CHRISTIAN CHILDREN'S FUND, INC

FINAL EVALUATION

OF

CANAH PROJECT II
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Final Report

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With the collaboration of the Health Districts
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ACRONYMS

ARI	Acute Respiratory Infection
ACT	Artemisinine Combined Therapy
BCG	Bacillus Calmette Guerin)
CAMA	Community Action against Malnutrition
CAMAT	Community Action against Malaria and Tuberculosis
CANAH	Community Action for Nutrition And Health
CCF	Christian Children's Fund
CFP	Child & Family Development Program
CW	Community worker/s
CHW	Community Health worker/s
KAP	Knowledge, Attitudes & Practices
CPON	Postnatal Consultation
CDD	Department Development Committee
CLD	Local Development Committee
CBO	Community based organization/s
CR	Communaute Rurale (Rural Community)
DANSE	Division of Child Feeding and Survival– Ministry of Health
DTCP	Vaccines Diphtheria, Tetanus, Whooping Cough and Poliomyelitis
DIP	Detailed Implementation Plan
DISC	Decentralization of Community Health Initiatives
PRSP	Poverty Reduction Strategy Paper
DS	District Sanitaire (Health District)
EB	Exclusive Breastfeeding
EPI	Extended Program of Immunization
EPS	Education Pour la Sante (Health Education)
FHI	Family Health International
GM	Grand-Mother
IEC	Information Education Communication
IGA	Income generating activities
IMCI	Integrated Management of Childhood Illnesses
IMCEC	Institut Mutualiste Communautaire d'Epargne et de Credit (Savings and credit Mutual)
ITN	Insecticide-Treated Net
ISF	Indice Synthetique de Fecondite (Fecondity synthetic index)
KPC	Knowledge – Practice – Coverage
LQAS	Lot Quality Assurance Sampling
MCH	Mother & Child Health
MSH	Management Sciences for Health
MIS	Management Information System
MOH	Ministry of Health and Medical Prevention
NGO	Non Governmental Organization/s
FP	Family Planning
NEP	Nutrition Enhancement Program
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PDIS	Plan de Developpement Integre de la Sante (Integrated Health Development Plan)
PHC	Primary Health Cares
PRC	President of the Rural Community
RH	Reproductive Health
SFE	Sage-Femme d'Etat (Registered Midwife)
AIDS	Acute Respiratory infections

SPNN	Peri – Neonatal Health)
SNP	Growth Monitoring
SP	sulfadoxine-pyrimethamine
SPC	Promotional Growth Monitoring
TDO	Traitement Directement Observe (Directly Observed Treatment)
TDCI	Iodine-related Deficiency
TPI	Intermittent Preventive Treatment
UNICEF	United Nations International Child and Education Fund
USAID	United States Agency for International Development
VAT	Anti Tetanus Vaccination
Vit.A	Vitamin A
WBW	World Breastfeeding Week
WHO	United Nations World Health Organization
WPG	Women's Promotion Groups
WRA	Women of Reproductive Age

GENERAL OVERVIEW

CCF initiated a child survival project in the health districts of the Mbour Department (Thiadiaye, Mbour and Joal) under the name “Community Actions for Nutrition and Health (CANAH), with USAID funding. The project aimed at the reduction of child and maternal morbidity and mortality. The first phase, CANAH I, was conducted from 1998 to 2002, and was limited to the health districts of Thiadiaye and Joal. Phase I gave encouraging results and led to a 4-year cost extension in Mbour in a second phase, CANAH II which ran from 2002 to 2006. To meet its objectives, CANAH developed a set of community-based activities using a participatory approach with the involvement of all the partners and beneficiaries.

The overall project approach was based on the integration of program activities into that of on-going activities of the health districts with a special focus on empowerment of households, community members and district health staff. This capacity building was intended to help target groups develop strategies and implement activities likely to curb child and maternal morbidity and mortality. The project therefore worked towards the improvement of the knowledge and practices of the population; consolidation and capacity building of the community workers; increased sustainability of interventions; reinforcement of supervision at all levels by the health district personnel; and cost recovery schemes (to ensure sustainability).

CANAH II has built upon the interventions initiated by CANAH I. These interventions have been enriched with additional components such as reproductive health, STI/AIDS control, etc. The strategies are articulated around greater access to curative, preventive and promotional care at both the community and health facility levels; a quality assurance approach consolidated through proper training; regular supervision of the community workers; greater consciousness and optimal mobilization of the population around child and maternal health; and a significant increase and diversification of funding sources, including IGA and cost recovery schemes.

The implementation of CANAH II’s strategies was carried out through the development of a stronger partnership with the communities, notably the grandmothers.

A final evaluation of all the activities implemented was planned for the term of the project (October 2002 - September 2006). This evaluation is meant to assess the progress realized during the four years of implementation, with a particular emphasis on a) the level of attainment of the objectives; b) the efficiency of the technical approaches; c) the efficiency of the involvement of the Ministry of Health agents, the CBOs, the community leaders, the NGOs in the project

activities; as well as to summarize lessons learned with the stakeholders at the end of the project for scaling up purposes. The methodology lies on a “before-after” descriptive and analytical survey using both the quantitative and qualitative approaches, using the KPC method as well as focus groups discussions, individual interviews with key informants and a questionnaire for CANAH II operational staff.

The main results of the final KPC are summarized below. The sampling targeted 300 women aged 16-46 years however, 317 were interviewed, because all the children of the last household sampled were taken into account. The break up of the age groups for both the baseline KPC and the final KPC showed that the proportion of women aged 16-19 years has practically doubled; growing from 4 to 7.9 %, while that of 36-46 years old had dropped from 18% to 11.2%. However for both surveys, more than 1/5 of the mothers belong to high risk pregnancy age groups. That situation bears witness to the tenacity of traditional practices and requires the development of preventive messages about prevention of precocious or late pregnancies, especially within the framework of women’s solidarity circles and through the grandmothers.

The percentage of illiterate mothers has decreased from 54.4% to 43%, which denotes considerable efforts made to reduce illiteracy in the project zones. Nevertheless, more than 40% are still unable to decode the health messages posted or written in French or in the local languages. About 60% of women interviewed were not involved in any kind of income generating activity.

The constitution of the age groups shows a predominance of children under 12 months. These results could be likened to those of the baseline KPC (59% of 0 -11 months and 41 % of 12-23 months old children).

Of the 317 women interviewed, 86.5% have had a health card compared to77% in the baseline KPC. Among them 65.9% have had 3 pre-natal consultations compared to an objective of 60% (baseline KPC 45%). 304 women (95.9%) have had a medical prescription for intermittent preventive treatment of malaria with sulfadoxine-pyrimethamine (SP). That variable which was not available in baseline KPC nears the 100%. 309 women (97.4%) have had an iron prescription. The 100% objective of iron supplementation of pregnant women has been nearly covered and the findings can be matched to that of the baseline KPC. As for the place of delivery, 73.4% of women delivered at health facilities (health post, health centre, health hut) (baseline KPC =59%) and 22.8% delivered at home.

131 parturient women (41.3%) received assistance from a skilled worker (Doctor, nurse, midwife) and 45.8% from a TBA/CHW, which gives an overall rate of 87.1% compared to 67% for the baseline survey (objective: 75%).As far as anti-tetanus vaccinations, 70.2% of women

received two ATV injections or more, a 35% increase compared to the baseline KPC (38%), which met the objective of 70% of women vaccinated.

As for post-partum care 77.9 % of the women have had an immediate post-partum consultation and 73.9% have had a postnatal consultation in 42 days after the delivery. (baseline KPC =57% - Objective: 80%).

As far as the mothers' knowledge of post-partum danger signs, 226 mothers (71.3 %) know at least two signs (the objective (70%) is covered and the baseline KPC was 39 %). As for new-born danger signs, 70 % know at least two signs (47 % in the baseline KPC).

In a sample of 317 interviewed women, 99 % were breastfeeding their child, thus demonstrating that breastfeeding remains the common mode of feeding the child during the first two years of life. Exclusive breastfeeding of 0-6 months children (defined by early breastfeeding within the first hour of birth and feeding the child only with maternal milk), has risen to 82 % on a sample of 88 infants, which is 13 points below the 95 % objective but 30 percentage points higher than the baseline KPC (52 %).

With regard to growth surveillance, the rate of usage (number of children weighed at least once during the last three months) has risen from 59.3 % in the baseline KPC to 72.9 %, of whom 85.5 % have put on weight, 6.8 % have unchanged weight and, 7.7 % have loss weight for a total of 207 weighed children. The objective was 80 %.

Among 312 children weighed during the final KPC, 91.7 % showed a satisfactory nutrition, 6.7 % (n = 21) presented moderate malnutrition and 1.5 % (n = 5) severe malnutrition. The baseline KPC identified 18.3 % malnourished children. So the objective to cut the rate of global malnutrition by 16.5 % has been widely surpassed.

The supplementation of vitamin A in children, either directly for those over 6 months or indirectly thru the mother during post partum for those under 6 months, has risen to 91.2 % compared to 64 % in the baseline KPC and an objective of 90 %**.** Iodized salt intake by households has risen from 17 % to 73.68%.

86 % of the children over one year of age were dewormed (baseline KPC = 36 %).

81 % of the 12-23 month old children are completely immunized and the objective of 80 % has been attained (baseline KPC = 57 %).

The prevalence of diarrhea estimated at 13.8 % has slightly increased compared to the baseline KPC (11 %). Among the children having had diarrhea during the 15 days preceding the survey, the ORT rate of usage is 96.3 %, 63 % used ORS and 33.3 % used house solutions for treatment, which is remarkable compared to the baseline KPC (50 %). With regard to diarrhea preventive methods 89.5 % of the mothers have reported hand washing with soap / ash before preparing

meals or feeding the child, compared to 32 % in the baseline. The objective of 60 % has been surpassed.

Prevalence of fever is estimated at 9.6 %. There is a decline when compared to the baseline survey (15%). Among the children having presented fever during the 15 days preceding the survey, 95.5 % have used a health facility (health hut, health post, health centre) and 50% have received adequate treatment (ACT) within the first 24 hours, compared to 15 % in the baseline survey. The objective of administration of anti malaria drugs during the first 24 hours remains to be covered (80 %).

Regarding malaria control measures, 81.4 % of the mothers have reported use of simple mosquito nets and 18 % the ITN compared to 62 % in the baseline survey. The progress is satisfactory and the objective has been totally met (75 %). It is worth noting that 76.3 % of the mothers possess an ITN and 97.4 % of the children and 99.1 % of the mothers effectively spent the night before the survey under an ITN compared with 49.80 % of the children in the baseline survey (objective = 70 %).

Prevalence of ARI is estimated at 3.8 %. There has been a very considerable cutback (28 % in the baseline survey). Among the children having had an ARI in the fortnight preceding the inquiry, 87.9 % of mothers sought care and 80.9 % among them went to a health facility. (74 % of these 80 % went to a health facility in the baseline survey); the 80% objective has thus been reached.

Among the women interviewed, 99.4 % have already heard about HIV / AIDS (baseline KPC = 93 %) and 97.3 % among them know that prevention is possible (baseline KPC = 77 %). 70.4 % of the mothers can cite 2 or more prevention methods (objective = 80 % / baseline KPC unavailable). 71.5 % of the women have reported 2 or more modes of HIV/AIDS transmission, an increase of more than 40 points with regard to the baseline KPC (30 %) for an objective of 50 % of women; 74.5 % know screening methods and 81.8 % know that the disease is incurable.(respectively 36 % and 77 % in the baseline KPC).

As for the impact of the project, all the project stakeholders have emphatically acknowledged progress in terms of knowledge of health and nutrition, as well as in terms of the behavior changes that has occurred. As a result, there has been better management of maternal and child health by women of reproductive age and grandmothers strongly involved in BCC activities.

The project also developed a collective consciousness towards hygiene, both individual and collective hygiene as promoted by the Environmental committees in the villages clusters. One leader said “children have become very clean and always dress neatly as newly-weds” while before “they were always naked and very dirty”.

The training of the relays has allowed them to acquire knowledge and competence to convey useful information about health, the mothers have said, which give them the nickname

"*Doctorou Kallama*" (the doctors of word). The mothers have acknowledged and asserted that without training, transmission of knowledge or competence would have been unlikely.

All community workers stated having been chosen by the communities for their participation in the program. Therefore, they have been involved in the implementation of the project at all the levels. They have said that they are aware that they work together with the communities for their own good. In Mbodiene a CHW has said "*our desire is health by the community for the community"*. Generally speaking, the community workers have declared that the community leaders support them in the execution of their activities. That support consists of mobilization of the target groups for health education activities and weighing sessions, and especially the elaboration of action plans, problem solving, and men's participation.

The women's CBO leaders all assert having been strongly involved in the various health and nutrition activities, which is important for the sustainability of the activities. The work realized with the project staff and the community workers has helped them to understand and initiate the same actions regarding social mobilization, support for the organization of relays' activities, etc. On the other hand they have noted that the activities introduced by the project are theirs since the project has helped them in many different ways. That help has come in the form of training of relays whom they have chosen among themselves, re-energizing the health hut committees, of which they are members for the greater part, developing ITN marketing and IGA initiatives, and finally integrating the health education activities and weighing sessions into their groupings.

As such the CANAH II project, on the basis of the lessons learnt by the first phase has widened its strategies, notably with the creation of 'pregnant women's solidarity circles'; the extension of the grandmother strategy; the support for the community worker organization in the development of IGA and accompanying of the outreach and mobile strategies; and the organization of child survival days. These new interventional orientations have strongly contributed to the substantial progress made in relation with the initial project indicators. The good results obtained must be maintained, strengthened and widened consequently by bringing more attention on schooling/literacy of the Community Workers (CW), by increasing supervision and generating stronger community mobilization around Maternal and Child Health and nutrition.

I - INTRODUCTION

Since its independence Senegal has made the health sector a national priority that supports economic and social development. This political will is asserted in the Constitution which guarantees the right to health for the whole country, and the State and communities guarantee that.

Senegal's health policy is articulated around "health for all" through primary health care and MOH's vision contained in the Poverty Reduction Strategic Paper (PRSP) which emphasizes social wellbeing with an effective and successful educational system, quality health care, and a healthy living environment.

The National Health Development Plan and its pedestal application, the Integrated Health Development Plan has put a specific focus since 1996 on four major objectives: the reduction of child mortality; reduction of maternal mortality; the decrease of the fertility index; and increased access to basic services for the most deprived. These objectives could be met through:

- strengthening of the primary health care (PHC) level through empowerment of communities in management of health issues;
- rationalization of resources mobilized in the execution of programs
- decentralization and empowerment of the health districts which are the operational level of effective implementation of health programs
- consolidation of the partnership with the private sector, NGOs and the nonprofit sector
- development of community-based health activities

CCF initiated a child survival project in the health districts of the Mbour Department (Thiadiaye, Mbour and Joal) under the name "Community Actions for Nutrition and Health (CANAH), with USAID funding. The project aimed at the reduction of child and maternal morbidity and mortality. A first phase, CANAH I, was conducted from 1998 to 2002. That phase, which was limited to the health districts of Thiadiaye and Joal, provided encouraging results and led to a 4-year cost extension including Mbour in a second phase called CANAH II that ran from October 2002 to September 2006.

A final evaluation of all the activities carried out was planned at the end of the project in Sept 2006.

II - OBJECTIVES

The final evaluation was meant to:

- estimate the progress accomplished during the four years of project implementation with a particular focus on: a) the level of attainment of the objectives, b) the efficiency of the technical approach, c) the efficiency of the involvement of the agents of the Ministry of Health, the community based organizations, the community leaders and NGOs in the project activities.
- evaluate the processes of continuous improvement of the knowledge and competencies of the project staff, including needs assessment and training methods (content and follow-up of the training)
- evaluate the quality of the services related to the project and the links between the structures and the communities
- evaluate the relevance of the M&E methods used at all levels
- evaluate the level of appropriation and mastery of the interventions by the agents of the Ministry of Health and the communities
- evaluate the perspectives of sustainability of the actions and experiences introduced within the framework of the project interventions
- summarize lessons learned at the conclusion of the intervention with all the stakeholders
- formulate relevant recommendations for the scaling up of the interventions.

III - OVERALL PRESENTATION OF THE PROJECT

1 Philosophy: CCF is a non-governmental organization founded in 1938. CCF has worked in Senegal since 1986. Originally CCF assisted deprived children worldwide, today however, its vocation has widened. CCF has joined in holistic programming with a comprehensive approach to the needs of the child, their family and their community. The areas of interventions range from emergency to health care and systems, nutrition, early childhood development, basic education, and sustainable development. That vision is materialized through CCF Child and Family Development Programs (CFDP) - parent-led programs and Special Programs including the Casamance program, the Micro-Enterprise Development Program and the Community Actions for Nutrition and Health (CANAH) project, which is the object of the present evaluation. CANAH II was a child survival project introduced by CCF for a duration of four years (October 2002-September 2006) with a USD 1,704,445

budget funded by USAID. CANAH was implemented in a first phase which was evaluated with compelling results.

2 ***Covered zones and targets*:** While the first phase of the project took place in the health districts of Thiadiaye and Joal, this second phase was extended to include an additional zone, Nianing, in the health district of Mbour. The project has voluntarily targeted children under five (U-5), and pregnant and breastfeeding women living in rural areas with the aim of reducing maternal and child morbidity and mortality. The number of beneficiaries of CANAH was 137,000 while the extension phase targeted an additional population of 26,393for a total of 163,393 persons. Children 0 - 5 years old represent 31,106 and women of reproductive age 37,654 giving an overall direct beneficiary population of 68,760.

3 ***The Project's Global Approach**:* The global approach of the project is rooted in the integration of the interventions into those of the health districts by emphasizing the capacity building of the households, the members of communities and the health district teams to develop strategies and carry out activities which lead to reduced maternal and child morbidity and mortality.

The project focuses on the improvement of the knowledge and the practices of the populations, the consolidation and the strengthening of the capacities of the community workers, the increase of sustainability conditions of the interventions, the intensification of the supervision at all the levels by the staff of the health district and cost recovery schemes.

CANAH II takes into account all the interventions initiated under CANAH I enriched with other constituents such as Reproductive Health, HIV/AIDS… The strategies have articulated around a broader access to curative, preventive and promotional care at the community level and health facilities, a quality assurance approach through comprehensive training, regular supervision of community workers, a broader awareness and an optimal mobilization of the population to address maternal and child health problems and a significant increase of the sources of funding, including the IGA and cost recovery.

The operationalization of CANAH II's strategies passed through the development of a more successful partnership with the communities, especially the grandmothers.

4 ***Technical Areas Covered**:*

Given the recommendations of the evaluation of CANAH I, the main areas of intervention retained for CANAH II were the following:

- Nutrition / breastfeeding / iodized Salt
- Maternal and neonatal health including HIV-AIDS
- Control of diarrheic diseases

- ARI Control
- Malaria Control

***5 Methods of interventions*:**

5-1. Approach to Behavior Change Communication

The global approach of the project in Behavior Change Communication (BCC) has been essentially based on a participatory method. The project's team has used Paulo Freire's adult educational model. That model is built on the principle of "awareness / responsibility" of the learners. The key elements for the success of such an approach are based on the exchange of ideas and experiences, the interactive dialogue on issues and problems, negotiation built on mutual respect and confidence, and finally the critical **reflection** on modern health and nutrition concepts and perceptions (beliefs, values) and practices of the community.

The project has thus established its communication approach based on the values, the beliefs and experiences of community members along with the preconceived health and nutrition messages conveyed by the MOH. In addition, the traditional mechanisms of communication were used, such as women's solidarity circles (community based organizations), men's groups, and grandmother pals' circles. Tools and methods adapted to the rural world were also included in the process of communication: role plays, open-ended stories, songs, drama, group discussions. The involvement of the grandmothers was a key strategy of the project that helped to strengthen the role grandmothers played in the management of health and nutrition issues. The involvement of the grandmothers also affected subsequent community mobilization thus optimizing behavior change. Grandmothers supported the youth and the heads of the family through their advice and their advocacy for the good practices promoted by community health workers.

The grandmothers have a considerable influence on the other members of the family and the community. Because grandmothers embody wisdom where the community values and practices are concerned, their advice is very often welcomed and sought. However, they are generally educated and trained according to traditional methods, which leads to consequent transmission of knowledge and practices only congruent with traditional practices. This project built on the strategy of a partnership with grandmothers consisting of negotiating the concomitant utilization of positive traditional practices and values in the same manner as modern health and nutrition concepts. Other participatory communication strategies have also been used by the project notably:

- **The "pregnant women's solidarity circle":** These circles are pregnant women's groups residing in the same village or neighborhood. It has been established that people who share the same living conditions, the same constraints or have undergone the same tribulations are generally open to the advice of their peers. The testimony of an experience such as pregnancy with underlying difficulties can constitute a non-negligible form of assistance to the least experienced to learn from others. It has allowed women to play down some pregnancy issues and to find solutions in the way others with more experience handled a particular situation. The "solidarity circle" duplicates the same methodology as that of group therapy. Many subjects related to pregnancy troubles, food, malaria, anemia, workload, neo-natal consultations, assisted delivery, exclusive breastfeeding, are discussed. Besides, the strategy allows the pregnant women to walk out of "forced" isolation of which they are victims because of socio-cultural considerations.

- Development of BCC activities within the community based organizations (women's groups, women's sponsorship groups, etc): In villages, women are forced into excess daily workload which leaves little spare time for them to attend health and nutrition activities essentially convened by the relays. The relays started using time-slots already agreed upon in women's calendar and set up by women's groups to append their BCC activities. That approach has not only been more acceptable for the women but has also made room for the development of capacities within the CBO to conduct BCC sessions thus promoting the emergence of leaders to support the adoption of more appropriate behavior.

- The systematic involvement of the community leaders (village chiefs, notables, heads of concessions) as actors for the promotion of behavior change: This key strategy has given a lot of satisfaction to the project because the elderly are still very influential in villages. Besides, these experienced persons are mostly heads of compounds who stay more often with the young mothers and the children. The heads of families are generally young people who work in the city or in other locations. Through involvement in the project during problem identification, planning, implementation and of self-evaluation of the activities, community leaders have acquired a lot of information about the best health and nutrition practices taught by the health district agents and those of the project. So, these leaders assist the community relays in their implementation of the activities directly or by intensifying the advice which the relays have given to the young mothers, the grandmothers and the young heads of families.

5-2. Advocacy and partnership

From the proposal elaboration phase of the project to the evaluation, the project has worked in good synergy with the authorities and all other influential stakeholders for a good appropriation of methods and results. With the advent of the second phase of the project (CANAH II), the authorities of the MOH (DANCE, Medical Region of Thiès and District Chief medical Officer) promoted extending the Project's components to interventions which address more specifically their concerns (technical priorities and strategic support). After that phase, the project and the health districts advocated for the interventions to the administrative, political and customary authorities (LDC, DDC), explained the intervention, collect their suggestions and got their support for activity implementation. Other partners like the NGOs, homeland services, and CBOs have also participated in these advocacy sessions. Finally, at the level of every village that has a health hut or a site, the project agents along with the chief nurse and a member of the community development team, teachers and members of others NGOs gathered the populations coming from all social categories to explain the interventions, collect the expectations, as well as discuss the roles and the responsibilities of every stakeholder in the management of health and nutrition issues.

The advocacy sessions which took place at all levels encouraged active participation of partners and communities throughout all the stages of the project's implementation. That method made room for the appropriation by the districts and the communities of the methods and the results obtained.

5-3. Training / Refresher sessions for the community workers

The Project adapted training manuals for CHWs TBAs and Community Relays according to the changes brought in the standards and the protocols relative to nutrition / exclusive breastfeeding, malaria and ARI. These adaptations have been made in conjunction with health agents at the national, regional and district levels. Refresher trainings for trainers (project staff and district health agents) were done first to prepare them for the training courses of the community workers (CHW, TBAs, relays, members of the health committees). Every time the Ministry of Health made changes to the management of health issues such as malaria, deworming, immunization, and ARIs, refresher sessions were organized.

Several important subjects in relation to the technical components addressed by the project were discussed during the training sessions. They consist of:

- BCC: talks, home visits, individual interviews, advocacy, community meetings, culinary demonstrations
- Planning / evaluation of the activities: self-evaluation/ planning meetings
- Growth monitoring: weighing technique for 0-36 months children

- Exclusive breastfeeding / child's additional food
- Supplementation: fight against deficiency in vitamin A, iron, iodine
- Prevention and management of diarrhea
- Prevention and management of ARI
- Systematic deworming of children 1–5 years old
- Immunization
- Curative care at the health hut level
- Management tools
- Fight against HIV/AIDS.

The training/refresher training activities were combined with the supervision (formative supervision) done by both the project's agents and the chief nurse, to make sure new content learned during the training sessions were being applied at the health hut level. In addition, the chief nurse and the midwives organize a monthly outreach strategy at the health huts level where they closely work with the community workers. They take advantage of this monthly gathering to look at the health hut management tools and discuss progress and then provide feedback or support when needed.

5-4. Use of the motivators and supervisors

In the first phase of CANAH, only motivators were used by the project at the community level to support the community workers with the implementation of the activities. With the second phase, the project extended to new villages and the health district of Mbour. The recruitment of twelve new motivators and 3 supervisors became necessary to ensure sufficient presence on the ground and at the same time ensured close supervision of the motivators. Each motivator had an average of 5 health huts. Motivators' tasks included supervision of community workers and follow-up of activities. Motivators and supervisors constitute the key elements of the project system. They help the communities, the health districts and other stakeholders translate all the technical and strategic interventions into concrete actions.

5-5. Monitoring and evaluation

The project has developed a specific monitoring and evaluation strategy built on several parameters, most of them technical:

- **Formative supervision of the project agents and community workers**. The formative supervision is based on a pyramid: the management team of the project supervised the supervisors and the motivators every quarter. The supervisors visited the motivators once a month on average. The motivators provided support to the community workers (CHW, TBAs, relay, CBO) once every week on average. The supervision was related to the mastery of the

activities and their content, organization and community mobilization, health hut management and bookkeeping tools. Community self-evaluation and planning meetings were organized monthly with the motivators, chief nurses, community leaders and CBOs.

- **The annual evaluation of the project's short term achievement**: The annual evaluation used quantitative methods (LQAS) and qualitative methods (focus group) as a basis for understanding and measuring the achievement of the project objectives as well as for the collection of community opinion regarding their satisfaction with the quality of interventions and the appropriateness of the strategies. The evaluation involved the health districts, the community and the project's personnel.

- **The mid-term evaluation (after 2 years) and the final evaluation** are occasions for in-depth documentation of the Project's achievement, measurement of the achievement of the objectives, and for investigation into the perceptions of the population with regard to project activities. This evaluation helps us summarize lessons learned and draw conclusions from them.

IV - EXPECTED RESULTS AND INDICATORS

A-Nutrition: Breastfeeding and Micronutrients (30 % of the budget): the nutritional objectives are aligned to those of the MOH and targeted:

- ✓ **Children from 0 to 59 months:**

+ 90 % of the children have been supplemented twice a year in vitamin A

+ 85 % of the 0-36-month-old children benefit from growth monitoring

- ✓ **Pregnant and Post-partum women:**

+ 70 % of women receive vitamin A supplements within 42 days of delivery

+ 100 % of pregnant women receive iron supplements during neonatal consultation

- ✓ **Breastfeeding**

+ 60 % of children are exclusively breastfed up to 6 months

+ 90 % of newborns are breastfed within the first hour of childbirth

B- Diarrheic Disease Control (15 %):

60 % of the WRA wash their hands before preparing food and before feeding their children

90% of the WRA know how to prepare ORS

100 % of the health facilities have ORS packets

C- ARI Control (15 %)

100 % of the children 0-5 years with signs of pneumonia are correctly cared for

75 % of the mothers know at least two danger signs for pneumonia

75 % of the mothers apply appropriate home treatments

D- ***Malaria control (15 %)***

80% of children of 0-5 years who have fevers are treated within 24 hours according to the MOH standards and protocols

70% of 0-5 children sleep under ITN

100% of pregnant women seen in neonatal consultations receive anti-malaria prevention treatment

70% of pregnant women sleep under ITN

E- ***Maternal and neonatal Health / HIV-AIDS***

75 % of the WRA know at least two pregnancy danger signs

60 % of the women who delivered have at least one postnatal consultation within 42 days

75 % of the WRA know at least two post-partum danger signs

75 % of the WRA know at least two newborn danger signs

80 % of the WRA know at least two HIV/AIDS prevention methods

V - METHODOLOGY

- *Type of study*: The survey is a « before and after » descriptive and analytical exercise containing two facets, a quantitative one with the KPC and a qualitative one with focus groups discussions, individual interviews with key informants and a questionnaire for CANAH 's operational staff.
- *Areas and sites of survey*: the investigation took place in the intervention areas of the CANAH II project in the health districts of the Department of Mbour (Thiadiaye, Joal and Mbour). The survey sites are the specific villages covered by the project.
- *Targets of the inquiry*: the inquiry targeted:
  - ✓ Mothers of 0-23 months children
  - ✓ Members of the health committees
  - ✓ CBO leaders
  - ✓ Chief nurses
  - ✓ Health district chief medical officer
  - ✓ CANAH II staff
  - ✓ CANAH II supervisors and motivators
  - ✓ Rural community presidents
  - ✓ Community leaders
- Sampling

1. **The KPC**: The final KPC has been realized within the framework of the final evaluation for the CANAH II Project. Congruent with USAID guidelines, CCF opted for a participative approach involving the Project's stakeholders and the various partners. These guidelines are published in the document « USAID-BHR: PVO Child Survival Grants Program - final Guidelines for mid-term and evaluations, » (CS-15, 1998-2002, December, 1999) and were used as a reference for designing the final evaluation. The final KPC is compared with the baseline KPC to measure quantitatively the progress achieved throughout the Project's implementation.

   Objectives of the KPC survey

   There are four objectives retained:

   - ✓ Evaluate the knowledge of the mothers of 0-23 months children on major child health issues: illness prevention, diarrhea control, malaria control, ARIs, breastfeeding and complementary feeding practices;
   - ✓ Evaluate the mothers' practices related to the main health issues for their children and themselves, especially during pregnancy, childbirth and post-partum;

- ✓ Evaluate the immunization coverage of the group of 12-23 month children against BCG, Measles, Yellow fever, DTCP/Pentavalent1 and DTCP/ Pentavalent 3 through access, rate of coverage and rate of dropout;
- ✓ Evaluate the knowledge of the mothers of 0-23 month children's on HIV/ AIDS.

Development of the tools

The evaluation team consisted of 17 members representing the regional health authorities, the health districts, the CFP, (CCF Child and Family Programs) and CANAH. It took into account the recommendations contained in the KPC 2000 Guidelines and the data contained in the baseline KPC. All the questions were reviewed and revised to reach a consensus. 78 questions covering the project's intervention priorities were retained:

- Questions 1 to 15 relate to general characteristics and maternal health (pregnancy and childbirth)
- Questions 16 - 29 on infant feeding, breastfeeding and weaning;
- Question 30 on iodized salt;
- Questions 31 - 37 on vitamin A, growth monitoring, deworming;
- Questions 38 - 42 on immunization;
- Questions 43 - 53 on IMCI;
- Questions 54 - 59 on diarrhea;
- Questions 60 - 65 on malaria;
- Questions 66 - 69 on ARIs;
- Questions 70 - 78 on HIV/AIDS.

Cluster sampling

The sample has been extracted from the villages with health huts in the intervention zones, using the sampling model in clusters of WHO/EPI. The sample was calculated using the following formula: $n=z^2(pq)/d^2$ (n = number of the sample; z= the degree of precision; Z=1.96 for a confidence interval of 95 %; P = True probability 0.5, q = False probability q=1-p = 0.5; D = degree of certainty: 10 %; therefore

$n = (1.96)^2(0.5x0.5)/(0.1)^2$

n=0.96 / 0.01

n=96

The model of sampling with 30 clusters suggests the doubling of the value n. So,

n= 96 x 2 =192. Which makes 192 / 30=6.4 persons by cluster, is rounded off to 7 persons by cluster for a total n = 210. To make sure that the sample will be rather wide, the KPC suggests to reach 300 persons therefore 10 persons by cluster.

Cluster determination

The village / hamlet was retained as a cluster. The selection of the clusters included listing all the villages of the zone. Then the cumulative population for every village was calculated. The sampling interval was determined by dividing the total population by the number of clusters (30), that is, 163393/30 = 5446. A random number equal or lower than the 5446 was drawn randomly (2184). The first cluster has been chosen on the basis of the cumulative population greater than or equal to the number drawn at random. The second cluster was chosen by adding the sampling interval (5446) to the total population of the first cluster. The third cluster has been calculated by adding the figure found for the second cluster to the sampling interval. The same process has been followed until the 30 clusters were chosen, that is 30 villages or hamlets.

Method and targets of the survey

The survey direction was determined using a bottle (where you spin a bottle on the ground to select a direction randomly) and from the identification of the sociological centre of the village. This "step by step" approach helped to determine the mothers to interview: 16-46 year old mothers with children aged 0-23 months. One mother was interviewed in each of the first nine households. At the tenth house, all the mothers living in the concession and fulfilling the criteria of inclusion were interviewed.

2-**Focus Groups**: The aim of the focus groups was to collect opinions and suggestions on project activities. The evaluation team had elaborated guidelines, based on the objectives of the evaluation, for group interviews with the community workers, the CBOs, the community leaders. The focus group sites were similar to those of the KPC.

3-**Individual interviews**: Individual interviews target key informants to collect their opinions and suggestions regarding the implementation of the project activities. The evaluation team developed individual interview guidelines for CANAH staff, the chief nurses, and the District's chief medical officer. Individual interviews were conducted with the management staff of the project (Director, coordinators, Administration and Finance Assistant, the support staff), the District's chief medical officers of four districts of Mbour department, and 2 chief nurses in each

of four districts (Nianing and Darou Salam in Mbour, Ngueniene and Santhie in Joal, Sandiara and Fissel in Thiadiaye, Toglou and Guerew in Popenguine).

4-**Questionnaire**: A questionnaire was elaborated and presented to all of the CANAH II supervisors and motivators to collect their opinions and suggestions.

Organization of the survey: The 17 member coordination team, including the key resource persons, was set up to review survey questions related to task achievement. Another team, (the restricted team) consisting of a few CANAH II staff and the consultant were responsible for close follow-up of the strategic activities.

The first activity was to clarify the objectives of the evaluation and choose the most appropriate data collection methods (documentary review, KPC, focus, discussion) to achieve them. Then, the key stages of the evaluation were identified. The coordination team reviewed the questionnaire used for the KPC and designed the tools for the focus groups, individual interviews and the questionnaire for the motivators. On this basis, the sample was selected and the teams formed. There were 10 teams of three for the KPC, including one supervisor and teams of two for focus group discussions while individual interviews were conducted exclusively by the consultant.

After the formation of data collection teams, a one-day workshop served as a briefing moment for the supervisors on the objectives of the evaluation as well as to clarify their roles and responsibilities. The workshop was followed by a training session for the 20 surveyors to discuss the questionnaire and harmonize the data collection to reduce discrepancies among the surveyors. All the administrative and logistic questions were discussed, resolved and explained to everyone involved in the data collection process.

Data collection

- ✓ **KPC:** Ten teams of three including one team leader visited one site per day during three days of inquiry reaching a total of 30 clusters. In each of these sites, the team leader met the village chief or hamlet chief to explain the objectives of the mission and seek his assistance. Then the team leader determined the direction of the survey and introduced the researchers to the heads of households. For every eligible mother, the researchers went through the entire questionnaire before asking the team leader to verify that it was completed correctly before leaving the village / site;
- ✓ **Focus Groups:** Ten teams of two conducted focus group discussions in the 30 sites retained after a random drawing. In each of these sites, these teams organized exchanges with groups from 4 to 8 community workers (CHW, TBA, relay); CBO

leaders; community leaders. Those focus interviews lasted on average 45 to 60 minutes and used specific tools to gather information; one of the teammates lead the focus group discussion and the other teammate took notes.

- ✓ **Individual interviews:** These interviews were led by the consultant through the use of semi structured interviews for project staff and support staff, the District Chief Medical Officer and the chief nurse. The discussions lasted on average one hour and notes were recorded in a diary.
- ✓ **Motivators Questionnaire:** This was a written questionnaire disseminated to all the motivators and the supervisors of the project for completion.

Data processing

- ✓ **KPC**: A template was elaborated; the data were entered and the control and the correction of the data made by means of range and coherence control with simple frequencies processes.
- ✓ For focus groups, the data was processed with the support of the restricted team;
- ✓ Individual interviews and motivators' questionnaire were manually handled by the consultant.

Data analysis: The certified data were exploited thanks to EPI Info 6 for the calculation of the KPC indicators; the analysis of the focus groups was made with the support of the restricted team; individual interviews and motivators' questionnaire were analyzed in the light of the literature.

***Disclaimer**: All the information collected during the evaluation remains the exclusive property of CCF CANAH and as such can only be the object of any exploitation, notably for purposes of publication or distribution with express permission of CCF National Director or their representative. No person shall be discriminated against based on their acceptance or refusal to participate in the survey. The inquiry shall in no way be harmful to the informants and the latter shall expect no profit either in kind or in cash tied to their participation.*

VI - RESULTS AND IMPACT OF THE PROGRAM

1. Quantitative Results

A - Presentation of the quantitative results by domain

1. General Characteristics

317 questionnaires administered to mothers of children from 0-23 months have been analyzed and the results concern 78 questions covering all the technical domains of CANAH II.

Age of the mother

Age group	Number	Percentage (%
16 - 19 years		7,9
20 - 35 years		81
36 – 46 years		11,1
Total		100

Compared with the baseline KPC, the percentage of mothers aged 20 - 35 years has grown from 77 % to 81 %, but that of the mothers aged 16 - 19 years has almost doubled (from 4 % to 7,9 %), whereas the mothers over 35 years represent 11,2 % compared to 18 % in the baseline. On the whole, high risk pregnancy groups (mothers being too young or too old) represent one fifth of the total population.

Age of the child

Age group	Number	Percentage (%
0 - 11 months	184	58,04
12 - 23 months	133	41,95

Level of schooling of the mother

None	136	43 %
French: primary	86	27 %
Secondary	13	4,2 %
Literacy courses	47	14 %
Koranic school (Arab)	35	11 %

The percentage of illiterate mothers has decreased from 54.4% to 43%, which denotes considerable efforts made to reduce illiteracy in the project zones. Nevertheless, more than 40% are still unable to decode the health messages posted or written in French or in the local languages

Income generating activities (occupation of the mothers)

None	189	59,7 %
Petty trade / saleswoman	128	40,3%
Agriculture	111	35 %
Maid	5	1,5 %
Other	10	3,1 %

More than half of the women interviewed of women interviewed were not involved in any kind of income generating activity, which hinders their access and their children's access to health care.

Some of the mothers are involved in several income generating activities at the same time. Compared with the baseline KPC, the proportion of mothers not involved in any kind of economic activity has remained unchanged.

2. Mother Health (Pregnancy and Childbirth)

Of the 317 women interviewed, 86.5% have had a health card compared to 77% in the baseline KPC. Among them, 65.9% have had 3 prenatal consultations compared to an objective of 60% (baseline KPC 45%).

73.4 % gave birth at a health facility (health centre, health post or health hut) compared to 59 % in the baseline KPC. 87.1 % of the childbirths were assisted by trained personnel (midwives, nurse, doctors, TBA) (baseline KPC = 67 %).

97.5 % of the women received a prescription for iron supplementation during their pregnancy, and 95.9 % received a medical prescription for intermittent preventive treatment of malaria with SP. On that account, the objective of iron supplementation and of anti-malaria prevention (100 % of the pregnant women) has almost been reached.

Regarding anti-tetanus immunization, 70.2% of the women have received two injections or more, which is a small progress of 2 percentage points compared to the baseline KPC (68 %).

2. Nutrition and Breastfeeding

On a sample of 317 interviewed women, 99 % were breastfeeding their child, thus demonstrating that breastfeeding remains the common mode of feeding the child during the first two years of life. Exclusive breastfeeding of children 0-6 months (defined by early breastfeeding within the first hour following the birth and feeding the child only with maternal milk), has risen to 82 % on a sample of 88 infants, which is 13 points below the 95 % objective but 30 percentage points higher than the baseline KPC (52 %).

77.7 % of the interviewed mothers practice optimal breastfeeding (early breastfeeding within the first hour following the birth + frequent and prolonged suckling + exclusive breastfeeding until 6 months + introduction of the complementary food from 5/6 month + pursuit of breastfeeding up to 24 months) compared to 52 % in the baseline KPC.

Regarding sources of Vitamin A, 78 % of the mothers know at least two vitamin A-rich foods.

With regard to growth surveillance, the rate of usage (number of children weighed at least once during the last three months) has risen from 59.3% in the baseline study to 72.9 % with 312 children weighed (objective of 85 %). 91.7 % showed a satisfactory nutrition (baseline KPC 80.5 %). 6.7 % presented moderate malnutrition and 1.7 % were severely malnourished based on the weight/age ratio. 85.5 % have put on weight (baseline KPC = 80.5 %), 6.8 % have unchanged weight (baseline KPC = 6.3 %) and, 7.7 % have lost weight (baseline KPC = 6.3 %).

Regarding vitamin A supplementation, 91.2 % of the children have been adequately supplemented directly or indirectly thru the mother during post partum (mothers of 0-23 month old children having been supplemented in 42 days after delivery) compared to 64 % in the baseline KPC for an objective of 90 %.

Regarding deworming of the children 1-5 years, 86 % of children over 1 year have been dewormed (baseline KPC for children 12-23 months = 36 %).

Finally regarding iodized salt: the households' survey done with an iodine test kit has shown that 73.68 % of households have iodized salt at their disposal compared to 17 % in the baseline KPC.

3. Immunization

- Out of 317 women interviewed, 86.5 % had a health card compared to 77 % in the baseline KPC.
- The evaluation of the immunization status of the children 12-23 months is based on the examination of the health card or the immunization card index.

The results show:

BCG (Access to the PEV (Enlarged Immunization Program))	127	98,4 %
Measles	110	90,2 %
Children fully Immunized	104	81 %

- The objective of 80 % of children12-23 month fully immunized has been reached by the project (baseline KPC = 57 %)
- As for knowledge about immunization, 71.7 % of the women answered correctly when asked about appropriate age required for the anti-measles immunization (objective = 85 %) and 94.8 % mentioned “mother and child protection” as the reason why women should get immunized against tetanus. (objective = 85 %).

4. Diarrheic Diseases Control

- Prevalence of diarrhea is evaluated at 13.9 %. It has risen slightly (11 % in the baseline KPC).
- Among the children having had diarrhea during the 15 days preceding the survey, the ORT rate of usage is 96.3 %. 63 % have used ORS and 33.3 % domestic solutions, which is remarkable compared to the baseline KPC (50 %) (objective 90 %).
- As for knowledge of the mothers, 260 out of 311 mothers (83.6 %) knew ORS and 223 out of 260 (85.8 %) knew how to prepare it (baseline KPC = 57 %)
- With regard to the diarrhea preventive methods, 223 out of 260 mothers (89.5 %) have reported hand washing compared to 32 % in the baseline (objective 60 %).
- In addition, 81.0 % of the women knew another diarrhea preventive method besides hands washing (baseline KPC = 29 %). The objective of 75 % has been surpassed.
- 82.9 % of the mothers have cited at least two danger signs of diarrhea. The percentage of those who know no sign of danger has dropped from 12 % to 3.6 %.

- Regarding the quantity of liquid given during the last episode of diarrhea, 87.9 % of mothers of children 0-23 months answered having given more than usual or the same (more than usually = 65.9 % and as usual = 22 %) for an objective of 100 % (Baseline KPC = 90 %);
- Regarding breastfeeding during diarrhea, 75 % of the mothers have answered that breastfeeding has to continue more than usual or as usual (objective = 100 %, baseline KPC = 85 %)
- Finally regarding the quantity of food given during the last diarrhea episode, only 9.8 % of women have answered they feed their child less than usual (Baseline KPC = 31 %).

5. Malaria Control

- Prevalence of fever is evaluated at 9.6 % (28 children) compared to 15% in the baseline KPC.
- Among the 28 children having presented fever in the 15 days preceding the survey, 95.5% had used a health facility (baseline KPC = 81 %) and 82.4 % received the adequate treatment (ACT) within the first 24 hours compared to 64 % in the baseline study (drug was chloroquine then).
- Concerning malaria prevention measures, 81.4 % of the mothers have reported use of simple mosquito net and 18 % the ITN compared to 62 % in the baseline survey. The progress is satisfactory and the objective of 75 % has been totally met.
- It is worth noting that 76.3 % of the mothers possess an ITN (baseline KPC = 53 %) and, 97.4 % of the children and 99.1 % of the mothers effectively spent the night before the survey under an ITN compared with 50 % of children and mothers in the baseline survey (objective = 70 %).
- Regarding knowledge of malaria danger signs, 95.2 % of the mothers could cite at least two signs (objective = 75 %).

6. Acute Respiratory Infections Control

- Prevalence of ARI is estimated at 25 % compared with28 % in the baseline KPC.
- Among the children having had ARI in the fortnight preceding the survey, 87.9 % of mothers sought care and 79.2 % of mothers went to a health facility (baseline KPC = 74 %)
- 80.9 % of the mothers have cited at least two danger signs of ARI for an objective of 75 % (baseline KPC = 57 %).

7. HIV / AIDS Control

Among the women interviewed, 99.4 % have heard about HIV/AIDS (baseline KPC = 93 %) and 70.4 % can cite at least two HIV/AIDS prevention method and 95.1 % at least one screening (baseline KPC = 77 % and objective = 80 %).

- 78 % of the mothers know where to get a condom (baseline KPC = 40 %) and have mentioned the health post (74.7 %), the pharmacy (72.8 %), relays / CHW (52 %).

B. Quantitative data Analysis

1. General Characteristics

It had been planned to interview 300 women 16-46 years for the survey. In the end, 317 mothers were interviewed, because all the children and mothers of the last compound sampled were interviewed. The level of completion of the questionnaires was satisfactory, showing the good work of the surveyors and the team leaders.

The break up of the age groups for both the baseline KPC and the final KPC showed that the proportion of women aged 16-19 years had practically doubled, growing from 4 to 7.9 %, while that of 36-46 years old one had dropped from 18% to 11.2%. However for both surveys, more than 1/5 of the mothers belong to high risk pregnancy age groups. That situation bears witness to the tenacity of traditional practices and requires the development of preventive messages about prevention of precocious or late pregnancies, especially within the framework of women's solidarity circles and through the grandmothers.

The level of education of the mothers still remains very low (43 % of mothers are illiterate) even if education is now considered as a fundamental right of the human being to ensure their well being. The low level of education and literacy are real hindrance to health education activities.

Stronger synergies with the CFPs and the literacy sector are imperative to remove this hindrance to the improvement of the health and nutritional situation and development.

Women's income generating activities are essentially linked to petty trade (sale of doughnuts, roasted groundnuts) and agriculture (millet, groundnut sold at weekly farmers' markets). About 60 % of women interviewed were not involved in any kind of income generating activity. This situation of poverty of the women hampers considerably the access of women and children to health services. Efforts have been made with some attempts at organizing women's groups to benefit from IMCEC loans, but they turned out to be insufficient, hence the urgent necessity to address this issue in a more resolute way.

2. Feeding / Nutrition

breastfeeding remains the common mode of feeding the child during the first two years of life (99%).

Exclusive breastfeeding of children 0-6 months has risen to 82 % on a sample of 88 infants, which is 13 points below the 95 % objective but 30 percentage points higher than the baseline KPC (52 %).The considerable progress made regarding exclusive breastfeeding practices is a direct result of the implementation of the grandmother strategy and the setting up of women's solidarity circles. The objective is not totally met due to constraints related to the mobilization of the mothers in urban areas. Indeed, women in urban areas get busy in various occupations aiming at finding ways to survive and feed their families in a context of poverty.

3. Immunization

It is noteworthy to observe that all the mothers of 12-23 month old children had a health record book or an immunization card. This is outstanding when you consider that most of these mothers are illiterate. 81 % of children 12-23 months were fully immunized thanks to frequent outreach strategies by the chief nurse and to community mobilization supported by a genuine involvement of the community leaders during the auto-evaluation and planning meetings at the health hut level. It also bears mentioning the decisive efforts of the health districts towards constant availability of vaccines and necessary equipment (auto-blocking syringes, iceboxes, security box for syringes safeguarding).

4. Diarrheic Disease Control

Prevalence of diarrhea still remains high and is slightly on the increase (13.8 % compared to11 % in the baseline KPC). We need to continue working on the availability of safe water, increase in latrines construction and dissemination of health education messages to successfully and definitively curb diarrhea.

The high usage rate of ORT for children with diarrhea (96.3%) shows that its usage is now common, but also that mothers followed directives given by the program. Increase of fluids and food intake, and breastfeeding for children with diarrhea, are commonly practiced at home, in accordance with the national directives on diarrhea management. The fact that mothers well were aware of diarrhea danger signs (82.9 % of the mothers know at least two danger signs) shows that the messages and communications channels used by the programs were appropriate. **The same channels should be used to disseminate relevant messages relative to water safety, food and hygienic elimination of fecal matter.**

5. Malaria Control

Prevalence of fever (9.6 %) has decreased (15 % in the baseline KPC) in spite of our being at the peak of the rainy season. This is the result of the development of a policy for the promotion of the use of ITN (thanks to the efforts of the project, the price of the ITN is at present of **FCFA 1000 ~$1.8**). The result is a coverage rate for ITN of 97.4 % for children and 99.1 % for pregnant women. In addition to its benefits in terms of malaria prevention, the promotion of ITN has also helped improve the economic status of women involved in the program, through small scale income generating activities linked to the sale and dipping of the mosquito nets. Equally

satisfactory are the early management of fever and recognition of malaria danger signs, showing that the BCC strategy was very relevant.

6. ARI Control

Prevalence of ARI has remained stable (25 % compared to 28 % in the baseline KPC). What has drastically changed is the early management of ARI thanks to the availability of antibiotic at the health hut level. As a consequence, the mothers' practices regarding appropriate and timely care seeking at any relevant facility are very satisfactory. This is a remarkable achievement in terms of access to health care.

7- HIV-AIDS Control

Although almost all women interviewed had already heard about HIV/AIDS (99.4 %) women's knowledge about prevention methods, key to successfully address the issue, needs to be improved (70.4 %). The Project will need to mobilize the populations, within the framework of its health promotion activities, around HIV/AIDS prevention methods and testing, which are key elements in the fight against this pandemic. A focus should be put on the promotion and use of condoms by making it available and accessible at the community level.

C- Crosscutting approaches: Results of the qualitative analysis

This analysis of the results was drawn from the focus group discussions (36 with the community workers, 37 with the leaders, 34 with the CBO), the individual interviews with 4 district chief medical officers, 8 chief nurses, CANAH II staff (n = 10), supervisors (n=4) and the questionnaires filled out by the motivators.

1- Results achieved

All the actors and beneficiaries of the project all praised emphatically the progress made by the project, especially regarding awareness raising, behavior change and a better management of mother and child health by the women themselves and the grandmothers, strongly involved in the BCC activities.

1-1 Impact of the Project

The chief nurses have observed a considerable decrease in severe cases of malaria and child deaths in general. This has been confirmed by the community leaders who have noted a better management of childhood illnesses at home, thanks to the BCC activities conducted by the CHW and the relays supporting the chief nurses, and the motivators through discussions, home visits, and individual interviews. These activities have increased the knowledge of women regarding recognition of danger signs of childhood illnesses and, above all changed women's practices regarding early management illnesses and prompt care seeking at the health hut or health post level. On this matter the easy access to ITN and their availability at the health hut level at an affordable price (the project provided community workers and CBO with ITNs at a subsidized price) coupled with the strong community mobilization, have all contributed to the substantial rollback of malaria cases.

Women's leaders (CBOs) also widely expressed the same satisfaction with the positive impact of the project activities, especially regarding better services for pregnant women (antenatal consultation), women who recently gave birth (postnatal consultation), the newborn (exclusive breastfeeding) and the infant (food diversification, supplementation in vitamin A, deworming).

Community leaders said that the regular and frequent outreach strategies (monthly visits to the health hut by the chief nurses, CANAH supervisors and motivators and involving the community workers, the partner CBOs) made a package of services available at the health hut level. This package of services included immunization against measles, the deadly illnesses and arising by epidemics (as the Wolof proverb says «count your children only after the epidemic of measles») and the whooping cough.

The project has also developed a collective awareness in terms of hygiene (both individual and collective) with the creation and the support of Clean Environment Committee in the village and hamlets. One leader said "children have become very clean and always dress neatly as newly-weds" while before "they were always naked and very dirty".

It is now well established for the community leaders and the CBOs that they should offer their support to the community workers for the implementation of the activities, as much for advocacy activities, than for community meetings, and social mobilization where every CBO leader takes care of the mobilization of their own members. The reason is that they became increasingly aware that all the activities led by the community workers were for the good of the populations. As a result, the leaders decided to support financially the Clean Environment committees and have actively taken part in the planning and self-evaluation meetings and in the monitoring and evaluation activities of the project. One school's headmaster told us he was being personally involved in the health and nutrition activities to establish better links between the education and health sectors.

Furthermore, new comportments are starting to spread regarding the involvement of the men in the planning, the implementation and the evaluation of the BCC activities. The mothers have noted that since men got involved, many problems have been resolved. Some men even bring their children to the growth monitoring sessions especially in Aga Ndimack, which is a very significant achievement in the rural areas.
In the other villages women concord on this point and said that men now offer their financial support for the growth monitoring sessions, pre-natal consultations or cooking demonstrations (donation of rice).

1-2 Infrastructure / Equipment / Quality of care

Most of the health huts are proper buildings with 2 to 4 rooms for consultation, deliveries and bandages. The mothers deplored the lack of a fence around the health hut, and the subsequent lack of intimacy. They mentioned it prevented some women from using the health hut. The absence of working latrines has also been noted as a pull-away factor. All the mothers interviewed were satisfied with the equipment brought to the health huts with the support of the project (consultation tables, chairs, delivery tables, culinary demonstration utensils, scales, thermometer, management tools, medicines, cart ambulances), allowing the health hut to take care of all cases presented to them.
The mothers value highly the services offered at the health hut. Mothers said that the management of drugs supplies was good thanks to the involvement of women in health committees. They appreciate the endless availability of the community workers (“services at the health hut are available at any time") in particular the traditional birth attendants: (“even if she has to refer a woman in labor, she accompanies her to the health post.”). As for the community workers, they are pleased with the fact that functional equipment is available to them and stress that in general, patients received at the health hut are satisfied with the services and care provided. They have also noted the support they received from the health committees and the leaders, especially during referral procedures.
The mothers viewed positively the decentralization of growth monitoring sessions to the hamlets as it has allowed them to meet more often with other women and to strengthen their cohesion. Thereby, the project has favored the institution of friendlier relations and stronger interactions among the members of the same CBO, between different CBOs; between community workers and CBOs, thus making the community stronger and more vigorous.
Regarding the men leaders, they view positively the services offered by the health huts or posts, in the sense that before the set up of the health huts, it was necessary to go a long way and spend a lot of money to get care. They believe that the health huts allow for a gain of time, energy and

money. Indeed, one leader of Aga Ndimack remembered: “when we had to seek care for a patient, we used to go to Thiadiaye or Ngueniene, the domestic cart was used and then the driver would not work, neither the accompanying person nor the horse. That day would be a wasted one, we lost money. And when we arrive at the post, more money was needed and we would spend all day. But now, with the health hut, even with FCFA 200, you can have your ticket and your medicines”.

The leaders have all welcomed the availability of medicines at the health hut and the presence of the community workers. Every month, the chief nurses and the midwives make consultations and some villages have even partnered with doctors who come to consult twice a week. They say that the community workers master the activities introduced by the project, for both preventive and curative services. All the cases brought to the health hut are either treated at the health huts and the person cured or they are referred in case of complications. The deliveries are assisted or referred when necessary. Thanks to the group discussions organized at the community level, the households have acquired good practices of hands washing before every meal. However, leaders mentioned that hand washing was not yet practiced all over the zone. In addition, leaders have expressed the wish to see the community workers do injections. Another necessity, according to the leaders, is the training and mentoring of the members of the health committees for a good management of the health huts. The intimacy of the health huts remains for most of the women and men leaders an important issue and they regret the lack of fences and neat separation between the consultation room and the delivery room. Sometimes the community workers are in the consultation room, which could reduce the frequentation of the health hut. They also suggest creating a waiting area for the patients.

Concerning the reference of the serious cases, in some villages the problem has been solved with a cart ambulance for the health hut. In other places, the leaders have not thought about this problem yet and mentioned that it was up to the families of the patients to find solutions for the transportation of the sick. Regarding representation in the health committees, leaders have said that women are represented and are even the most active members. They have also noticed that bookkeeping by the women is generally clearer and more viable. Thus, they encourage the presence of women at this level of responsibility, actually strengthening the feminine leadership.

1-3 Capacity building

Capacity building is one of the pillars of the health and nutrition activities at the community level under the leadership of the community workers. The community workers are resource persons from the communities, chosen by communities on the basis of their commitment and of their presence, but at the beginning with limited skills.

From this point of view focus group discussions with the community workers can be summarized by this quote from a community worker “it is better to give me a field and seeds to cultivate than to offer me food.” Unanimously, the community workers have said that the project allowed them to acquire knowledge in health and nutrition through training and refresher training sessions, as well as during the formative supervisions led by the project staff and the district health teams.

According to the mothers, the training of the relays has allowed them to acquire knowledge and skills to convey and disseminate useful health information. That was what gave them the nickname of "Doctorou Kallama" (literally: Doctors of words). The mothers thus understood and said that without training, there would have been no possibility of transmission of knowledge and competence. This is the list of skills they have:

- appreciate the nutritional status of the child
- prepare adequate meals (well-balanced)
- recognize the danger signs of some diseases (Malaria, ARI.)
- treat mosquito nets with insecticide and re-dipping of mosquito nets.

As for the community leaders, they have noted and praised the capacity building of the actors led by the project in health and nutrition. They have said that among other things, the agents of the project truly knew how to transfer their skills and knowledge to the community workers, who then were able to transfer them to the populations. The community leaders praised this particular capacity building approach of the project, which, as a result, walked the community into the adoption of good and durable practices. In many interviewed groups the leaders have said that “the project, instead of giving us some fish every day, taught us how to fish, which is more essential and more long-lasting.” Other leaders have added that that the knowledge acquired will be for long because “instead of giving me one thousand to prepare the meals, give me seeds and land to cultivate, so that I shall have my millet granary to prepare myself my own meals.”

The women CBO leaders have also said that the project has allowed them to get better organized. Most of them now benefit from IMCEC loans and are running IGA (cattle breeding, petty trade). In addition, they fervently think that it is thanks to the IEC activities led by the community workers that most of the behaviors changed for good, especially regarding their own capacity to interpret the nutritional status of their children on the growth monitoring cards and the mastery of the immunization calendar. On this matter, a community worker has added that in zones like Sandiara, some children have refused to eat unless they have their hands washed with soap.

1-4 Involvement of the communities

The community agents all mentioned that they had been chosen by their communities. They have thus been involved in the implementation of the Project at all the phases. They said they were aware of the fact that they were working together with the communities for their own health. In Mbodiene a community worker said “our wish is health by the community for the community.” The community agents said that in most cases, they receive support from the community leaders for the implementation of the activities. That assistance has come in different ways; from mobilizing the target groups around the IEC activities to growth monitoring sessions and especially in the elaboration of the action plans, problem solving and involvement of the men.

The community workers also said that the participation of the women in the activities that was introduced by the project, has allowed them to develop prevention strategies and home based management of diseases such as malaria, diarrhea and ARI. The community agents also have said that meetings were organized at the health hut level (financial management, evaluation of the talks, the home visits) to present health hut activities and evaluate what were the strong points and weak points of every activity in the presence of the CBOs and the community. The leaders have also underlined that the project and the district have organized community sessions after each evaluation of the activities (mid-term evaluation with the involvement of the members of the community) to present the results.

The results obtained through the involvement of the communities are different and vary according to the community agents, but all said they are better respected in the community thanks to the services that they provide (growth monitoring sessions, the talks, the home visits, the supplementation in vitamin A). A community agent said in Tattaguine Serere “now we are not anybody anymore because we are more useful to ourselves and to our neighbors.”

In the same perspective, the CBOs have had an outstanding involvement in the implementation of the activities: planning, evaluation, problem solving, and implementation of the activities. However, in some villages, young mothers don’t take part in the IEC activities and growth monitoring sessions (talks or weighing sessions); At the Ndame health hut they have said that they were not informed or that they had traveled or that they were busy doing house chores.

The women leaders have told us that they consider themselves as relays within their group and within their family. They help the community workers in the community mobilization. They have even said to have managed in some zones to mobilize the men around health and nutrition activities.

The majority of the leaders said they were involved in the activities of planning, evaluation, problems identification and solving. For example, in some villages (Aga Ndimack for example), the leaders have even managed to start IGA activities, to raise funds to build the first room which served as health hut and also to resolve health problems such as reference of serious cases. They all have declared to have participated in the health and nutrition sensitization. They also have

contributed to the purchase of mosquito nets, organized malaria and diarrheic awareness raising (talks, conference on malaria and cholera in Sandiara). Another leader has added “as a worker, he takes care of all the mending works at the health hut” while the village chief, takes care of the organization in rows during the immunization sessions. The leaders have said that they have always encouraged the community agents to move ahead. However, other leaders (in Mbodiene) have acknowledged not to have been involved in the planning and evaluation activities. They said they did not feel the necessity of such involvement because, according to them, this role is devolved to the health committee.

1-5 Appropriation and Sustainability

All the male leaders were unanimous in saying that given the scale of the activities and their mastery by the community workers the activities can be continued after the withdrawal of the project. They have said that they will not be careless anymore and that the communities won’t go back to their state prior to the project when diseases were ravaging the population. Therefore, according to them, the auto-evaluation and programming meetings will be systematized in order to continue discussing health issues and finding appropriate solutions. For that purpose some of them believe that it will also be necessary to choose in the village somebody likely to hold the project agent's role of overseeing all these activities and provide support to the community workers. Still in order to continue the activities at the community level, some health committee member leaders suggest granting a substantial part of the profits of the health hut to the community workers to motivate them, help them with their transportation by allowing them to use the cart ambulance for their trips to the nearby hamlets. Another solution could be for the community to cultivate the community workers’ fields, in order to free them some time to conduct health and nutrition activities. This idea was suggested in Aga Ndimac and has already been implemented in Ndame where the leaders have set up a collective field, a portion of which is used for the motivation of the community agents and the other part for the purchase of medicines. However, some leaders have showed some anxiety about sustainability of the activities because for them, without the financial motivation of the community agents by the project, no durability could be foreseen.

Most of the leaders have said they are convinced that with the knowledge acquired by the community workers, the equipment provided and the supply of medicine received, they are equipped to continue the IEC and curative services after the end of project. But one of them who is a native of the village of Sandiara is rather convinced than the activities will continue only with the cooperation of women.

The CBO women's leaders have unanimously said they had been strongly involved in the various health and nutrition activities. The work realized with the project agents and the community workers allowed them to better understand community mobilization and to start the same actions themselves and supported the implementation of the activities of the relays. They have also said that they consider the activities introduced by the project are theirs since the project has really assisted them by training the relays whom they have chosen among themselves, by re-energizing the health huts' management committees of which they are members of, by developing of marketing and IGA initiatives, and by integrating the talks and of growth monitoring sessions into their groups' activities.

Along the same lines, the women have said they wouldn't even suspect the activities might stop after the project ends, because the relays are CBO and health committee members. Some CBO leaders even said that they had started IGA within their groups to raise funds to support the relays and for the organization of health and nutrition activities (collective field, cattle breading, sound system, chairs and tarpaulin rental). However the CBO women's leaders thought that both the project and the administrative and political authorities should still seek funding to support the health activities at the community level.

Recommendation for the sustainability of the project:

- Frequent and regular dialogue for the elaboration of the action plans
- Identification and participation of the most motivated persons
- Increase in financial resources for the health huts thanks to the contributions of the populations
- Literacy programs for women so that they can best manage funds raised through the IGA
- Spread information widely so that everyone can play the relay's role
- Better scheduling and management of the chief nurses' workload with regard to their responsibilities at the district level and their responsibility with regard to the community health hut;
- Introduction of micro-credit programs to retain the community workers,
- Strengthening of the supervision
- Continue the capacity building of the community workers;
- Involvement of the community workers in the supervision to relieve the motivators;
- Creation of an organization (CBO) of community workers for exchange and sharing of experiences, and to allow access to collective micro credit and IGA schemes.

2-Synergies developed with the partners

Partnership: The chief nurses told us that the collaboration between the Health Post and the Project has been fruitful and went smoothly. Generally the role played by the project agents has been strongly appreciated by the chief nurses since the support provided allowed for many activities to be implemented and for substantial progress in health care coverage and behavior change. However one chief nurse questioned CANAH supervisors' role saying he never clearly understood what they were supposed to do in the area covered by his health post.

Links between the CANAH II Project and the BASICS projects are ongoing, productive and fruitful. Both programs work together: they prepare tools for the relays, exchange documents and refer to each other for technical questions. Staffs from BASICS and CANAH II consult each other in order to offer the most effective support to the health posts and health huts and to coordinate their actions at the field level. Thanks to this cooperation, new interventional approaches have been designed and implemented like the pilot testing of community management of ARI and its extension and the development of pre & neonatal services at the health hut level.

The CANAH II Project also established a fruitful relation with MSH in the reproductive health sector, especially for Family Planning. This partnership resulted in the dissemination of the standard day method in all the intervention areas, with the use of a string with beads to identify the infertile days from the fertile days.

The CANAH II Project also worked with the GoS/Nutrition Enhancement Program (NEP), and in partnership with another CCF program (CAMA), organized social mobilization activities with the aim of improving the nutritional and health situation in the Mbour zone. Together they also organized growth monitoring sessions with the women's groups.

The partnership with the UNICEF was originally focused on the organization of the small salt producers and the promotion of the consumption of iodized salt at the household level. Although for cost/ efficiency reasons, the project with the small salt producers did not take place. With UNICEF, the project also started local "child survival days." Unlike the national vitamin A supplementation days, the activities at these "child survival days" were diversified (prenatal consultations, deworming, immunizations, vitamin A supplementation, promotion of ITN). This strategy is now operational in most of the health districts of the country.

The staff of CANAH II project expressed high respect for their partners. The collaboration is excellent; as one of them put it "we became a family."

Resources: The CANAH II project supported the districts with material, financial and human resources. The CANAH II project equipped all the health huts with material and essential medicines. At the district and health post levels, the CANAH II project provided logistic support by chartering vehicles and providing fuel for the outreach strategies and the mass campaigns of immunization, supplementation in vitamin A and of deworming of the children.

The CANAH II project also provided financial resources, paying for the perdiem of the district staff traveling to the health huts for outreach strategies. Regarding the human resources, the project has made its supervisors and motivators (that the chief nurses usually consider as their second man) available to the districts for the district's coordination meetings. In addition the Project has helped the districts for the organization of the National Micronutrients Days, National Immunization Days, the World's Breastfeeding and Iodine Deficiency Illnesses Week, the Tuberculosis Day, the Child Survival Days, etc. Regarding the organization of these events, the interviews conducted during this evaluation showed some misunderstandings related to who was responsible between the project and the health district to provide financial resources for the organization of such events. Finally regarding transportation, the biggest problem raised is the district's lack of logistical means to ensure regular supervision of the health huts.

Capacity building: "The community level has always been the Achilles hell of the system" has declared the primary health care supervisor of Thiadiaye. However, according to Sirot, "the force of a chain is measured at the level of its weakest point" and the CANAH II project helped remove this weakness at the community level. Indeed the district management teams, the chief nurses, the supervisors and motivators of the CANAH II project and the community workers have benefited from multiple and diverse trainings on health and nutrition. In particular they have been trained in community management of ARI, the prenatal and neonatal health, the use of the bi-therapy and ACT to treat malaria care, growth monitoring (based on the expected weight), the management of the health hut resources and the use of management tools … In their opinion, these trainings have resulted in their acquisition of new knowledge and skills which have positively impacted their performances. They have found that the training materials were adapted although they wish to be involved in their conception and elaboration in the future. The participative methods used during the training sessions were very appropriate according to those who participated because they allowed for exchanges of experiences and problem identification and solving by the participants themselves. One of the biggest satisfactions, according to the Director of the project, is the speed at which many agents started working effectively in their areas in a relatively short period of time. This was possible thanks to the step-down training. The training system is so that the chief nurses and the motivators trained the CHW and the relay at

the health post, after they themselves were trained by the District's management team and the project's staff. This allowed for a rapid scale up of the activities, with the training in a relatively short period of time of more than 280 community workers. On this topic, the training coordinator for the CANAH II project added that the health committees' members were also involved in the trainings, especially regarding the filling out of the monitoring forms and the financial management. In addition to the training sessions, the community workers also attended refreshers courses and received support through formative supervision.

The chief nurses interviewed said they had received the training manual used during the various sessions (for management of chronic ARI, bi-therapy, use of ACT…) and that they appreciated the high technical quality and ease of use of the manuals. However all of them wished there were more copies.

One of the capacity building activities which received the highest approval was the organization of a study trip for the District's management team, the chief nurses and the community representatives to Kebemer district to learn from their prenatal and neonatal care experience. All participants congratulated the Project on this initiative which allowed them, on the basis of the information received and of their direct observations, to measure the potentials offered by prenatal and neonatal services for the reduction of the child mortality. Such experiences are to be encouraged.

Supervision: The supervision system is set up as follows: from the district down to the health post and from the health post down to the health hut. This project mostly focused on the strengthening of that second level. The chief nurses, with the help of the project's motivators, are responsible for the supervision and capacity building of the health huts and the community workers. From our discussions with the chief nurses, we understand that the motivators have ensured regular supervision of the community workers. The supervision was scheduled monthly during the self-evaluation and planning meetings at the community level; but few chief nurses managed to lead this activity along with the motivators. To explain this fact, some of chief nurses mentioned that they were responsible for too many health huts (14 health huts for one chief nurse in Sandiara for example) or while some others mentioned their workload at the level of the health post. Most of them have taken advantage of outreach strategies to oversee their health huts. With regard to the sustainability of the activities of health hut supervision after the end of the project, only two chief nurses are convinced the activities will continue with the same intensity. Some chief nurses suggested helping them strengthen the human resources available at the health post level in order to continue the supervision of the activities at the health huts.

Monitoring & evaluation:

- Annual evaluation of the short term achievements of the project: It uses a quantitative method (LQAS) and a qualitative method (focus group) that makes way for an appreciation of the level of attainment of the objectives and the opinion of communities on the level of satisfaction with regard to the quality of the interventions. It involves the health districts, the communities and the project agents.

- Mid term evaluation (after 2 years) and final evaluation: Their objectives were to document the achievements of the Project and the level of attainment of the objectives, to investigate the perceptions of the populations with regard to the project activities and to draw lessons. The District's management team, the chief nurses and the communities have welcomed their strong involvement in the monitoring and evaluation of the project from the planning of the activities to the presentations of the results that were organized for them.

Information Management: CHW and relays' activities are recorded in different tools elaborated by the project with the support of the health district: consultations book, receipts book, stock cards, IEC book, growth monitoring register, monthly activity report and community meetings report … All this information is synthesized monthly by the CHW with the assistance of the motivator and passed on to the chief nurses to be integrated in the chief nurses' zone report and report to the project. Three main observations worth noting here:

- ✓ because of the low level of instruction of some community workers, the monthly synthesis of the activities is usually written by the motivators
- ✓ the information is not always channeled properly and the chief nurses have not been proactive and prompt to collect the health hut reports;
- ✓ the MIS needs to be redesigned in order to be able to store all the information contained in the reports from the health huts. .

Sustainability: The chief nurses think that the activities are going to continue at the end of the Project although opinions on the sustainability of some particular activities differ considerably. No one thinks that group discussions will actually stop. Some motivators think that maybe curative services and the activities lead by the TBA will continue. Others think that without the follow-up and the supervision of the chief nurses and the midwives, no activity is going to continue. The explanations for the lack of sustainability have been the lack of motivation of some of the community workers, their lack of autonomy, and the time and transportation constraints. For the supervisors of CANAH, "sustainability can only happen with the commitment of the district and the rural community." The health district will have to create the conditions for regular supervision and support of the community workers and the rural

community could provide financial contributions for medicines. For others, the level of engagement of the community workers and their motivation remain the key to sustainability of the activities.

CASE STUDY

Documentation of the transfer of responsibility for the health huts from the project to the districts

The health huts are the epicenter of the activities of the CANAH II project. They have generally been built in big villages and cater to small satellite villages or hamlets. The project offered close, ongoing support to the health huts from the training of the community workers, the equipment of the health hut, to the monitoring of the implementation of the activities and management support.

The continuation of the health huts' activities after the end of the project being was such an important issue that the project decided to conduct an "operational research" on this question. After 4 - 6 years of support to health huts in Thiadiaye and Joal, the project decided to test the level the sustainability of the activities, through an early withdrawal (before the planned withdrawal in September, 2006.)

A. The transfer process

A process aiming at the total transfer of the management of the heath hut to the communities was thus started. To ensure appropriation of the plan, the districts' Chief Medical Officers, the Presidents of the rural community, the village chiefs, the villages' health committees, the community workers and the CBO leaders lead the process.

The main stages of the phase out

1. An information and negotiation meeting was organized with the Districts' management teams and the local governments to exchange on the withdrawal strategy: its principle, eligibility criteria and the roles and responsibilities for each party.
2. An information and negotiation meeting was then organized in each community hosting a health hut. The Districts' management teams, the chief nurses, the health committees of the health post, the representative of the rural council, the health hut committee, the CBO leaders and the project's agents participated in the meetings.

Criteria for enrollment of health huts in the withdrawal plan:

- The community workers (CHW, traditional birth attendants, relays and health committees) are competent, present in the community and motivated to lead the activities;
- The hut has minimal resources for the purchase of medicines and products (the hut has to prove a minimal balance of FCFA 50.000 at the time of the negotiation of the phase out)
- The community leaders are committed to support the community workers for the social mobilization activities
- The CBO have the capacity to support all the activities of the community workers
- The health hut has a cart ambulance available for the management of the serious cases referred to the health post (not decisive criterion)
- The community workers got organized to access micro-credit (existence of an association of community workers with enrollment in IMCEC / CCF saving and credit mutual).

The activities that the health huts and community workers had to implement were:

1. Growth monitoring
2. Curative care at the health hut level
3. Talks
4. Culinary demonstrations
5. Promotion of ITN
6. Vitamin A supplementation
7. Systematic deworming
8. Home visits
9. Individual interviews
10. Evaluation and planning meeting (1 meeting every two months)
11. Community Meeting (2 meetings a year)

The roles and the responsibilities of the various stakeholders were:

- Community health workers: Offer curative care and support the relays in the execution of the preventive care and health promotional activities
- The chief nurse: Ensure the supervision of huts at least once every two months within the framework of integrated outreach strategies (antenatal & postnatal consultations, Family Planning, immunization and support for the activities of the community health workers)
- Districts' management team: Visit the huts every two months and set up a plan to support the Chief nurse outreach activities (fuel, logistics)

- Health post committee: Financial support for outreach strategies/supervision of health huts (10 % of the revenues of the committee)
- Rural council: Support the huts with medicines with their allocated funds
- CANAH II project: Provide additional funding for the supervision and outreach strategies (funds managed by the health post committee); Training/refresher training sessions for the community workers, support for the mass campaigns, the promotion of ITN; the development of M&E tools with the district and documentation of the phase out process.

This final evaluation documented the phase out process to address the question of sustainability.

B. Methodology

The tools used by the evaluators were both qualitative and quantitative:

1- Direct observation: Visit to the health hut to investigate the following issues:

- Physical conditions of the premises (number of rooms, lay out and occupancy)
- Equipment available and their condition (scales, timers, consultation tables, delivery tables, delivery kits)
- Availability of essential drugs
- Use of management tools (consultations register, receipts, stock cards, IEC book, Growth register, monthly synthesis of the activities, minutes of community meetings, use of posters on the wall for the monitoring of the activities(Growth monitoring, vitamin A supplementation, monthly prevalence rate of main diseases), the posting of the monthly plan of activities
- Capacity of the community health workers to treat or refer cases of the main diseases (ARI, malaria, diarrhea).

2- Focus groups: Group interview guidelines for the CBO, the community workers and the community leaders were elaborated. Group interviews were then organized to gather opinions, suggestions and perceptions of all these actors on the phase out process which was implemented, and on the results achieved.

3- Individual interviews: Individual interviews were conducted with the Chief Medical Officer, the chief nurses and CANAH II project staff (motivators, supervisors and coordinators of the project).

a. Sample: 30 huts were eligible for the phase out process. The evaluation team decided to document the process in 3 health huts: Ndianda (CR of Ngueniene), Koulouck Mbada (CR of Ndiaganiao) and Sessene (CR of Sessene). The health huts were chosen on the following basis: one hut where the experience seems to have worked well, a hut where the experience fairly worked and a hut that "did not perform well."

b. Results

1-**Direct Observation**: all the buildings had between 2 to 4 rooms being used for the consultation of the patients, childbirth, care and the reception of the patients. Only one hut had latrines, in Sessene. No hut is fenced. A source of water exists in all the huts drawn from drilling. Electricity is available only at the Ndianda health hut. All huts had the following equipment: a table for consultations, a delivery table (or a bed in Sessene), 1 - 2 delivery kits, with scales (weighing balance and salter) and a timer. The hut in Ndianda has about fifty chairs and a sound system. Regarding the availability of essential medicines, the situation is satisfactory in Ndianda and Koulouck, but not in Sessene. Regarding the use of the management tools and the use of the registers, the consultations are in general recorded well in the three huts, but the management tools for medicines (stock cards) are not used well, especially in Sessene where the last entry for paracetamol goes back to April, 2004. Donated medicines are not entered in the stock of the hut while used in the same way as the medicines bought by the committee. The wall posters on the performances of the hut (growth monitoring, supplementation in vitamin A, disease charts) are very well presented and up to date except in Sessene where for example no data for the year 2006 appears on the wall posters. We had the opportunity to observe directly the care for a sick child in Ndianda: The procedures were well respected (patient information entered in the register, the identification of the complaints, weigh and temperature check-up, search for signs of danger, evaluation of the main symptoms, classification, advice and follow-up). The observed weak points were on the comparison of the weight with regard to the growth curse and the administration of the first dose of medicine using DOTS.

2-Focus group and individual interviews:

a. On the concept of withdrawal: There are divergent opinions on the issue. For the President of the Communauté Rurale of Ndianda, it is up to his community to take responsibility for a transferred competence (community health). The community has to look and find the means to ensure the continuation of the activities previously supported by the project. These activities had unmistakably very positive effects on the health situation of the community. For the community workers, the CBO and the community leaders of Ndianda and Koulouck, there have been many

apprehensions regarding the phase out process, but for them the phasing out process was an occasion for the population to take on their responsibilities: “it is better to teach to somebody to fish that to give them some fish.” In the contrary in Sessene, the phase out was very badly welcomed and considered as a "constraint", the village not having considered itself "ready": “the idea was considered as a choice of the project and not the community.”

b- Evaluation of the process: the steps taken to create the best conditions for a “gentle” a transfer " were very helpful in Ndianda: provision of additional equipment for the health huts (chairs, sound system for the meetings and for rent to generate additional resources, ITN donation, provision of equipment for hygiene operations (shovels, rakes, wheelbarrows, gloves), provision of medicines at subsidized price, organization of the community workers into association, granting of loans for IGA in Koulouck with the support of the CFP, the transfer was also a positive experience. On the other hand in Sessene, the dissatisfaction dominated the rural community; the health committee and the CBO remained indifferent.

c- Activities: They were limited exclusively to the curative care in Sessene. The reasons mentioned were the lack of preparation for the withdrawal of the project and the extreme poverty of the community. In Ndianda and in Koulouck, thanks to the support of the local authorities, the community leaders and the CBOs and to the commitment of the community actors, the talks, home visits, monthly growth monitoring sessions, the community auto-evaluation and planning meetings were all going on in a satisfactory way. Additional activities were even added, for example in Ndianda, with the reorganization of the health committees, the extension of the relays network up to the level of the various hamlets of the village and the creation of a roll-back malaria committee. Qualitative improvements were also noted in the relays’ performance. For examples, some were given the nickname of "Mrs Occasions" which was given to them in reference to their "opportunism and the fact that they exploit all the forms of assembly in the village to diffuse health and nutrition / hygiene messages.”

d- Level of mastery of the activities: In Sessene, the total absence of IEC activities and community meetings, the frequent shortage of medicines and the irregular opening hours of the health hut gradually installed distrust for the community workers and a loss of consideration for the hut to the benefit of the structures in Thiadiaye and Sandiarra. In Ndianda and Koulouck, the community workers benefit not only from the confidence of the populations who appreciate their remarkable performances but also of their support and encouragements.

e- Health hut Supervision by the health post and the district: In Sessene, the last supervision goes back to January 28th, 2004 (which is more than two and a half years ago). The hut however, received ACT medicines and some support from the district for the organization of special events (National Micronutrient Day and National Immunization Day). The situation is totally different in Ndianda and Koulouck where regular supervisions of the hut take place with integrated outreach strategies (antenatal consultations, postnatal consultations, immunizations, growth monitoring, FP), the participation of the chief nurse in several community meetings, and the support of the district for ITN and medicine purchases.

f- Factors of success in a transfer process: It was unanimously agreed that some of the factors were: a more substantial stock in medicines and also the availability of transportation and logistics for the community workers to reach the other villages and the hamlets and to ensure the reference of serious cases to the health posts and health centers. The community workers also propose the "reinforcement of the motivation." (financial support)

g- Global Evaluation of the process: Generally, the community workers and the populations consider that it is possible to sustain the key activities held within the framework of the phase out plan. We have noted a very encouraging reflection "moss na ko, nekhna, bayina ko, dett", (we often keep things we are delighted about). This reality allowed for the continuation of the activities.

h. Lessons learned

- Sustainability must be experienced first as a pilot test within the framework of the project and should be implemented during the lifetime if the project.
- The negotiation and find out if the populations feel "ready" or not to take on their responsibilities is a key stage of a withdrawal plan
- The leadership of the communauté rurale (rural community) is a determining factor for the sustainability as it can provide financial and moral support
- The follow-up and the support of the health district and the chief nurse seems to be determining for the pursuit of the activities: regular supervision, planning of outreach strategies, logistic backup and organization of the mass campaigns
- The every day support of the village authorities and the CBO permitted a strengthening of the activities and an extension of the scope of the promotional and preventive services (assistant relays in hamlets assisting the health hut relays)
- The creation of a psycho-affective (trust), social (recognition) and financial (IGA)

motivating environment for the community workers greatly facilitates the sustainability of the activities

i. Recommendations:

1. To CANAH Project:

Minimal conditions need to be secured before proceeding to the transfer of the activities of a Project to a community; such as the following

- make sure of the availability and functionality of the equipment of the health hut, increase the stockpile of medicines, set up logistics and transportation for community workers and the reference of the patients
- Strengthen the system of motivation of the community workers (facilitate access to the micro credit, small IGA projects, build their capacities in management).

2. To the Health District and the chief nurses

- Plan to make sure the activities initially led by the motivators of the CANAH Project continue (find substitute).
- Ensure continued supervision of the health huts and regular outreach and mobile strategies
- Participate in the community meetings to motivate and value the community workers.
- Ensure regular monitoring of the health huts

3. To the PCR, community leaders and CBOs

- Include a budgetary line for the activities of health huts
- Develop local partnerships for the mobilization of additional resources for the health huts
- Initiate and / or support all the community mobilization initiatives with the aim of improving the health situation of the populations.

4. To the community actors

- Make sure to organize regular bimonthly community meetings for self evaluation and planning
- Ensure rigorous execution of the strategic activities

DIRECT OBSERVATION OF A COMMUNITY AUTO EVALUATION AND PLANNING MEETING

While visiting the Guereo health post of, we were able to observe how community evaluation and planning meetings are organized.

1. *Objectives*: Assess the level of implementation of the activities planned for July, identify the strong and weak points, elaborate corrective strategies and plan the activities for August 2006
2. *Participants*: Women's community leaders, members of the health committees, Clean Environment Committees, representatives of the community workers, (community health workers, Traditional birth attendants, Relays), CANAH motivator, chief nurses. They were all gathered at the health post seated in circle with chairs, mats and benches.
3. *Methodology:* Summary on flipchart of all the activities planned in July to measure the level of achievement and the lessons learnt from their implementation; and planning of the activities for August, 2006
4. *Results:* Level of achievement of the activities planned was estimated at 75 % and the participants have identified the following difficulties: lack of garbage dumps, very high level of absence of the children in the growth monitoring sessions, absence of culinary demonstrations, insufficiency of scales, shortage of product for reimpregnation of bednets.
5. *Recommendations:*
    - ✓ Organize training sessions on waste management with the assistance of the district's Service d'Hygiene (Hygiene Services)
    - ✓ Organize culinary demonstrations during all growth monitoring sessions to mobilize more children
    - ✓ Seek CANAH II project's help for donation of 2 scales and products reimpregnation of bednets
    - ✓ Train the community workers in growth monitoring (based on expected weight)
    - ✓ Document all the activities of the community workers (talks, home visits, weighing, culinary demonstrations, individual interviews)

6- *Opinions*:

This kind of monthly meeting strengthen the partnership between the health structures and the communities through an ongoing and fruitful dialogue. We noted the enthusiasm of the various participants and their pride to serve their community. The promising results are linked to the commitment of communities for health and nutrition questions and we truly believe that Guereo is moving towards that.

TECHNICAL APPROACHES

1. Availability of iodized salt at the community level

The project has generalized the availability of iodized salt at the community level through three main actions:

- ✓ Organization and empowerment of the relays' associations, the community based organizations and the community leaders. These people control the quality of the iodized salt in their villages but also buy and sell iodized salt themselves
- ✓ Systematic control of the salt at the household and shop level by the community relays.
- ✓ Close collaboration between the project and the technical services (internal trade, police, hygiene brigade, prefecture and sous-prefectures) through a systematic control of the trade of salt in the various zones of the project especially in the markets (wholesalers and dealers).

Organization of the small salt producers

The iodisation of the locally produced salt should have been done with the support of UNICEF. UNICEF was to pay for the set-up of the iodisation unit. Several working sessions were held with UNICEF where they asked us to collect baseline data and start mobilizing salt producing communities. After the baseline studies, UNICEF technicians finally concluded that the small quantities of salt produced locally did not warrant the large investment of an iodisation unit.

2. Advocacy for access to drinking water

Advocacy sessions were organized with the authorities and the local elected leaders. However in many zones of the project the groundwater is deep and often salty. These difficulties coupled with the limited financial means available prevented the necessary expensive works and access to drinking water is still problematic. In some areas, with the help of the CCF CFP, wells have been drilled where the water layer was not so deep.

3. Scaling up of community management of ARI

Community management of ARI with Cotrimoxazole is currently being implemented in all the health huts covered by the CANAH II project that where eligible based on the criteria defined by the Ministry of Health. The training of the workers and the allocation of medicines and tools was completed in June, 2006 and the service is now available.

4. Operational research on neonatal health associated with GM strategy and positive deviance

That activity has not been realized for two reasons: the financial resources were not available; the consultant retained to support the methodology was not available at the time the activity was planned.

6. Documentation of the CCF experience of the health huts

The documentation activity took place and a document narrating all the experience has been drafted and shared with the various partners.

STRATEGIES

1. Promotion/ encouragement of the work of the community leaders

This strategy is ongoing and is made possible through all the activities where the leaders have been involved: evaluation / programming meeting, community mobilization, results dissemination sessions, advocacy, etc.

2. Strengthening of HIV / AIDS related activities

The fight against the HIV / AIDS has been strengthened with an extension of the target to all the community groups. The promotion of the use of condoms has been conducted in all the health huts. The collaboration with the other partners (FHI, MSH, Red Cross, Districts) has contributed a lot to the strengthening of the program.

3- Reinforcement of the competence of the CFP social workers

The CFP are CCF Senegal sponsorship programs. It had been planned to build the capacities of the CFP social workers as part of institutional building. The motivators and supervisors of CANAH II worked with the social workers of the CFP to teach them how to set up and lead activities. CANAH has also organized training workshops for social workers in communication techniques and in participative approach.

4. Training sessions for the community workers on IMCI

That activity has been executed in each health huts in the form of “educational days” and during supervision capacity building sessions.

5. Capacity building for CBOs and health committees

The health committees were trained in financial management at the beginning by the project. The CBOs were trained only in health and nutrition information and the management / sale of insecticide treated mosquito nets.

6. Provision of new scales in every health hut

The health huts have been given new scales under this project. The defective balances were replaced when needed. Currently, every health hut has at least one Salter type functional scale.

7. Support to the CBOs and community actors for access to micro credit

CCF-Senegal has savings and credit mutual (community banks) in all the zones covered by the Project (1 in Sandiarra, 1 in Ngueniene, 1 in Ndiaganiao 1 in Thiadiaye). The community actors and the CBOs were given information and organized to get involved in the various activities organized by mutual (credit accounts, administrative committees). Most of the relays and CBO benefit from IMCEC credits and are also doing IGA.

8. Speeding up of the phase out process for some health huts:

The activity concerns the negotiation of the withdrawal of the project from certain huts considered as autonomous enough to work without the support of the Project. The process which started just before the mid-term evaluation was afterward accelerated. The experience has been the object of an ongoing documentation and during the present final evaluation.

PROJECT MANAGEMENT

1. Planning

Since the first phase of the project, participative planning has always been a key element for the CANAH project. This is the reason why all the project's partners (health districts, communities, BASIC, UNICEF, DISC, MSH) took part in the planning workshop, organized to develop the strategies and interventions of the project. That participative approach allowed first to gather information on the needs of the beneficiaries and the other partners, and second, to integrate the project activities into the operation plans of the health districts. In the course of the implementation, the project was strengthened thanks to the partnerships with the CCF's implemented CAMAT Project (Community Actions against Malaria and Tuberculosis), CAMA Project (Nutrition Enhancement Program's Implementer), and of the Health Huts Project (construction of health huts). The various partners interviewed have are very positive about this approach.

2. Training of the Project's staff

The management team of the project benefited from short training sessions on all the new strategies introduced into CANAH II (ARI-C, peri and neonatal health, Bi-therapy, ACT). To improve their performances, some have benefited from specific trainings, that's the case of the M&E Coordinator who took part in a workshop on the monitoring method called LQAS (Lot Quality Assurance Sampling) and of the Reproductive Health Coordinator who was trained in Reproductive health technical guidelines and the standard day method of family planning.

The supervisors and the health motivators were trained when they started working for the project. Afterward, they have attended several training sessions and workshops with the other stakeholders, either as participants, or as trainers. Overall, ongoing training has been ensured

through close monitoring from the management team (direct supervision and training) rather than through formal training seminars.

Several activities of the Project such as the preliminary inquiries, situational analysis, M&E and mid-term evaluation can be considered as moments of extensive learning for all the staff of the project. It would also be desirable to strengthen the capacities of the staff of the Project through the organization of study tours. The staff of the project, like the supervisors, regrets the absence of more formal training schemes for them (with formal diplomas).

3. Supervision

The project has recruited the supervisors in its second phase. Within their zone of responsibility, their mains tasks were to supervise the motivators and community actors and to participate in the coordination meetings of the health districts, thus constituting a vital link between the project and the health districts. The concept of supervisor was a novelty introduced by the CANAH II project.

Apart from the addition of the supervisors, the supervision system set up in the first phase of the project (CANAH I) was kept in the second phase. This system has two levels: supervision of the supervisors by the management team and supervision of the motivators by the supervisors, every month while the motivators supervise the community workers on a weekly basis, with the help of supervision guidelines drafted by the project. It is also important to note that the monthly self-evaluation and planning meetings at the community level are also opportunities for capacity building. At the coordination office level, coordination meetings gathering the project staff and the supervisors are held every month to monitor the implementation of the project.

It is also important to note that the Districts' management teams did not often lead joint supervisions activities with the project staff.

4. Human Resources Management

The organizational chart of the project was as follows:

- One Director, in charge of the administration and management of the project
- One Training / BCC Coordinator
- One Monitoring / Evaluation coordinator
- One Reproductive Health coordinator
- One Malaria / Tuberculosis coordinator
- One Administrative and financial assistant and her assistant

- One secretary
- Two drivers
- One cleaner
- Supervisors
- Motivators

The roles and the responsibilities of every member of the team are clearly defined in their job description and there were no conflict about areas of responsibility amongst the staff.

The exchanges with the staff of the project have highlighted a cordial, sometimes brotherly or filial professional interaction. Practically for all the agents, the management of the project is remarkable and according to one of them “the Director made the team a family wherein a friendly and warm climate prevails”. This good environment explains that despite the excess workload, each staff member gives their best for the smooth implementation of the activities.

The project agents suggested the consolidation of this spirit beyond the working environment through a more steady "socialization", but also through the holding of periodic "retreats" in a relaxed atmosphere to examine in “a calm setting” the life of the organization.

5. Financial Management

CCF Dakar office manages CANAH II project’s budget and allocates the funds following budget request submitted by the Project for the implementation of the planned activities. The receipts for the expenses are then sent back to the National Office.

The interview with the Finance Assistance showed some difficulties with the central level in the Dakar Office relative to slowness in the allocation of funds. However the biggest difficulty lies in the absence of a "clear visibility" of the resources allocated to the various constituents of the project at both the Dakar and Richmond levels that resulted in poor follow-up and management of the project’s budget. One of the major constraint related to the budget for the CANAH II Project, was the fall of the US dollar against foreign currencies, and especially the euro (to which the FCFA is linked). That depreciation of the dollar has resulted in loss of revenue, thus forcing the management team to look for additional resources, especially to pay for salaries and benefits.

6. Logistics

Two 4x4 vehicles were bought by the project (1st phase) and they have been used for eight years. Their over-utilization resulting from the very high numbers of the activities implemented made the drivers say that the “vehicles have reached the peak of their capacity and must be replaced”. However thanks to their qualification (the drivers are also mechanics), their dexterity and

continued maintenance, the vehicles have been used until the end of the project. Sometimes because of several activities being implemented at the same time the management team of the project had to borrow the vehicles of the health districts or to rent taxis.

Motorcycles

All the supervisors and the motivators were given motorcycles to ensure they could travel easily in their zone. During the phase II, the motorcycles bought (Yamaha) were much more adapted to the environment than the motorcycles bought during the 1st phase and as the result there were much less recurring breakdowns of the motorcycles. Nevertheless, the absence of a stock of spare parts has constituted a handicap to the speed and the efficiency of the repairs.

7. Information Management

The information management system of the Project is pyramidal, in accordance with the structure of the health system. Data are collected on an ongoing basis at the level of every health hut from registers and cards. At the end of each month, the community workers, with the help of the motivators, conduct reviews and record the activities led at both the health hut level and the hamlet level, in a synthesis form that serves as health huts' monthly report. These documents are then handed to the zone's supervisor who compiles the reports and passes them on to the chief nurse to be inserted in the district Area report and to the project M&E Coordinator to feed the quarterly activity report and the global statistics.

The monthly report includes the following items: financial management (petty cash, medicines sales register), curative activities (patients and who saw them, U5 diarrhea care, U5 fever / malaria care, U5 ARI, childbirth) preventive activities (prenatal consultations, immunization of children and of WRA, nutrition and growth monitoring of 0-24 month old children) and promotion activities (talks, individual interviews, demonstrations, projections and debates, community meetings, theater, radio broadcasts, outreach strategy, home visits).

The constraints encountered by the project with the monthly report of the health huts are linked to the low level of instruction of some community workers, and the fact that the chief nurses were not proactive in integrating the information coming from the health huts into their Area reports. The Chief Medical Officer all appreciated the fact that the CANAH II project quarterly reports were sent to them although their "feedback" was not provided back to the project on a regular basis.

In addition to ongoing monitoring, M&E surveys were conducted during the lifetime of the project. These surveys were initially conducted on quarterly basis, and then became biannual and

now annual. The M&E surveys looked at delivery of services at the health huts (survey based on documents) and at the Knowledge, Attitudes and Practices through interviews with the target groups of women of reproductive age, communities' resource persons, and grandmothers.

The purpose of these M&E surveys was to allow the Project to monitor the activities introduced and implemented at the community level over the period covered. A briefing was generally organized with all the teams before starting the survey on the ground, to allow everyone involved to get acquainted with the data collection tools and the questionnaires. Information sharing sessions with the local community authorities (village chief, presidents of the rural communities) and community actors (community health workers, traditional birth attendants, relays, members of committee of health) were also organized one week before start up of the M&E survey. During the sessions, the community leaders and community workers were informed about the dates of the M&E survey and its objectives. At the end of the M&E survey, debriefing meetings were organized with the team coordinators, District's chief medical officers, the Primary Health Care Supervisors and the management team of the Project and a report written up. Finally, the results obtained within the framework of these activities of M&E were disseminated, first at the district level and second at the community level (health hut) for the community.
Finally the project staff evaluated quarterly the action plans. These evaluations are meant to assess the level of attainment of the planned activities, bring out shortcomings or delays, to identify the constraints and propose adapted solutions. Districts are invited to participate in this exercise but their presence has not been regular, because of scheduling conflicts.

OTHER ISSUES

1- **Motivation:** A problem threatening the sustainability of the activities is the motivation of the community actors. Measures have been taken to resolve this problem: implementation of medicines cost recovery scheme with a percentage of profits assigned to the community actors, the population helping with the agricultural workload of the community actors, donation of a cart ambulance to the community workers to ease their work, constitution of the associations of community workers with possibility of granting them IMCEC loans, tontines (traditional collective saving scheme) of relays / community health workers / traditional birth attendants, social motivation with graduation ceremonies for community workers, badges, and free health care services at the local health structures … However these measures remain insufficient. Indeed, the health huts gains (thanks to the small consultation fee) decreased steadily as the population got healthier after having received information on healthy behaviors. In addition, also thanks to the collective information sessions, many mothers now know how to recognize signs of

illness and how take care of them early at home These community actors also have domestic responsibilities and cannot dedicate infinitely their time free of charge for the well-being of the community. Consequently income generating programs must be seriously considered for the remuneration of these community actors to make sure they will stay at the health hut.

2-Low level of education and literacy of community workers: One of the criteria for the selection of the relays was their level of education or their ability to read and write (to be literate), but that was not always possible. The low educational level of the relays affected their understanding of the project and consequently their work. At present, more than 40 % of relays are neither educated, nor literate. This situation hampers optimal performances, especially regarding the documentation of the activities implemented. The relays' literacy must be considered as a structural aspect for the good implementation of the community based activities. This recommendation confirms the need to develop stronger ties between the health project and the other development projects implemented by CCF and other partners in the education / literacy sectors.

3-**Recruitment of the supervisors**: One of the recommendations of the final evaluation of fist phase of the project (CANAH I) focus on the potential promotion of some motivators. Some motivators actually got promoted during the second phase of the project, when supervisors were recruited amongst the motivators already hired. This internal promotion was not accepted in the same way by all stakeholders. For the motivators, it has allowed them to be given more responsibilities and to improve their social status, but they worry about the double role which they play by assuring simultaneously the functions of supervisor and motivator. The District Chief Medical Officer recognize the supervisors play an important role in support to the district management team of the. According to the Joal chief medical officer « the CANAH supervisor plays the primary health care supervisor's role in the district." However for the chief nurses, there are no clarity of roles between the chief nurse and CANAH supervisor, and their roles sometimes overlap, creating some harmful misunderstandings. It is therefore necessary to clarify the roles and levels of intervention at this point for all the technical staff.

In addition, a few motivators have resigned during the course of the project (choice of new professional areas). These resignations were a net loss in investment that may have had negative effects on the optimal implementation of the activities, especially given the time needed to hire and train the new recruits. It would be desirable for the project to count more on endogenous human resources, available locally, and less on external persons who view their jobs as a springboard towards other areas.

VII –LESSONS LEARNED

1. *The health staff's mobility*: The second phase of the project has been marked by important changes in the district's chief medical officers. This situation reflected on the project because of it took sometimes a log tie for the new district chief medical officers to understand the philosophy and the interventions of the project.

2. *The weak support of the health districts*: The project has brought substantial support to the health huts and non-negligible support to the health posts, but not enough support to the health centers. A more consequent support to the health centers would contribute to the sustainability of the key activities after the end of the project.

3. *The strong CANAH presence on the ground with the motivators*: The extensive and close follow-up of the community actors by the motivators is one of the keys to the successes registered by the project. This close presence strongly contributed to the reinforcement of the interventional and organizational capacities of the community workers, increased their self confidence and that of the populations in them; hence a greater credibility and more credit for the community workers. A strong conviction is that the chief nurses will not be able to offer this kind of close follow-up in the community at the same level as the motivators did.

4. *Strengthening of the collaboration between the CANAH II project staff and the Districts' management teams:* Concerted planning introduced within the framework of the project with the health districts encountered a lot of difficulties, especially regarding punctual requests from the districts to organize activities that were never planned. Such situations could be reduced with the presence of ALL participants in the quarterly coordination meetings, where the priorities are fixed.

5. *The involvement of the community leaders:* The extensive advocacy meetings have helped setting up the basis for an appropriation of the project activities by the populations. .Those meetings have targeted the community leaders (presidents of CR, village chiefs, monks, teachers, Women's group, community health workers, traditional healers.) and have been led by the project with adapted approaches. The community commitment has sometimes translated into highly significant financial investments in health (more than five millions in

the CR of Nguediene). That use of the endogenous resources guarantees the sustainability of the interventions.

6. *The introduction of innovative strategies:* The CANAH II project was enhanced with the introduction of the "pregnant women's solidarity circles" (structure of exchanges and problem resolution), the capacity building of the community health workers in treatment of malaria cases with bitherapy and the ACT, the introduction of antibiotic at the health huts level, and the introduction of new systems in growth monitoring… These new approaches helped increase the number of services offered at the health hut and as the result, they helped adapting the services to the needs of the beneficiaries. This is a major success of the program, especially considering that the community workers provide good quality services with a strict compliance with the protocols. In addition, the scaling up of the "Grandmother strategy" into other sectors of maternal and child health has contributed to bend some taboos and to the evolution of ideas and behaviors in the direction inspired by science.

7. *CANAH successes:* The genuine achievements obtained by CANAH was the reason why new activities were introduced, in partnership with the other institutions, even if they did not appear initially in the original project objectives. According to a supervisor "the project was a victim of its good performances".

8. *The involvement of the men:* CANAH I had focused very little on men; and this situation was corrected during CANAH II with systematic meetings with the "decision-makers" at the domestic level and the holders of the economic power. Their opinions and suggestions strongly contributed to the resolution of the problems encountered.

VIII-CONCLUSIONS AND RECOMMENDATIONS

The CANAH II Project, has developed new strategies and expanded already existing ones based on the lessons learned during the first phase of the project (CANAH I). The new strategies are namely the pregnant women solidarity circles, the extension the grandmothers' strategy, the support to the community workers' organization in the development of IGA, the support to outreach and mobile strategies by chief nurses and the organization of the Child Survival Days. Those new orientations have strongly contributed to the considerable progress of all the project indicators.

The experiences must be maintained, strengthened and widened by focusing on the schooling / literacy training of the community workers, the strengthening of the supervision and stronger community mobilization for mother and child health and nutrition.

RECOMMENDATIONS

A- *To CCF Richmond*: create a framework for the optimal allocation of financial resources to the project and the monitoring of spending

B- *To CCF Senegal National Office*

- Speed up the cash disbursement procedures to ensure the implementation of the activities within the planned and required timeframe
- Delegate human resources management tasks to the operational level (the project), for instance to the CANAH administrative and finance assistant with an updated job description
- Strengthen the communication between the CCF national office and the project sub-office in order to improve efficiency
- Set up a system for regular follow-up of the budget allocated to the CANAH II project and other programs implemented from the field office in Mbour
- Start a CFP project in Popenguine to support CANAH activities.

C- To CANAH II:

- Strengthen the integration of the project activities in the health district operational plans.
- Maintain the monthly project staff meetings with the supervisors and bring the motivators in periodically (every 4 to 6 months)
- Set up an “intranet" for optimal, real-time information sharing and link it to the CCF National Office
- Ensure or contribute to vocational and/or on the job training of the project agents, including study tours, in order to increase the number of job opportunities for them at the end of the project
- Train the supervisors in supervision techniques in a more systematic way
- Replace the vehicles purchased under CANAH I
- Support the organization of relays into group and initiate IGA for them
- Provide bicycles to the relays to increase their mobility
- Strengthen the dialogue with the Districts’ management teams through actual holding of quarterly meetings.
- Support the equipment of the health posts and health centers in addition to health huts especially with scales, furniture, etc.
- Proceed to a regular inventory of the supplies and find a functional stockroom to securely stock supplies
- Train the Administrative and Financial Assistant in USAID / CCF financial procedures
- Provide the cleaner with necessary scrubs, headgear and gloves
- Limit the number of health huts by motivator to a maximum of five and reduce supervisors' role to supervision only (and release them of their motivator’s tasks)
- Strengthen the relations with the traditional healers and the partnership with the school during the implementation of the activities
- Pilot test children’s iron supplementation
- Evaluate the impact of the interventions through a maternal and child mortality survey to measure effectively the level of attainment of the objectives.

D - To the Districts' management teams

- Participate regularly in the planning meetings and quarterly project activity review meetings
- Follow strictly the planning of activities developed
- Include all the health huts activities in the district's activity report
- Create an environment favorable to the regular monitoring of the project activities, especially the support to health posts for health hut supervision and outreach strategies
- Develop consistent advocacy toward the local authorities for a greater mobilization of resources for the health huts
- Integrate the health hut monitoring as part of the improvement of the quality of services to clients
- Document the lessons learned from the implementation of the community actions

E- To the chief nurses

- Regular supervision of the health huts' activities
- Participate more frequently in the community self-evaluation and planning activities
- Strengthen the outreach strategies to ensure a wider coverage of the community services
- Continue training and refresher training for the community workers
- Integrate the health huts reports into those of the health post

F- To the Communities

- Create a budget line at the level of the Rural community to make sure the health huts continue to be functional.
- Develop partnerships at all the levels to support the health and nutrition activities
- Strengthen and widen the involvement of the community leaders in the conduct of the health hut activities
- Encourage the creation of village Clean Environment Committees and Malaria Committees and make them operational
- Select educated or literate community workers if possible
- Reinforce the moral, psychological and financial motivation of the community workers: badge, services, micro-credit, ITN policy, cart ambulance initiative, literacy

PROMINENT POINTS

- Based on the lessons learned from the 1st phase CANAH II has enriched its strategic range with the pregnant women's solidarity circles. These are pregnant women's groups living in the same village or cluster. It has been established that people who share the same living conditions, the same constraints or have undergone the same problems are generally open to the advice of their peers. The testimony on an experience such as pregnancy with its underlying difficulties can constitute a non-negligible form of assistance to the least experienced to learn from others. It allows them to play down some pregnancy issues and to find solutions in the way others who are more experienced did it. The solidarity circle duplicates the same methodology than group therapy. Many subjects related to pregnancy troubles, including food, malaria, anemia, workload, prenatal consultations, assisted delivery, exclusive breastfeeding, are discussed. Besides, the strategy allows the pregnant women to walk out of forced isolation in which they are trapped due to socio-cultural practices.
- Another major striking point has been the official introduction of antibiotic at the health hut level. The CANAH II project has been strongly involved in the operational research to test the feasibility of the management of child ARI by the community health workers. That innovative experience allowed for the elaboration of training materials and tools for management of ARI at the community level with the support of the project. In its experimental phase the community health workers of the huts retained were trained, equipped and supervised during 12 months. The experience has been conclusive and has shown that a CHW who is literate, trained, equipped and supervised could correctly manage IRA cases at the health hut level. In the present day extension of the strategy to all the health huts in the project areas has been effective, which constitutes a major headway towards bringing the health services closer to the beneficiaries;
- Along the same line, management of malaria at the community level was completely transformed during the implementation of the project. Indeed, the National Malaria Program (PNLP), on the basis of the results of the research on chloroquino-resistance first opted for a transitional phase with the use of SP + Amodiaquine, then of ACT. That new situation has led the project, in association with the NMP to successfully test the use of these drugs by the community health workers at the level of health huts by elaborating the training materials and the management tools (including documentation of side effects).
- As for the collaboration with the Nutrition Enhancement Program, The CANAH II

Project also worked in partnership with another CCF program (CAMA), and organized social mobilization activities with the aim of improving the nutritional and health situation in the Mbour zone. Together they also organized growth monitoring sessions, base don the concept of expected weight gains, with the women's groups in the community. This new approach recommended by the MOH allows for refinement of the interpretation of the nutritional status of the children 0 - 2 years old and a more adapted decision-making.

- It is also important to note the efforts of the project in the promotion of ITNs. These efforts have allowed for a better organization of the women's groups responsible for the sale of the ITN. ITNs have been sold at reduced and accessible price (FCFA 1000 presently, representing a FCFA1500 or 2000 discount). These efforts have also allowed for the re-impregnation of bednets and the creation of Clean Environment and malaria committees in numerous villages. All these strategies explain largely the exceptional rates of ITN coverage in children under five years (97.4 %) and pregnant women (99.1 %); and the substantial decrease of the number of severe cases of malaria reported by all the health agents active in the project zone and the populations.

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ANNEXES

1. KPC Guidelines
2. Guidelines for the Mothers / CBO focus group
3. Guidelines for community Leaders focus group
4. Guidelines for the focus group with community leaders
5. Interviews Guidelines for the chief medical officers
6. Interviews Guidelines for the staff of CANAH
7. Interviews Guidelines for the chief nurses
8. Questionnaire for the Motivators and Supervisors
9. Documentation tools for the emancipated health huts Cases (Focus CBO, Leaders, CW)
10. List of the restricted and extended workgroups
11. List of the KPC teams
12. List of the Focus Groups teams
13. List of the survey zones for the KPC and Focus groups
14. Focus group and KPC Agenda
15. Motivators/supervisors Synthesis questionnaire

LIST OF PEOPLE MET

1. Ali NDAO, President of the Rural Community of Ngueniene
2. Oumy NDOUR, CHW Ngueniene
3. Catherine NDOUR, TBA
4. Seynabou NDIAYE, Relay
5. Marthe DIAGNE, Relay
6. Pape TOP, President Youth & Sports Association
7. Mbagnick DIOUF, Institutor, President of the Nursery
8. Ousmane NDIAYE, Chef de village
9. Marie NDIAYE, WPG
10. Marie DIOP, Clean Environment Committee, WPG
11. Fatou NIANG, Clean Environment Committee
12. Latyr FAYE, Manager CFP Koulouck Mbadane
13. Salif FAYE, village chief
14. Cheikh Faye, Literacy Officer, CVD
15. Ndeba GNING, Notable
16. Alassane FAYE, President Managing committee of the Kindergarten
17. Modiane DIONE, President Schoolchildren's Parents Association
18. THIAW, President Health Committee
19. Dioth NGOM, Village chief
20. Amath TINE, President of the Health Committee
21. Latyr DIENG, President ASC
22. Bouri Dieng, Notable, Traditional healer
23. Modou SARR, local CBO leader
24. Dibocor NGOM, Secretary CVD
25. Diambogne Faye, WPG
26. Yacine SENE, WPG
27. Dibor NGOM, WPG
28. Marie NGOM, WPG
29. Ndofe FAYE, Treasurer
30. Salla DIEYE, WPG
31. Diakhene SENE, WPG
32. Ndew MARONE, WPG
33. Cossene TINE, CHW
34. Penda FAYE, Relay
35. Arame MARONE, Relay
36. Ndeye NIASS
37. Mamadou DIAGNE, Director CANAH
38. Ibrahima TOURE, Coordinator IEC FORMATION CANAH
39. Kalala LAZIN, M&E Coordinator
40. Mrs Diarietou THIAM, Coordinator SR
41. Mme Ndeye WADE, Coordinator Malaria / Tuberculosis
42. Mrs COLY Henriette, Finances CANAH
43. DR BA Ousmane, chief medical officer, Popenguine
44. Elhadji DIOUF, Supervisor hygiene, Popenguine
45. MME NIANG Bintou Toure, RH Supervisor, Popenguine
46. Mamadou GAYE, PHC Popenguine
47. Dr. Cheikh HANNE, chief medical officer, Joal
48. Germain SANKA BAKOURINE, Administrative Assistant
49. Mlle Aby DIALLO, Secretary
50. Mousse Gueye, PHC Supervisor, Thiadiaye
51. DR Marie SARR, chief medical officer, Mbour

52. Ndiaga MBENGUE, CANAH Driver
53. Abdou Mbacke KEBE, CANAH Driver
54. Amidou MANSALY, chief nurse, Toglou Serere
55. Yerim FAYE, CANAH Supervisor
56. Elhdaji MBODJI, CANAH Motivateur
57. Diame SENE, CANAH Supervisor
58. Mohamed TANDIANG, Supervisor CANAH
59. Mamadou Lamine GUEYE, chief nurse, Guereo
60. Kor SARR, chief nurse Santhie Joal
61. Elhadji SAMB, chief nurse, Mbour
62. Aly NDAO, chief nurse, Fissel
63. Ousmane SAMB, chief nurse, Sandiara
64. Alfousseyni CISSE, CP Ngueniene
65. Gana DIOUF, chief nurse, Nianing

CCF-Senegal / USAID

Health districts of
Thiadiaye, Mbour,
Joal and Popenguine
CANAH II projects - CAMAT

Focus Group Guide

Mothers / CBO Focus Group

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you in a mutual exchange to allow collection of the points of view of each of you. This information will help us improve the health and nutrition programs in the future.

1. **How do you appreciate the evolution of the health of the children before the Project and now** (since the CANAH project is in your village, what changes did you notice in terms of child health?)

2. **Which aspects / activities of the Project did you find the most useful**: cares supplied by the health hut (ARI), Malaria), immunization, culinary demonstrations, mosquito nets (purchase, dipping, popularization and sales), home visits, medicines … Explain

3. **What aspects / activities of the Project did you find the least useful**?: care supplied by the health hut, the immunizations, the culinary demonstrations, the mosquito nets (purchase, satisfaction, popularization, mode(fashion) of transfer), home visits, medicines … Explain

4. **Do you often listen to the community radio? Have you ever heard health and nutrition messages on the community radio? If yes, how do you appreciate them?**

5. **What are the problems that you have faced with the activities of the Project**?: As far as the health hut, the immunizations, the culinary demonstrations, the purchase of mosquito nets, the home visits or any other thing?

6. **How were these problems resolved**? Who helped you to find solutions?

7. **Which appreciations could you make of or difficulties that ever you ever encountered in your relations** a) **with the community actors** (that is traditional birth attendants, relays, community health agents), b) **with the Project** staffs (motivator, supervisor), c) **the chief nurses, the midwives, the other agents of the Health District ?**

8. **How were the problems / difficulties resolved**?

9. **What has the project done to increase your knowledge in the field of the health and nutrition?**

   - What has the project done to help you to realize your activities of health and nutrition?

10**Do you think that your training / information in health and nutrition is sufficient?** Explain

11. **Have you met difficulties during the mobilization of the women?** Explain

12. **Do you think that your community mobilization activities around health and nutrition can continue after the end of the Project**? Why? Why not?

13. **What other activities do you think you can continue after the retreat of the Project?** (Dipping of mosquito nets, marketing, weighing, education ...)

14. **Why did you stop continuing these activities and not the others?**

15. **In your opinion, what are the most adequate community measures to be taken to guarantee the sustainability of the health and nutrition activities after the end of the Project?**

   - How do you plan to maintain the experiences in terms of behavior after the retreat of the Project?

16. **Do you work with the IMCEC that CCF set up in the zone? What IGA have you led with IMCEC?**

17. **How do you feel about men in the health management bodies of the village** (health committees, activity auto-evaluation and programming meeting)?

18. **Are your opinions or preoccupations taken into account in these health management bodies**? Give examples

19. **What do the men do to support you in the management of the health and nutrition problems**? **Do you think the men should support you otherwise? How would you wish that the men would support you**?

20. **What could the Project have done to help you better realize your health and nutrition activities?**

Do you have any general comments or suggestions to make on what we have discussed?

Thank you

CCF-Senegal / USAID
Health districts of
Thiadiaye, Mbour,
Joal and Popenguine
CANAH II - CAMAT projects

Community Leaders Focus Group

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you to a mutual exchange to allow collection of the points of view of each of you. This information collected will help us improve the health and nutrition programs in the future.

1. **In what activities introduced by the Project are you involved**? Explain Why?

2. **Why are you involved in the health and nutrition activities?**

3. **How do you appreciate your involvement in the planning, auto-evaluation activities?**

4. **What has been your contribution in the management / reference of the serious cases of illnesses?** (Horse-driven cart or other means)

5. **what have you done to ease the work of the community actors?**

6. **How do you appreciate the evolution of child health before the Project and now?**

7. **How do you appreciate the activities of health and nutrition led within the framework of the Project?**

8. **What activities worked well? What activities did not work well?** Why?

9. **How do you appreciate your involvement in the community mobilization?**

10. **Who do the community leaders work for? Who do the community actors work for? Who do the motivator / supervisor work for?**

11. **Have you already executed health and nutrition activities without the support of the motivator?** If yes, give examples and say what urged you to do that? If not, why didn't you do it?

12. **After the end of the Project, do you think you can execute the activities with the other members of the community?**

13. **How do you appreciate the presence of women in the various health management committees?**

14. **What activities are organized to strengthen feminine leadership** (Empowerment of women in decision-making about health and nutrition)?

15. **In your opinion, which are the most adequate community measures to be taken to guarantee the sustainability of the health and nutrition activities after the end of the Project**

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Health districts of
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CANAH II projects - CAMAT

Focus Group with the community leaders: Health committee, CHW, TBA, relays

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you to a mutual exchange to allow collection of the points of view of each of you. This information collected will help us improve the health and nutrition programs in the future.

1. **How do you appreciate the evolution of the mother and child health before the Project and now?** (Since the CANAH project is in your village, what changes have you regarding mother and child health)?

2. **What aspects / activities of the Project did you find the most useful?** Explain

3. **What aspects / activities of the Project did you find the least useful?** Explain

4. **Which problems / difficulties did you encounter in the implementation of the activities;** home visits, use of huts, supply in essential medicine …

5. **How have these problems / difficulties been resolved?**

6. **Have you participated in self-evaluation, planning and mobilization actions?** How do you appreciate your participation in these activities?

7. **You have been a participant in the training sessions organized by CANAH Project. How do you appreciate:**

    a. The contents of the training?
    b. the teaching methods?
    c. the actual organization of the seminar?

8. **What improvements do you suggest for the trainings?**

9. **What materials did the Project provide you with to facilitate your work**? What materials are useful? Useless?

10. **Was the material sufficient, insufficient, of good quality**? Explain

11. **What other materials do you suggest to facilitate your work?**

12. **How do you appreciate the supervision led by motivators and chief nurses**? Was this supervision useful or useless? Explain

13. **How do the members of the community perceive the health educational activities which you lead?**

14. **Who participates in these health educational activities?**

15. **How are the preoccupations of the community taken into account in the health educational activities**?

16. **What difficulties do you face in the execution of the health educational activities?**

17. **What do you suggest to improve the execution of the health educational activities?**

18. **What benefit do you get working as a community agent for your village? Did you start income generating activities? What did the agents have to have to do to facilitate you to access IGA? What benefits did you gain from these IGA?**

19. **What encourages you to lead the health and nutrition activities? What discourages you?**

20. **Do you think that your health and nutrition activities will continue after the Project ends?** Explain why

21. **What activities in particular can continue**? Explain

22. What do you suggest to encourage the continuation of the health and nutrition activities after the Project ends?

Do you have any general comments or suggestions to make on what we have discussed?

Thank you

CCF-Senegal / USAID
Health districts of
Thiadiaye, Mbour,
Joal and Popenguine
CANAH II projects - CAMAT

Interviews with the Chief Medical Officers

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you to a mutual exchange to allow collection of the points of view of each of you. This information collected will help us improve the health and nutrition programs in the future.

1. **General Appreciation of the Project** (strengths, weaknesses)

2. **What do you think of the planning system implemented within the framework of the Project?** (Level of involvement of the Health District, the initiatives of the district to ensure the continuation)

3. **Roles and responsibilities of the Health District in the implementation of the activities**

4. **Support received from the Project** (supervision, material, logistics, resources)

5. **Training received and appreciation of the training session provided within the framework of the Project**

6. **What is your appreciation of the quality of the services offered within the framework of the project?**

7. **How can you qualify the links between the health structures and the communities**?

8. **What do you think of the level of appropriation of the project by the populations?**

9. **Appreciation of the strategies of sustainability:** give your opinion on "autonomous" health huts »

10. **How does the district give its agreement for the follow up of the activities led within the framework of the Project?**

11. **What would the Project have done to be more efficient?**

12. **Scaling up issues:** How do you think that the experiences of the project can be scaled up?

13. **Lessons learnt by the Project:** which are the lessons learnt from the project implementation

14. **General Recommendations**

15. **Anything else you would want to share?**

Have you comments or suggestions of general order to be made on what we discussed?

Thank you

CCF-Senegal / USAID
Health districts of
Thiadiaye, Mbour,
Joal and Popenguine
CANAH II projects - CAMAT

Interviews with the Project's staff

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you to a mutual exchange to allow collection of the points of view of each of you. This information collected will help us improve the health and nutrition programs in the future.

1. **What is your role in the Project?**

2. **What major activities have you conducted in the Project life?**

3. **What is your general appreciation of the project activities** (Strong points, Points to improve, success factors, hindrance factors)

4. **Training received within the framework of the project** (technical contents, teaching methodology, Monitoring & Evaluation)

5. **Appreciation of the Project management**

6. **What appreciation do you make of your relations with the staff of the project?**

7. **What appreciation do you make of your relations with the staff of the health structures?**

8. **How do you evaluate the relations between the health agents of the health structures and the populations?**

9. **What do you think of the level of appropriation of the project by the communities?**

10. **Scaling up issues:** How do you think the experiences of the project can be scaled up?

11. **What would the Project have done to be more efficient?**

12. **What lessons have you learnt from the Project? And on a personal plan?**

13. **General Recommendations**

14. **Any other thing that you wish to add?**

Have you comments or suggestions of general order to be made on what we discussed?

Thank you

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Health districts of
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Joal and Popenguine
CANAH II projects - CAMAT

Individual Interviews with the Chief Nurses

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you to a mutual exchange to allow collection of the points of view of each of you. This information collected will help us improve the health and nutrition programs in the future.

Health post of _____ _____

Number of huts of the zone _____ of which _____ are under the Project

Interview conducted by _____ _____

_____

Supervision of the health huts activities

(System, functioning, qualification of the supervisors, contents, tools, perception of the actors, description, constraints, possible improvement, durability)

Who does the supervision of the health huts and activities of the community health workers / TBA / Relays / Committee?

What do you think of the M&E system, the joint evaluation chief nurse / Project?

On average, how many supervision visits do you make every month?

Alone? _____ With the staff of the Project? _____

What are your problems / difficulties with regard to the supervision of the huts (tools, logistics, time, workload at the post)?

How can we improve the supervision of the activities of the health hut?

Do you think that at the end of the Project, the activity of supervision will still be guaranteed? By what means or measures can we sustain this supervision?

Elements of sustainability of the health huts

Probably, at the end of the Project some of the activities are going to continue easily, others will be poorly led and\or less frequently, others will be abandoned. Do you agree with that assertion? If yes, why; If not, what is your forecast?

What measures were taken to sustain the activities at the end of the Project?

What are your propositions so that the activities continue, even in the absence of a Project?

Support brought within the framework of the Project to improve the competence and the intervention capacities of the chief nurses (documentation, training, related activities, equipment, logistics)

What documentation did you receive from the project to improve your intervention capacities in health and nutrition?

Was that documentation sufficient in quantity and quality? If not, why?

You participated in training workshops / seminars of the Project. If yes, which one?

What is your appreciation of the methodology used during the training sessions?

Have you participated in the other particular activities with the staff of the Project (working sessions, informal exchanges, etc.)? If yes, of what type and which is your appreciation?

Have the training activities supported by the Project allowed you to improve your knowledge in child survival?

No a little Fairly A lot

How do you appreciate the activities led collectively? (Immunizations, weighing sessions, antenatal consultations, M&E etc.)

Number of joint activities:	Not many	Average	Too many
Usefulness:	useless	useful	very useful
Difficulties:	difficult to lead		Not difficult

Other observations

What equipment did you receive from the Project to improve your capacities in health and nutrition?

Was that equipment sufficient in quantity and quality?

No	A little	Average	Fairly	Very much
Bad quality		Fairly good	Good quality	

Other observations: _____

What logistic backup did you receive from the Project to improve your intervention capacities in health and nutrition?

Was that logistic backup sufficient in quantity and quality? If not, why?

Level of involvement of the chief nurses in the activities of planning, execution, M&E of CANAH project (collaboration of the chief in the activities of the Project, constraints, appreciations, sustainability).

Have you participated in the realization of the following Project activities:

- Planning of the activities of huts with the community actors?

- Coordination meeting of the activities of huts with the community actors?

- Community dissemination (after M&E and evaluation)?

- Evaluations?

In your opinion this collaboration is:

Useless	Useful	Very useful
Difficult to realize	Too time consuming	Does not pose any problem

What are the difficulties or the constraints of this collaboration?

What suggestions do you have to improve your involvement in the Project activities?

At the end of the Project do you think of continuing these activities? What difficulties do you foresee when continuing? What solutions do you propose?

With regard to CANAH Project, do you have other remarks, critics, wishes or suggestions to propose?

Have you comments or suggestions of general order to be made on what we discussed?

Thank you

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Health districts of

Thiadiaye, Mbour,

Joal and Popenguine

CANAH II projects - CAMAT

Interviews with the CANAH Supervisors and motivators

Introduction: We have arrived at the term of the CANAH project. We need everyone's opinions about the strength and weaknesses in the implementation of the project. We invite you to a mutual exchange to allow collection of the points of view of each of you. This information collected will help us improve the health and nutrition programs in the future.

How were you recruited by the Project?

Number of huts / sites under the responsibility of motivators _____

Time in the Project _____ Level of schooling / diploma _____Gender: _____

Supervision of the activities of huts / sites

(System, functioning, qualification of the supervisors, contents, tools, perceptions of the actors, constraints, improvements possible, sustainability)

Who assures the supervision of huts / sites and activities of the community health workers / TBA / Relays / Committee?

With regard to the supervision of the activities of the community health workers / TBA / Relays / Committee, what is your role as a motivator?

What is the supervision that you carry about? (List elements)

What do you think of the system of joint supervision Chief nurse / Project?

On average, how many visits of supervision do you make every month?

Alone? _____ With the staff of the District? _____

What are your problems / difficulties with regard to the supervision of the huts (tools, logistics, time, overloads with work in the post)?

How can we improve the supervision of the activities of the hut / site?

Support brought within the framework of the Project to improve the competence and the intervention capacities of Motivators in health and nutrition / TB (Documentation, training, related activities, equipments, logistics)

What documentation did you receive from the Project to improve your intervention capacities in child survival?

Was that documentation sufficient in quantity and quality? If not, why?

Have you participated in training workshop / seminars organized by the Project. If yes, which one?

What is your appreciation of the methodology used during the training sessions?

Have the training activities supported by the Project allowed you to improve your knowledge in health and nutrition?

No a little Fairly A lot

How do you appreciate the activities led collectively? (Immunizations, weighing session, antenatal consultations, M&E etc.)

Number of joint activities: Not many Average Too many

Usefulness: Useless Useful Very useful

Difficulties: Difficult to lead Not difficult

Other observations

What equipment did you receive from the Project to improve your capacities in health and nutrition?

Was that equipment sufficient in quantity and quality?

No A little Average Fairly Very much

Bad quality Fairly good Good quality

Other observations: _____

What logistic backup did you receive from the Project to improve your intervention capacities in health and nutrition?

Was that logistic backup sufficient in quantity and quality? If not, why?

Elements of sustainability of the health hut activities

Probably, at the end of the Project some of the activities are going to continue easily, others will be poorly led and\or less frequently, others will be abandoned. Do you agree with that assertion? If yes, why; If not, what is your forecast?

What measures were taken to sustain the activities at the end of the Project?

What are your propositions so that the activities continue, even in the absence of a Project?

With regard to the project, do you have other remarks, critics, wishes, suggestions to propose?

For Motivators

How do you appreciate the relations with:

- the supervisors?

- the Project’s management teams

- the chief nurses

How do you appreciate your motivator status(salary, working conditions, career plan)

For the supervisors:

How do you appreciate your relations/ collaboration with:

- Your motivators

- the Project's management team

- the District's management team

- the chief nurses

Which lessons have you learnt from your experience with the Project?

- On a personal plan

- in terms of health and nutrition implementation?

Have you comments or suggestions of general order to be made on what we discussed?

Thank you

CCF-Senegal / USAID
Health districts of
Thiadiaye, Mbour,
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CANAH II projects - CAMAT

Early withdrawal from the health huts

Interview Guidelines for the Community Leaders and Health Committees

Introduction: We thank you beforehand for accepting to discuss the lessons learnt about the self-running of the health huts. Any views are welcome for they will help us to understand what has taken place during that period. They would also help us appreciate the capacities of the community to put on a health hut without the support of a project.

1. How did you accept the idea of the early withdrawal of the project from your health hut?

2. What have you done to make sure the phase out of the project does not hinder the functioning of the hut and the activities?

3. What activities have you been able to continue in spite of the Project's end?
   - Monthly auto-evaluation / programming meeting?
   - Talks? Home visits?
   - Growth monitoring sessions? Culinary demonstrations?
   - Outreach strategies? Mass campaign?
   - Support to the community actors to mobilize the other community groups?

4. What key persons are generally involved in the realization of these activities?

5. What is your impression of the level of mastery of the activities by the community agents?

   - Do you really think that they carry the activities well?
   - What may improve the execution of the health and nutrition activities?

6. What difficulties / constraints did you meet in the realization of the activities?

7. Why haven't some of the activities planned during the discussions on the phase out plan have not been realized?

8. What did the health post / district do to help you in this period of retreat of the Project?

9. What did the rural community do to help you in this period of retreat of the Project?

10. What would have done the Project before the pullout from the project to help you succeed better in the realization of the activities?

11. How do you think you would maintain the activities after the ultimate withdrawal of the Project?

12. What suggestions or comments do you have on the strategy of early withdrawal from the health huts introduced within the framework of the CANAH Project?

13. How do you think to maintain the experiences in terms of changes of behavior that occurred during this period after the departure of the project?

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Health districts of
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CANAH II projects - CAMAT

Early withdrawal from the health huts

Interview Guidelines for the CW (CHW, TBA, Relay)

Introduction: We thank you beforehand for your accepting to discuss the lessons learnt about the self-running of the health huts. Any views are welcome for they will help us to understand what has taken place during that period. They would also help us appreciate the capacities of the community to put on a health hut without the support of a project.

1. How did the idea of the early withdrawal of the project of the management and the functioning of the hut come up?

2. Who participated in the preparatory meetings about the pullout of huts by the Project?

3. Why was your hut selected for the early withdrawal? What was your point of view in this idea of the pullout of the Project from your hut?

4. What arrangements did the project make before withdrawing from the health hut? What could have done the Project to prepare you more?

5. What are the activities that are currently implemented?
   - at the level of the health hut?
   - at the level of the community?
   - How many talks did you realize since the beginning of the month?
   - How many times did you go to do home visits since the beginning of the month
   - Are the self-evaluation / programming meetings held every month? With whom?

6. What are the activities that you did not manage to continue? Why?

7. Since the project withdrew, are there other persons or partners who have come to see you or brought you any support in your activities?
   - Whom are they generally?
   - What do they do they do with you when they come to see you?
   - How do you appreciate their support or presence during the activities?

8. Did you receive support coming from the health post or from the district? What are they? What is the use of this support?

9. What has the rural community done since then to help in the functioning of the hut and in keeping up the health and nutrition activities in your village?

10. Do you think you can continue to maintain the hut and other activities without the support of the project? How?

11. How do you think you could maintain the experiences such as the changes obtained with the project if we consider that it is going to withdraw definitively from your zone?

12. What is your appreciation of the principle of early withdrawal??
    -Was it a good or bad strategy? Please explain?
    - What has the early withdrawal of the Project allowed you to achieve?

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Health districts of
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Joal and Popenguine
CANAH II projects - CAMAT

Early withdrawal from the health huts

Interview Guidelines for the CBOs

Introduction: We thank you beforehand for your accepting to discuss the lessons learnt about the self-running of the health huts. Any views are welcome for they will help us to understand what has taken place during that period. They would also help us appreciate the capacities of the community to put on a health hut without the support of a project.

1. Were you involved in the preparatory meetings to plan for the pullout of the project from the health hut?
   - what is your appreciation of this idea of early withdrawal the project?

2. In what activities were you involved after the withdrawal of the project?
   - What impression do you have about the functioning of the hut at present? How would you compare it with the situation before the withdrawal of the Project?
   - What appreciation do you have of the organization and the progress of the activities at present? How would you compare them with the situation before the pullout of the Project?

3. What activities are well implemented by the Community workers? What are those that are poorly implemented?

4. What should be done at present to improve the functioning of the hut? The implementation of the activities?

5. What difficulties did you meet in the realization of the activities since the pullout of the Project?

6. Do you think that there are things that the project should have done before withdrawing from the hut? Please explain.

7. what do you plan to do to ensure the continuity of the activities given that the project is definitively going to leave the zone?

8. How do you think of maintaining the experiences in term of changes of behavior because the project is definitively going to disappear?

CANAH II Final KPC Survey Team

27, 28, 29 July 2006

N°	Team Supervisor	Team Members	Day 1		Day 2		Day 3	
			Village	***Logistics***	**Village**	***Logistics***	**Village**	***Logistics***
1	Alphousseyni Cisse, chief nurse Ngueniene	Pape Abdoulaye Dieng, mob. Marietou Ndoye, motivator	Godaguene	Motorbike	Mbelambouth	Motorbike	Diob	Motorbike
2	Colane Faye, chief nurse Mb Secco	Amary Ngom, motivator Amadou Dieng, motivator	Yabo - Yabo	Motorbike	Sessene	Motorbike	Ndiaganiao	Motorbike
3	Mamadou Diame, Primary Health Sup, Joal	Mamadou Sy, motivator Birane Tine, motivator	Sandiara	Vehicle	Fissel	Vehicle CCF 043	Tattaguine Sere	Vehicle CCF 043
4	Serigne Mbacke Diop, supervisor	Kor Youm, motivator Moustapha Dieng, motivator	Diokhar	Motorbike	Ndioukh Thiorok	Motorbike	Niomar	Motorbike
5	Diambogne Ndour, Midwife	Alphonsine Dione, Fadial Marieme Mbengue, Midwife	Kouthie wolof	Vehicle CCF 003	Ndame	Vehicle CCF 003	Koulouck wolo	Vehicle CCF 003
6	Khady Sow, Thiadiaye	Mamadou Faye, chief nurse Mossane Dione, chief nurse Ndiag	Ndollor	Vehicle CCF 002	Back	Vehicle CCF 002	Mbedap	Vehicle
7	Aly Ndao, chief nurse	Jean Leon Badji, motivator Oumar Niass, motivator	Ngueniene	Motorbike	Mbodiene	Motorbike	Ndiaganiao	Motorbike
8	Abou Cisse, motivator	Mamadou Ndour, motivator Gabriel Diouf, motivator	Roff	Motorbike	Nianing	Motorbike	Aga Ndimak	Motorbike
9	Ousmane Samb	Awa Leye, CS Mbour Kangou Sagne, midewife	Mbafaye Sandock	Vehicle CCF/BN	Aga Biram	Vehicle	Ndoffane	Vehicle
10	Laurent Manga, supervisor	Baye Seck, Freelance surveyor Cheikh Mbaye, motivator	Mbouleme	Motorbike	Ngueniene	Motorbike	Ngueniene	Motorbike

CANAH II / CAMAT Focus Group Teams

Coordinator: Ibrahima Toure

27 – 28 – 29 *July 2006*

	Day 1			**Day 2**			**Day 3**		
	Village	***Focus***	***Logistics***	***Village***	***Focus***	***Logistics***	***Village***	***Focus***	***Logistics***
Mohamed Tandia Yirim Faye	Ndayane	-Com. worker - CBO	Motorbike	Nguekokh	- CBO - Com. worker - Ill (2)	Motorbike	Mboulouctene Sec	- Com. worker/leaders - Ill (1)	Motorbike
Adji Mahe Faye Djibril Senghor	Mbodiene	- Com. leaders. - Com. worker	Vehicle rent	Ngueniene	- CBO - Com. worker	Vehicle rent	Aga Ndimack	- Com. leaders. - Com. worker	Vehicle Rent
Diame Sene Demba Diagne, Joal	Ndame	- Com. leaders - CBO	Motorbike	Sandiara/ Sessene	- Com. leaders. - Com. worker	Motorbike	Tattaguine Serere	- CBO - Com. worker	Motorbike
El Hadji Mbodji Mbaye Diallo	Mbourokh	- Com. leaders - CBO	Motorbike	Mbour ONCAD	- Com. leaders. - Com. worker - Ills (3)	Motorbike	Joal Santhie	- Com. leaders. - CBO - Ills (3)	Motorbike
Mamadou Ndiaye Ndiouck Ndiaye	Nianing	- CBO - Com. worker	Vehicle rent	Mbouleme	- Com. leaders. - CBO	Vehicle	Back	-Com. leaders. - CBO	Vehicle Rent

Synthese des focus : 31 July 2006
1er August 2006
2 August 2006