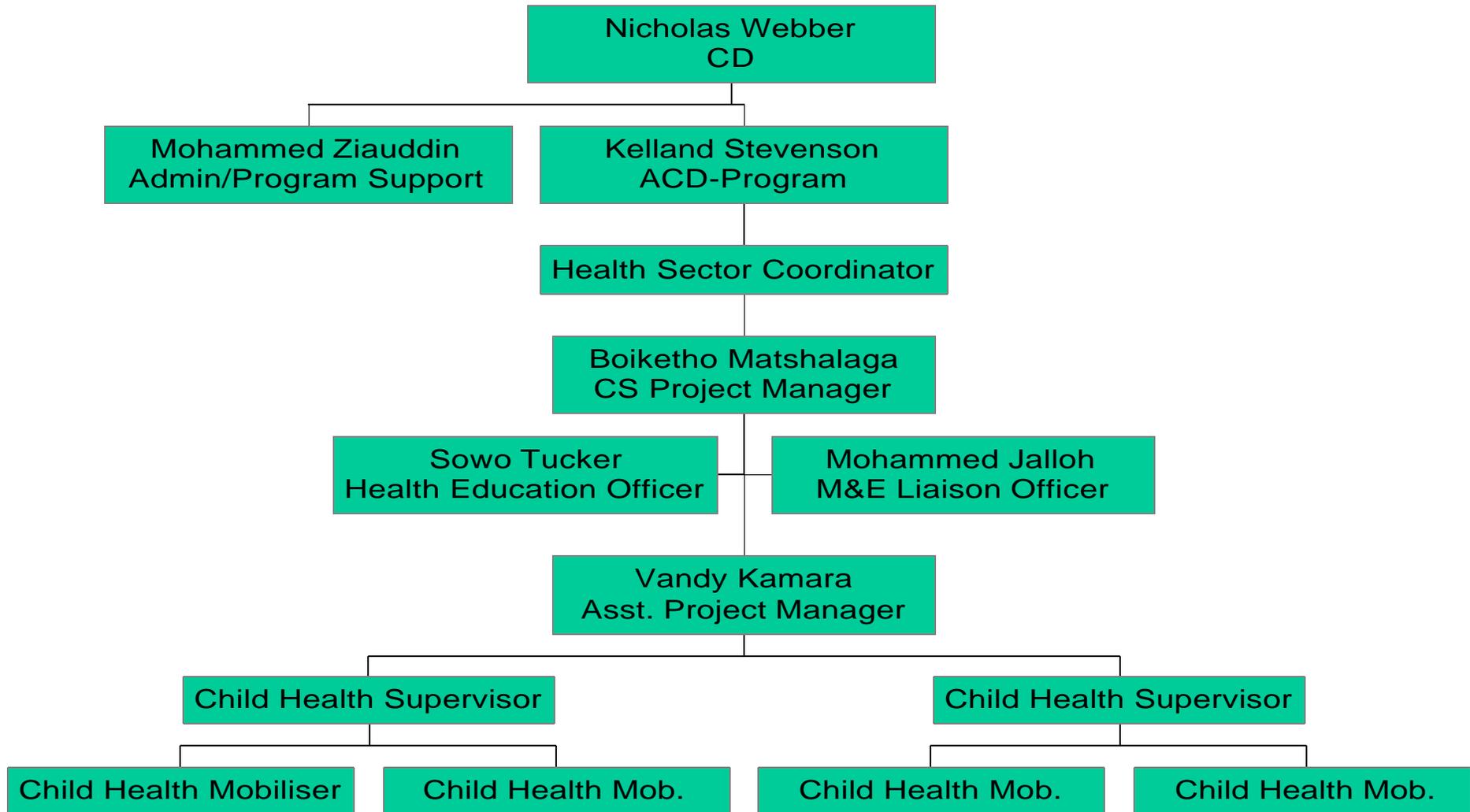
Koinadugu District



ANNEX 7

Organizational Chart

For Di Pikin Dem Wel Bodi (For the Health of the Children)



ANNEX 8

**Sustainability Working Group
Meeting draft report**

ANNEX 9

Stakeholder Meeting

ANNEX 9a

List of Participants

List of Participants in Child Survival Stakeholder Planning Workshop

Name	Agency
Vandy Kamara	CARE
Alfred Makavore	CARE
Sayoh Francis	CARE
Lovell Sesay	CARE
Morie Amadu	CARE
Isattu Kamara	CARE
Edmond Brandon	CARE
Mustapha Massaquoi	CARE
Mohamed Koruma	CARE
Sr Wani Lahai	MOHS
Abdullai Jalloh	MOHS
Mohammed Jalloh	CARE
Fanta S. Kamara	Sengbe Chiefdom Representative
Deen Mansaray	Wara Wara Yagala Chiefdom Representative
Boiketho Matshalaga	CARE
Abu Bakarr Conteh	Follosaba Dembelia Chiefdom Representative
M.B. Jalloh	Christian Extension Services

ANNEX 9b

Agenda



Child Survival Stakeholder Planning Workshop 7th – 8th April 2004

Time	Activity	Who?
DAY 1		
0830-0900	Welcome and Introductions	Ketho
0900-0915	Workshop Objectives	Ketho
0915-0940	TEA	All
0940-1015	Child Survival Project Summary Including Key Intervention Areas (KIA)	Vandy
1015-1100	Project Baseline Survey – Preliminary Findings	M. Jalloh
1100-1130	Overview of Health Interventions in Koinadugu (MOH and NGOs)	MOHS
1130-1230	Defining our Interventions Social Marketing	Ketho
	Integrated Management of Childhood Illnesses (IMCI)	Ketho
	Community Based Growth Promotion (CBGP)	Ketho
	Community Health Clubs (CHCs)	Alfred
1230-1330	Developing the Framework for the BCC Strategy	Ketho
1330-1430	LUNCH	
1430-1530	Finalising the BCC Strategy	Ketho
1530-1615	Health Systems Strengthening Organisational Capacity Assessment Quality of Care	Ketho
1615-1650	Sustainability within child survival Next steps in process towards achieving sustainability.	Vandy
DAY 2		
0830-0930	Collaboration and co-ordination – setting the foundation (Roles and responsibilities of different institutions in the project)	Vandy
0930-1000	TEA	
1000-1030	Monitoring and Evaluation The Project's Monitoring and Evaluation Framework	M. Jalloh
1030-1230	Preparation of the Draft Project Work plan	Ketho
1230-1330	LUNCH	
1330-1530	Finalisation of the Draft Project Work Plan	Ketho
1530	Close	Vandy

ANNEX 10

Revised Budget