Plan International USA

EXPANDED IMPACT CHILD SURVIVAL PROJECT (EIP) CAMEROON

CHILD SURVIVAL PROJECT XXI

COOPERATIVE AGREEMENT NO.: GHS-A-00-05-00015-00

4TH ANNUAL REPORT

Covering October 1, 2008 to September 30, 2009

PROJECT LOCATION: Cameroon

11 Health Districts:
Akonolinga | Awae | Bafut | Batouri | Bertoua | Doume |
Esse | Fundong | Mbengwi | Ndop | Nguelemindouka

PROJECT DATES: September 30, 2005 to September 29, 2010

REPORT SUBMITTED: October 31, 2009

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ACRONYMS

ACMS	*Association Camerounaise pour le Marketing Social* (PSI affiliate in Cameroon)
ACT	Artemesin Combination Therapy
AHS	Assistant Health Supervisor
BCC	Behavior Change Communication
BSL	Baseline
CBO	Community Based Organization
CBS	Capacity Building Supervisor
CCM	Community Case Management
CDF	Community Development Facilitator
C-HIS	Community-Health Information System
C-IMCI	Community-Integrated Management of Childhood Illnesses
COGE	Health Area Management Committee
CS	Child Survival
CSSA	Child Survival Sustainability Assessment
DMO	District Medical Officer
EIP	Expanded Impact Project
ENA	Essential Nutrition Actions
HKI	Helen Keller International
HNAW	Health and Nutrition Action Week
HS	Health Supervisor
IEC	Information, Education, Communication
IHC	Integrated Health Center
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Presumptive Treatment
ISP	Internet Service Provider
ITN	Insecticide Treated Net
KPC	Knowledge, Practices and Coverage
LLITN	Long-lasting Insecticide Treated Net
LNGO	Local Non-governmental Organization
LQAS	Lot Quality Assurance Sampling
MCHNAW	Maternal and Child Health and Nutrition Action Week
MOH	Ministry of Health
MTE	Mid-term Evaluation
PC	Project Coordinator
PD/Hearth	Positive Deviance/Hearth
PMTCT	Prevention of Mother-to-child Transmission
PSI	Population Services International
PU	Program Unit
PUHC	Program Unit Health Coordinator
RBM	Roll Back Malaria
U5	Children Under 5 years
USNO	United States National Office (PLAN)
VAS	Vitamin A Supplementation
WHO	World Health Organization

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A. KEY PROGRESS AND MAIN ACCOMPLISHMENTS

Since its inception, the Cameroon Expanded Impact Child Survival Project (EIP) has made significant progress towards the achievement of its objectives.

Scale-up: In collaboration with the Ministry of Health (MOH), EIP has contributed significantly to scale up in the areas of Integrated Management of Childhood Illness (IMCI), malaria and nutrition through trainings, operations research and other national working group meetings and engagements. IMCI has been adopted by the MOH as a strategy to reduce child mortality.

Community-IMCI (C-IMCI): The EIP has developed several health education materials and job-aids which facilitate community-based organizations (CBOs) in their behavior change efforts in the community. EIP has increased access to maternal and child health information by training 25,860 CBO members who promote key C-IMCI behaviors among pregnant women and mothers of children under 5 in their communities.

The following changes in key maternal and child health behaviors have been reported:

- Insecticide-treated net (ITN) use by under-2 children increased from 11.8% (at baseline) to 48.0%.
- Exclusive breastfeeding among target children increased from 50.8% (at baseline) to 72.3%.
- Vitamin A supplementation (VAS) for children 6 to 23 months increased from 80.9% (at baseline) to 90.1%.
- Appropriate hand washing increased from 7.7% (at baseline) to 25.7%.

IMCI: The EIP is supporting the scale up of health facility IMCI by training a pool of national trainers. To date, 659 health staff have been trained and are practicing IMCI (284 in the EIP project area and 375 in other regions of the country) in more than 133 health facilities in all 10 regions of the country. In addition, a one-week training module on IMI has been integrated into the curriculum of post-graduate residents in pediatrics at the University of Yaoundé 1, and plans are underway to integrate IMCI into undergraduate medical studies, and to have nursing and medical students do internships at PROFAM clinics.

Roll Back Malaria: Access to ITNs has increased through the provision of 42,800 ITNs, increasing ITN use among children U2 from 11.8% to 48.0% and among pregnant women from 15.7% to 43.2%. These ITNs are distributed free of charge by the MOH to pregnant women and mothers of children under 5 in all health facilities. EIP supported the training of 2,000 community-based Malaria Relays to manage simple malaria at home within and outside of the EIP project area.

Nutrition: At the national level, the EIP provided financial, technical and material assistance to the National Nutrition Working Group to convene the first meeting of the nutrition stakeholders after advocating to the Ministry of Public Health the need to create the group in August 2008. In addition, EIP provided technical and financial support for the preparation, organization and evaluation of two rounds of Maternal and Child Health and Nutrition Action Week (MCHNAW) this year. During these MCHNAWs, the following high impact interventions were offered to mother and child: Vitamin A supplementation, deworming, catch-up immunizations, intermittent presumptive treatment (IPT) for pregnant mothers, and ITN distribution for children. Furthermore, after integrating zinc for the treatment of diarrhea into the essential drugs list, advocacy for importation and use continues. Zinc is now available in the drug kits destined for refugee camps in the country.

At the local level, training of extension workers on Essential Nutrition Actions (ENA) continued in the East. 101 people participated in two workshops on behavior change communication (BCC) related to nutrition. In partnership with UNICEF, ENA packages (community and health facility) have been introduced in 7 health districts in the Far North region which are hosting Chadian refugees.

Diarrhea Disease Control: ACMS has started importing both zinc and low osmolarity ORS for the treatment of diarrhea. According to recommendations from operations research commissioned by EIP in the East region, kits containing 2 sachets of low osmolarity oral rehydration salts and 1 tablet of zinc (10-day regimen) are now available in the PROFAM network. Scaling-up to national level is planned starting October 2009.

The main areas of progress achieved during year 4, as per the M&E plan, are shown in the table below:

OBJECTIVES	%	COMMENTS
MALARIA		
Increase from 11.7% to 60% children age 0-59 months who received a full course of recommended anti-malarial within 24 hours of onset of fever.	2005: 11.7% Target: 60% 2009: 82.8%	Increase in supervision by health promoters and EIP staff, IMCI training, and regular supply of anti-malarials have contributed to the increase. Community relays have increased access to and affordability of early treatment.
NUTRITION		
Increase from 50.8% to 75.8% children age 0-5 months who were exclusively breast-feeding during the last 24 hours.	2005: 50.8% Target: 75.8% 2009: 72.3%	Improvement realized. This behavior is mainly promoted by trained CBOs and health providers. ENA training in 7 health districts reinforced this behavior.
Increase to 90% children age 6-59 months who received vitamin A supplementation in the prior 6 mo.	2005: 80.9% Target: 90% 2009: 90.1%	Considerable progress due to distribution of vaccination cards by EIP, which enhanced data tracking. Also reinforced by MCHNAW.
DIARRHEA		
Increase from 7.7% to 30% mothers of children age 0-23 mo. who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.	2005: 7.7% Target: 30% 2009: 25.7%	Appreciable progress realized. Close to the target due to the training of more CBOs on C-IMCI, but CBOs need to put more effort on this behavior to achieve the final target.
PNEUMONIA		
Increase from 65.9% to 80% mothers of children age 0-23 months who know at least 2 signs of childhood illness (fast breathing and chest in-drawing) that indicate the need for treatment.	2005: 65.9% Target: 80% 2009: 85.9%	Good progress. Local NGOs (LNGOs) and CBOs need to sustain education of mothers about signs and symptoms of pneumonia. The community case management (CCM) of pneumonia (to begin in first quarter of FY10) will foster the attainment of this objective.

OBJECTIVES	%	COMMENTS
Increase from 37.4% to 67.7% children with signs of severe childhood illness who were seen by a qualified public or private provider in the past 2 weeks.	2005: 37.4% Target: 67.7% 2009: 57.3%	Indicates effectiveness of C-IMCI training. However, CBOs and Health Promoters should reinforce efforts to assist mothers to identify signs of severe illness and to seek care early.

B. ACTIVITY STATUS

The status of key activities as per the year's work plan is illustrated in the table below.

Major Activities	Status	Comments
Malaria		
C-IMCI curriculum development workshop; printing and distribution of materials	Completed	Following MTE recommendations, two workshops were held to develop the C-IMCI curriculum. The final version and the message booklets were released in Jan 2009. The EIP also printed and distributed 15,000 copies of visual aids.
Training of IHC staff and CDFs on C-IMCI and C-HIS	Completed	During the third quarter, the EIP team organized a 7-day training in Bamenda and Bertoua for health staff and Plan staff on C-IMCI and C-HIS.
Refresher IMCI/RBM training for Staff at District Hospitals, IHC and private health providers (PROFAM); training for local NGO staff based on the new C-IMCI curriculum	Completed	In Jan 2009, ACMS supported the Ministry of Public Health to train 24 health care providers of the PROFAM network, one nutritionist from HKI, one medical doctor from MOH and the ACMS IMCI coordinator on IMCI case management. The EIP team organized two nine-day TOT sessions on C-IMCI in Mar/Apr 2009.
Supervision and monitoring of MCHNAW; post-training supervision in the East region	Completed	
▪ Printing educational material on malaria ▪ Develop and produce the "New Mother's guide" and "fighting malaria" flipchart	Not completed	According to MTE recommendations, the budget line for these communication activities was transferred to the IMCI training for PROFAM healthcare providers due to the turnover of trained staff and recruitment of new staff.
Nutrition		
Operation of community health promotion activities (PD/ Hearth, VAS, MCHNAW, etc.)	Ongoing	PD/Hearth training was also conducted in the Bertoua program unit during the second quarter of the year.
Development of nutrition education strategy, materials and messages	Completed	A 22-sheet flannel graph has been developed with key messages on early initiation of breastfeeding, exclusive breastfeeding, proper positioning and attachment to breast, complementary feeding, feeding of sick children, etc.

Major Activities	Status	Comments
Organization of VAS campaigns (Health and Nutrition Action Week)	Completed	Took place in December 2008 and June 2009
Training of trainers on BCC related to ENA	Ongoing	Continuing in the East region
Pneumonia		
Operations research on CCM for pneumonia	Ongoing - on target	The Ministry of Public Health organized an operations research startup meeting in Feb 2009. The research protocol has been completed and is pending ethical clearance.
Diarrhea Disease Control		
▪ Printing educative material on Orasel and Sûr'eau/ Waterguard ▪ Produce Orasel posters and "on sale here" stickers	Not completed	According to MTE recommendations, the budget line for these communication activities was transferred to the IMCI training for PROFAM healthcare providers due to the turnover/departure of trained staff and recruitment of new staff.
Immunization		
Organization of Health and Nutrition Action Week	Completed	Took place in December 2008 and June 2009
Capacity building		
Practical training of medical students	Ongoing – on target	Integrating IMCI training has started at the specialization level. Post-graduate residents in pediatrics at the University of Yaounde 1 have a one-week training module on IMCI. Plans are underway to also integrate IMCI into the training program of junior medical students.
Nutrition Working Group	Ongoing – on target	The Nutrition Working Group had its annual meeting in March 2009. Networking is ongoing.
Sustainability		
Training of PROFAM providers	Completed	An 11-day IMCI Case Management training was organized by ACMS and MOH for PROFAM network providers in January 2009. The training was attended by 24 providers of the PROFAM network, the IMCI coordinator of ACMS, the HKI nutritionist and an MOH medical doctor.
Monthly supervision of PROFAM providers	Ongoing – on target	Regular monthly supervision of the trained providers has been done throughout the year in the 24 PROFAM health centers. 4,005 children aged 0 to 5 years were managed using IMCI principles.
Training of local NGOs & CBOs on ACMS product use	Completed	15 CBOs were monitored, 502 sales points were visited and revitalized, and 87 sales points were created

Major Activities	Status	Comments
Dissemination of study results, lessons learned and best practices	Ongoing – on target	Two posters were presented at the Micronutrient Forum in Beijing in May 2009. An oral presentation on using local maps to promote community diagnosis and action will be presented at the Nov 2009 APHA meeting. LQAS methodology was shared with other organizations and has been used for post-immunization external evaluation.
Dissemination of events	Completed	The lessons learned were shared during the Tunis retreat and conveyed in the ISP network via its website.
PSI posts lessons learned on The Wave		
Other		
Production of EIP 2009 calendar	Completed	5,000 copies made available to Plan Cameroon for distribution to NGOs, CBOs and health workers. The rest were distributed to HKI and other partners.
Dissemination of MTE results	Completed	All three PUs held MTE results-sharing workshops with MOH, LNGOs and community representatives.
Revision of monitoring and reporting tools; district monitoring using LQAS and IHFA	Completed	
PROFAM network monitoring using IHFA	Completed	IHFA monitoring was conducted and the results are included in the M&E table (Annex 1)
Quarterly and annual reports to PLAN	Completed	Quarterly and annual reports for EIP/ ACMS activities have been drafted and forwarded to Plan Cameroon.

C. CONTEXTUAL FACTORS THAT HAVE INFLUENCED PROGRESS TO DATE

Key challenges and constraints and how they were overcome: EIP is training CBOs on C-IMCI; they are passing the knowledge and skills acquired to community members at large. A major challenge is ensuring that the CBOs continue implementing C-IMCI training and supervision in their respective communities after EIP support has ended. In order to overcome the challenge, the project not only trained in-house staff and MOH health center personnel who should continue supervision of the CBOs after the project has ended, but also strengthened collaboration between the implementing partners through multiplying their meetings and highlighting the mutual benefits of their actions.

Key enabling factors: Excellent collaboration with the MOH and partners, including local NGOs and community relay structures, has been a major enabling factor. Increased visibility of activities in the community has built trust and confidence.

Factors impeding progress towards achievement of overall goals and objectives: Operational action plan for year 4 according to the DIP was implemented to about 90%. Early in the year, the country was caught up in running battles between citizens and police because of riots instigated by increasing food prices. Bamenda was severely affected and social services and service delivery were hampered for some time in the North West Province. The Plan Office in Bamenda (North West Province) was closed for a

little while during this time. Also, the Ministry of Health suffered ruptured stock for vaccinations and ITNs which severely affected routine immunizations and ITN ownership and use by children and pregnant mothers. Operations Research for Community Management of Pneumonia was delayed due to conflicting schedules and the fact that MOH personnel are involved in multiple activities outside of EIP. The operational research protocol has now been completed and is awaiting ethical clearance from the national ethical committee for its commencement. IMCI case management integration in pre-service courses has also been delayed for student nurses and doctors but a one-week induction has already been commissioned for pediatric residents in the University of Yaoundé.

D. AREAS REQUIRING TECHNICAL ASSISTANCE

As the EIP project is entering its fifth and final year, Technical Assistance will be needed to conduct the final evaluation of the project. Plan and partners will be drawing up the terms of reference of the evaluation and will begin looking for a competent evaluator locally or internationally. The call for recruitment of the evaluator will be launched early next year. Locally, all stakeholders involved in EIP are making sure all reports and other documents related to the project are available and up to date.

E. SUBSTANTIAL CHANGES

There have been no substantial changes requiring modification of the Cooperative Agreement this year. Dr. Shu Atanga Joseph, the Project Coordinator, left the project at the end of September 2009 to take up a new position in the DRC. He has been replaced by Dr. Ephraim Toh.

F. SUSTAINABILITY PLAN

As at baseline, EIP constructed a sustainability dashboard at MTE along the following indicators: health outcomes, health social services, organizational capacity, organizational viability, community competence and environment (political, economic and policy). These indicators were evaluated in the 11 health districts implementing the project. Generally, there has been a significant increase in these indicators from the baseline results, though at different levels, and plans are underway to sustain these improvements (see Annex 6 for complete results).

In addition, the government of Cameroon has recently signed a decree on decentralization which will give local municipalities the power and autonomy to manage, among other things, health issues within their areas of jurisdiction. Given this development, the EIP team is planning to organize a meeting with all District medical officers, mayors and the regional public health delegates of partnering regions to share the results of the KPC surveys; this will help to bring them on board concerning MCH issues. The EIP sees the involvement of non-traditional stakeholders as a key to sustainability and scale-up—bringing them on board will help the project to leverage more resources and greater political support for its activities. Therefore, advocacy is continuing with mayors to convince them to allocate funds to sustain EIP achievements in the communities. Initial reactions from the mayors have been positive.

The EIP has also actively participated in the Global Fund Round 9 process for Cameroon, through the Cameroon Coalition against Malaria—an NGO umbrella organization—to seek to share community experience with malaria and sustain some of the promising practices amongst civil society partners.

As the project approaches phase out, additional steps have been taken to ensure that the project's achievements are sustained, and that appropriate activities are maintained after the project ends. For

example, in Bamenda Program Unit, a C-IMCI focal person (who is Plan staff funded outside of the EIP) has been appointed to assist in the monitoring and supervision of local health promoters and CBOs. This will help to ensure that a support structure remains after the project phases out.

G. ACTIONS TAKEN IN RESPONSE TO MTE RECOMMENDATIONS

After the MTE in August 2008, several activities, as shown in the table below, have been done to address the issues raised. Full recommendations and actions taken are provided in Annex 3.

Recommendations	Activities	Date Completed
1. The behavior change strategy is not as effective at the community level as it could be. - To address this, the EIP needs to review the doer/non-doer surveys, and in consultation with the LNGOs and CBOs, develop community-based activities that will more effectively promote behavior change, especially in the area of nutrition.	• Develop a C-IMCI curriculum and incorporate key activities and messages from the BEHAVE Framework • Develop and conduct a mini training for LNGO promoters on how to effectively conduct a community growth monitoring and promotion program. A refresher will be organized within the context of the new C-IMCI curriculum to be developed • Develop and distribute flip charts to CBOs; develop a training course for CBO members on how to use the two flip charts most effectively during home visits to promote behavior change, especially for nutrition	• Oct 2008 • Nov 2008 • Nov 2008
2. Local partner strengthening efforts are not as strong as they could be. - The Organizational Capacity Assessment needs to be redone using the new tool and an organizational capacity strengthening plan developed for each LNGO partner organization, with great involvement of PU staff. As part of this, a standard reporting format for LNGOs needs to be developed, along with a supervision checklist for use by CBSs.	• Develop quality supervision checklist for LNGOs and CBOs to include minimum performance indicators • Train LNGO promoters on effective use of the tool at community level • Train CBOs on C-IMCI and C-HIS • Supervise CBOs on a monthly basis and monitor implementation of the minimum activities • Review the minimum performance indicators of CBSs	• Oct 2008 • Nov/Dec 2008 • Monthly (ongoing) • Monthly (ongoing) • Oct 2008
3. The training on C-IMCI for CBO members needs to be strengthened. - The current set of C-IMCI technical notes needs to be developed into a modular curriculum that is appropriate for semi-literate populations. This should be used to train the remaining CBOs. For trained CBOs, the focus should be on training them to effectively use the visual aids provided.	• Consider providing a course to LNGO promoters (and perhaps EIP staff) on Learner-centered Adult Education • Develop C-IMCI Curriculum and incorporate a module on the use of IEC materials (including the flip charts) • Train LNGO promoters using the developed C-IMCI curriculum • Train new CBOs/refresh old ones during supervision	• Oct 2008 • Nov/Dec 2008 • Jan 2009 (ongoing)

H. CONTRIBUTING TO SCALE

The project strives to contribute to scale by increasing the number of beneficiaries reached. As the project nears the end of its five-year implementation, it is clear that the successful implementation of the project is having a large impact beyond the project area itself.

The EIP has taken a lead role in forming the National IMCI and the Nutrition Working Groups. As a result of Operational research commissioned by the EIP, Zinc utilization for management of diarrhea is now MOH policy. Operations research for case management of pneumonia is now in the preliminary stages.

A central part of the project is the Maternal and Child Health and Nutrition Action Week, a key biannual activity whereby the EIP is able to collaborate with district and national partners to reach districts beyond the project area. This activity has been very successful in improving the coverage rate of key interventions such as childhood/maternal vaccinations and Vitamin A supplementation.

In addition, the project has been successful in building staff and organizational capacity. At provincial level, IMCI case management training teams now exist and are providing training support to all districts (not just EIP districts).

Following the initiation of the EIP, PSI Cameroon was awarded a grant from the Canadian International Development Agency (CIDA) for a four-country IMCI project. Some staff members involved in the EIP were given the opportunity to participate in the initial planning meetings, enabling them to share key learning from the current project for incorporation into the new project.

In addition, Plan was nominated as the principal recipient for a Global Fund Round 9 malaria project in Cameroon. This is an important recognition of Plan's organizational capacity and technical strength, and will facilitate the continuation and scaling up of key malaria interventions throughout the country.

I. PROJECT MANAGEMENT SYSTEM

The project's three implementing partners each have different project management systems, but all systems are based on accountability and transparency.

1. Financial Management System

The EIP budget, expenditure tracking, procurement of goods and services, and cash management are managed through the financial management systems of Plan and guided by the findings of the first audit done by Price Waterhouse Coopers (PWC).

Budget management and project cost control

Budget operational plans (Project Outlines), developed from the approved Detailed Implementation Plan, are incorporated in the General Ledger (GL) and Program Project Module (PPM) software. Plan administration has put in place bulk purchase to reduce cost and time.

EIP operates a separate bank account for the project. Funds are transferred to this account from Plan headquarters according to the project's cash needs. Monthly and quarterly reimbursements are made

to sub-recipients (PSI/ACMS and HKI) by Plan International Headquarters to their various bank accounts. All Plan EIP in-country payments are made by checks through this bank account. Bank reconciliation is prepared at the end of the month to monitor and manage cash flow in and out of the bank.

The accrual accounting system is used as the financial management procedure.

While HKI sends financial reports of the activities undertaken on a monthly basis, PSI/ACMS sends its reports quarterly to Plan Cameroon for verification and consolidation. These reports are sent together with their requests of reimbursement to Plan Cameroon for payment from Plan Headquarters.

2. Communication System and Team Development

In the EIP, every project activity is used as an opportunity to plan, consult and re-evaluate together. Thus, a team spirit is maintained despite the staff's dispersion across the project area. The child survival activity cycle has also helped solidify the team. At field level, the coordinator and the EPC have been responsible for maintaining communication systems between different parts of the EIP partnership.

3. Local Partner Relationships

The health district and the communities are the local partners of the EIP. At this level, dialogue structures exist, with membership from the local government services and the community. All local partners have been regularly involved in project activities since its inception. These activities have included baseline surveys, the startup workshop, CSSA training, Dialogue Structures training, BEHAVE framework training, C-IMCI trainings, the setting up of the community health information system, training on the development of IEC materials and PD/Hearth training.

At the district level, monthly coordination meetings continue to be the occasion that brings local partners together. During these meetings, EIP activities are discussed and solutions are found locally o to improve project performance.

4. PVO Coordination/Collaboration in Country

The three field implementing partners (Plan, ACMS and HKI) generally come together to draw up integrated quarterly action plans and write quarterly and annual reports. Though EPC meetings were planned for every six months in the DIP, it was agreed by the partners that quarterly meetings would be more appropriate for better follow up. These quarterly meetings have been regular.

J. LOCAL PARTNER COLLABORATION AND CAPACITY BUILDING

The EIP partnered with 10 local NGOs (LNGOs) during the first half of the project and seeks to improve both their organizational capacity as well as their MCH programming abilities. To this end, the project conducted an Organizational Capacity Assessment (OCA) in order to assess each organization's strengths and weaknesses and classify them into three categories: beginner, intermediate and advanced. What specific strengths and weaknesses they had to merit this placement was not clear, nor was a specific plan developed to help guide the efforts of the Capacity Building Supervisors (CBS) to improve the LNGOs organizationally. PLAN now has a more simplified OCA tool which it can reapply to the NGOs.

After an audit, mismanagement of project funds led to the definitive non-renewal of the contracts of 3 partner LNGOs. PLAN is now directly contracting the promoters who worked for these 3 LNGOs to continue working on the project. These promoters work out of Plan's Provincial Unit offices which are shared with the MOH.

The financial mismanagement revelation, as well as dissatisfaction with the quality of work of some LNGOs, also caused PLAN to reconsider the type of contracts maintained with the remaining 7 local partners. As a result, in March 2008 when all of the LNGO contracts expired, they were not immediately renewed. Rather, the renewal of their contracts was linked to performance indicators. Very clear and specific performance indicators have been developed to contain some measures of quality. Since the CBSs are instrumental in strengthening the LNGOs, tools to help CBSs monitor their efforts have also been developed, and the CBS performance indicators modified.

Private Sector Strengthening

ACMS runs 24 private health centers (PROFAM) in Yaoundé; the staff have been trained in IMCI by the EIP. This not only improves the quality of care being provided, but it is planned that when IMCI is incorporated into the pre-service training of medical students and nurses, these clinics will provide opportunities for students to do their IMCI practicum. This plan will help sustain IMCI long beyond the life of the project.

Training

One of the most important achievements of the EIP is the number of people trained. At the community level, the EIP has trained approximately 30 people in each of 862 villages, for a total of nearly 25,860 community members (mostly women) who have been trained in C-IMCI. This 4-day training was conducted by LNGO promoters who were previously trained by EIP staff. Forty-seven promoters from 10 LNGOs have been trained in both C-IMCI and the community health information system.

K. MISSION COLLABORATION

There is no USAID Mission in Cameroon. USAID-funded activities for the region, including Cameroon, are managed out of the West Africa Regional Office (WARO) based in Accra, Ghana. Direct collaboration between the USAID mission and in-country EIP staff is not easy. However, PLAN and EIP staff maintain contact with the Program Officer, Daniel Agoonz, at the US Embassy in Yaoundé who attends Yaoundé-based project meetings when possible. Furthermore, all key project documents, such as the proposal, DIP and annual reports, have been shared with the Regional USAID office and Mr. Agoonz.

USAID/WARO has only one project in Cameroon: the AWARE Project which focuses on reproductive health. In Bamenda region, the EIP supported the efforts of the AWARE project to increase access to PMTCT services by increasing women's attendance at health clinics for prenatal consultations. In this way, the EIP helped AWARE achieve its objectives.

ANNEX 1. M&E TABLE

	OBJECTIVES	INDICATORS	BSL %	TARGETS%	MT %	2009 %	COMMENTS
	MALARIA						
1	Increase from 11.8% to 60% children age 0-23 months who slept under an ITN the previous night	% of children age 0-23 months who slept under an insecticide-treated net the previous night.	11.8	60	60.7	48.0	LLITNs are distributed free of charge by the MOH to pregnant women and under 5 children in all public health facilities. Purchase of the nets was supported by funds from the Global Fund. The drop in Y4 compared to MT may be explained by the fact that there have been several LLITN stock outs and the existing ITNs in people's homes have "expired." Also, the voucher system employed by MOH to provide ITNs to pregnant women and newborns has not worked well because of this rupture of stock.
2	Increase from 11.7% 60% children age 0-59 months who received a full course of recommended anti-malarial within the 24 hours of onset of fever	% of children age 0-59 months who received a full-course of recommended anti-malarial (according to the MOH's home-management protocols) within 24 hours of the onset of fever	11.7	60	36.6	82.8	Significant increase. Increase in the number of supervisions by health promoters and EIP staff this year supported the implementation of IMCI in communities leading to increased care and better recognition of signs of malaria. IMCI training and regular supply of anti-malarials were also key aiding factors. Establishing community relays for home management of malaria and cheap ACTs have increased access to and affordability of early malaria treatment.
	NUTRITION						
7	Increase from 50.8% to 75.8% children age 0-5 months who were exclusively breast-feeding during the last 24 hours.	% of children age 0-5 months who were exclusively breast-feeding during the last 24 hours	50.8	75.8	63.1	72.3	Improvement. This behavior is promoted primarily by the trained CBOs and health providers trained in IMCI. ENA training that took place in the 7 health districts reinforced this behavior.

	OBJECTIVES	INDICATORS	BSL %	TARGETS%	MT %	2009 %	COMMENTS
10	Increase to 90% children age 6-59 mo who received vit A supplementation in the prior 6 months.	% of children age 6-59 month who received a Vitamin A supplement in the prior 6 months	80.9	90	76.6	90.1	Considerable progress due to distribution of vaccination cards by EIP. This enhanced data tracking and eliminated reliance on mothers' memory. VAS was also reinforced by MCHNAW.
11	Increase to 80% mothers giving birth in the last 12 months who received two vitamin A supplements within 8 weeks post partum.	% of mothers of children age 0-23 months who received two Vitamin A supplements within 8 weeks post partum	21.6	80	30	28.9	Slight drop from MT may be mothers' recall issue. However, the drop is not significantly different from MT (P=0.238). Most mothers give birth at home and do not frequent the health center soon after delivery. Recommendation: CBOs should be given a supply of Vit. A. Health workers do not go for outreach activities with vitamin A capsules.
12	Increase from 9.2% to 40% sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	% of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks.	9.2	40	14.6	11.1	Health promoters and CBOs will reinforce this message at community level and during points of contact with health care providers. Home visits to sick children by CBOs should also focus on this.
	DIARRHEA						
15	Increase from 7.7% to 30% mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending a child who has defecated.	% of mothers of children age 0-23 months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after a attending a child who has defecated.	7.7	30	15.5	25.7	Appreciable progress, close to the target with the training of more CBOs on C-IMCI, but CBOs need to put more effort on this behavior to achieve the final target.

	PNEUMONIA						
16	Increase from 65.9% to 80% mothers of children age 0-23 months who know at least 2 signs of childhood illness (fast breathing and chest in-drawing) that indicate need for treatment.	% of mothers of children age 0-23 months who know at least two signs of childhood illness (fast breathing and chest in-drawing) that indicate need for treatment.	65.9	80	70.4	85.9	Good progress. LNGOs and CBOs need to sustain education of mothers about the signs and symptoms of pneumonia. The operations research for CCM of pneumonia (to begin in the first quarter of Year 5) will foster this objective.
17	Increase from 37.4% to 67.7% children with signs of severe childhood illness who were seen by a qualified public or private provider in the past 2 weeks.	% of children with signs of severe childhood illness who were seen by a qualified public or private provider in the past two weeks.	37.4	67.7	51	57.3	This is an indication that C-IMCI training is yielding good fruits in the communities, and few severe cases of childhood illness occur. However, CBOs and Health Promoters should reinforce sensitization efforts during trainings to assist mothers in identifying signs of severe childhood illness and to seek health care early.
	IMMUNIZATION						
18	Increase from 70.5% to 80% children age 0-23 months who received vaccination coverage for all the antigens	% of children age 12–23 mo. fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	70.5	80	73	41.1	Poor progress due to rupture. Mothers of many children declared to have vaccinated their children, but due to the fact that vaccination cards were not seen, they were considered not completely vaccinated.
19	Increase from 58.9% to 80% mothers of children age 0-23 months who received 2TT during their last pregnancy	% of mothers of children age 0-23 months who received 2TT during their last pregnancy	58.9	80	56.8	47.0	Poor progress due to rupture. The MOH has a 5 TT policy during the reproductive life of a woman. Many women could not recall having received a second dose of TT during the last pregnancy.

ANNEX 2: WORKPLAN

EXPANDED IMPACT CHILD SURVIVAL PROJECT (EIP)
POST-MTE TRAINING TABLE AND ACTION PLAN TABLE FOR YEAR 5

Training Plan

Training activities address both staff knowledge and motivation, as trained staff are more likely to find satisfaction in their work. Training also improves the client-provider relationship, as clients feel more secure in seeking care from a highly-skilled professional.

Type of training	Trainee	Trainer	Place of training	Frequency	Y5
Refresher IMCI/RBM training through annual district workshops, annual provincial workshops and MOST	Staff at District Hospitals, IHC and private health providers	Provincial IMCI trainers	Duty Station, Itinerant, annual workshops at districts and province	Continuing MOST. Annual workshops at districts and provinces in years 2, 3, 4 and 5	X
Training on the organization of community-based health activities	Women-based CBOs	Staff from local NGOs hired by the EIP	Communities	Continuing	X
Training on the organization and management of community health activities and facilities (HIS/Financial Management)	CBOs COSA/COGE	EIP staff and staff from local NGOs hired by EIP	Communities	Continuing	X
Practical internships on the field implementation of IMCI/RBM	Senior medical and nursing students	PROFAM and University staff	PROFAM clinics, Yaoundé	Continuing	X
Training on the community-based health information system	CHRP, CBO and COGE/COSA	Staff from local NGOs hired by the EIP	Communities	Continuing	X
Growth monitoring/ Counseling/ ITN Retreatment	CBO Members	EIP staff, District Health team, Local NGOs	Communities	Continuing	X

Work Plan:

WORKPLAN Plan/EIP

Major Activities	Year 5				Personnel
	Q1	Q2	Q3	Q4	
Management and coordination					
Meetings of the National Planning Committee	X		X		EIP coordinator
Meetings of the Provincial Implementation Committees	X		X		Provincial EIP staff
Meetings of District Coordination Committees	X	X	X	X	Provincial EIP staff
Training and community health activities					
Refresher IMCI/RBM training using quarterly district coordination and semi annual provincial planning meetings plus MOST continuous training sessions for staff at District Hospitals, IHC and private health providers (PROFAM)	X	X	X	X	MOST
Training of CBO, CHRP and COGE/COSA	X				Local NGO
Operations research on CCM of pneumonia	X	X	X		MOH/Plan
Operation of MOH supervision	X	X	X	X	MOH
Operation of community health promotion activities (PD/Hearth, VAS, IFA, Health and Nutrition Action Week, etc.)	X		X		CHRP, CBO, COSA/COGE
Dissemination events and visits					
Annual IMCI/RBM Technical Update Workshop				X	National IMCI Working Group with Plan
Global Health Conference			X		Plan
Monitoring and evaluation					
Final evaluation			X		3 PVO/MOH
District monitoring using LQAS and HFA			X		MOH/Plan
Operation of the Community HIS	X	X	X	X	Local NGOs
Annual reports to USAID	X				3 PVOs
Support to policy making and fundraising					
TA to MOH for policy making and fundraising	X	X	X	X	Plan, PSI/ACMS, HKI
PVO headquarters backstop					
Visit of PVO HQ staff to EIP	X		X		3 PVOs
Meeting of HQ backstops	X		X		3 PVOs

Major Activities	Year 5				Personnel
	Q1	Q2	Q3	Q4	
Coordination with USAID WARP					
Report sharing with USAID WARP	X		X		Plan

WORKPLAN ACMS/EIP

Major Activities	Year 5				Personnel
	Q1	Q2	Q3	Q4	
Production of calendars	X				Com. Coordinator
Continuous PROFAM supervision	X	X	X	X	PROFAM supervisor
Practical internships of medical students	X	X	X	X	PROFAM supervisor
Quarterly report to PLAN	X	X	X	X	PROFAM supervisor
PROFAM network monitoring using RHFA	X				PROFAM supervisor
Annual reports to PLAN	X				PROFAM supervisor
Final evaluation				X	BUNDLE (EIP)

WOKPLAN HKI/EIP

Major Activities	Year 5				Personnel
	Q1	Q2	Q3	Q4	
Training of extension workers		X			NPO
Organization of vitamin A supplementation campaigns (Health and Nutrition Action Week)	X		X		OPO
Advocacy towards the government to purchase zinc					
Nutrition Working Group meetings		X			NPO
Semi-annual partner meeting (HKI/US)		X		X	HKI backstopper
Supervision and monitoring	X	X	X		NPO/OPO
Dissemination of study results, lessons learned and best practices		X	X		NPO
Final evaluation				X	

ANNEX 3: ACTIONS TAKEN IN RESPONSE TO MID-TERM EVALUATION

After the MTE in August 2008, several activities have been done to address issues raised during this evaluation as shown in the table below:

Recommendations	Activities	Responsibilities	Timeframe
Technical Issues			
1. The anticipated level of achievement for the indicator related to ITN use by children should be increased to 70% (MOH national objective has been increased from 60% to 80%).	• Continuous advocacy for MOH to procure more LLITNs • Continuous sensitization of mothers of children under 5 and pregnant mothers to sleep under the nets • Promoting retreatment of ordinary ITNs, transforming them into LLITNs	• EIP staff • LNGO promoters, CBOs, EIP staff • EIP staff (ACMS) , LNGOs, CBOs	Ongoing
2. The project staff should review the results of the doer/non-doer surveys and based on the identified determinants of change, develop specific activities at the community level that CBO members should implement to more effectively promote the desired behaviors.	• Develop a C-IMCI curriculum and incorporate key activities and messages from the BEHAVE Framework	• MOH/EIP staff	October 2008- done
3. The EIP should develop and conduct a mini training for LNGO promoters on how to effectively conduct a community growth monitoring and promotion program. Once LNGO promoters are trained, they should in turn train the active CBO members.	• Training had been done. A refresher will be organized within the context of the new C-IMCI curriculum to be developed	• EIP staff (HKI/Plan)	November 2008- done
4. LNGO promoters need to review with CBO members 'what is a home visit' (to distinguish it from the behavior map data collection visit) and how it should be done. This might require a review with the LNGO promoters by CBSs.	• C-IMCI curriculum has information for CBOs on what is a home visit how and when to conduct it		
5. More specific guidelines for when to do home visits should be developed and discussed with the CBOs. The Community HIS should be modified to track home visits.	• When to conduct a home visit by CBOs is incorporated into C-IMCI curriculum and supervision checklists of LNGOs, Plan frontline staff	• EIP staff	Ongoing

6. The most responsible CBOs or Malaria Relays should be given Vitamin A for distribution post partum.	• Advocate with MOH to include in the National Vit A supplementation strategy the possibility of CBOs keeping and dispensing a stock of Vitamin A	• EIP (HKI)	Ongoing from Oct. MOH did not accept this strategy
7. During Health Week and all other mass outreach activities, health care providers should record the administration of Vit. A on the vaccination card as well as the tally sheet.	• EIP supported the Government with vaccination cards on which Vit A supplementation will be recorded	• EIP staff	July 2009- done
8. CBO members need to emphasize postpartum Vit. A supplementation during home visits to lactating women	• Negotiations are underway with the MOH to give a consignment of Vit A capsules to CBOs for distribution	• EIP staff	Ongoing from Oct. MOH did not accept this strategy
9. CBO members need to focus attention on nutrition of sick children (Vit. A rich foods, and increased liquid and food consumption) during home visits.	• Incorporate messages in the C-IMCI curriculum • Insist on this issue during CBO training and supervision • Continuous education and sensitization of mothers in communities by CBO members	• EIP staff • LNGO promoters EIP staff • CBO members	October 2008 Ongoing Ongoing
10. HKI should develop a flip chart – similar to the one developed by ACMS on malaria, diarrhea, immunization and pneumonia – and provide several copies to each community.	• Development of flipchart • Printing of copies for distribution • Distribution of flipcharts to CBOs (block chiefs); 4-5 per CBO	• EIP (HKI) • EIP (HKI) • CBS/LNGO	Oct 2008 Nov 2008 Nov 2008
11. EIP staff should develop a training course for CBO members on how to use the two flipcharts most effectively during home visits to promote behavior change, especially in the area of nutrition.	• Curriculum development for C-IMCI	• EIP/ MOH	Oct 2008
12. Train LNGO promoters to conduct the CBO training (use of the two flipcharts)	• Organize two workshops for LNGO promoters on C-IMCI based on the	• EIP (HKI, Plan, ACMS)	Nov/Dec 2008

	developed curriculum and flip charts		
13. The project should consider adding an indicator on zinc use	• No action		
14. EIP staff (Health Coordinators and Capacity Building Supervisors) should review with LNGO promoters the decisions that CBOs are expected to make based on the Community Health Information System so that these promoters are better able to reinforce this practice at the community level. (Ex. Promote attendance at outreach strategy or Health Week by children whose vaccinations are not up to date.)	• Development of quality supervision checklist for LNGOs and CBOs to include minimum performance indicators • Train the LNGO promoters on the effective use of the tool at community level	• EIP staff • EIP staff	Oct 2008 Sept 2008
15. The CCM Ops Research protocol should be reviewed before implementation to make sure that it will respond to the concerns of those who had doubts about the approach.	• Development of the OR protocol for CCM of pneumonia • Carry out OR	• MOH • MOH/EIP	Nov/Dec 2008 Jan-Mar 2009
Cross Cutting Issues			
1. The project staff should review the results of the doer/non-doer surveys and based on the identified determinants of change, develop specific activities at the community level that CBO members should implement to more effectively promote the desired behaviors.	• Develop the C-IMCI curriculum • Revise the C-IMCI technical notes • Identify and incorporate activities from the Behave Framework into the curriculum	• MOH/EIP • MOH/EIP • MOH/EIP	Oct 2008 Oct 2008 Oct 2008
2. HKI should review the results of the doer/non-doer survey when developing the flip chart on nutrition to make sure that it reflects the most powerful determinants of behavior change.	• Incorporate major BCC determinants from the Behave framework in the flipchart on nutrition	• EIP(HKI)	Oct 2008
3. Project staff should review the performance indicators for the Community Relays, and through a discussion with each CBO, bring them into conformity with actual expectations (expectations of the CBO of itself).	• Development of quality supervision checklist, including minimum performance indicators, for LNGOs and CBOs. • Train the LNGO promoters on effective use of the tool at community level • Train CBOs on C-IMCI and C-HIS • Supervise CBOs on a monthly basis and	• EIP staff • EIP staff • LNGOs • LNGOs	Oct 2008 Nov/Dec 2008 Ongoing (monthly)

	monitor implementation of minimum activities		
4. During monthly supervisory visits, the LNGO promoters should work with the trained CBO members (block chiefs, President and Secretary) to compile the data from the Behavior Maps, and help the CBO members to better understand what the data means in terms of health status of the community. This information should be included in the monthly reports that the LNGOs send to EIP HQ (total number of children, total number of children weighed, total number of children underweight, total number of children who lost weight, children sleeping under ITNs, children under 6 month exclusively breast fed, etc.). This information should also be used to decide which activities the CBO members need to undertake the following month to help change behaviors or to maintain certain behaviors.	• Development of quality supervision checklist for LNGOs and CBOs to include minimum performance indicators. • Train LNGO promoters on the effective use of the tool at community level • Train CBOs on C-IMCI and C-HIS • Supervise the CBOs on a monthly basis and monitor implementation of the minimum activities • Development of quality supervision checklist for CBSs to include minimum performance indicators for LNGOs • Supervise LNGOs on a monthly basis and monitor the effective implementation of activities based on the performance indicators	• EIP staff • EIP staff • LNGOs • LNGOs • EIP • CBS/ PUHC	Oct 2008 Nov/Dec 2008 Jan 2009 Monthly (ongoing) Oct 2008 Monthly
5. Redesign the Community Health Registers in current villages, and introduce the new format in all future villages. Through monthly supervision, help CBO members understand how to assess the health status of the community by analyzing the register and how to make decisions and plans based on the information.	• Train LNGOs on content of register (simplified format) and how to trace it out • Re-draw community registers (both old and new) with CBOs based on proposed format and oversee its use	• EIP (CBS) • LNGOs/CBS	Nov/Dec 2008 Ongoing, starting Sept 2008
6. PLAN should reassess the organizational capacities of its partner LNGOs using the more sophisticated tool and use these results to design a capacity-building plan to be implemented by the three CBSs.	• Plan is working with LNGOs that had been assessed at project inception. The new tool will be used for new LNGO partners in the future.	• EIP staff	Completed
7. Future contracts with LNGOs should not only be tied to quantitative performance indicators (numbers of training events or supervisory visits), but also quality measures (number of trainees who score 75% or higher on their post test) and timeframes (monthly	• Develop very specific performance-based contracts with LNGOs or health promoters for performance-based financing	• EIP	Dec 2008-completed

one-day supervisory visits to each community).			
8. Tools to help CBSs monitor their OD efforts need to be developed, and the CBS performance indicators will need to be modified accordingly.	• Development of quality supervision checklist for CBS to include minimum performance indicators for LNGOs. • Review the minimum performance indicators of the CBS	• EIP	Oct 2008-done
9. For the remaining communities in need of C-IMCI training: The EIP should consider hiring a consultant familiar with the learner-centered adult education methodology to develop a C-IMCI curriculum. This curriculum would be based on the C-IMCI technical notes and an analysis of the training needs of the CBOs and would be appropriate for marginally literate populations.	• MOH/Partners in-country expertise to be sought and curriculum developed from the existing one and the BEHAVE Framework (Doer/Non-Doer results available)	• MOH/Partners/EIP	Oct 2008-ongoing
10. For the communities already trained: Develop a training course (set of modules) for CBOs/Community Relays that teach them how to effectively use the ACMS and (to be developed) HKI flip charts (boite a image). CBSs should train LNGO promoters in their use and the promoters will train the active CBO members /Community Relays during supervisory visits.	• Develop C-IMCI Curriculum and incorporate a module on the use of IEC material (including the flipcharts) • Train the LNGO promoters using the developed C-IMCI curriculum • Train new CBOs and refresh old ones during supervision	• MOH/EIP • EIP • LNGOs	Oct 2008-done Nov/Dec 2008-done Jan 2009-ongoing
11. The C-IMCI pre and post test should be revised to more accurately reflect the content of the course. It needs to be appropriate for marginally literate people. 70% should be considered reflective of adequate learning on the post test. Results of pre/post tests should always be included in training reports provided by LNGOs to PLAN. The new contracts being drawn up with LNGOs should reflect training results.	• During all C-IMCI trainings, pre and post tests are obligatory. Contracts drawn with health promoters include pre/post tests results of individual CBOs trained.	• EIP	Ongoing
12. Consider providing a course to LNGO promoters (and perhaps EIP staff) on Learner-centered Adult Education.	• Noted		
13. CBS and Health Coordinators should provide formal	• Organize C-IMC/C-HIS trainings for	• EIP	Feb 2009-

orientation to District Medical Teams and Integrated Health Center staff on C-IMCI and EIP community activities with CBOs. This orientation should explain in some detail the work of the CBOs and the C-HIS so that when opportunities arise (and after the project ends), these MOH staff can support the community-based activities.	the DMT and IHC staff		done
14. RHFA results should be shared with respective Provincial Delegates and their teams, and with the PROFAM clinic supervisor. An analysis of the results should produce a plan to address the causes for lower-than-expected performance.	• Organize Provincial and District level MTE results sharing meetings (KPE/RHFA)	• EIP	Jan/ Feb 2009-done
15. If, by March 2009, there has not been a noticeable improvement in the MOH leadership in the East Region, PLAN and its partners should consider whether further investment in this area is the best use of project funds.	• Leadership at the regional delegation of health in the East region has changed and collaboration ties between MOH and Plan very cordial.	• EIP/MOH	Done
16. LNGO promoters, CBSs and Health Coordinators should provide a formal orientation on C-IMCI and the specific activities of the trained Community Relays to the IHC heads.	• See 13 above		
17. The teams who developed the district-level CSSA dashboards should be encouraged to update them and develop concrete sustainability plans with objectives and activities that can be monitored and evaluated at the end of the project.	• Develop District CSSA Dashboards • Develop CS Sustainability Plan	• EIP/DMOs • EIP	Nov 2008-Done Nov 2008-done

ANNEX 4: PAPERS AND PRESENTATIONS

PAPER # 1

Cameroon: Using Local Maps to Promote Community Diagnosis and Action

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ABSTRACT

More than 83,000 children die each year in Cameroon from preventable illness. Lack of child health information and access to quality care hampers efforts to address the prevention and treatment of malaria, malnutrition, diarrheal disease, and pneumonia. Since 2005, Plan Cameroon (an international, humanitarian, private organization) and the MOH are implementing an USAID-funded child survival project in 11 health districts benefiting 211,473 under-five children and 481,441 women of reproductive age.

One of the important project components is to promote community action through a better identification of local problems and solutions. In this regard, the project spearheaded the use of community behavior mapping. In this approach, community members (with the assistance of project staff) drew up poster-size maps of their communities to represent all the households and landmarks. The households in these maps were then split into groups of 10 to 15 households, each group assigned to two to three community members for home visits, direct support and monitoring of healthy behaviors. The household's fulfillment of four to six healthy behaviors (i.e. hand washing with soap) were tracked on the maps by colored thumbtacks placed besides each household to show the compliance (or non-compliance) to the chosen behavior, each color representing a given behavior. For example, the house with all its members sleeping under an insecticide-treated network merited a blue thumbtack in the map. With little support from a project staff, the community volunteers consolidated all the bloc maps during monthly meetings, where data analysis, interpretation and decisions were taken in an action plan for the next month. By the third year of the project (September 2008), behavior mapping was being implemented in 762 communities. Indicators at year 3 had improved over the baseline: ITN use among under-five children was 60.7% up from 11.8%; ITN use among pregnant women was 43.2% up from 15.7%; IPT completion in pregnancy was 51.4% up from 18.5%; exclusive breastfeeding 63.1% up from 50.8% and timely care seeking behavior for suspected malaria to 51% up from 37.4%.

A simple and community-owned visual health information system can go a long way to boost community behavior change interventions in a sustainable manner leading to improved maternal and child health.

PAPER # 2

Key determinants/barriers to observing a 10-day regimen treatment with zinc during diarrhea episode in Cameroon

Xavier Crespin[1],Martin NANKAP[1], Shu Joseph Atanga[2], Adang Florence[3], Tata Japjet Ngoh[3], [1]Helen Keller International. Yaoundé Cameroon, [2] PLAN Cameroon, [3] Ministry of Public Health

ABSTRACT

BACKGROUND: Recent scientific findings showed that zinc supplementation for 10-14 days during an acute diarrhea episode reduces the duration and severity of the episode and reduces the incidence of diarrhea in the following 2-3 months. Based on this, UNICEF/WHO and other partners issued a joint statement in 2004 on the clinical management of acute diarrhea in children under five recommending zinc supplementation for 10-14 days. However, factors affecting compliance to treatment need to be identified and addressed in order to achieve successful scaling-up the use of zinc in the treatment of diarrhea. This is why a study was carried out in 10 health catchment areas of the Bertoua Health District in the East region of Cameroon.

Aim: The aim of the study was to identify key determinants of and barriers to mothers' compliance with administration of a 10-day regimen of zinc treatment to their child during the child's diarrheal episode.

METHOD: A doer / non-doer barrier analysis survey was conducted using individual interviews. Mothers who had accessed zinc either through a health facility or a community-based organization to treat their child's diarrhea episode in the past two weeks were interviewed. The questionnaire consisted of six questions: two questions to explore the perceived positive and negative consequence in completing the treatment; two questions on the perceived self efficacy, two questions on the perceived social acceptability. A total of 60 mothers were involved in the study, 30 of whom had completed the treatment for 10 days (Doers) and 30 who had not (Non-Doers). Statistical analysis where performed to compare Doer and Non-Doer responses.

RESULTS: The major determinants identified are: no negative consequence perceived; no difficulty to administer the treatment and the self motivation whereas the longer duration of treatment and early cessation of diarrhea are mentioned as barriers to completing a 10-day zinc treatment during diarrhea episode

CONCLUSIONS: The identification of key determinants will help in developing BCC activities to address the key factors that affect compliance to treatment, designing messages that are relevant to audience and preparing counseling sessions. Training of frontline health staff and ultimate sensitization of caretakers on these determinants will go a long way to changing key management behaviors and save the lives of many children from diarrheal diseases.

PAPER # 3

Lessons learned in scaling-up Maternal and Child Health and Nutrition Action Week in Cameroon

***Daniel Sibetcheu*[1], Martin NANKAP[2], Xavier Crespin[2], Shu Joseph Atanga[3], Denis Garnier[4]**
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ABSTRACT

Background: In Cameroon, the under-five mortality rate is 142 ‰ while maternal mortality is estimated to, be 670 maternal deaths per 100,000 live births. During the past decades, isolated interventions such immunization, vitamin A supplementation, and measles campaigns were implemented with very little improvements on the overall mortality rates of vulnerable groups.

Within the framework of the Bundled Expanded Impact Child Survival Project funded by USAID, the Government of Cameroon has piloted Maternal and Child Health and Nutrition Action Week in 11 health districts but with technical support of PLAN/HKI/PSI. This approach has brought to mothers and children a package of high impact interventions on their survival. With the support of WHO/UNICEF/HKI/PLAN, this event was scaled-up at national level in July 2008 to enable the country to move progressively towards the achievement of the Millennium Development Goals by offering twice yearly an integrated package to alleviate maternal and child morbidity and mortality.

Aim: Identify lessons learned while scaling up Maternal and Child Health and Nutrition Action Week

Framework: During the month of July 2008, Maternal and Child health and Nutrition Action Week was organized through out the country. The package of interventions included vitamin A supplementation of children (6-59 mo) and post partum women, deworming of children (12-59 mo), polio immunization, tetanus vaccination of women at child bearing age in 50 health districts and for pregnant women, routine immunization, administration of intermittent preventive treatment of malaria to eligible pregnant women and behavior change communication focusing on promotion of exclusive breastfeeding. Data were collected using tally sheet and a survey on sources of information carried out.

Lessons learned:

1. Integration of many interventions at larger scale is feasible and did not compromise the results of traditional interventions like polio immunization and vitamin A supplementation.

2. Scaling-up of MCHNAW has provided the opportunity to bring together more partners and to improve collaboration among participating institutions.

3. MCHNAW is an efficient strategy to promote the concept of high impact interventions for child and maternal survival and therefore the urgent need for integration.

4. MCHNAW can bring additionality to routine EPI coverage, access to IPT for pregnant women and vitamin A for post partum women.

5. More resources need to be allocated to community and proximity mobilization which seem to be highly contribute more than printing materials which absorb a large part of social mobilization/communication resources.

ANNEX 5: RESULTS HIGHLIGHTS

INNOVATIVE IDEA: Behavior mapping to improve community diagnosis and action

BACKGROUND. The health information system in Cameroon is weak and incomplete, lacking community-based information for appropriate decision making. Each year, 83,000 under-five children die from preventable illnesses. Lack of community mother and child health information and poor health-seeking behaviors hamper efforts to prevent and treat malaria, malnutrition, diarrheal disease, and pneumonia.

PROJECT INPUTS. Since 2005, Plan Cameroon, in collaboration with the Ministry of Health, has been implementing a USAID Child Survival Project in 11 health districts. One key component is promoting community action through better identification of local problems and solutions using community registers and behavior mapping. From 2007 to 2009, the project supported communities through:

- Capacity building of community members on behavior mapping, diagnosis and action
- Logistical support to Plan staff and local health promoters for supervision and follow up of trained CBOs
- Printing and distribution of 16,000 C-IMCI message booklets and flannelgraphs to CBOs
- Distribution of didactic materials (registers, markers, conference paper, etc.) to each CBO

With the assistance of project staff and local health promoters, community members drew up community registers and poster-size maps of their communities to represent all key healthy family behaviors, households and landmarks. The households' fulfillment of four to six healthy behaviors (e.g., hand washing with soap) were tracked on the registers and maps using colored thumbtacks to show the compliance (or non-compliance) in each household, with each color representing a given behavior. With minimal support from project staff, the community volunteers were able to consolidate all the bloc maps during monthly meetings, during which data was analyzed and interpreted, and action plans for the next month were created.

MAGNITUDE OF INTERVENTION. By the fourth year of the project (September 2009), behavior mapping was being implemented in more than 762 communities.

RESULTS. Community behavior mapping provided a community-based database for planning and monitoring of health activities, thus complementing the national health information system which lacked a community component. It also helped to increase uptake of maternal and child health services in the community and at facility level.

Indicators at year 4 had improved over the baseline: ITN use by under-2 children increased from 11.8% to 48.0%, exclusive breastfeeding among target children increased from 50.8% to 72.3%, vitamin A supplementation for children 6 to 23 months increased from 80.9% to 90.1%, and appropriate hand washing increased from 7.7% to 25.7%.

In addition, community mapping has a more abstract impact. By providing information pictorially, all community members can easily understand the current status of health behaviors in their community. Such access to information is empowering, as it allows community members to identify inequities in the community, and begin to speak up against them at the local level.

ANNEX 6: CHILD SURVIVAL SUSSTAINABILITY ASSESSMENT

EXPANDED IMPACT CHILD SURVIVAL PROJECT (EIP) CAMEROON

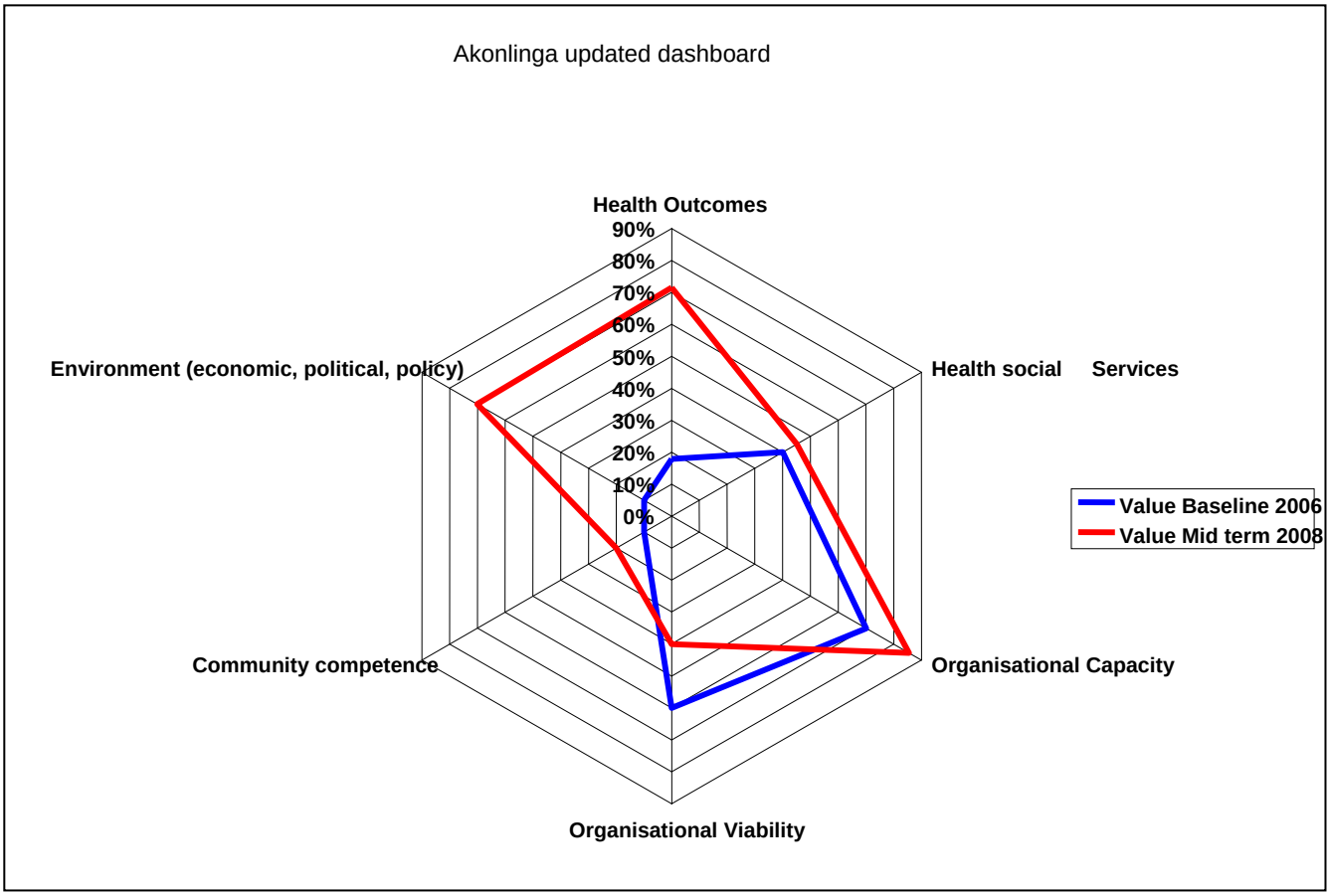
Child Survival

Child Survival Sustainability Assessment
(Mid term)

January 2009

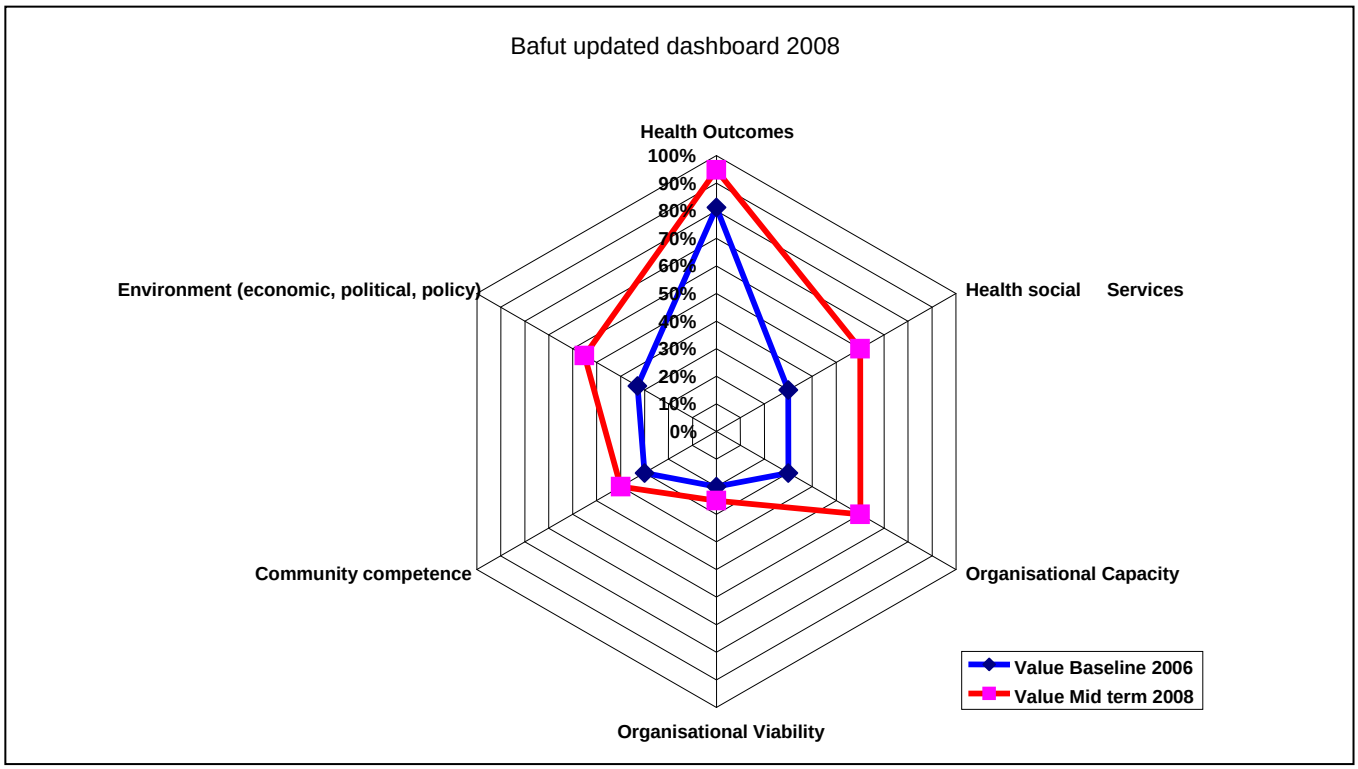
1-AKONOLINGA HEALTH DISTRICT

#	Components	Elements	Indicators (names)	Value Baseline	Value Mid term
1	Health Outcomes	Childhood illness (Malaria)	Sleeping under ITN	17.9%	72%
2	Health social Services	Local access (Physical)	Geographic Access	40%	45%
3	Organizational Capacity	Constituency Empowerment	Empowerment Clients	70%	85%
4	Organizational Viability	Financial Stability	Org. with more than one funding source	60%	40%
5	Community competence	Financial management skills	Ability to manage project finances	10%	20%
6	Environment (economic, political, policy)	MOH efficiency	MOH personnel retention	10%	70%



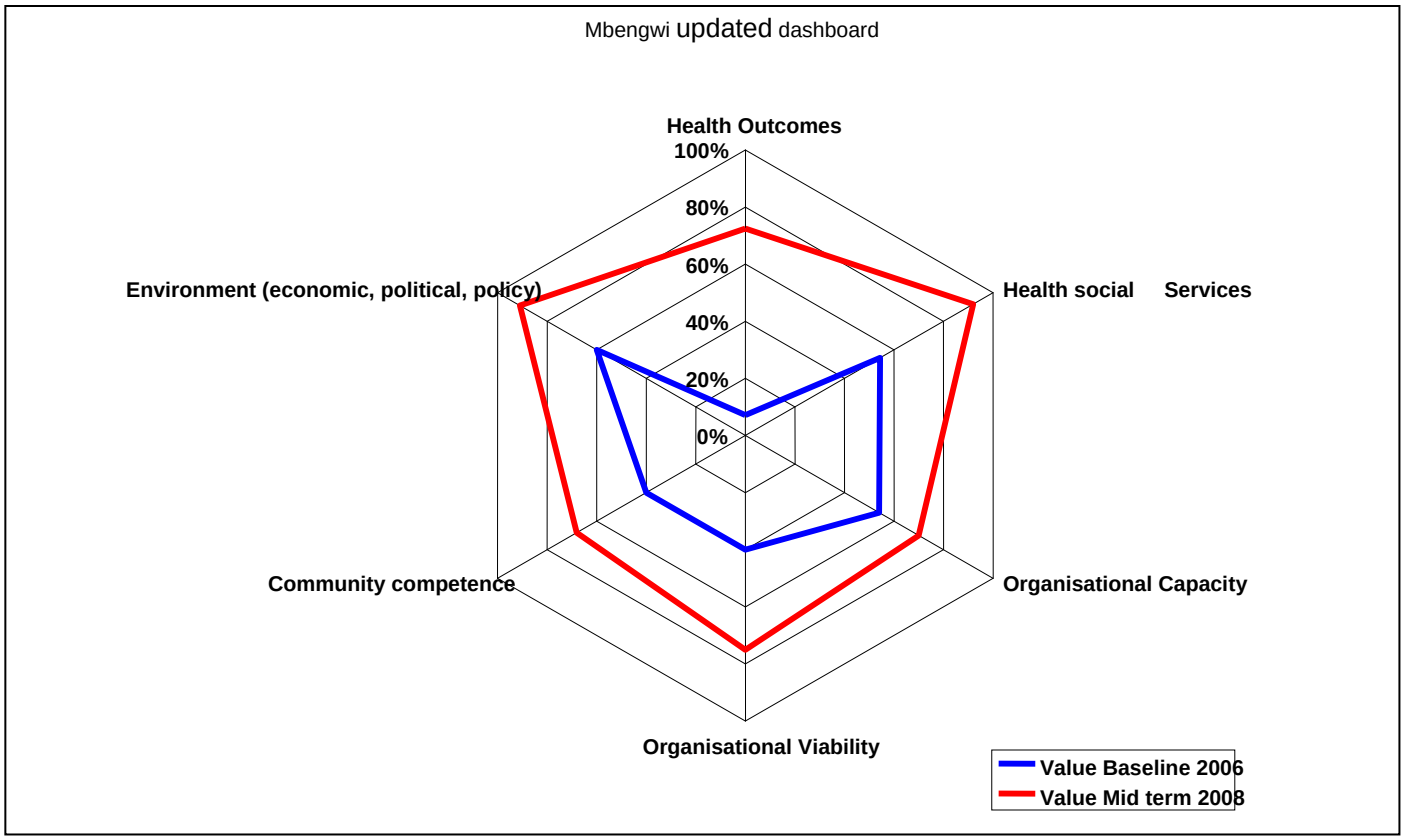
2-BAFUT HEALTH DISTRICT

ELEMENTS	INDICATORS	Baseline value	MTE value
Health out comes I- Improve on vaccination Coverage	% Children between 12-23 months who are adequately vaccinated	81.2 %	94.8
Health and social services II - Correct Diarrhea	Correct diarrhea treatment rate	30 %	60
Organisational capacity III - Planning and execution of health activities	N° of planning meetings held with communities in six months	30 %	60
Organisational viability IV - NGOs Self-Reliance	N° of NGOs with income generating activities	20 %	25
Community competence V - Implementation of the project	Ability to mobilize resources	30 %	40
Ecological, Human, Economic etc VI Female Literacy	% Of literate women ()	33 %	55%



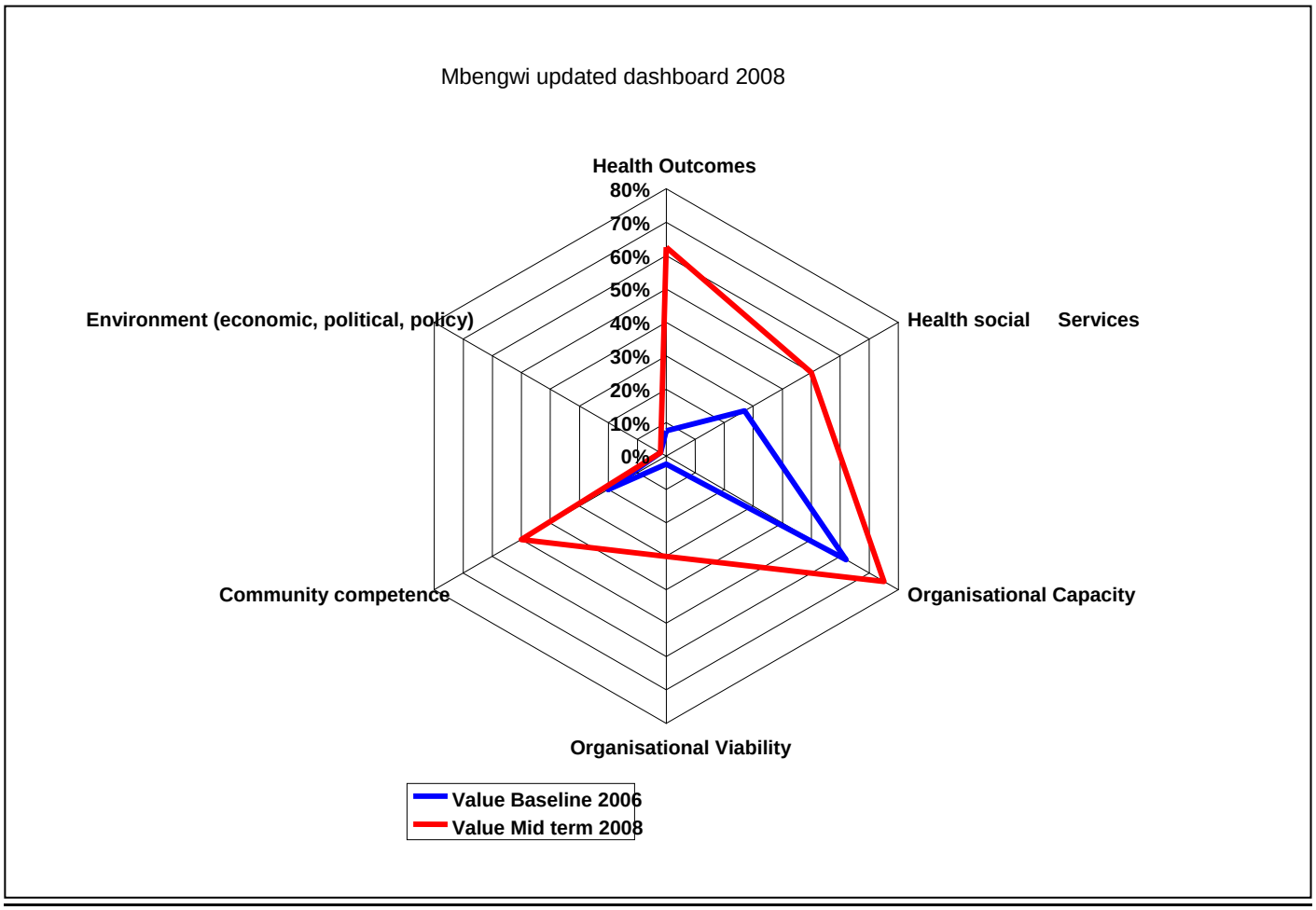
3-MBENGWI HEALTH DISTRICT

DIMENSION	COMPONENT	ELEMENT	INDICATOR	BASELINE VALUE	MTE VALUE
1	Health out come	Malaria ITN	% Of children 0-23 months who use ITN	7.5	72.5
2	Heath and social services	Poor quality provider care	Appropriate child treatment rate	54,4%	92
3	Organisational capacity	Application of technical knowledge	Technical excellence	54%	70
4	Organisational viability	Government collaboration	Extent to which organizations collaborate with gov't	40%	75
5	Community capacity	Leadership	Vision and Innovation	40%	68
6	Environment	Staff retention	Extent to which gov't staff are transferred	60%	91



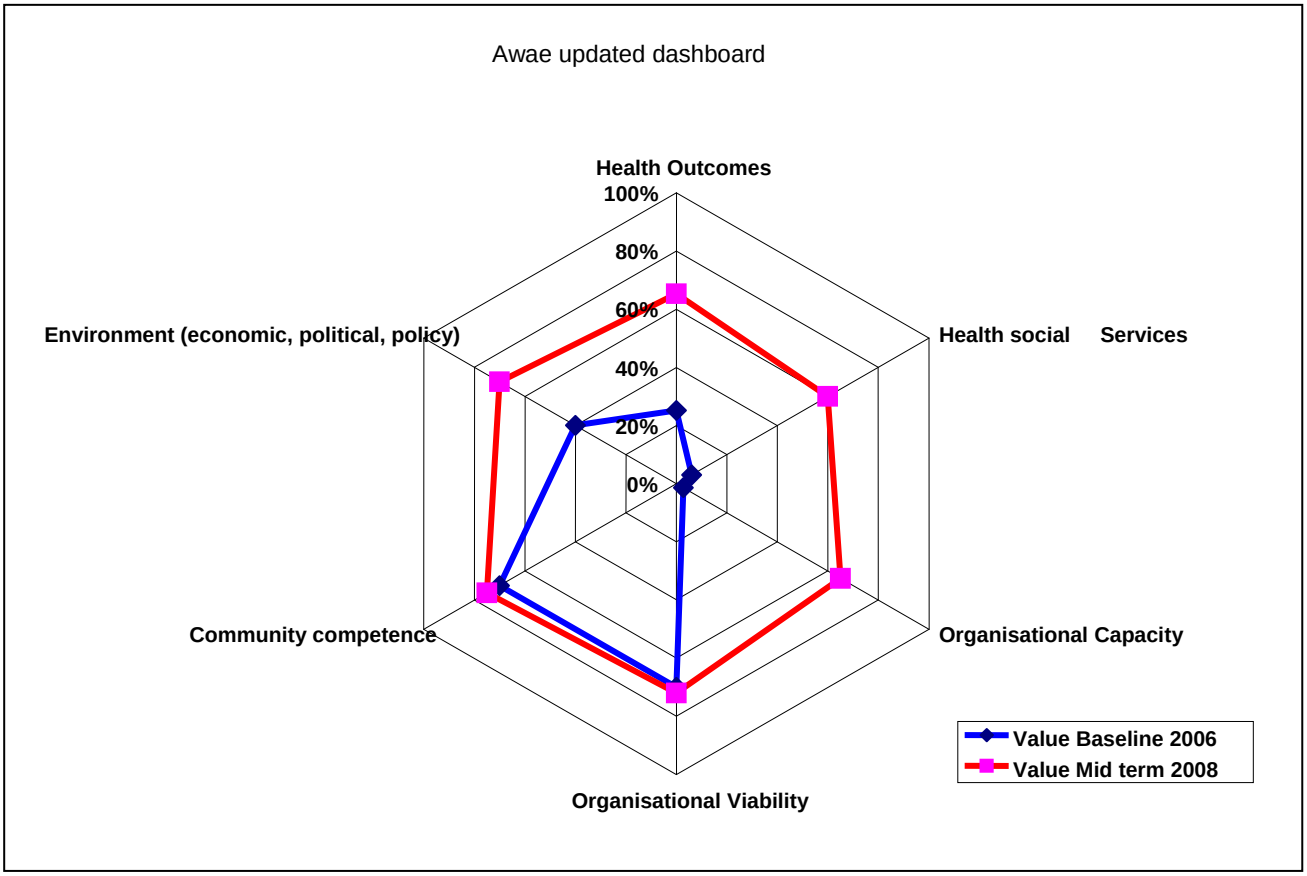
4-FUNDUNG HEALTH DISTRICT

Component	Indicators	Source of information	Baseline value	MTE Value
Health outcomes	% Children under 5 years sleeping under ITN	LQAS	7.5%	65.2%
Health social services	% Health centres WSRN	QHS	27%	50
Org. capacity	% Organizations with technical strength	DHS	62%	75
Organization Viability	% Organization with diversified source of income	DHS	2.4%	30
Community competence	Extent of identification and involvement of stakeholders	DHS	20%	50
Environment	# Of kms of paved secondary roads	DDPW	2%	2



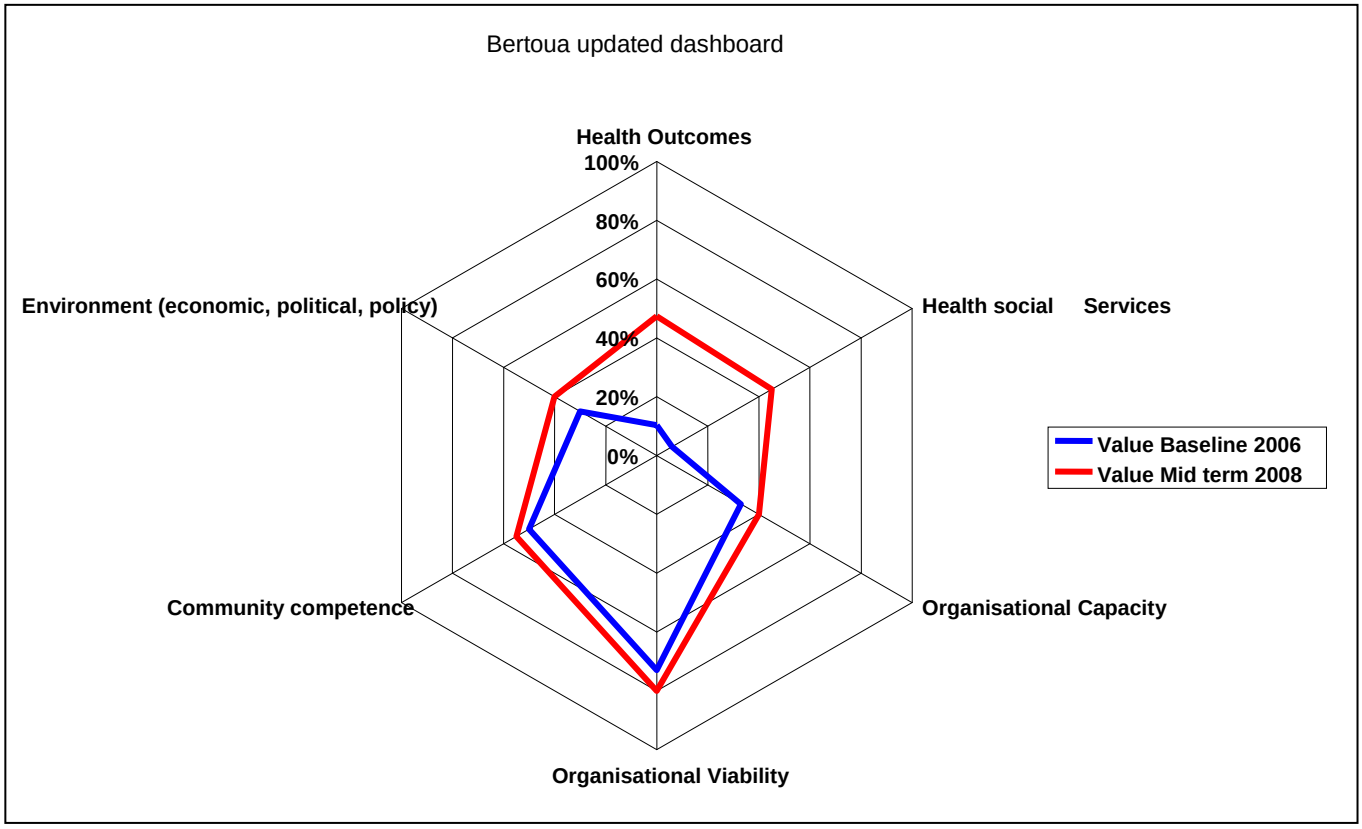
5- AWAE HEALTH DISTRICT

DIMENSION	COMPONENT	ELEMENT	INDICATOR	BASELINE VALUE	MTE VALUE
1	Health out come	Malaria ITN	% Of children 0-23 months who use ITN	25.2%	65%
2	Heath and social services	Poor quality provider care	Appropriate child treatment rate	6%%	60%
3	Organisational capacity	Application of technical knowledge	Technical excellence	2,7%	65%
4	Organisational viability	Government collaboration	Extent to which organizations collaborate with gov't	70%	72%
5	Community capacity	Leadership	Vision and Innovation	70%	75%
6	Environment	Staff retention	Extent to which gov't staff are transferred	40%	70%



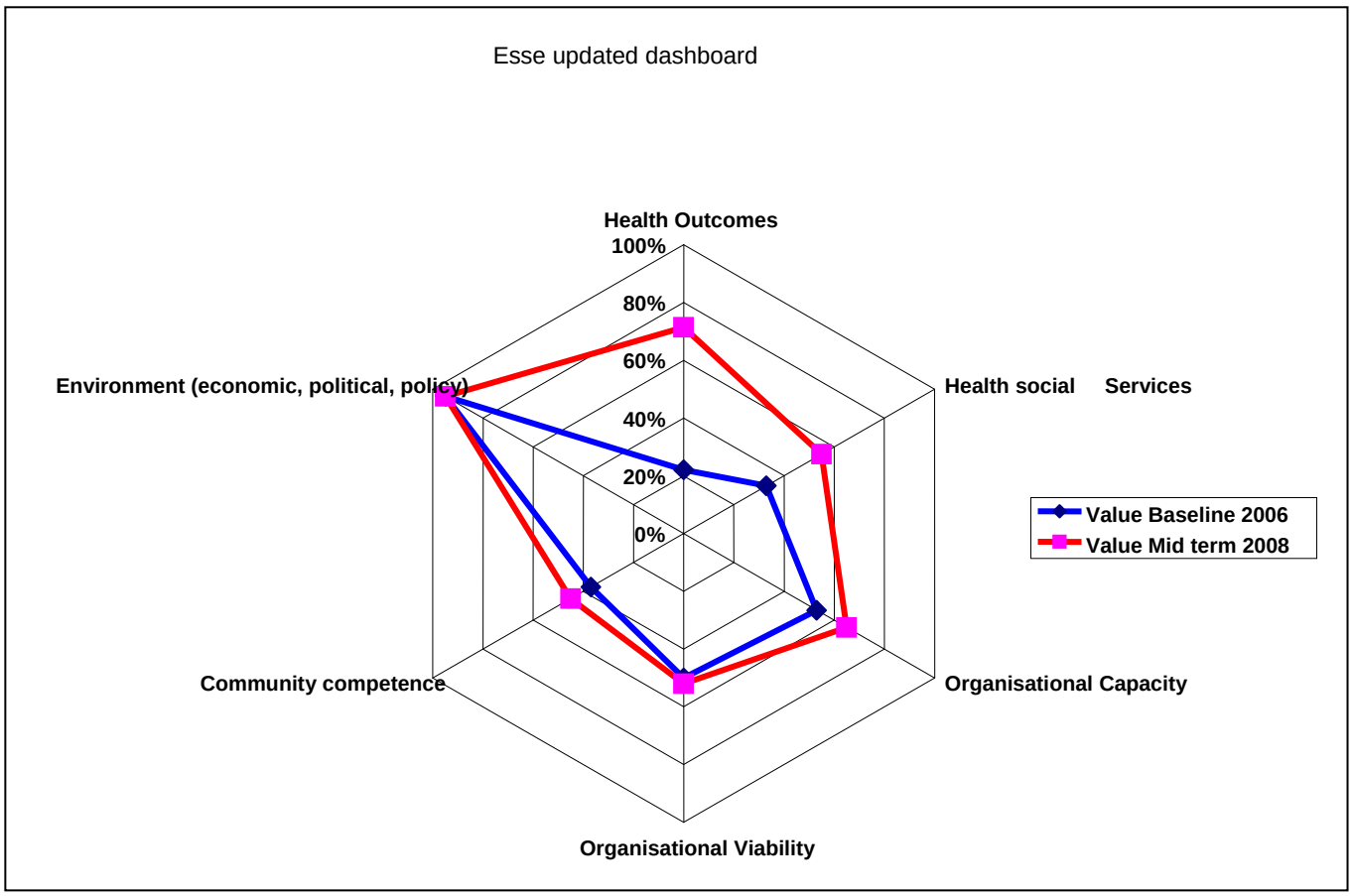
6-BERTOUA HEALTH DISTRICT

DIMENSION	COMPONENT	ELEMENT	INDICATOR	BASELINE VALUE	MTE VALUE
I	Health out come	Child diseases	ITN coverage	10.3%	47%
	Health services	Low quality provider care	For danger sign	6%	45%
II	Local organisation capacity	Management system and practices	Management Information system	33%	40%
	Local organisation viability	Financial problem	Resources development and mobilisation capacity	73%	80%
III	Community competence/capacity	Planning project skills	Ability to reach consensus in action	50%	55%
	Ecological human economic, politic policy environment	Women literacy	Girls primary education	30%	40%



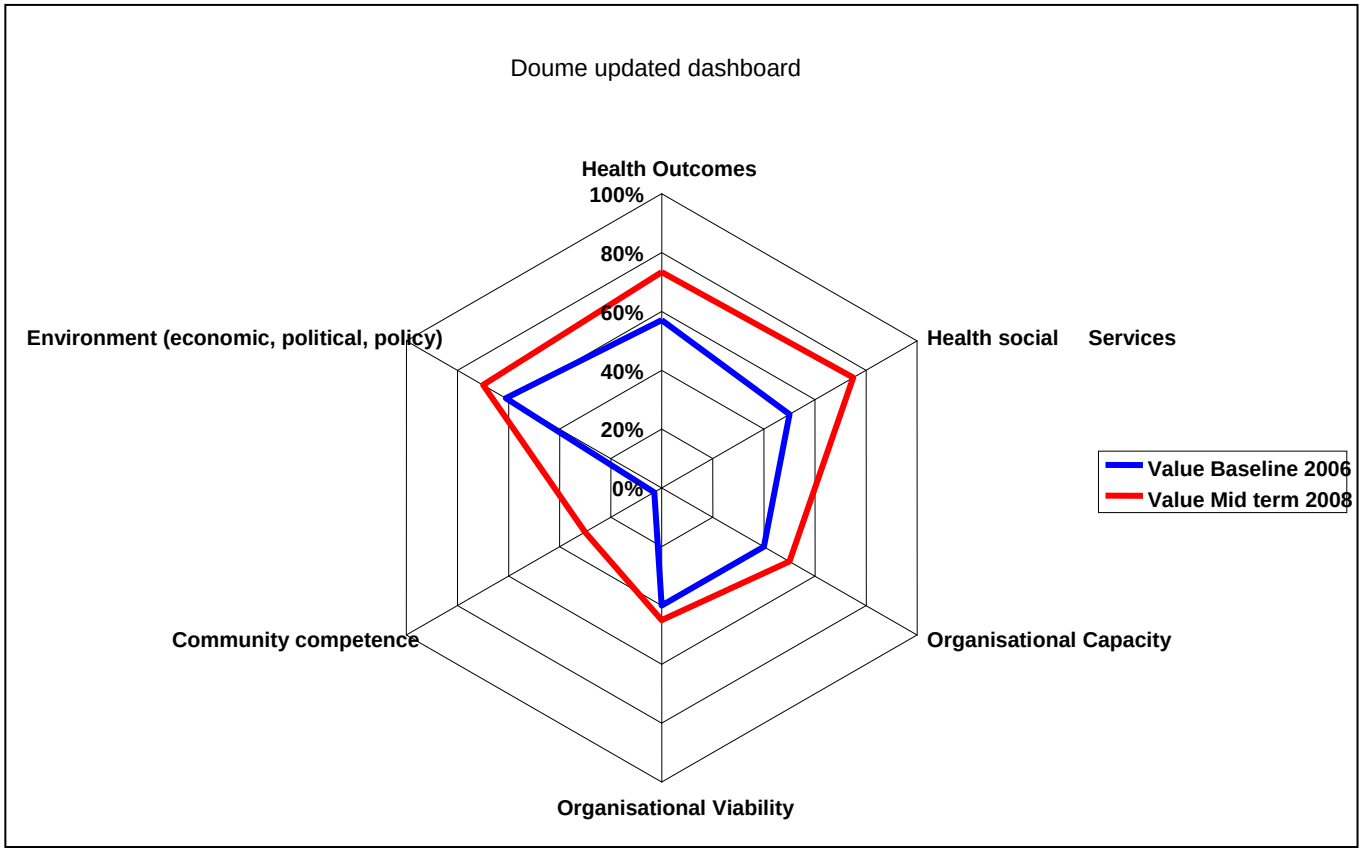
7- ESSE HEALTH DISTRICT

DIMENSION	COMPONENT	ELEMENT	INDICATOR	BASELINE VALUE	MTE VALUE
I	Health outcome	Malaria ITN	% Of children 0-23 months who use ITN	21..1%	71%
2	Heath and social services	Poor quality provider care	Appropriate child treatment rate	33%	55%
3	Organisational capacity	Application of technical knowledge	Technical excellence	53%	65%
4	Organisational viability	Government collaboration	Extent to which organizations collaborate with gov't	50%	52%
5	Community capacity	Leadership	Vision and Innovation	37%	45%
6	Environment	Staff retention	Extent to which gov't staff are transferred	95%	95%



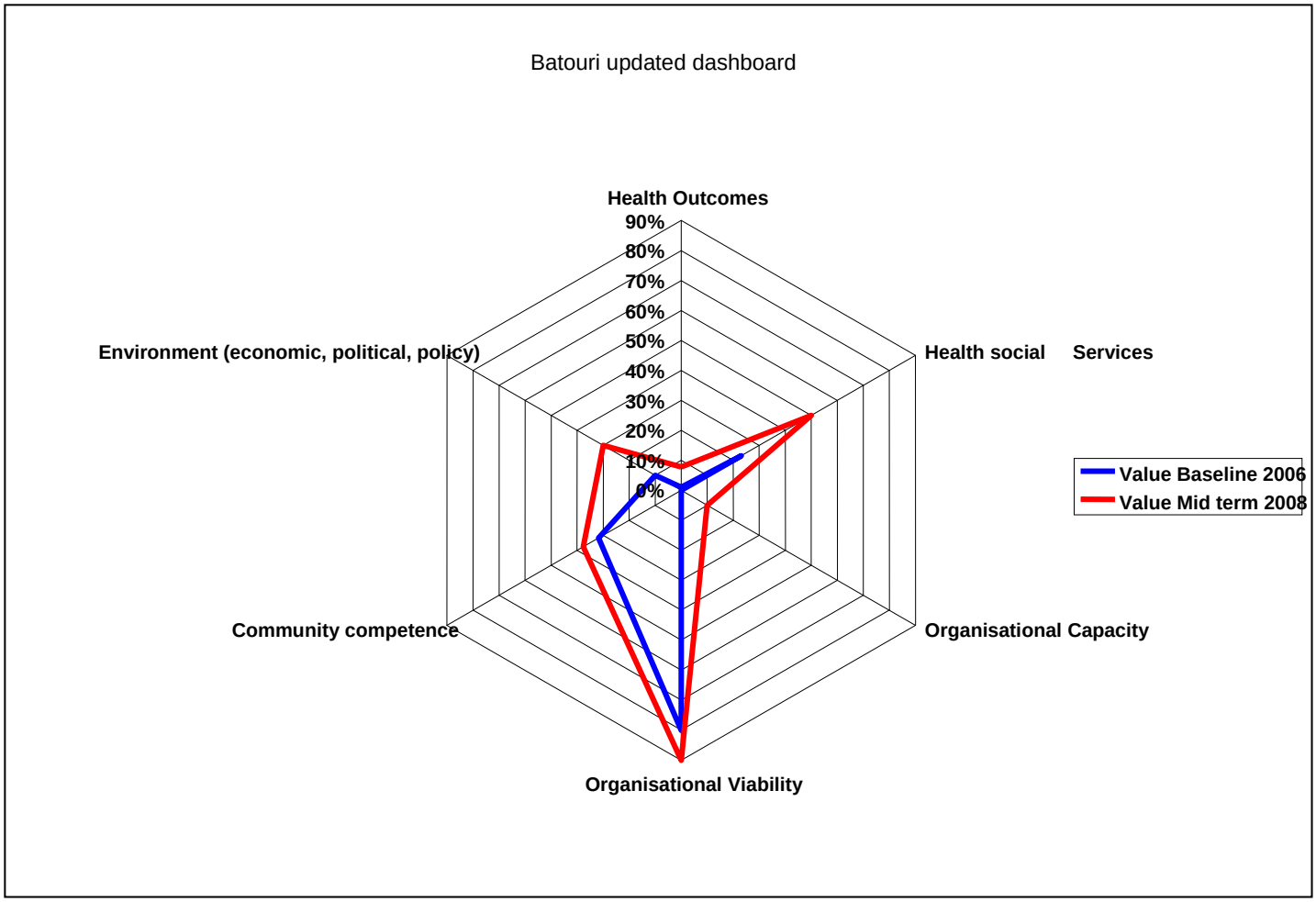
8-DOUME HEALH DISTRICT

COMPONENT	ELEMENTS	INDICATORS	BASELINE VALUE	MTE VALUE
Health outcome	Immunization	Immunization coverage	57%	73%
Heath and social services	Outreach activities	Access to health services	50%	75%
Organisational capacity	Train CBO on management	Management of resources	40 %	50%
Organisational viability	CBO with IGAs	Proportion of CBOs with one source of funding	40 %	45%
Community capacity	Development committee with two activities carry out the last 2 years	Proportion of development committees that carried out at least two development activities in the last 2 years	3%	30%
Environment	Women Knowledge on HIV/AIDS	Proportion of women knowing 2 Prevention methods of VIH/AIDS	61%	70%



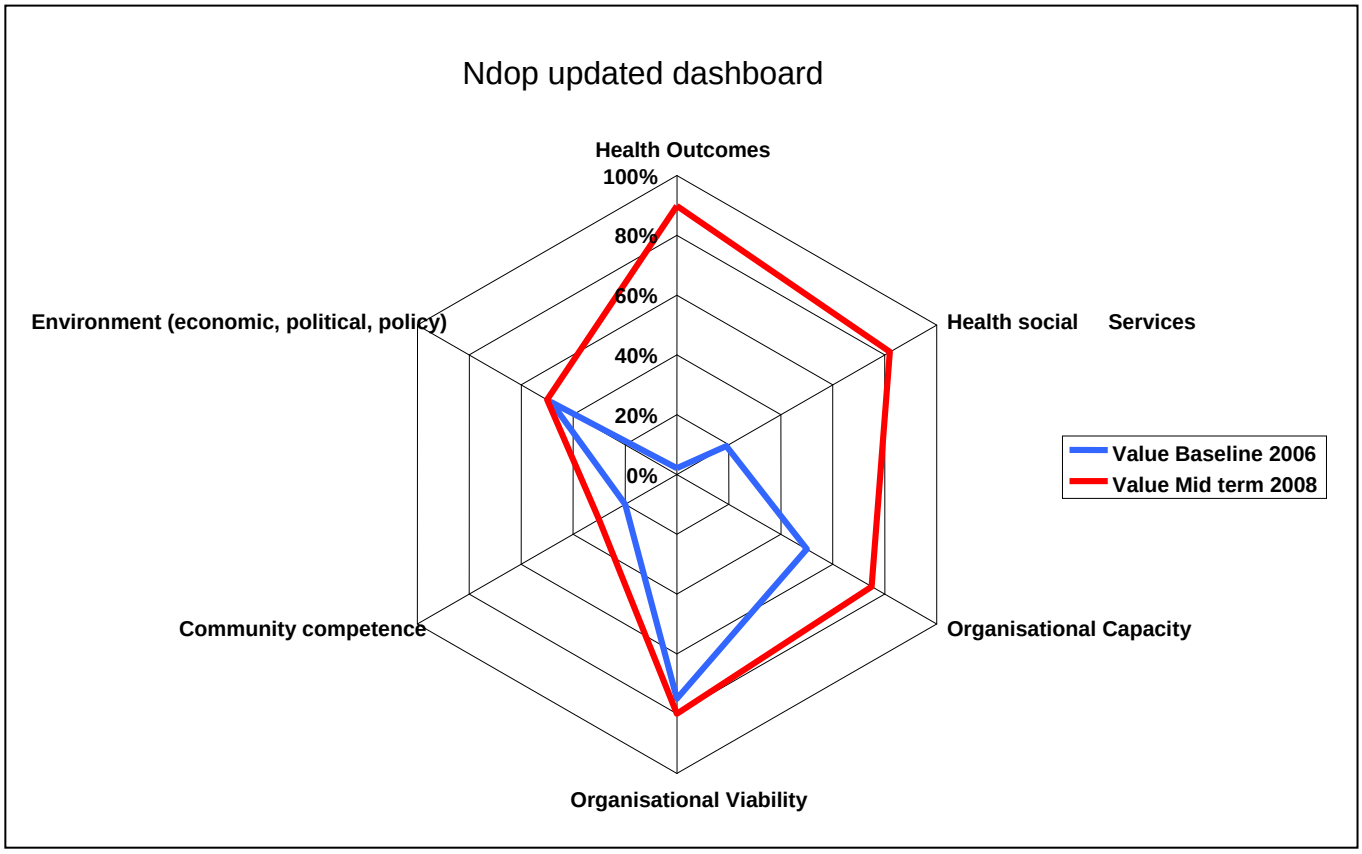
9-BATOURI HEALTH DISTRICT

DIMENSION	COMPONENT	ELEMENT	INDICATORS	BASELINE VALUE	MTE VALUE
I	1-Health outcomes	Diarrhea	% Of mother with children age 0-23 month who reports that they wash hands with soap before feeding children after defecation & after attending to a child who defecated	1.1%	8%
	2-Health and social services	Lack of health information	% Of mothers with children age 0-23 month w report that the birth of their last child was in health facility	23%	45%
II	3- Local organisation capacity	Poor or low community solidarity mechanisms	% of health facilities with a health mutual	0 %	10%
	4- Local organisation viability	Financial mobilisation capacity	Extent to which project finances are being managed well (Financial reports accurate and timely)	80%	90%
III	5-Community competence capacity	Delayed community care seeking	% of children with an episode of ARI in the last 2 weeks whose care taker sought advice from an appropriate health care worker within 48 hours of symptom	31%	38%
	6-Ecological, human economy, political and policy environment	Poverty	% of population living in a house with tin roof	10 %	20%


Batouri updated dashboard
Health Outcomes
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Health social Services
Organisational Capacity
Organisational Viability
Community competence
Environment (economic, political, policy)
Value Baseline 2006
Value Mid term 2008

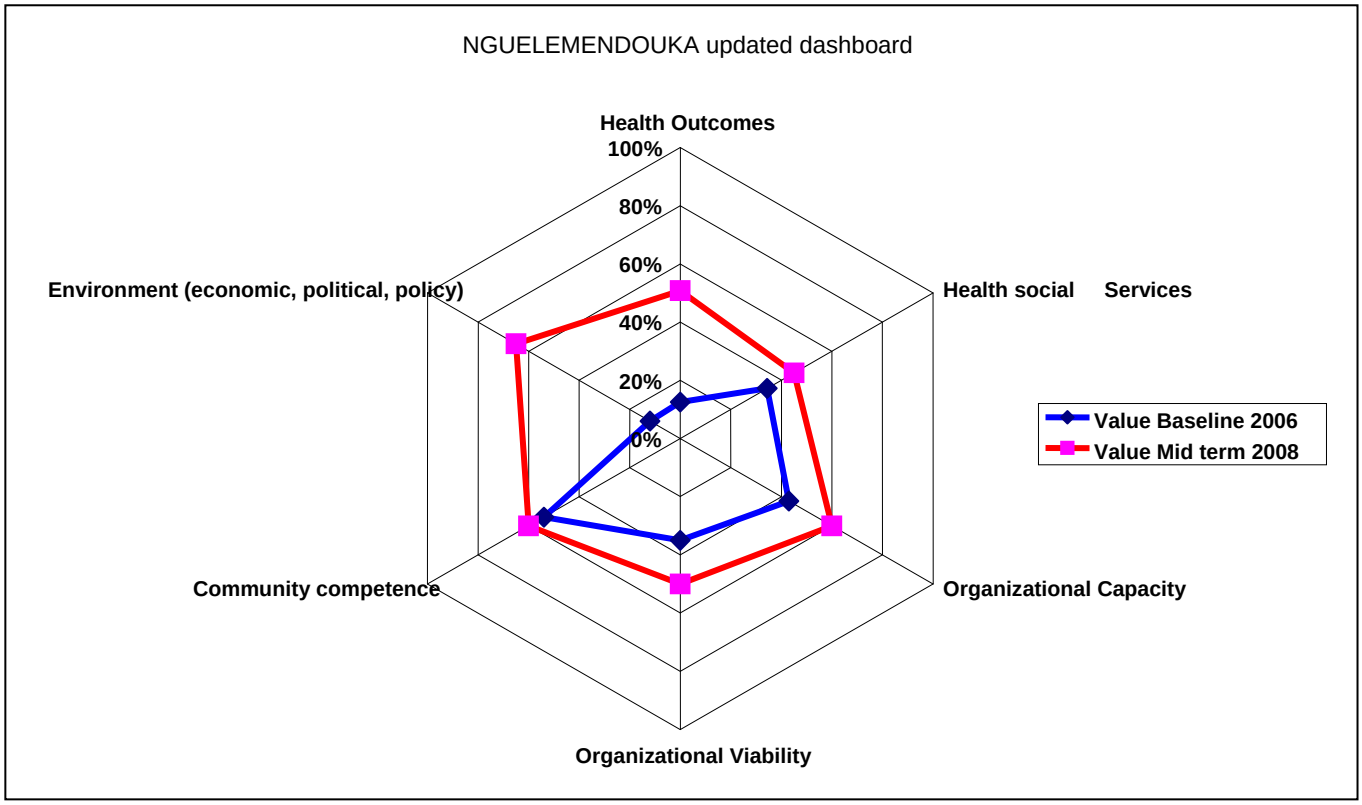
10-NDOP HEALTH DISTRICT

Comp	Element	Indicator	Result (Baseline)	Results (MTE)
1	Malaria control	% Of children 0-23 months who slept under and ITN the previous night	2.1 %	89.8%
2	Health worker performance in screening	% Of children whose weight is checked against growth chart (i.e. children 0-23 months)	19 %	82%
3	Programmatic capacity	Extent to which participatory planning implementation and evaluation is performed	50 %	75%
4	Capacity Building Expertise	Extent to which organisation maintains a leadership role by identifying its own and partners capacity gaps and engaging in capacity building activities to address these needs	75 %	80%
5	Project planning	Extent to which consensus has been searched in an Action plan	20 %	30%
6	Women's status	% Of girls attending secondary school	48.5 %	50%



11-NGUELEMENDOUKA HEALTH DISTRICT

DIMENSION	COMPONENT	ELEMENT	INDICATOR	BASELINE VALUE	MTE VALUE
1	Health out come	Malaria ITN	% Of children 0-23 months who use ITN	12.5	51%
2	Heath and social services	Poor quality provider care	Appropriate child treatment rate	34,4%	45%
3	Organizational capacity	Application of technical knowledge	Technical excellence	43%	60%
4	Organizational viability	Government collaboration	Extent to which organizations collaborate with gov't	35%	50%
5	Community capacity	Leadership	Vision and Innovation	54%	60%
6	Environment	Staff retention	Extent to which gov't staff are transferred	12%	65%



ANNEX 7: THIRD PROJECT MONITORING REPORT

EXPANDED IMPACT CHILD SURVIVAL PROJECT (EIP)

CAMEROON

THIRD PROJECT MONITORING REPORT

Integrated Health Facility Assessment (IHFA) and Knowledge Practice and Coverage (KPC)

August 2009

Prepared by
NGWA AKONWI FUH
(Health Information Assistant)

ACRONYMS

ACMS	Association Camerounaise de Marketing Social, the Cameroon branch of the American NGO Population Services International (PSI)
BASICS	Basic Support of Institutionalizing Child Survival
CBO	Community Based Organization
C-IMCI	Community Integrated Management of Childhood Illnesses
EIP	Expanded Impact (Child Survival) Project
EPI	Expanded Program of Immunization
HD	Health District
IHFA	Integrated Health Facility Assessment
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
LLITN	Long Lasting Insecticide Treated Net
LNGO	Local Non Governmental Organization
LQAS	Lots Quality Assurance Sampling
MOH	Ministry of Public Health
PU	Program Unit
Rapid CATCH	Rapid Core Assessment Tool on Child Health
TT2	Tetanus Toxoid vaccine second dose

INTRODUCTION

In fourth year of implementation, the Bundled Expanded Impact Child Survival Project (EIP) is implemented by Plan Cameroon, HKI and ACMS in collaboration with the MOH with funding from USAID.

The main goal of the project is to support the MOH to scale up IMCI in all its components and Roll back Malaria in Cameroon by actively intervening in 11 health districts in three provinces (East, North West and Center) with spill over to 55 other health districts in these three provinces and nationwide.

The project is implemented within five domains of intervention: Malaria (40% level of effort), malnutrition (30% level of effort), diarrhea (10% level of effort), ARI (10% level of effort), EPI (10% level of effort).

During the Detailed Implementation Planning (DIP) of the project the organization of bi annual monitoring surveys was envisaged to track the progress made in the implementation of the health facility and the community components of IMCI. The results of these surveys are required to influence the planning of activities at the community, district, provincial and central levels, to foster the and maintain the good performances, to carry out corrective activities for those indicators not yet meeting the expectations, and to influence MOH policy to boost the scaling up IMCI implementation within the country. After the baselines had been done in February 2006, the first monitoring session which was expected around July 2006 did not take place because none of the planned activities likely to influence the status of project's baselines indicators had yet been delivered. The program units were still completing the IMCI facilitators training prior to the training of the frontline health cares provider, the ministry of public health was still designing the community relay structures training modules on C-IMCI. After the project's DIP had been approved and some frontlines health care providers trained on IMCI, the EIP agreed to hold the first monitoring surveys in April 2007 despite the fact that the CBO training on C-IMCI effectively begun in March 2007. It was acknowledged that enough activities likely to influence the project's performance were delivered. All the three program units Bamenda, Bertoua and Biteng had trained frontline and intermediary staffs on IMCI and IMCI training and supervision facilitation. The LNGOs who are implementing the C-IMCI were exposed to capacity enhancement sessions including: trainings on the Child Survival Sustainability Assessment framework, the Malaria Competence framework, the BEHAVE framework, the Community Behavior Mapping and a training of trainers on community IMCI. ACMS officially launched the water chlorination kit Sur'Eau/ Waterguard in Douala.

These results show the trends in the global tendency to improvement in both the health staff practice and the community practice and behaviors. How ever three health districts: Bertoua, Doume and Nguelemendouka all from Bertoua PU are not in the general move as community IMCI the indicators there are stagnant or sometimes decreasing. While encouraging the two others PUs to foster their progress as to meet or even go beyond the expectations at the end of the project (September 2010), the beginning of CBO training in Bertoua health district is recommended as well as more supervision of Bertoua, Doume and Nguelemendouka by the EIP team in order to join the evolution trend leading to the EIP objective.

INDICATORS

The monitoring surveys measure the progress made by EIP while striving to meet the project's end term objectives. The six month periodicity of these surveys is not enough to expect change in all the EIP's indicators that is why only a limited number of indicators from those measured during baseline and Mid term at both the community and the health facility levels was selected and discuss among the EIP partners prior to the study.

IMCI Practice by Health Care Providers

Health care providers in the past received training on the practice of IMCI and supervision facilitators were trained in all the three EIP target provinces. The availability of these local facilitators allowed the training of frontline health care provider on child health handling using IMCI technology. The EIP used two components of the Integrated Health Facility Assessment tools developed by BASICS and used during the project's baseline and mid term evaluation in August 2008. Since the aim of the survey was to appreciate the improvement of the health providers after being trained on IMCI, the observation checklist and the caretaker exit interview were the most appropriate with their related indicators. In order to appreciate the trainings received by medical practitioners, an amendment was brought to the exit interview checklist with few questions asked to the health staffs to know if he or she has been trained on IMCI and also if he or has been receiving supervisory visits.
Screening, clinical examination, treatment and interpersonal communication tasks are reported by the observation checklist while the exit interview checklist appreciates how well the messages are received by the caretakers who are advised by the health care provider at sick child visit. The indicators were calculated using the formulas provided by the IHFA facilitation guide developed by BASICS.

The following indicators were retained:

Table 1a: IHFA indicators

Management task	Indicator	Formula	Source
Screening	Proportion of children who were assessed for all danger signs;	Cases with all danger signs assessed	IHFA Observation checklist BASICS
		Total number of cases observed	
	Proportion of children who were assessed for all main symptoms;	Cases assessed for all main symptoms	
		Total number of cases observed	
Clinical examination	Proportion of assessment tasks completed for sick children with a history of diarrhea;	Number of assessment tasks completed for cases with a history of diarrhea	
		Total number of assessment tasks required for sick children with a history of diarrhea	
	Proportion of assessment tasks completed for sick children with a history of ARI;	Number of assessment tasks completed for cases with a history of ARI	
		Total number of assessment tasks required	

Management task	Indicator	Formula	Source
		for sick children with a history of ARI	
	Proportion of assessment tasks completed for sick children with a history of fever;	Number of assessment tasks completed for cases with a history of ARI	
		Total number of assessment tasks required for sick children with a history of ARI	
	Proportion of children who had nutritional status assessed;	Cases assessed correctly for nutrition	
		Total number of cases observed	
	Proportion of children whose weight was plotted on a growth chart;	Cases whose weight was plotted on a chart	
		Total number of cases observed	
	Proportion of children who were weighed the day of the survey;	Cases whose weights were determined	
		Total number of cases observed	
Immunization	Proportion of children who had vaccination card checked at sick child visit;	Cases whose health worker asked for child's vaccination card	IHFA Observation checklist BASICS
		Total number of cases observed	
	Proportion of children who needed an immunization who received it on the day of the visit or were referred for vaccination;	Cases with a vaccination card needing a vaccination who received an immunization the day of the visit or were referred	
		Cases not up to date	
Treatment	Proportion of children who received an appropriate medication for the diagnosis made by the health worker;	Cases with treatment appropriate for diagnosis	
		Total number of cases requiring treatment	
	Proportion of children with simple diarrhea who received ORS/RHF;	Number of cases with simple diarrhea who received ORS/RHF	
		Number of cases with simple diarrhea	
	Proportion of pneumonia cases who received an appropriate antibiotic;	Pneumonia cases who received an appropriate antibiotic	
		Total number of pneumonia cases	
	Proportion of malaria cases who received an appropriate antimalarial;	Malaria cases who received an appropriate antimalarial	
		Total number of malaria cases	
	Proportion of children with simple diarrhea who received an antibiotic or an antidiarrheal	Simple diarrhea cases who received an antibiotic or an antidiarrheal medication	
		Total number of simple diarrhea cases	
	Proportion of children with simple URTI who received an antibiotic;	Cold/allergy/simple cough cases who received an antibiotic	
		Total number of cold/allergy/simple cough cases	

Management task	Indicator	Formula	Source
Interpersonal communication	Proportion of treatment counseling tasks completed for sick children;	Number of treatment counseling tasks completed for sick children	IHFA Observation checklist BASICS
		Total number of treatment counseling tasks required for sick children	
	Proportion of children whose caretakers were counseled on the importance of giving fluids at home;	Cases whose caretakers were told by HW the need to give the same quantity or more liquid at home	
		Total number of cases observed	
	Proportion of children whose caretakers were counseled on the importance of giving food or breastfeeding at home;	Cases whose caretakers were counseled by HW on the need to continue feeding or breastfeeding at home	
		Total number of cases observed	
	Proportion of children whose caretakers were given advice on when to return;	Cases whose caretakers were told at least three messages on when to bring the child back	
		Total number of cases observed	
	Proportion of children whose caretakers were told how to administer oral medications;	Cases whose caretakers were told how to administer all oral medications	
		Total number of cases given or prescribed oral medications	
Training and supervision	Proportion of health workers who saw sick children and who had received training in the management of child illness in the last 12 months;	Number of health workers who had received at least one training in the last 12 months	IHFA Exit interview checklist
		Total number of HWs interviewed	
	Health staffs who consulted the children and received a training on IMCI;	Health staffs who consulted the children and received a training on IMCI	
		Total number of HWs interviewed	
	Proportion of health workers who had received at least one supervisory visit in the last 6 or 12 months	Number of HWs who received at least one supervisory visit in the last 6 or 12 months	
		Total number of HWs interviewed	
	Average number of supervisory visits per year per health facility		
Management of sick child at home	Proportion of children receiving oral medications whose caretakers knew correctly how to administer the treatment at home	Caretakers who knew how to give ALL essential medications correctly	IHFA Exit interview checklist
		Total number of caretakers interviewed whose child was given or prescribed oral medication	
	Proportion of caretakers who knew how to correctly	Number of caretakers who knew at least two aspects of home case management	

Management task	Indicator	Formula	Source
	manage the child at home	Total number of caretakers interviewed	
	Proportion of caretakers who knew at least two signs of when to return if the child became worse at home	Number of caretakers who knew at least two signs of child getting worse at home	
		Total number of caretakers interviewed	

The family practices and behaviors

A list of indicators likely to change within six months was prepared and presented to the EIP partners. The amended list resulting from the stakeholder's reactions was discussed with Dr Metangmo the EIP US-based backstopper during his last stay in Cameroon in March 2007. To the eight indicators retained, five others requested by HKI and ACMS were added to the list.

The list of eight indicators taken from the baseline list and five other indicators serving as proxy to an EIP objective, or simply likely to commend or influence the planning of activities likely to help EIP reach an expected objective. The selected indicators are as follows:
Evidence of growth monitoring: this process indicator replaces the impact indicator weight-for-age, to see how effective growth monitoring is in the communities. EIP set as objective to decrease from 15.9 to 10% the proportion of children having low weight for age. Since this indicator is not expected to change too much within a 6 months period, another indicator was built to follow the effectiveness of the growth monitoring in the communities. Monthly growth monitoring in the communities is alert system that can commend an intervention like PD/Hearth when the necessary conditions are met;
TT2 for pregnant women: progress is appreciated compared to baseline;
Exclusive breastfeeding: the monitoring Rapid CATCH allows the appreciation of the project regarding this indicator.
Measles vaccine coverage: this indicator is used as a proxy to Expanded Program of Immunization calendar completion; the measles vaccine is taken with Yellow fever vaccine at the last contact (ideally nine month of age) marking the completion of the EPI calendar by a child.
Vitamin supplementation A for children: requested by HKI to measure the coverage after the distribution during December 2006 measles campaign;
Vitamin A supplementation to breastfeeding mothers: progress is appreciated compared to baseline;
ITN use by children less than two years: progress is appreciated compared to baseline;
LLITN use by children less than two years: requested by ACMS to measure the outcome of the LLITN distribution in Batouri health district by ACMS and Bertoua health district by the Japanese government.
Knowledge by mothers or caretakers of two illness signs at least indicating the need for a treatment; progress is appreciated compared to baseline;
Increased fluid and continued feeding during an illness episode of the child: progress is appreciated compared to baseline;
Hand washing behavior by the mothers: progress is appreciated compared to baseline;

Use of ORS during a diarrheal episode: requested by ACMS to measure the utilization of ORS during diarrheal episode. The prescription of ORS by health care providers for simple diarrhea is also measured in the health facility assessment.

Table 2b: Rapid CATCH LQAS indicators

Indicator	Description	Source
Evidence of growth monitoring	Proportion of children less than 24 months who were weighted and the weight plotted on the growth monitoring chart at least once in the two months preceding the survey	Module one – general module
	Total number of children in module one	
TT2 for pregnant women:	Number of children 0-23 months whose mothers received at least two tetanus toxoid injections before the delivery of their last surviving babies	Module one – general module
	Total number of children in module one	
Exclusive breastfeeding	Number of children who received only breast milk the day and the night preceding the interview	Module one – children 0-6 months
	Total number of children in module one	
Measles vaccine coverage:	Number of children 12-23 months who received the measles vaccination	MODULE 2 VACCINATION – children 12-23 months
	Total number of children in module two	
vitamin A supplementation to breastfeeding mothers:	Number of mothers of children aged 0-6 months who received two Vitamin A capsules with the eight weeks following their delivery with 24 hours interval	Module one – children 0-6 months
	Total number of children in module one	
ITN use by children less than two years:	Children 0-23 months who slept under an insecticide treated net the night preceding the survey	Module 4 – general module 0-23 months
	Total number of children in module 4	
LLITN use by children less than two years:	Children 0-23 months who slept under a long lasting insecticide treated net the night preceding the survey	Module 4 – general module 0-23 months
	Total number of children in Module 4 in Bertoua and Batouri health districts	
Knowledge by mothers or caretakers of two illness signs at least indicating the need for a treatment;	Numbers of children 0-23 months citing at least two danger signs indicating the need for a treatment	Module 4 – general module 0-23 months
	Total number of children in Module 4	
Increased fluid and continued feeding during	Children who received more fluid and at least the same quantity of food during an illness episode.	Module three – sick children 0-23 months
	Total number of children in Module 3	

an illness episode of the child		
Hand washing behavior by the mothers:	Mothers who report washing their hands before cooking the food, before feeding the child, after being in the toilets and after removing children tools.	Module 4 – general module 0-23 months
	Total number of children in Module 4	
Use of ORS during a diarrheal episode:	Mothers who used the Oral Rehydration Solution during the child's last episode of diarrhea.	Module three – sick children 0-23 months
	Total number of children who had diarrhea	

SURVEY INSTRUMENTS DESIGN

The survey tools were adapted to meet the list of the indicators of the two surveys. The observation checklist and the caretaker exit interview constituted the Health facility assessment tool[1], with few question for the health care provider who observed the child to say if he or she has been trained on IMCI and receiving supervisory visits.

Rapid CATCH questionnaire[2] used during the mid term evaluation was also adapted. That is unnecessary questions were removed, and more questions added to meet the requirements of the new indicators. Four modules addressing each age group were developed to meet the LQAS requirement to have a lots sample size of 19 for each indicator. One indicator might not have met this requirement as a separate module was not developed for children who had diarrhea to measure the use of ORS. Enough answers were collected and will help present district level results.

The survey tools for Bertoua and Biteng PU were translated into French.

CAPACITY BUILDING

Capacity building of stakeholders allows local handling of data with a minimum dependency on EIP at central level. In the Bamenda PU, during the training facilitation was done by the monitoring and evaluation point person for EIP at the regional delegation, the regional chief for onchocerchiasis control and the CBS for Plan Bamenda under the supervision of the Health Advisor for Plan and the Regional delegate for Public health. In Bertoua, this workshop was facilitated by the PUHC, CBS/EIP and the HIS assistant. At Biteng, the training which was initially planned for the 10th and 11th of August 2009 was carried out on the 11th of August 2009 following the reduced nature of the modules. It took place in the council hall of the Akonolinga Rural council.

[1] See annex 1
[2] See annex 2

PARTNERSHIP

Logistics contribution by MOH partner was a valuable expression of partnership during the surveys. At all health districts, the MOH personnel supported the training by providing the training hall. They also supported the data collection by making available some vehicles and personnel to falicitate and participate as surveyors. This reduced the costs in training hall and vehicle hire. In addition to the provision of IHFA facilitators and surveyors, the provincial delegations also provided computers for data entry. The EIP contribution there was only support in the training of surveyors, fuel, coffee breaks and provision of the EPI Info data entry view.

The ownership of the organization of these surveys is really welcomed as one of the goals of the project is a spill over of IMCI to those other health districts from the EIP target provinces which are not directly covered by EIP. If the provincial delegations succeed to find other funds, the availability of the IMCI and IHFA facilitators will allow an implementation of IMCI in those districts with little dependency from MOH central level or EIP.

DATA COLLECTION PRACTICE BY HEALTH CARE PROVIDERS

THE SURVEYORS

The health facility assessment data collection was done by qualified health personnel.
In the Biteng PU, some used external surveyors were used. In Bertoua, even though the EIP focal person for the regional delegation (Monitoring and Evaluation) proposed external surveyors, the EIP HIS disqualified these and selected surveyors from the regional Nursing school to replace the Disqualified surveyors. Bamenda amongst the three PUs decided to hire people who really have interest in the IHFA results; the team was mainly made of staffs posted in the Bamenda provincial delegation of health from the EPI, malaria and other IMCI related programs. This may contribute to reinforced integration of these programs and also more advocacy for IMCI at the intermediary level.
Prior to going in the field for data collection the surveyors were trained for one day on the questionnaire administration. Bamenda once more showed an accentuated sense of ownership of the EIP because the monitoring and evaluation point person for EIP at the regional delegation, the regional chief for onchocerchiasis control and the CBS for Plan Bamenda handled the training of surveyors under the supervision of the Health Advisor for Plan and the Regional delegate for Public health. Doing it that way helped to constitute a local permanent pool of IHFA surveyors and facilitators. The wish is that Bertoua and Biteng follow the ownership example from Bamenda in preparing the MOH provincial delegation staffs to own the monitoring of IMCI in the whole province since one of the goal of the EIP is that IMCI/RBM go beyond EIP target districts. The surveyors who did the data collection in PROFAM network were selected, trained and supervised by ACMS.

DATA COLLECTION

At least 25 health facilities were expected to be visited within the three days following the training of surveyors. At the end a total of 87 health care providers were observed in the 11 EIP target districts and PROFAM target zone as follows:
Bamenda: 24 health facilities.
Bertoua: 24
Biteng: 18
PROFAM (Yaoundé): 29.
In Each health facility, a team of two surveyors and one supervisor whose mission was to observe the consultation of each child less than five years coming for sick visit, and administer and exit interview checklist to the caretaker was received. At the end of the day few questions were asked to the health staff who consulted the children in the health facility about his training and supervision IMCI history.

DATA ANALYSIS

The data entry was done in all the program units. The data sets were conveyed to Plan country office for data cleansing and analysis. It is our greatest desire to reinforce the capacities of the PUs in order that they can locally analyze their data in the nearest future.

RESULTS

STUDY INDICATORS

This monitoring gave evidence of a general improvement in the management of childhood illnesses by health care providers in the post IMCI training era. This visible amelioration is backed by the IMCI training received by the health providers in the EIP Zone. This progress as testified by the big improvement observed in the PROFAM network and Bamenda PU whose frontline health care providers were exposed to IMCI training. Globally, we noticed that 40.2% of the health personnel observed in the survey were trained on IMC. An insight into this result shows that there is dispersion in the percentage of health personnel trained on IMCI as were move from one project site to another. This therefore requires that in the analysis, each project site will be sort out and its situation analyzed. This will reorientate decisions about training and supervision towards poorly performing project sites and activities.
The greater part of this report will look at the comparison between the three monitorings in order to identify weakly performing indicators and well performing indicators.

Description of the sample

87 health staffs were observed from the same number of health facilities. 43 target health facilities were private institutions including: 10 hospitals, 13 medicalised health centers and 64 health centers. Of the eighty seven medical personnel observed, 8 were medical doctors, 20 state register nurses, 2 midwives, 45 nurses, 10 nurse aids and 2 state agents. Each child of age zero to 5 was observed who came for consultation
The distribution of the children observed are shown in the table below.

Table 3*:* Reasons for Child's Visit to Health Facility*.*

SAMPLE DESCRIPTION										
REASON FOR CHILD'S VISIT TO HEALTH FACILITY	EIP ZONE		BAMENDA PU		BITENG PU		BERTOUA PU		PROFAM ZONE	
DIARRHEA/ VOMITING	142	31.3%	24	19.5%	29	37.7%	56	42.7%	33	26.8%
	454		123		77		131		123	
FEVER/ MALARIA	254	55.9%	61	49.6%	38	49.4%	85	64.9%	70	56.9%
	454		123		77		131		123	
COUGH/ DIFFICULT BREATHING	224	49.3%	77	62.6%	37	48.1%	67	51.1%	43	35.0%
	454		123		77		131		123	

A total of 454 children were observed, 31.3 % who complained about diarrhea/ vomiting, 55.9% complained about fever/malaria and 49.3% complained about cough or difficult breathing

Table 4: Health facilities visited and personnel observed

	EIP ZONE	BAMENDA PU	BITENG PU	BERTOUA PU	PROFAM ZONE
HEALTH FACILITY VISITED	87	22	15	21	29
HOSPITAL	10	4	2	2	2
MEDICALISED HEALTH CENTRES	13	3	1	4	5
HEALTH CENTRES	64	15	12	15	22
Status of the health facilities assessed	87	22	15	21	29
Public	44	16	14	14	
Private	43	6	1	7	29
HEALTH PERSONNEL OBSERVED	87	22	15	21	29
MEDICAL DOCTORS	8	4	2	1	1
STATE REGISTERED NURSES	20	9	1	8	2
MIDWIVES	2	1	0	1	
NURSES	45	4	10	10	21
NURSE AIDS	10	3	1	1	5
STATE AGENTS	2	1	1		

Table 5: Age distribution of children observed

	EIP ZONE	BAMENDA PU	BITENG PU	BERTOUA PU	PROFAM ZONE
CHILDREN OBSERVED					
A:<6 MONTHS	79	22	10	28	19
B: 0-11MONTHS	170	42	32	51	45
C:12-23 MONTHS	122	36	14	37	35
D:0-23 MONTHS	292	78	46	88	80
E: 24- 59 MONTHS	162	45	31	43	43
TOTAL 0-59 MONTTHS (D+E)	454	123	77	131	123

THE SURVEY RESULTS

Sick child screening

In order that the medical personnel may identify critically ill children and either attend to them or refer immediately, screening for all danger signs is necessary. Screening for all main symptoms helps to ensure the identification of other concurrent illnesses the caretaker might not have been aware of, thus increasing the chances of taking care of all of the child's problems and in a holistic manner.

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No	Indicator	Numerator/ Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
SREENING FOR ALL DANGER SIGNS																	
1	Proportion of children who were assessed for all danger signs	Cases with all danger signs assessed / Total number of cases observed	4.8%	47.3 %	57.0 %	0.5%	43.0 %	48.8 %	17.5 %	31.4 %	64.9 %	9.8%	35.6 %	41.5 %	1.0%	67.0 %	75.6 %
SCREENING FOR MAJOR SYMPTOMS																	
2	Proportion of children who were assessed for all main symptoms	Cases assessed for all main symptoms / Total number of cases observed	7.8%	60.4 %	54.0 %	2.2%	54.7 %	43.9 %	26.3 %	31.4 %	66.2 %	15.2 %	38.6 %	32.1 %	1.0%	95.3 %	79.7 %

The two indicators that were used to assess the effectiveness of screening of the sick child were: Screening for all danger signs and Screening for all main symptoms. Screening for all danger signs permits the consulting nurse to identify children who are critically ill and attend to

them or refer immediately. Screening for all main symptoms helps to ensure the identification of other concurrent illnesses the caretaker might not have been aware of, thus increasing the chances of taking care of all of the child's problems and in a holistic manner.

The proportion of children who turned up for consultation who were screened for all danger signs increased from 47.3% to 57.0% (P=0.012) in the entire project area. The greatest increase was obtained in Biteng that moved from 31.4% to 64.9% (P=0.0001). Other increases were obtained in the PROFAM zone, Bamenda and Bertoua PUs. As per screening for major symptoms, we observed a decrease from 60.4% to 54.0% (p=0.231). Despite this decrease, in project areas like Biteng, we obtained a significant increase from 31.4% to 66.2 %(P=0.000) and Bertoua – 38.6% to 43.9%. The greatest drop was obtained in the PROFAM zone were we got a decrease from 95.3% to 79.7%.

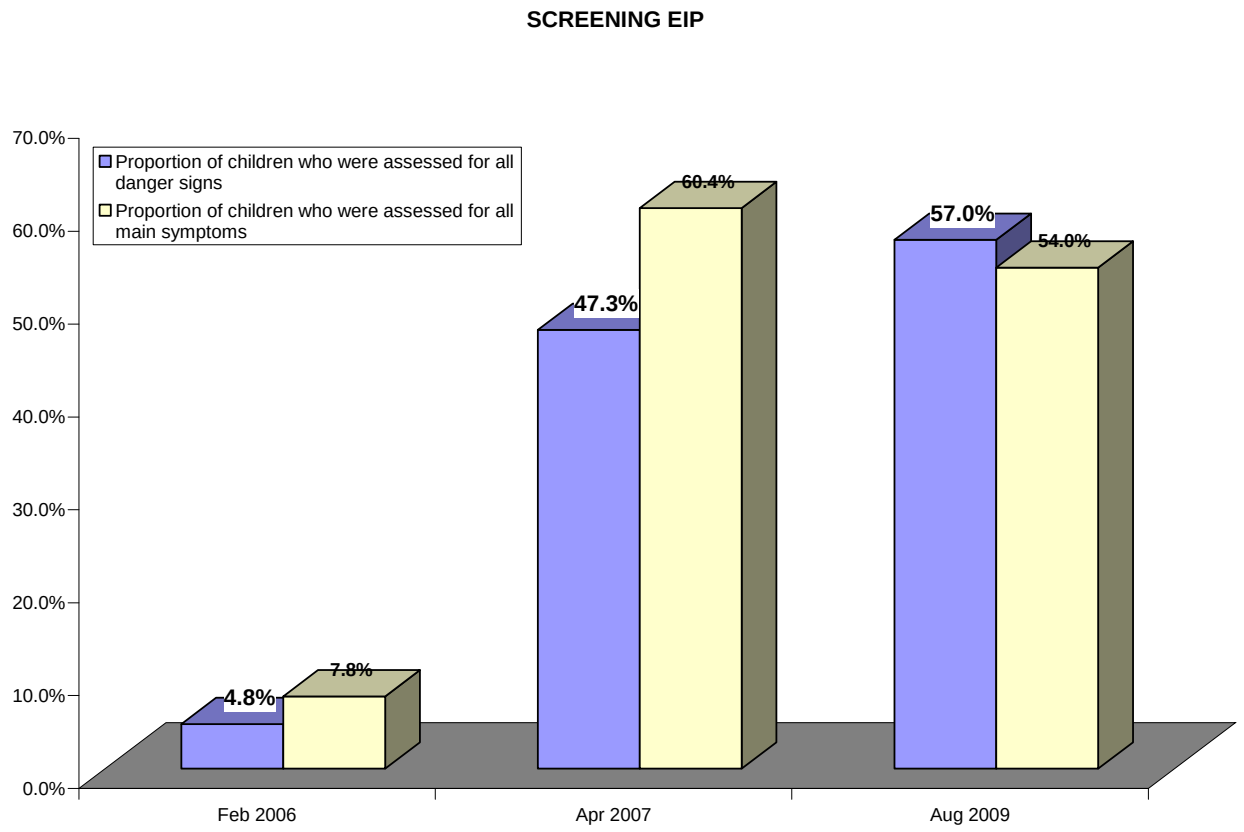


Figure 1: Screening in EIP zone

With the project objective of having at least 65% front-line MOH and private providers manage sick children according to the MOH's IMCI protocol, we notice that there is a drop in the IMCI practice in the major zones two years after the IMCI training. The zones that were trained first in the practice (Bamenda and PROFAM) are dropping in its application meanwhile the other zones (Bertoua and Biteng) are on the rise. If the EIP is on the trend leading to the project objective, the sustainability of the global move is necessary. This may imply that after the baseline and mid term refresher courses are necessary to sustain the practice of the protocol. Appropriate supervision and insurance that priority is given to frontline staffs when planning IMCI training are recommended to help sustain this effort.

Clinical examination

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No	Indicator	Numerator/Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
CLINICAL EXAMINATION																	
3	Proportion of assessment tasks completed for sick children with a history of diarrhea	Number of assessment tasks completed for cases with a history of diarrhea / Total number of assessment tasks required for sick children with a history of diarrhea	41.7%	57.8%	57.5%	33.3%	60.7%	58.5 %	49.7 %	46.2 %	41.7%	41.0 %	54.4 %	64.1 %	49.2 %	64.5 %	70.9%
4	Proportion of assessment tasks completed for sick children with a history of ARI	Number of assessment tasks completed for cases with a history of ARI / Total number of assessment tasks required for sick children with a history of ARI	52.5%	78.9%	74.1%	48.8 %	75.9%	84.5 %	56.6 %	69.5 %	54.9 %	56.0 %	73.3%	74.4%	56.6 %	90.5 %	79.1%
5	Proportion of assessment tasks completed for sick children with a history of fever	Number of assessment tasks completed for cases with a history of fever / Total number of assessment tasks required for sick children with a history of fever	40.3%	70.3%	69.1 %	31.6%	68.6 %	69.2 %	36.8 %	61.3%	47.5%	48.7%	56.2 %	72.1%	49.4 %	93.5%	86.1 %
6	Proportion of children who had nutritional	Cases assessed correctly for nutrition	8.5%	36.0%	43.1%	0.5%	22.1 %	24.0 %	29.8 %	60.0 %	58.1%	12.0 %	20.8 %	37.6%	7.6%	53.8%	58.7%

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No	Indicator	Numerator/Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
	status assessed	Total number of cases observed															
7	Proportion of children whose weight was plotted on a growth chart	Cases whose weight was plotted on a chart / Total number of cases observed	20.1%	55.8%	64.8 %	23.0 %	23.3%	39.8 %	40.4 %	31.4%	83.6 %	20.7%	46.5 %	55.3%	3.8%	99.1 %	87.6 %
Supporting information																	
	Proportion of children who were weighed the day of the survey	Cases whose weights were determined / Total number of cases observed	87.6%	90.6%	91.7%	88.5 %	91.9 %	90.1 %	77.2%	85.1%	93.3%	85.9 %	85.1%	90.6 %	93.3%	100.0 %	93.4 %

Thorough clinical examination enables the consulting staff to make the correct diagnosis, classify appropriately and also prescribe the appropriate treatment. Consequently, six indicators were used to assess the completeness of the clinical examination of the sick child: The number of assessment tasks completed for cases with history of diarrhea, ARI, fever, nutrition status, weight plotting on the growth chart and cases whose weights were determined.

The proportion assessment tasks completed for sick children with history of diarrhea did not change from the 2007 monitoring (57.8% to 57.5%). However, looking at the tendencies at the level of the PUs we notice that in the PROFAM zone and Bertoua PUs, we obtained significant increases from the 2007 monitoring (64.5% to 70.9%,p=0.01 and 54.45 to 64.1%, p=0.00001respectively). Thus the relative stability in the overall EIP result is due to the drops observed in the Bamenda and Biteng PUs. The number of assessment tasks completed for children with a history of Fever/ malaria and children with a history of ARI did not change significantly from the 2007 monitoring. Nevertheless, in Bamenda we obtained a significant increase from 75.95 to 84.5% (p=0.0001) and an insignificant increase was obtained in Bertoua (from 73.3% to 74.4%). The overall result is drowned by the significant drops obtained in the Biteng PU (69.5% to 54.9%, p=0.00001) and the PROFAM Zone (90.5% to 79.1%). Though there is a drop in the number of assessment tasks completed for ARI, fever and diarrhea, the assessment of nutrition increased from 36% to 43.1% in the whole EIP zone. The efforts of Bamenda, Bertoua and PROFAM (24.0, 37.6 and 58.7% respectively) are limited by the non significant decrease obtained in the Biteng PU (from 60.05 to 58.1%, p=0.835).

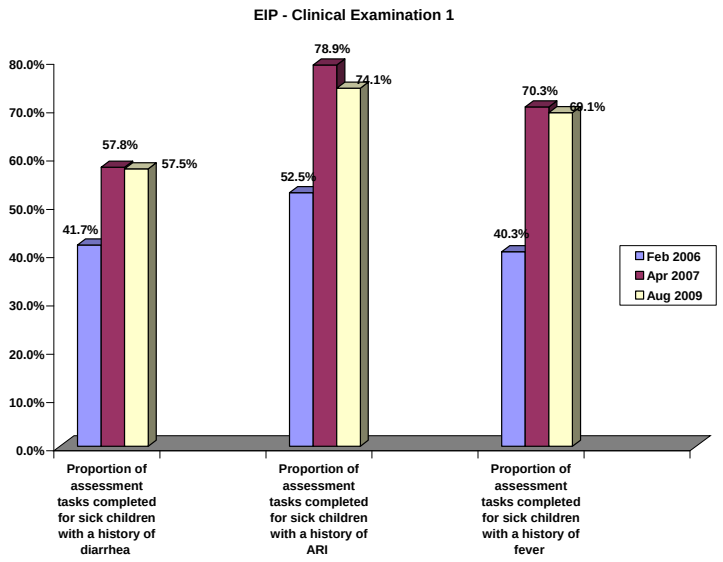


Figure 2a: Clinical examination – EIP

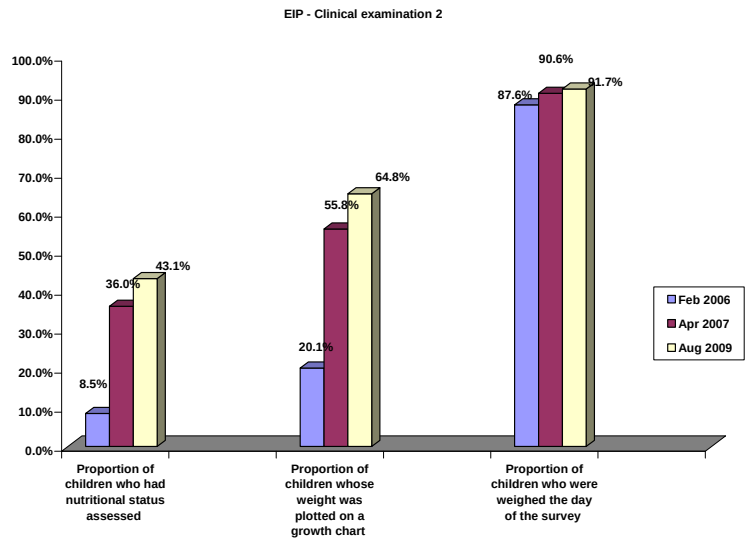


Figure 2b: Clinical examination 2 - EIP

Immunization

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No	Indicator	Numerator/Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
IMMUNIZATION																	
8	Proportion of children who had vaccination card checked at sick child visit	Cases whose health worker asked for child's vaccination card / Total number of cases observed	50.3%	74.1%	83.7%	47.5%	67.4 %	69.7 %	50.9 %	68.6 %	93.3%	65.2 %	70.3%	76.6 %	41.9 %	84.9 %	99.2 %
9	Proportion of children who needed an immunization who received it on the day of the visit or were referred for vaccination	Cases with a vaccination card needing a vaccination who received an immunization the day of the visit or were referred / Cases not up to date	48.1 %	52.9 %	66.9 %	44.4 %	37.0%	70.0 %	72.7%	61.8 %	52.9 %	14.3%	64.0 %	41.3%	/	/	88.7 %

More staffs checked the vaccination card at the sick visit of the child (74.1% to 83.7% p=0.0000), and there was substantial improvement in vaccinating the cases not up-to-date at their sick visit or referring them to the next vaccination session as testified by the significant increase of the related indicator from 52.9% to 66.9% with a p=0.0000.

Efforts have to be orientated toward improving and sustaining the completeness of ARI, fever and diarrhea assessment tasks in the districts. Coordination meetings to review the nutritional status mandatory assessment as per IMCI is required. Emphasis on assessment tasks and the necessity for medical personnel to screen for all danger signs and major symptoms should be made at the various districts. The results gotten so fare are not bad but there is need for much more improvement on the part of the health personnel.

Treatment

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No	Indicator	Numerator/Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
TREATMENT																	
10	Proportion of children who received an appropriate medication for the diagnosis made by the health worker	Cases with treatment appropriate for diagnosis / Total number of cases requiring treatment	51.7%	68.0 %	83.4 %	66.1 %	70.9 %	90.6 %	43.9 %	77.1%	76.0 %	47.8 %	56.4 %	66.7 %	34.3%	73.6%	98.3 %
11	Proportion of children with simple diarrhea who received ORS/RHF	Number of cases with simple diarrhea who received ORS/RHF / Number of cases with simple diarrhea	50.0 %	70.5%	92.5 %	32.0 %	60.0 %	80.0 %	58.3%	75.0%	100.0 %	61.5 %	43.8 %	90.6 %	64.3 %	94.7 %	100.0 %
12	Proportion of pneumonia cases who received an appropriate antibiotic	Pneumonia cases who received an appropriate antibiotic / Total number of pneumonia cases	17.6%	64.7 %	48.9 %	17.7%	17.9%	47.7%	36.4 %	85.0 %	52.5 %	28.6 %	74.3%	93.5 %	11.5%	80.0 %	21.2 %
13	Proportion of malaria cases who received an appropriate antimalarial	Malaria cases who received an appropriate antimalarial / Total number of malaria cases	56.9 %	63.7%	83.8 %	68.4 %	60.7 %	83.3%	52.6 %	42.1 %	73.7%	65.6 %	65.6 %	86.8 %	35.3%	71.9%	87.0 %
Supporting information																	

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No	**Indicator**	**Numerator/Denominator**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**
	Proportion of children with simple diarrhea who received an antibiotic or an antidiarrheal	Simple diarrhea cases who received an antibiotic or an antidiarrheal medication / Total number of simple diarrhea cases	78.3%	36.0 %	46.3 %	92.0 %	60.0 %	60.0 %	70.6 %	25.0 %	25.0 %	66.7 %	31.3%	63.6 %	/	/	22.7%
	Proportion of children with simple URTI who received an antibiotic	Cold/allergy/simple cough cases who received an antibiotic / Total number of cold/allergy/simple cough cases	72.1%	60.5 %	41.5%	82.1 %	76.9 %	45.8 %	33.3%	61.5 %	46.4 %	28.6 %	47.1%	72.2%	/	/	10.4 %

Four indicators were used to assess prescription of appropriate treatment: 'appropriate treatment for diagnosis', 'ORS/RHF for simple diarrhea', 'appropriate antibiotic pneumonia' and 'appropriate anti-malarial for malaria. Prescription of appropriate treatment will lead to cure of the illness, reinforce the confidence of the mothers/caretakers in the care provider and cut down the cost of treatment.

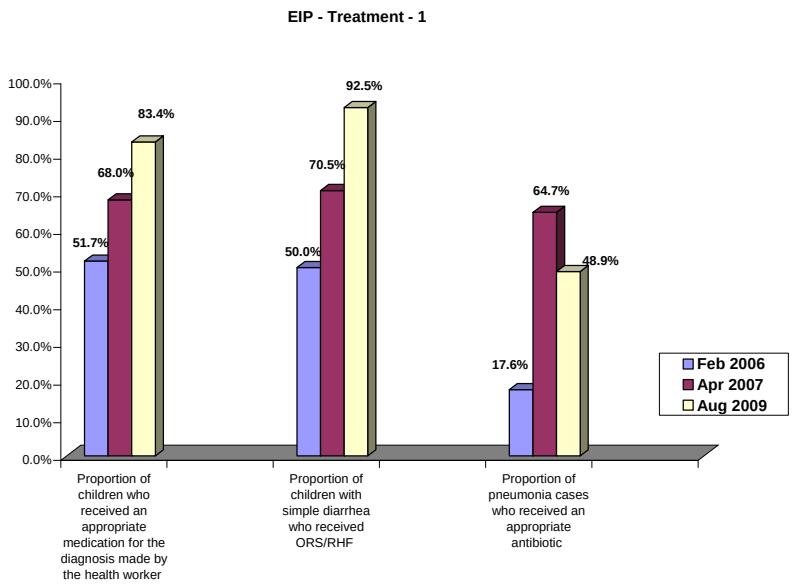


Figure 3a: Treatment – EIP

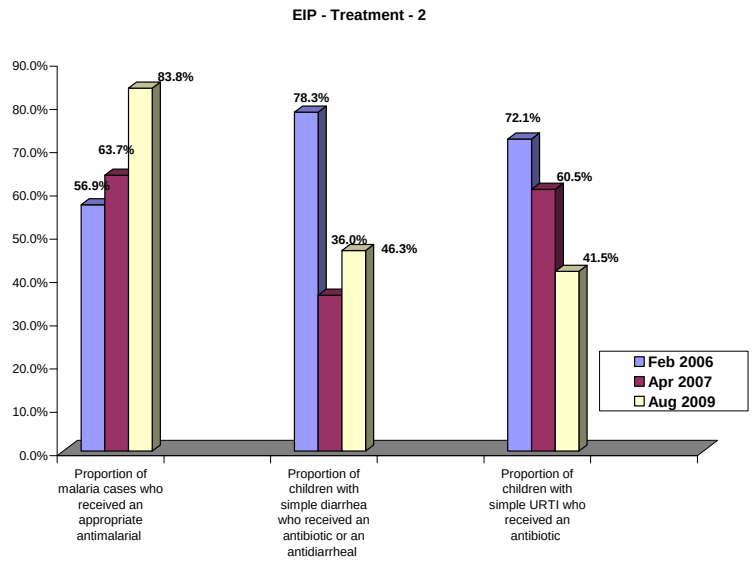


Figure 3b: Treatment 2 - EIP

Compared to mid term evaluation, the prescription effort of the appropriate medication for the diagnosis witnessed a significant increase from 68.0% in the mid term to 83.4% (p=0.0003). This increase was boosted by the large jumps observed in the PROFAM zone (73.6% to 98.3%) and Bamenda PU (70.9% to90.6%). It was noticed that though an increase in this indicator was found in all the project areas, the minimal increases in the Biteng and Bertoua PUs slowed down the overall coverage. A significant increase in the prescription of ORS/RHF for simple diarrhea from 70.5% to 92.5% (p=0.0000) was due to the great boosts obtained in the Biteng PU and the PROFAM Zone with 100% prescription. This is due to the proximity of ACMS ORS/RHF sales points. We notice that the resistance observe during the mid term in Bertoua and Bamenda have greatly reduced. Though there is a great decrease in resistance to Antibiotics for simple URTI, Bamenda still demonstrate a decree of resistance that cannot be neglected. The Districts should thus monitory the supply of essential IMCI medication to the nukes and cranes of the district.

Interpersonal communication

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No.	indicator	Numerator/Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
INTERPERSONAL COMMUNICATION																	
18	Proportion of treatment counseling tasks completed for sick children	Number of treatment counseling tasks completed for sick children / Total number of treatment counseling tasks required for sick children	42.7%	53.5%	69.7 %	34.9 %	58.5 %	71.9%	53.5%	55.2 %	71.6%	51.4%	48.5 %	51.3%	/	/	87.3%
19	Proportion of children whose caretakers were counseled on the importance of giving fluids at home	Cases whose caretakers were told by HW the need to give the same quantity or more liquid at home / Total number of cases observed	20.6 %	40.5 %	68.9 %	19.1%	40.7%	65.5 %	42.1 %	34.3%	58.6 %	30.4 %	42.6 %	65.0 %	2.9%	40.6 %	83.0 %
20	Proportion of children whose caretakers were counseled on the importance of giving food or breastfeeding at home	Cases whose caretakers were counseled by HW on the need to continue feeding or breastfeeding at home / Total number of cases observed	26.8 %	64.0 %	82.5 %	27.3%	61.6 %	76.9 %	43.9 %	54.3%	80.0 %	38.0 %	56.4 %	77.5%	6.7%	76.4 %	94.9 %
21	Proportion of children whose caretakers were given advice on when to return	Cases whose caretakers were told at least three messages on when to bring the child back / Total number of cases observed	18.5%	56.1%	72.5%	18.6 %	44.2 %	66.7 %	29.8 %	40.0 %	71.2%	27.2%	47.5%	64.2 %	4.8%	79.2%	88.0 %
Supporting information																	

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No.	**indicator**	**Numerator/Denominator**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**
	Proportion of children whose caretakers were told how to administer oral medications	Cases whose caretakers were told how to administer all oral medications / Total number of cases given or prescribed oral medications	82.0 %	89.4 %	85.1%	87.1%	87.2%	92.4 %	84.9 %	82.9 %	88.6 %	87.1%	87.1%	65.2 %	71.0%	95.3%	95.8 %

Despite the increase in the number of assessment tasks completed for sick children (53.5% to 69.7%), the proportion of children whose caretakers were told how to administer oral medications dropped. However, the proportion of women counseled on the importance of giving more food/fluid increase and the proportion of women counseled on when to return increased (56.1% to 72.6%). This because through out the project area, we noticed considerable significant increases from the mid term value (except for the PROFAM Zone where the increase was not significant. The proportion of children whose mothers/caretakers were told how to administer oral medication dropped from 89.4% to 85.1%. though the decrease is not significant (p=0.118), it is an indication that the health care providers are relenting efforts of educating mothers and caretakers on how to administer oral medication.

It is does recommended that the importance of completing all counseling and demonstrating the administration of oral medication should be highlighted during upcoming coordination meetings. The compliance of caretaker/mother to treatment depends on the practice of good interpersonal communication

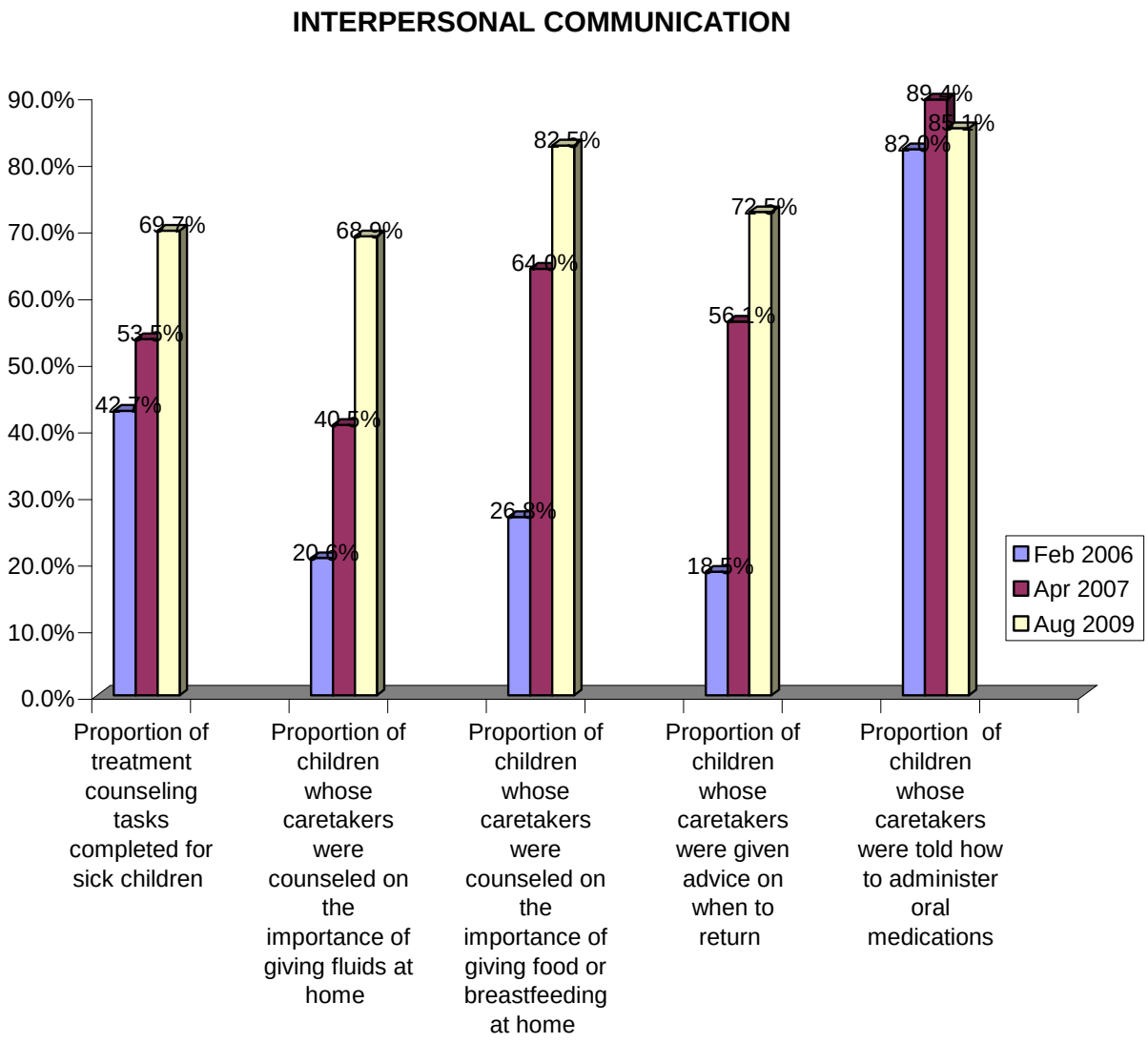


Figure 4: Interpersonal communication – EIP

Training and supervision

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No.	indicator	Numerator/Denominator	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009	Feb 2006	Apr 2007	Aug 2009
TRAINING																	
22	Proportion of health workers who saw sick children and who had received training in management of child illness in the last 12 months	Number of health workers who had received at least one training in the last 12 months / Total number of HWs interviewed	46.9%	71.0%	48.8%	50.0%	79.2%	50.0%	52.4%	55.0%	26.7%	50.0%	51.6%	4.8%	36.0%	100.0%	100%
Supporting information																	
	Health staffs who consulted the children and received a training on IMCI	IMCI / Total	31.4%	59.0%	42.7%	0.0%	45.8%	36.4%	52.4%	60.0%	26.7%	61.1%	35.5%	14.3%	0.0%	100.0%	83.3%
SUPERVISION																	
24	Proportion of health workers who had received at least one supervisory visit in the	Caretakers who knew how to give ALL essential medications correctly / Number of HWs who received at	83.2%	75.0%	90.2%	86.2%	50.0%	95.5%	76.2%	50.0%	66.7%	84.6%	90.3%	90.5%	84.0%	100.0%	100%

	last 6 or 12 months	least one supervisory visit in the last 6 or 12 months															

The present Integrated Health Facility Assessment demonstrates that of all the Health care providers who consulted children on the day of survey, only 42.7% were trained on IMCI. This is a decrease from the mid term value of 59.0%. All the Program Units witnessed a drop in this indicator. This probably is due to the transfers of staff trained in IMCI to other zones not covered by the EIP. Secondly, we noticed that the proportion of staff who had received any other training in the previous 12 months also dropped (71.0% to 48.8%) meanwhile the proportion of staff who were supervised in the last 6 to 12 months increased significantly from 75.0% to 90.2%, p= 0.0000. this means that the health care providers are regularly supervised but their knowledge and skills are not regularly refreshed. Thus in the near future, we think that advocacy with the MOH will center around the organization of refresher courses on IMCI.

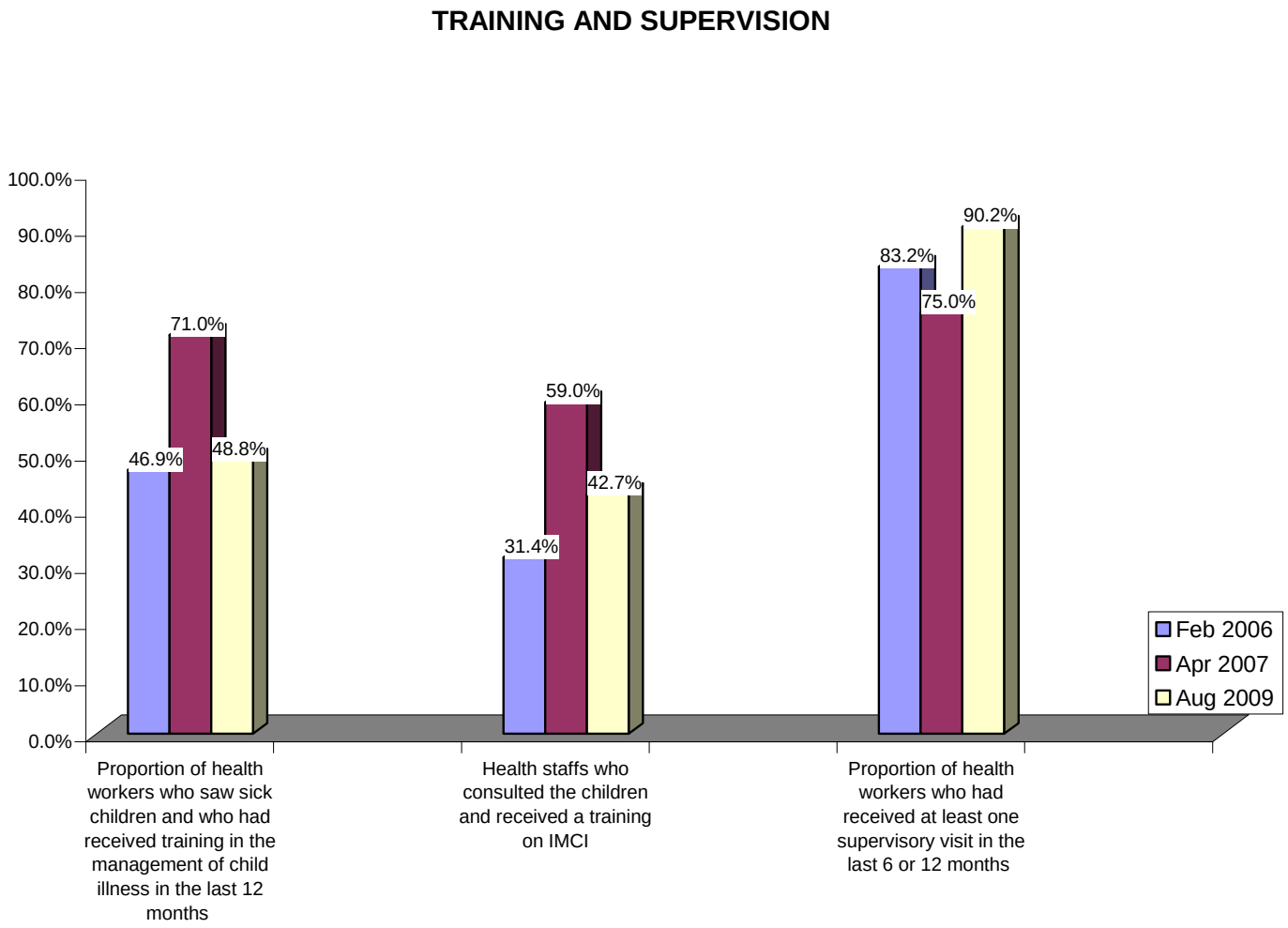


Figure 5: Training and supervision - EIP

Management of sick child at home

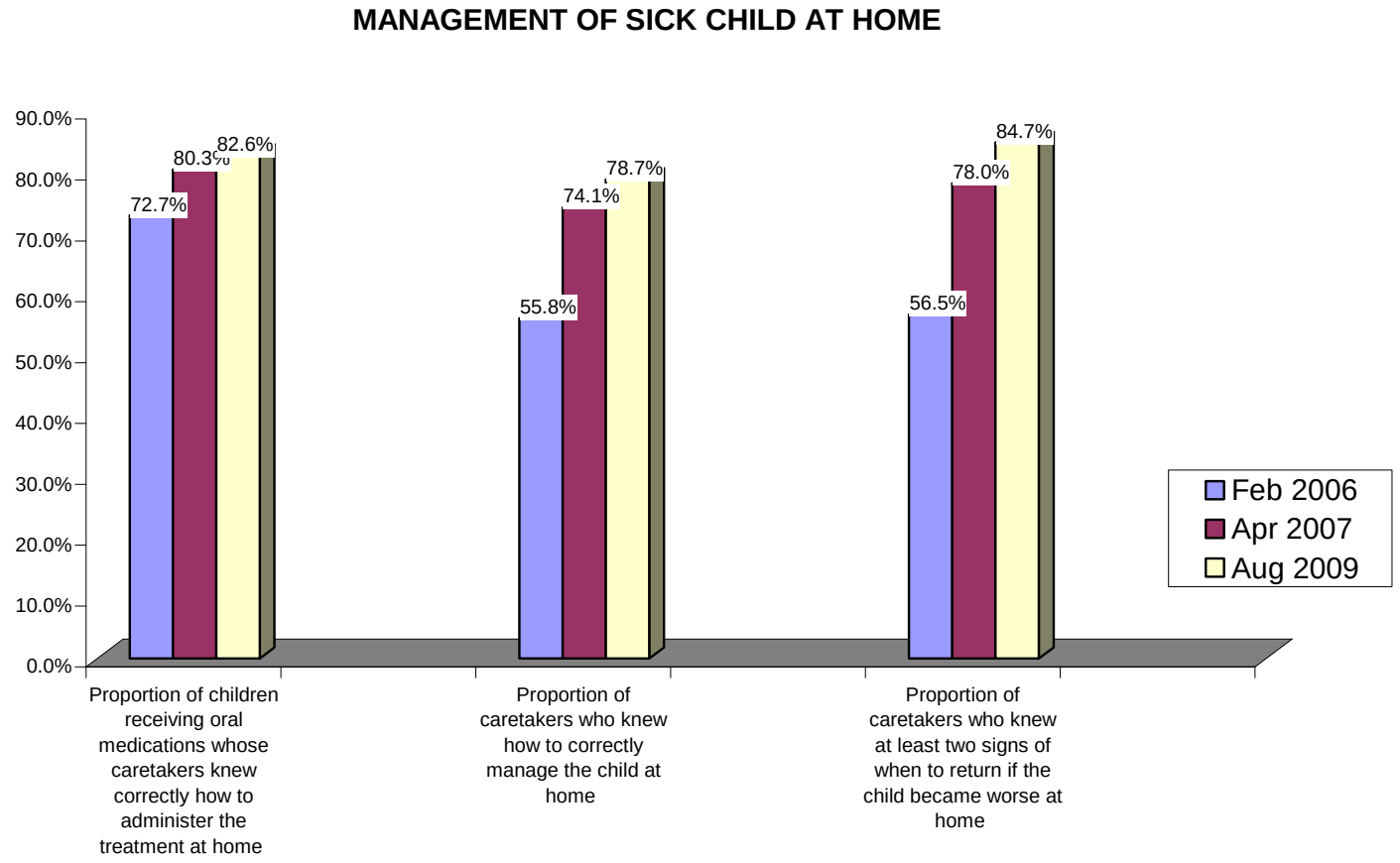


Figure 6: Management of sick child at home - EIP

Compared to the last monitoring, all the indicators for the management of sick child at home increased. The proportion of children receiving oral medication whose caretakers knew correctly how to administer the treatment at home increase from 80.3% to 82.6%, the proportion of caretakers who knew how to correctly manage the child at home increased for 74.1% to 78.7% and the proportion of caretakers who knew at least 2 danger signs also increased. This can be explained by the fact that the health personnel have improved on their practice of interpersonal communication. This is a good booster for the CCM of Malaria that has begun and the CCM of Pneumonia to being in the next year of the project.

			EIP			Bamenda			Biteng			Bertoua			PROFAM		
No.	**indicator**	**Numerator/Denominator**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**Apr 2007**	**Aug 2009**	**Feb 2006**	**April 2007**	**Aug 2009**	**Feb 2006**	**April 2007**	**Aug 2009**	**Feb 2006**	**April 2007**	**Aug 2009**
MANAGEMENT OF SICK CHILD AT HOME																	
25	Proportion of children receiving oral medications whose caretakers knew correctly how to administer the treatment at home	Caretakers who knew how to give ALL essential medications correctly / Total number of caretakers interviewed whose child was given or prescribed oral medication	72.7%	80.3 %	82.6 %	82.3 %	85.7%	83.3%	62.5 %	78.8%	82.7%	64.8 %	77.9%	75.0%	67.6 %	79.2%	88.9 %
26	Proportion of caretakers who knew how to correctly manage the child at home	Number of caretakers who knew at least two aspects of home case management / Total number of caretakers interviewed	55.8 %	74.1%	78.7%	57.8%	79.1%	89.9 %	57.8%	68.6 %	85.7%	73.8%	66.3 %	50.9 %	29.5 %	79.2%	89.1 %
27	Proportion of caretakers who knew at least two signs of when to return if the child became worse at home	Number of caretakers who knew at least two signs of child getting worse at home / Total number of caretakers interviewed	56.5 %	78.0%	84.7%	66.7 %	74.4%	91.6 %	50.9 %	68.6 %	85.7%	57.6%	75.2%	68.4 %	41.0 %	86.8 %	93.3%

CONCLUSION AND RECOMMENDATION

An overall improvement is observed in the management of child illnesses within the project zone as shows the movement of the various indicators in the expected direction. The p value is almost equal to zero in majority of indicators while comparing the baseline and April 2007 situations, comforting the idea that the training on IMCI received by the health staffs is impacting on their child illnesses management skills and behavior. While a significant improvement is observed within the whole project zone, each program unit will need to improve its individual areas of weakness.

The following recommendation are formulated to foster the EIP in its attempt to meet the project objective which is to have at least 65% front-line MOH and private providers manage sick children according to the MOH's IMCI protocol by end September 2010.

MOH and the project's partners will have to ensure that that priority is given to frontline staffs when planning IMCI training;

The supervision teams and training facilitators will also have to emphasize the assessment tasks of the nutritional status, continue to rise the health personnel conscience on the need to reduce missed opportunities by using every contact with a child who is due vaccination to administer the required vaccine;

The districts should monitor and ensure the availability of the IMCI essential drugs in the remote health center as stock-out in these leads to inappropriate prescription;

The district should use all the meeting opportunities to discuss the area of weaknesses

The need to complete all the counseling tasks other than just demonstrating the administration of oral medications by the health staffs should be highlighted during district coordination meeting.
An advocacy should be conducted by district and provincial teams with the support of the bundled partners, to maintain those health staffs trained on IMCI within the EIP zone.

THE COMMUNITY PRACTICES BEHAVIORS DATA COLLECTION

This year, the Rapid CATCH monitoring was organized at district level with the participation of the EIP staff

SURVEYORS

The surveyors were recruited among health and LNGO staffs, and community representatives. Prior to field data collection, the surveyors received a one days training by a team made of the district management team supported by EIP staffs. The training was done in way to consolidate a pool of local facilitators and surveyors so that next sessions will gather the district stakeholders only for a one day to plan the data collection and another one day for data analysis instead of another whole training session.

DATA COLLECTION

As per the LQAS methodology, the surveyors were to administer each of the four questionnaire modules to 19 mothers randomly selected within the health areas serving as supervision area. The health staffs and LNGO staffs incorporated the data collection to their normal work plan and this took two to three weeks.

DATA ANALYSIS

The data collected was entered in an excel file with cross liked formulae prepared by the EIP HIS Assistant. This automatic tool was designed such that a spreadsheet was for one supervision area (health are in this case). The file was programmed such that it could automatically calculate the number of good answers for the health area. This was then combined with the decision rule and the coverage on another sheet to reveal the indicators that were adequate and those that were inadequate for the health area. These Excel files were given to the District Medical officers of each District in the Project area and the EIP HIS trained them on how to enter data in the sheet and how to interpret the results obtained. This reduced work and facilitated access of result. The DMOs could even use the tool for further monitoring of their health areas in the absence of EIP staff.

Data entry work sheet for a supervision area

D36 | s

Tabulation results for an health area: mothers of children 0-23 months

Health District: MBENGWI | Supervisor's name:

Health area: Abebung | Date:

(CORRECT = "C", INCORRECT = "I", SKIPPED = "S" and MISSING = "M")

Q. NO.	QUESTION / INDICATOR	Correct answer	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Total de Corrects dans l'AS	Echantillon total de l'AS Tous les corrects et les incorrects	Couverture du district	Decision pour un lot de 19
		EXCLUSIVE BREASTFEEDING AND NUTRITION CHILDREN 0-5 MONTHS																							
Q23	"When (NAME) was sick, was he/she offered less than usual to eat, about the same amount, or more than usual to eat?"	Q23='2' ou '3'	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	2	1				
6	More liquids and at least the same quantity of food during an illness episod.	Q.17 = '1' AND Q.18 = '1' AND Q.19 = '1'	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	0	19	0%	NA
	DIARRHEA	*Type "1" If "A" is circled in question 21.otherwise type "M"*	s	s	s	s	s	s	s	1	s	s	1	s	s	s	s	s	s	s	1				

Abebung / Acha / Ajei / Andek / Bome / Kob / Mbengwi_urb / Munam / Ngyen-Mbo / Nj

District coverage sheet for each indicator

J14 | ='AWAE URBAN'!X29

Result Tabulation for Field Area: Mother's of Children 0-23 months

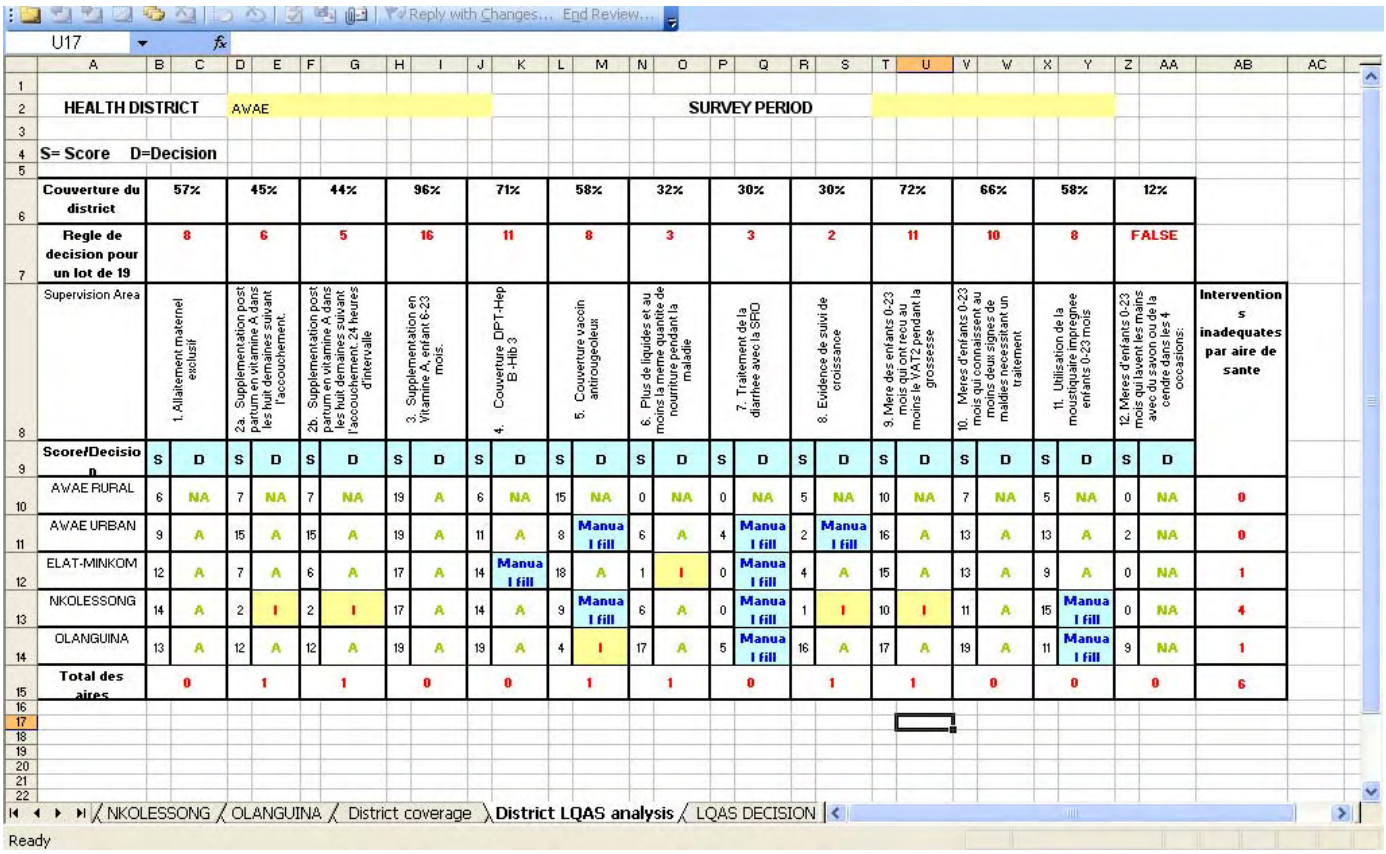
Health District: MBENGWI

(CORRECT = "C", INCORRECT = "I", SKIPPED = "S" and MISSING = "M")

Q. NO.	INDICATOR	Correct answer	Correct answer: WAE RURA	WAE URBA	LAT-MINKO	KOLESSON	OLANGUIN	Sample: WAE RURA	WAE URBA	LAT-MINKO	KOLESSON	OLANGUIN	Total correct in the district	Total District sample	District Coverage	Decision Rule for a lot of
1	Exclusive breastfeeding	Q10="C"	6	9	12	14	13	19	19	19	19	19	54	95	57%	8
2 a	Post partum Vitamin A supplementation in the eight weeks following delivery	Q11="1" and Q12="2"	7	15	7	2	12	19	19	19	19	19	43	95	45%	6
2 b	Post partum Vitamin A supplementation in the eight weeks following delivery within 24 hours	Q11="1" and Q12="2" and Q13="1"	7	15	6	2	12	19	19	19	19	19	42	95	44%	5
3	Vitamin A supplementation children 6-23 months.	Q.14="1"	19	19	17	17	19	19	19	19	19	19	91	95	96%	16
4	Coverage DPT-Hep B -Hib 3	Q16 a = "1" OR Q19="3"	6	11	14	14	19	19	19	14	19	19	64	90	71%	11
5	Coverage vaccine against measles	Q16 b = "1" OR Q.20 = "1"	15	8	18	9	4	19	18	19	18	19	54	93	58%	8
6	More liquids and at least the same quantity of food during an illness episod.	Q.17 = "1" AND Q.18 = "1" AND Q.19 = "1"	0	6	1	6	17	19	19	19	19	19	30	95	32%	3
7	Use of ORS during a diarrheal episode:	Q21="A" and Q24="1"	0	4	0	0	5	7	9	6	3	5	9	30	30%	3
8	Evidence of growth monitoring	Q.22 = "C"	5	2	4	1	16	19	18	19	19	19	28	94	30%	2

AWAE URBAN / ELAT-MINKOM / NKOLESSONG / OLANGUINA / District coverage / District

District LQAS SHEET for the health district



HEALTH DISTRICT: AWAE — SURVEY PERIOD

S= Score D=Decision

	1. Allaitement maternel exclusif	2a. Supplementation post partum en vitamine A dans les huit demaines suivant l'accouchement.	2b. Supplementation post partum en vitamine A dans les huit demaines suivant l'accouchement. 24 heures d'intervalle	3. Supplementation en Vitamine A, enfant 6-23 mois.	4. Couverture DPT-Hep B-Hib 3	5. Couverture vaccin antirougeoleux	6. Plus de liquides et au moins la meme quantite de nourriture pendant la maladie	7. Traitement de la diarrhee avec la SRO	8. Evidence de suivi de croissance	9. Mere des enfants 0-23 mois qui ont recu au moins le VAT2 pendant la grossesse	10. Meres d'enfants 0-23 mois qui connaissent au moins deux signes de maldies necessitant un traitement	11. Utilisation de la moustiquaire impregnee enfants 0-23 mois	12. Meres d'enfants 0-23 mois qui lavent les mains avec du savon ou de la cendre dans les 4 occasions:	Interventions inadequates par aire de sante
Couverture du district	57%	45%	44%	96%	71%	58%	32%	30%	30%	72%	66%	58%	12%	
Regle de decision pour un lot de 19	8	6	5	16	11	8	3	3	2	11	10	8	FALSE	
Supervision Area														
Score/Decision	S D	S D	S D	S D	S D	S D	S D	S D	S D	S D	S D	S D	S D	
AWAE RURAL	6 NA	7 NA	7 NA	19 A	6 NA	15 NA	0 NA	0 NA	5 NA	10 NA	7 NA	5 NA	0 NA	0
AWAE URBAN	9 A	15 A	15 A	19 A	11 A	8 Manual fill	6 A	4 Manual fill	2 Manual fill	16 A	13 A	13 A	2 NA	0
ELAT-MINKOM	12 A	7 A	6 A	17 A	14 Manual fill	18 A	1 I	0 Manual fill	4 A	15 A	13 A	9 A	0 NA	1
NKOLESSONG	14 A	2 I	2 I	17 A	14 A	9 Manual fill	6 A	0 Manual fill	1 I	10 I	11 A	15 Manual fill	0 NA	4
OLANGUINA	13 A	12 A	12 A	19 A	19 A	4 I	17 A	5 Manual fill	16 A	17 A	19 A	11 Manual fill	9 NA	1
Total des aires	0	1	1	0	0	1	1	0	1	1	0	0	0	6

NKOLESSONG / OLANGUINA / District coverage / District LQAS analysis / LQAS DECISION

It is note worthy that this tool has reduced cost and decrease time input in LQAS data analysis. This is because once data entry is finished, we simply turn to the district coverage sheet and get the district coverage for each indicator and then to the district LQAS sheet to identify adequately performing and inadequately performing indicators in each health area.

Overview of the results

1. Evidence of growth monitoring

EIP set as objective to decrease from 15.9 to 10% the proportion of children having low weight for age. Since this indicator is not expected to change too much within a 6 months period, another indicator was built to follow the effectiveness of the growth monitoring in the communities.
This first measurement of evidence of growth monitoring indicator show that half of the children in the sample were weighted and their weight reported on the growth monitoring chart at least one time in the two months preceding the survey. Bamenda highly influences the result with a proportion of 69.3% for the whole Program. The lowest effectiveness of growth monitoring is observed in Biteng (21.3%),
Considerable e

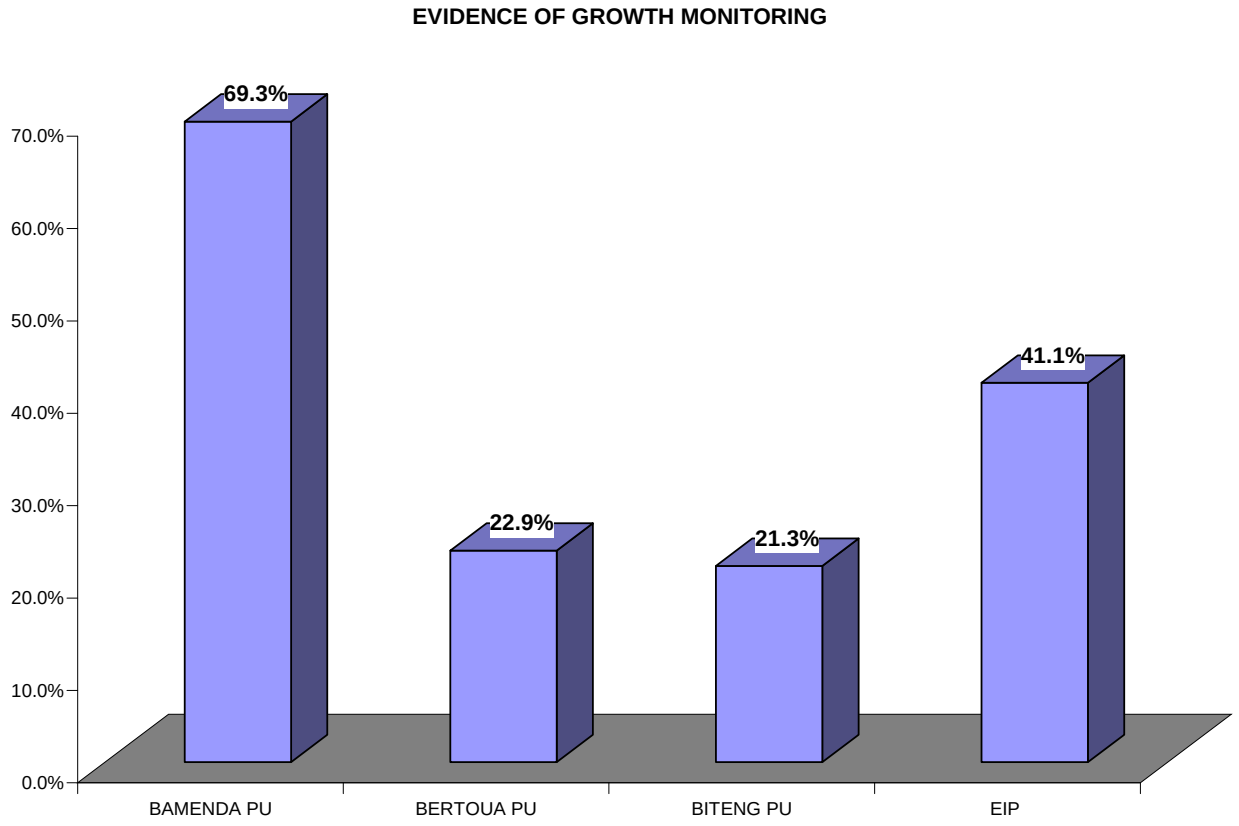
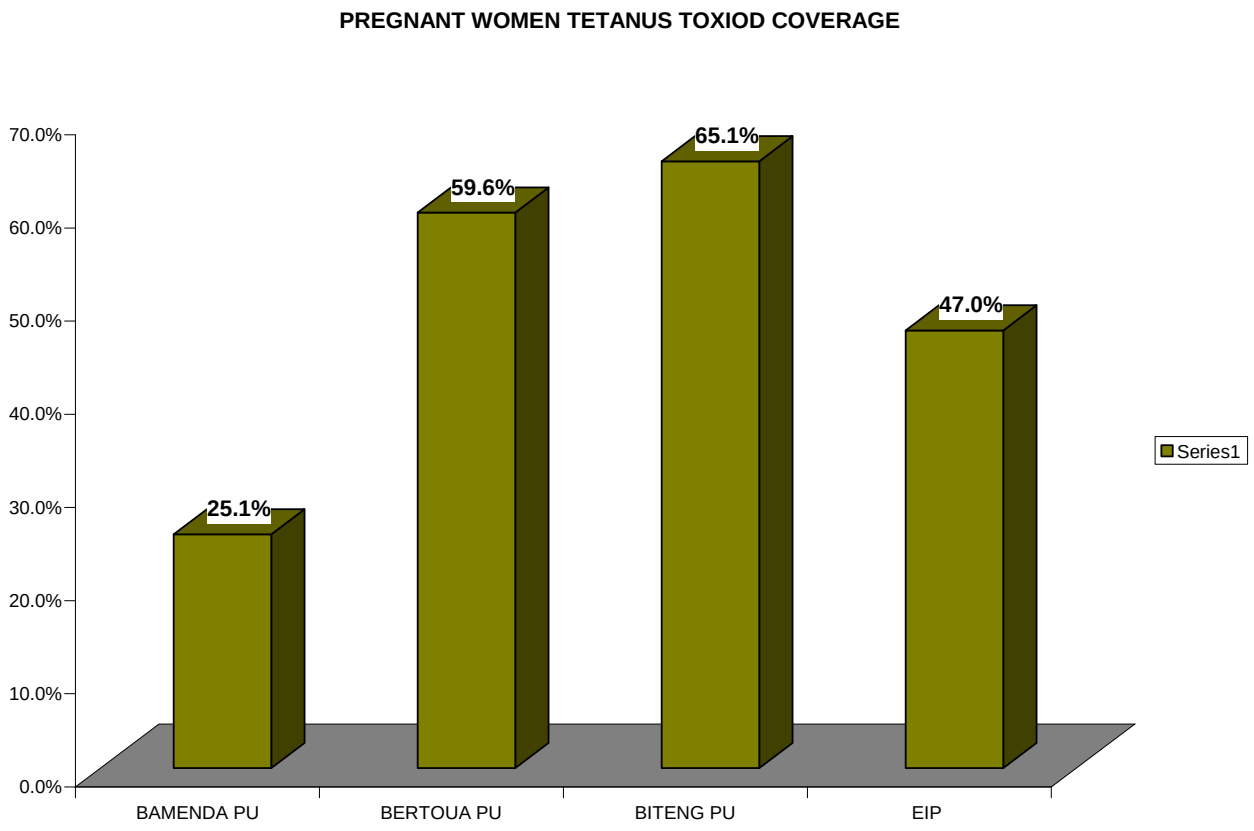


Figure 3: Evidence of growth monitoring within EIP

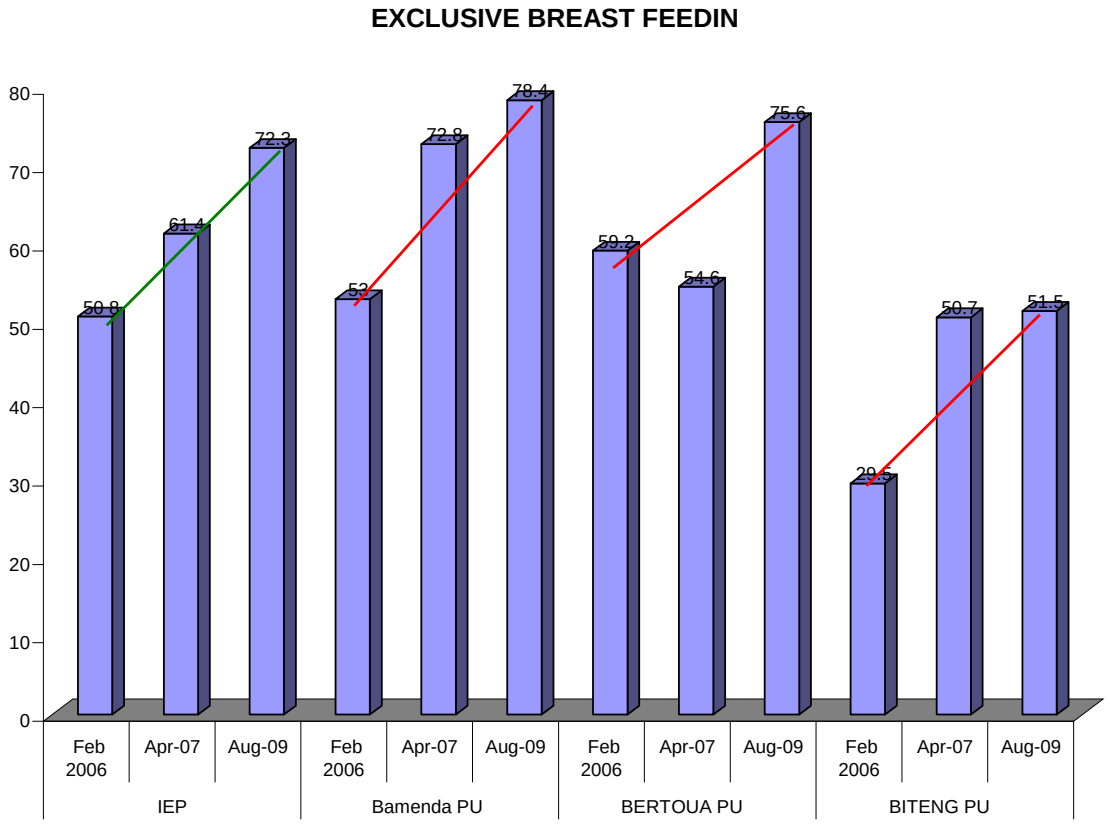
2. Pregnant women Tetanus Toxoid coverage



IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
58.90%	65.5	47.0%	61.5	65.9	25.1%	61.7	60.8	59.6%	54.7	73.7	65.1%

The monitoring Rapid CATCH measured the progress in mothers of children less than 24 months who received at least two tetanus toxoid doses during their last pregnancy. TT2 coverage decreased from 65.5% to 47.0%, below the linear trend leading to the project's objective (80% in 2010). The highest drop was recorded in the Bamenda PU with more than 20 points below the coverage in the whole EIP project area. Considerable effort has to be put in by the District team and the LNGOs and CBOs to emancipate this behavior. This year, the programmed trainings in Community IMCI will be a major boost to the advancement of this indicator.

3. Exclusive breastfeeding children 0-6 months



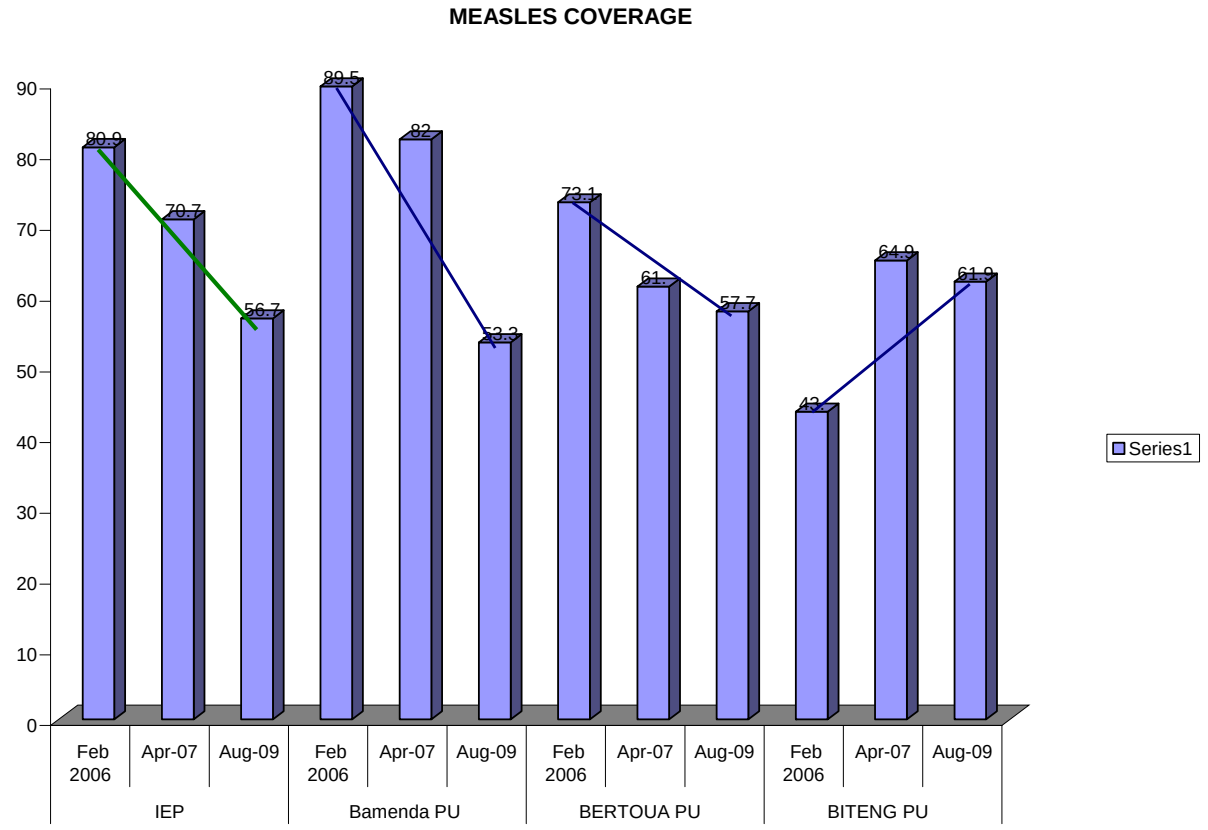
IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
50.8	61.4	72.3	53	72.8	78.4	59.2	54.6	75.6	29.5	50.7	51.5

The proportion of children less than 6 months who are exclusively breastfed increased witnessed an increase in all the project area from 61.4% to 72.3%. This value is very close to the EIP target of 75%. However, the Biteng PU has to put in much more effort to join the global trend since the increase was not significant.

4. Measles coverage children 12-23 months (proxy EIP calendar completion)

IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
80.9	70.7	56.7	89.5	82	53.3	73.1	61.2	57.7	43.5	64.9	61.9

The measles vaccine served as a proxy to EPI calendar completion as its administration in the same time with the Yellow Fever vaccine graduates the child from the EPI vaccination program. The value of the proxy here is compared to the effective EIP calendar completion measured during the Midterm Rapid CATCH. The EPI completion indicator measured during baseline and mid term will be measured again during the EIP final evaluation.

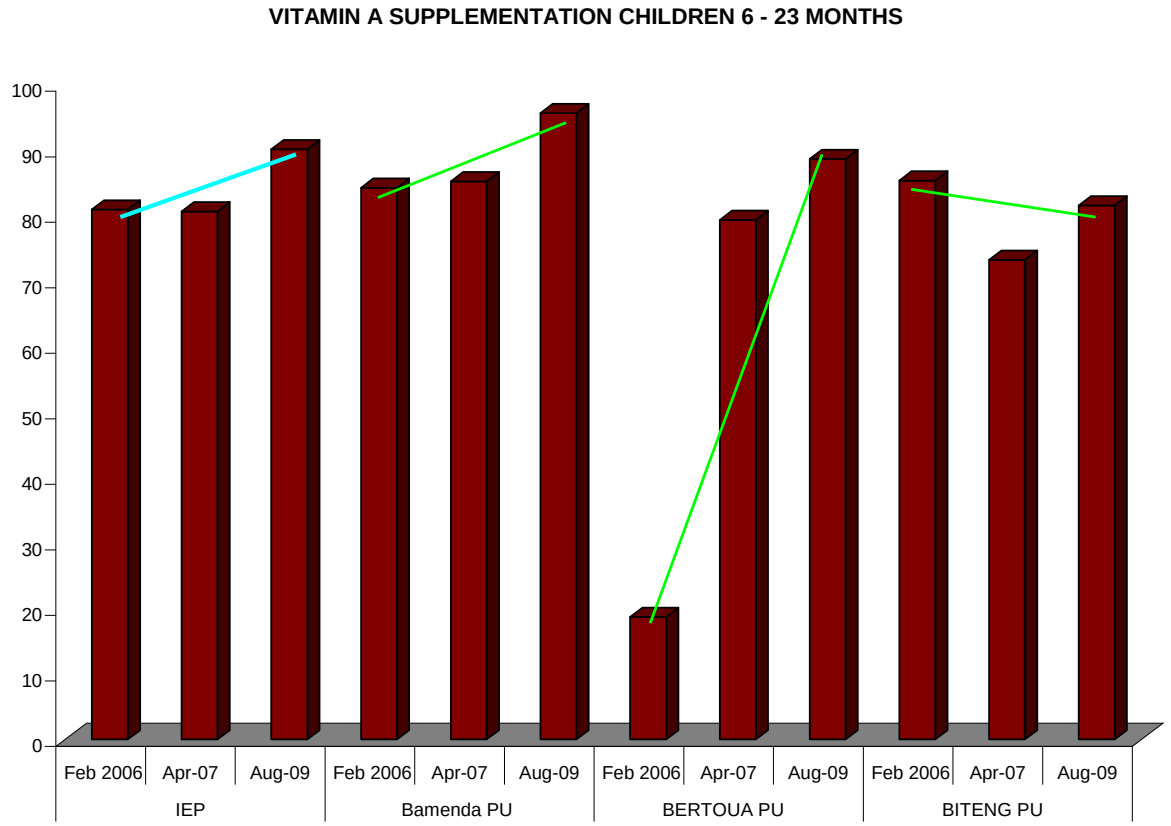


The EIP has witnessed a consistent drop concerning EPI completion (70.7% to 56.7%). The drop observed in Bamenda (82.0% to 53.3%), Bertoua (61.2% to 57.7%) did not allow the increase in the Biteng PU (59.3% to 64.9%) to influence movement towards the project's objective. This consistent drop should be a memory recall issue.

5. Vitamin A supplementation children 6-23 months

IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
80.9	80.6	90.1	84.2	85.2	95.6	18.7	79.3	88.6	85.3	73.2	81.5

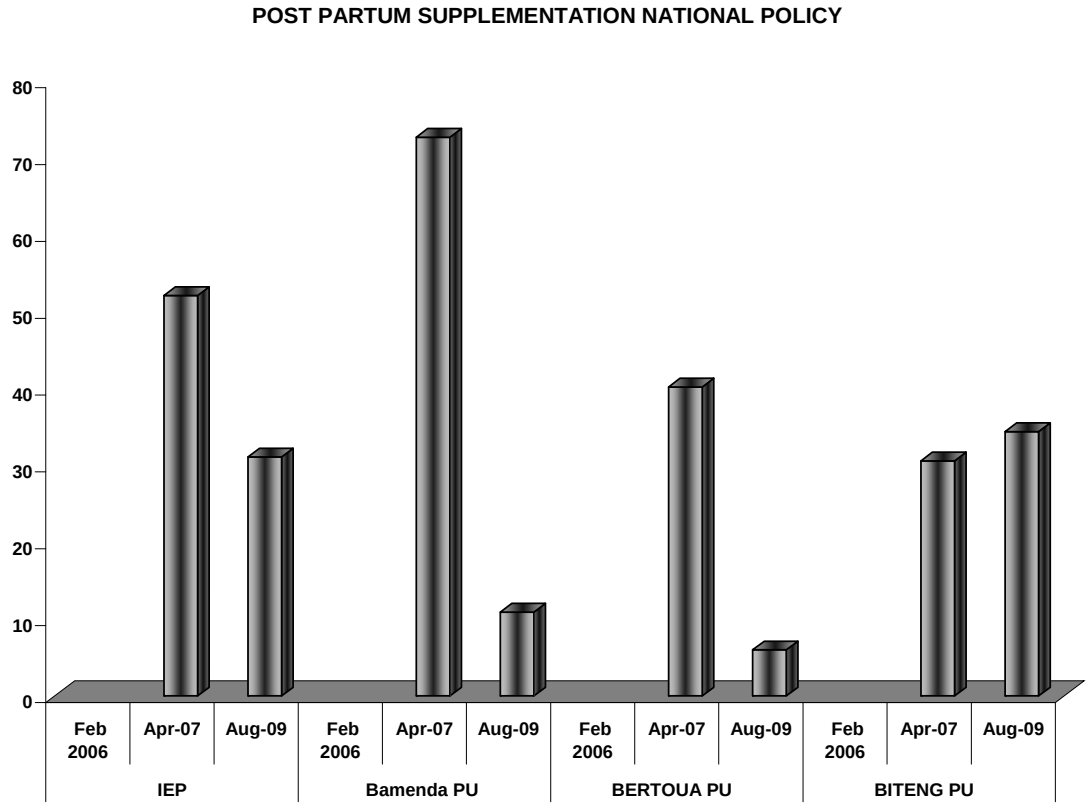
This indicator was retained after deliberation and it witnessed a consistent increase towards the targets. The normal indicator of the Vitamin A supplementation targets the children between – and 59 months. The Vitamin coverage here was measured on children 6-23 months in order to respect the study agreed. Only a cross sectional view of this indicator is given here as no baseline exists on the indictor using the 6-23 months target.



IND 5.c Post Partum supplementation national policy

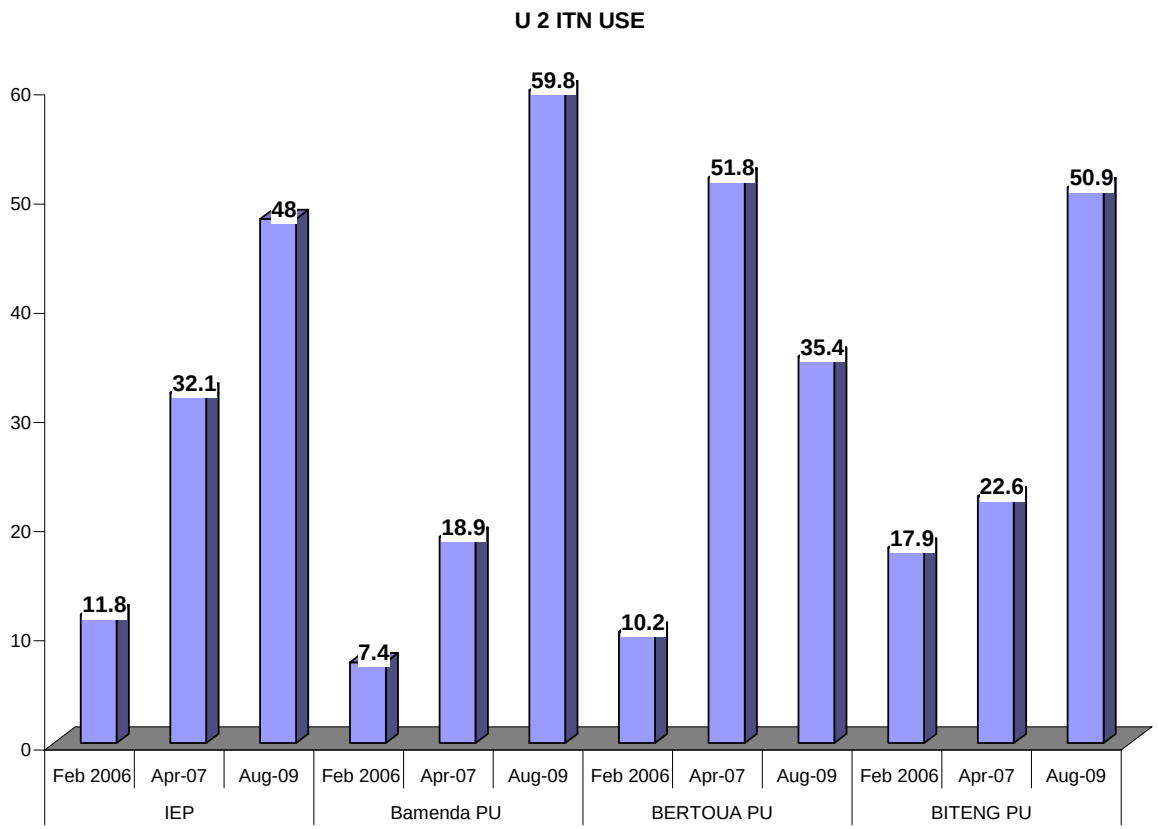
IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
	52.1	31.1		72.7	10.9		40.2	6		30.6	34.4

The proportion of mothers of children 0-23 months who received two doses of Vitamin A capsules with 24 hours interval within the eight weeks following the delivery of their last surviving child decreased from 52.1 to 31.1% within the EIP zone. As in the above case of Vit A supplementation, this should be a mother's recall issue.



6.a ITN use children U2

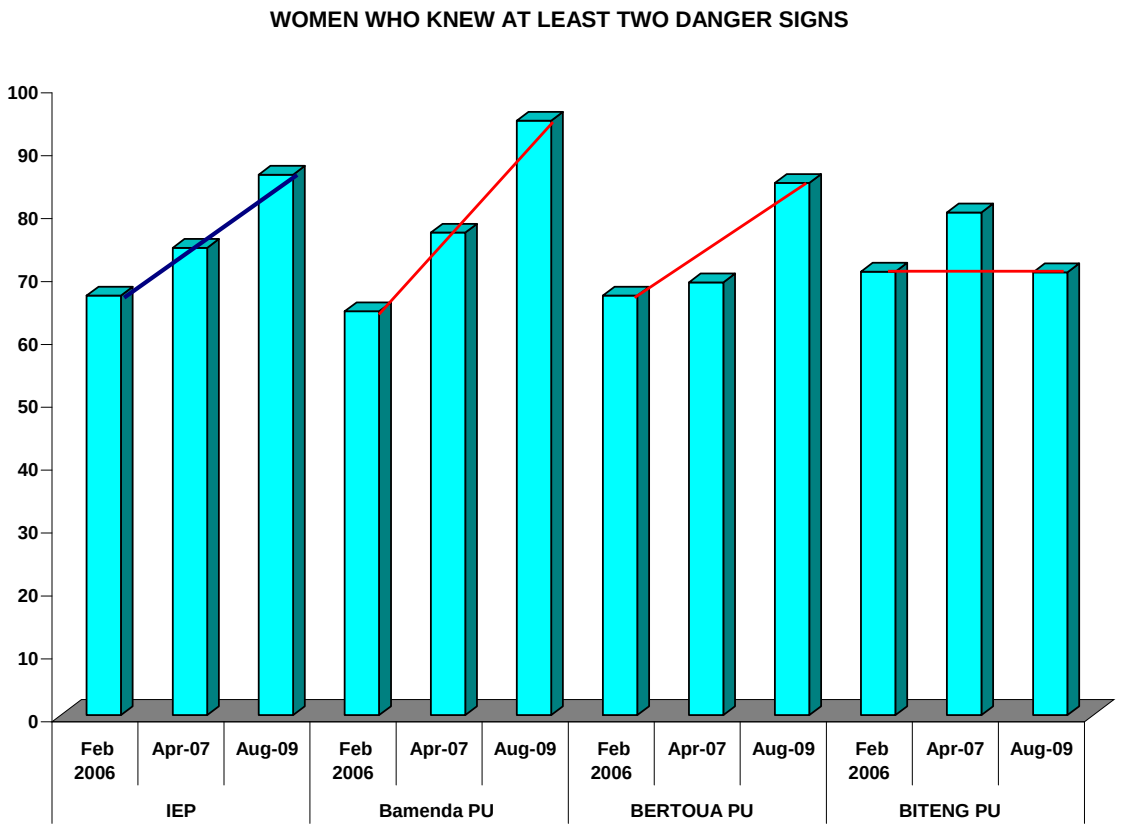
IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
11.8	32.1	48	7.4	18.9	59.8	10.2	51.8	35.4	17.9	22.6	50.9



From the baseline to the present monitoring, the proportion of children who slept under ITN has witnessed a continuous increase. It is remarkable that the increase is due to the mass distribution of LLITNs by the MOH during the last year in the project area. Though there is a general increase, the Bertoua PU witnessed a drop from 51.8% to 35.4%. Given that the EIP objective is 60%, there is still a lot more work to do.

7. Mothers of 0-23 knowing at least two signs of illnesses indicating the need of treatment

IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
66.7	74.3	85.9	64.2	76.7	94.5	66.7	68.8	84.6	70.5	79.9	70.4

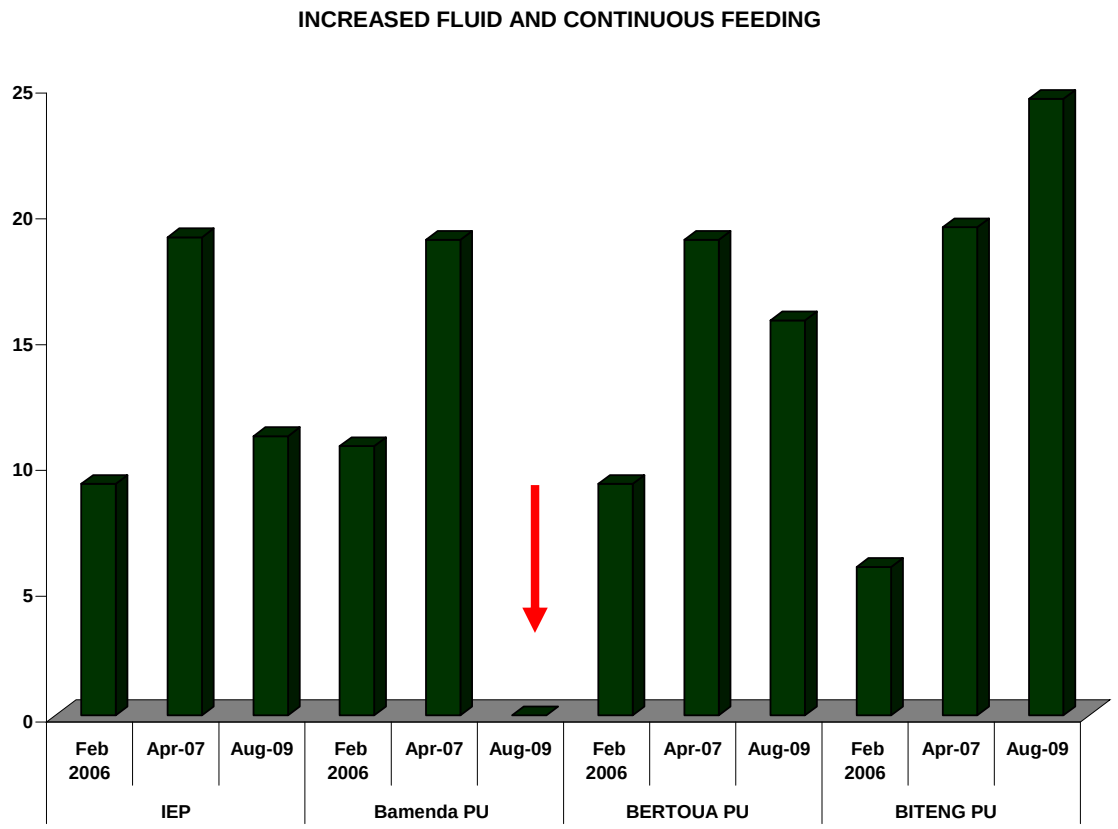


Like ITN utilization, the progress of the knowledge of illness signs indicating the treatment by mothers falls in the linear trend leading to the project objective as. While Bamenda and Biteng PUs perform beyond the objective linear trend and Bertoua PU passed below the trend line during the 2007 monitoring, the situation has change this time around. The Bamenda and Biteng PUs witnessed significant increases from 18.9% - 58.8% and 22.6% - 50.9% respectively. This increase could cover the drop in Bertoua

8. Increased fluid and continued food during an illness episode

IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
9.2	19	11.1	10.7	18.9	0	9.2	18.9	15.7	5.9	19.4	24.5

Compared to the base line, there is a drop from 19% to 11.1% in the EIP area. This is due to the fact that Bamenda registered 0% in this indicator. The reason for this 0% is not yet understood. However, the Bertoua and Biteng PUs recorded significant increases from the baseline in a trend towards the global project objectives.



9. Hand washing behavior - mothers of U2

IEP			Bamenda PU			BERTOUA PU			BITENG PU		
Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09	Feb 2006	Apr-07	Aug-09
7.7	15.2	25.7	10.5	13.7	25.6	5.8	13.7	34.1	1.1	21.3	6.8

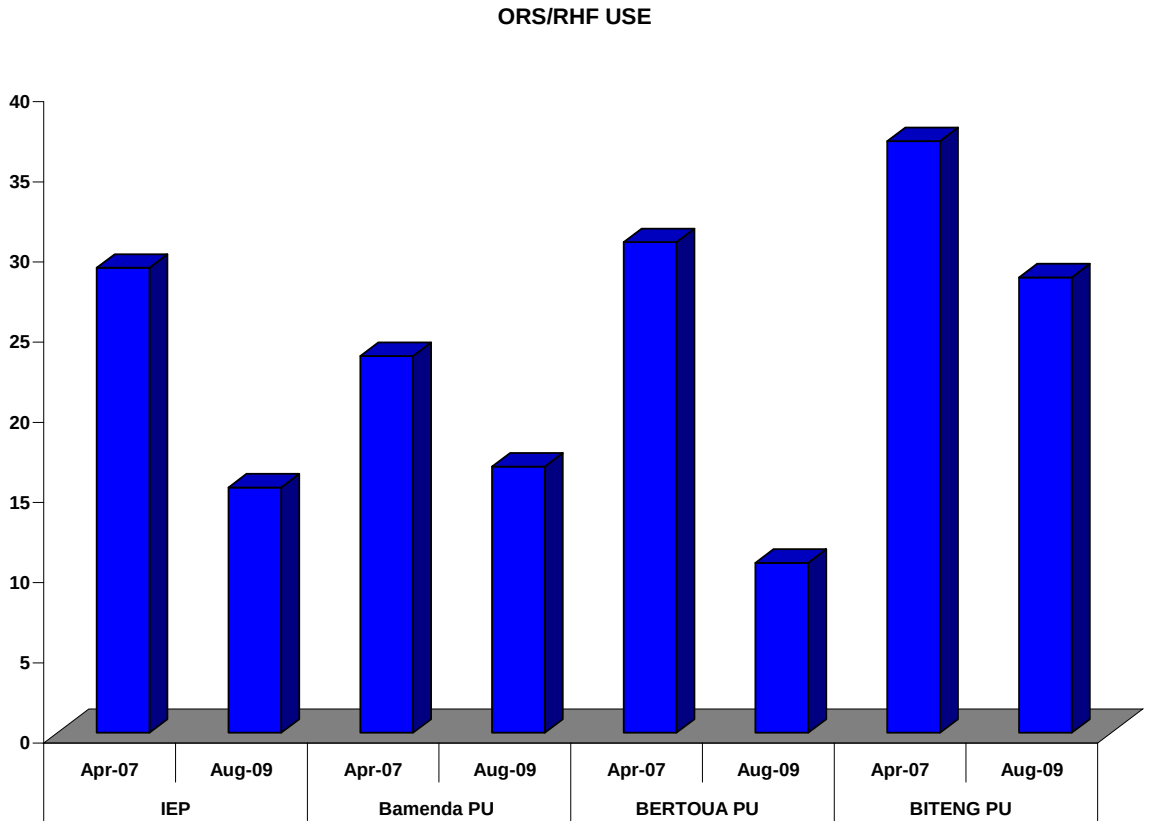
Like the knowledge of illness signs indicating the need for a treatment, the proportion of mothers of children who declare washing their hands with soap or ash on the four occasions defined by C-IMCI[3] increased by 10 points over two years. While the EIP gears towards the targets, the Biteng zone recorded a drop in this indicator.

10. ORS use during a diarrheal episode

[3] Before preparing the food, before feeding the child, after attending a child who has defecated and after being in the toilets.

IEP		Bamenda PU		BERTOUA PU		BITENG PU	
Apr-07	Aug-09	Apr-07	Aug-09	Apr-07	Aug-09	Apr-07	Aug-09
29	15.3	23.5	16.6	30.6	10.6	36.9	28.4

ORS use in the project area witnessed a consistent drop and this can be explained by the fact that the former low osmolarity ORS is being replaced by a High Osmolarity package including Zinc tablets.



USING THE RESULTS

The results of the monitoring KPC will be used by the districts and the local NGOs while planning the community IMCI interventions, and the district health and nutrition action weeks. These results will help to identify the priority communities for the community based organizations training on IMCI and IEC techniques. The results will also determine the priority interventions to incorporate in the district health and nutrition weeks for each district. The KPC results will also foster the health staffs in their counseling tasks.

CONCLUSION AND RECOMMENDATIONS.

The EIP globally records an Improvement in the status of the indicators measured during the April 2007 and the 2009 survey, as results of the community IMCI already implemented in eleven health districts, the counseling effected by the health personnel at sick children visits in the health facilities and the free distribution by ACMS in Batouri health district, and by the Cameroon ministry of public health in Bertoua, Doume and Nguelemendouka health districts, The Improvement scenario is not observed by all the health districts and by all the program units; many indicators remained stagnant or decreased in Bertoua program unit. The following recommendations are formulated in order to help Bertoua program Unit to join the global move towards the 2010 project's objectives, and to foster the two other program units:

Use the monitoring surveys results in activity planning at the district level;

Implementation of the community IMCI refreshers in all health districts;

Render the community behavior operational in all the communities already trained on C-IMCI to correct the shortcomings, maintain the good performance and insure the sustainability of the interventions by stimulating the behavior change towards children health in the community and the demand of health services by the communities;

ACMS to ensure the availability of the KO-tab, water chlorination kit and the ORS at the community level;

The EIP staffs should intensify the formative supervision of the local NGO staffs, and the local NGO staffs to closely monitor the community progress helping them to analyze the community behavior map findings and facilitate the community evidence-based decision making;

Use the district meeting opportunity to give an orientation to the frontline health staffs on the community IMCI framework and stimulate their ownership of the strategy;

Reach the hard to reach during the district health and nutrition action weeks;

ANNEXES
Annex 1 THE IHFA QUESTIONNAIRE

1. OBSERVATION CHECKLIST-- SICK CHILD

Program Unit : _____ Health District: _____

HW Category:_____ Date: ___/___/_____

Facility name : _____

Facility type: _____ Facility status: _____

Interviwer number: _____

Child's age : _____ Child ID No: _____

Begin Timing the Observation Now. Time:_____

1. What reason does the caretaker give for bringing the child to the health facility? ***(Check all that apply.)***

____**Diarrhea/vomiting** ____**Fever/malaria** _____**Difficulty breathing/ cough/pneumonia**

2. Does the health worker ask the age of the child or have the age available? Y N

3. Is the child weighed? .....……..... Y N

3.a Is the child's weight plotted on a growth chart?…….. Y N

4. Is the child's temperature checked?. ……. …….. Y N

Does the health worker ASK about (or does the caretaker REPORT)--	Does the health worker perform these EXAMINATION tasks--
Danger signs: 5**. Not able to drink or breastfeed? Y N**	13. **Look for lethargy or unconsciousness? Y N**

6. **Vomits everything?……..**	**Y**	**N**			
7**. Convulsions? ……**	**Y**	**N**			
8**. Change in consciousness/ lethargic/sleepy?**	**Y**	**N**			
9.a Diarrhea?	**Y**	**N**	14**. Observe drinking or breastfeeding? ……..**	**Y**	**N**
.b **For how long?**	**Y**	**N**			
.c **Is there blood in the stool?**	**Y**	**N**	15. **Pinch the skin on abdomen?**	**Y**	**N**
			16. **Look for sunken eyes?…… …….**	**Y**	**N**
10.a Cough or difficult breathing? **……**	**Y**	**N**	17**. Raise the shirt? ……**	**Y**	**N**
.b **For how long?……**	**Y**	**N**	18. **Count breaths/minute? ……..**	**Y**	**N**
			19. **Look for chest indrawing?…… ……**	**Y**	**N**
11.a Fever? **……**	**Y**	**N**	20. **Look or feel for stiff neck?**	**Y**	**N**
.b **For how long?… ……**	**Y**	**N**	21. **Look for generalized rash?**	**Y**	**N**
			22. **Look for cough, runny nose, or red eyes?..**	**Y**	**N**
12.a Ear problem? **……**	**Y**	**N**	23. **Look for pus from ear?**	**Y**	**N**
.b Ear pain? ……	**Y**	**N**			
.c Ear discharge?	**Y**	**N**	24. **Feel for swelling behind ear?…… …**	**Y**	**N**
.d If YES, **for how long?**	**Y**	**N**			
			Malnutrition:		
			25. **Undress and look for wasting?**	**Y**	**N**
			26. **Look for palmar or conjunctival pallor?**	**Y**	**N**
			27. **Look for edema of both feet?**	**Y**	**N**

A. All danger signs (Q. 5 to Q. 8 [or Q. 13]) assessed?	**Y N**
B. All main symptoms (Q. 9 to Q. 12) assessed?	**Y N**
C. Number of diarrhea assessment tasks completed? **(History and Examination)**	0 1 2 3 4 5
D. Number of ARI assessment tasks completed? **(History and Examination)**	0 1 2 3 4

E. Number of fever assessment tasks completed? **(History and Examination)**	0 1 2

F. Nutritional status correctly assessed? (Q. 4, Q. 25 to Q. 27)	**Y N**

Immunization and Screening

28.a Does the health worker ask for the *child's* immunization card? ... **N/A Y N**

If NO, go to question 29. **Y N**

.b If YES, **does the child have the card? .....**

.c Is the *child* referred for vaccination--

__1.Today __2. Another day __3. Not referred __4. Up to date

29.a Does the health worker ask for the *caretaker's* vaccination card?..... **N/A Y N**

If NO or N/A, go to question 30.

.b If YES, **does the caretaker have the card? .....** **Y N**

.c Is the *mother* referred for vaccination--

__1.Today __2. Another day __3. Not referred __4. Up to date

Diagnosis

How does the health worker classify the child?					
30. **Simple diarrhea**	**Y**	**N**	39. **Very severe febrile disease**	**Y**	**N**
.a **No dehydration ……..**	**Y**	**N**	40. **Malaria ……**	**Y**	**N**
.b **Some dehydration**	**Y**	**N**	41. **Severe complicated measles**	**Y**	**N**
.c **Severe dehydration**	**Y**	**N**	42. **Measles (eye and mouth**	**Y**	**N**
31. **Dysentery**	**Y**	**N**	**complications)**		
32. **Persistent diarrhea**	**Y**	**N**	43. **Measles ……**	**Y**	**N**
33. **Severe persistent**	**Y**	**N**	44. **Fever, other cause ……**	**Y**	**N**
diarrhea…			**(specify) _____**		
34. **Severe pneumonia**	**Y**	**N**	45. **Mastoiditis ……**	**Y**	**N**

35. **Pneumonia ……..**	**Y N**	46. **Acute ear infection ……..**	**Y N**
36. **Upper respiratory infection (cough or cold)……..**	**Y N**	47. **Chronic ear infection……**	**Y N**
37. **Severe malnutrition**	**Y N**	48. **No diagnosis……**	**Y N**
38. **Anemia or very low weight (moderate malnutrition)…….**	**Y N**		

If validation is performed:

G.a Health worker classification agrees with validator?		Y	N
G.b Severely ill children classified correctly?	N/A	Y	N

Treatment

What does the health worker administer or prescribe for the child?			
49. Immediate referral?	**Y N**		
50. Antimalarial injection …….	**Y N**	**57. ORS/RHF ……..**	**Y N**
		58. Antidiarrheal/antimotility	**Y N**
51. Antimalarial tablets/syrup…..	**Y N**	**59. Metronidazole tablet/syrup ….**	**Y N**
52. Paracetamol/aspirin ……	**Y N**	**60. Tablet/syrup, unknown type…**	**Y N**
53. Tepid bath ……..	**Y N**		
54. Antibiotic injection …	**Y N**	**61. Injection, unknown type**	**Y N**

55. Antibiotic tablets/syrup …….	**Y**	**N**	**62. Other (specify) _____ ….**	**Y**	**N**
56. Vitamin A or vitamins……	**Y**	**N**	**63. None……..**	**Y**	**N**

H. Is the medication appropriate for the diagnosis?	Y	N

I.a Diarrhea case received appropriate medication?	N/A	Y	N
I.b Pneumonia case received appropriate medication?	N/A	Y	N
I.c Malaria case received appropriate medication?	N/A	Y	N

If validation is performed:

J.a Is the child treated correctly?		Y	N
J.b Severe classification correctly referred?	N/A	Y	N
J.c Pneumonia case correctly treated?	N/A	Y	N
J.d Diarrhea case correctly treated?	N/A	Y	N
J.e Malaria case correctly treated?	N/A	Y	N

Interpersonal Communication

For all oral medications--

64.a **Does the health worker explain how to administer medications/ORS? ..**	**N/A**	**Y**	**N**
.b **Does the health worker demonstrate how to administer medications/ORS? ……**	**N/A**	**Y**	**N**
.c **Does the health worker ask an open-ended question to verify the comprehension of how to administer medications/ORS?**	**N/A**	**Y**	**N**

K. Number of treatment tasks performed? (Circle one.)	0	1	2	3

65. Does the health worker explain when to return for follow-up? **Y N**

66. Does the health worker explain the need to give more liquid at home?.... **Y N**

67. Does the health worker explain the need to continue feeding or breastfeeding at home? …….. **Y N**

68. Does the health worker tell the caretaker to bring the child back for the following signs?

Child is not able to drink or drinking poorly	**Y**	**N**
Child is not able to breastfeed/eat	**Y**	**N**
Child becomes sicker	**Y**	**N**
Child develops a fever	**Y**	**N**
Child develops fast or difficult breathing	**Y**	**N**
Child develops blood in the stool	**Y**	**N**
Change in consciousness/lethargic	**Y**	**N**

L. Are at least three of the Q. 68 messages circled?	Y	N

69. Does the health worker give the caretaker any advice on nutrition?..... **Y N**

Check the Time of the Observation as the Caretaker Leaves: Time:_____
Duration of observation:_____minutes

- The surveyor may need to ask the health worker about the diagnosis made and the treatment given during the consultation, but only if these two components were not stated during the consultation.
- The surveyor must complete this form before the next child observation**.**

END OF HEALTH WORKER OBSERVATION

2. EXIT INTERVIEW--SICK CHILD

Program Unit: _____ **Health District :** _____

Facility Name _____ Facility Type _____

Facility Status _____ Interviewer Number _____

Date ___/___/___ Child's Age (months) _____ **Child ID No.** _____

Greet the caretaker and say that you would like to ask some questions about his/her visit to the health facility today.

1. **Did the health worker give you any oral medicines at the health facility today?** **Y N**
   If NO, go to question 2.
   If YES, **compare the caretaker's medications with the samples for identification of the oral medicines.**

Complete the table beloew for the listed oral medications. Fill in the information in the table below by asking -

HOW MUCH medicine will you give the child EACH TIME?
HOW MANY TIMES will you give it to the child EACH DAY?
HOW MANY DAYS will you give the medicine to the child?

If the caretaker's answer is -

"As required," write AR in the appropriate cell.
"Until Completed," write UC in the appropriate cell.
"I don't know," write DK in the appropriate cell.

Medicine	How Much Each Time?	How Many Times/Day?	How Many Days?	All Correct? (Y or N)
Amodiaquine tab/syrup…..				Y N
ACT……..				Y N
Antibiotic tab/syrup **Name:**_____ **Dose/tab:**_____				**Y N**
Aspirin tab/syrup **OR** **Paracetamol tab/syrup** **Dose/tab:**_____				**Y N**
ORS/RHF				Y N
Other:_____				Y N
A. Caretaker knows how to give ALL *essential* medications correctly?				**N/A Y N**

2. What will you do for your child when you return home? (Check all that apply.)

____Doesn't know

____Continue feeding or breastfeeding the child

____Give the same quantity or more fluids to the child

____Complete course of medications/ORS/RHF

____Bring the child back if he/she doesn't get better or gets worse

____ Other precise _____

B. Caretaker knows at least two aspects of home case management?…….	**Y N**

3. How will you know if the child becomes worse at home? (Check all that apply.)

____**Doesn't know**

____**Fever begins or doesn't go away**

____**Child unable to eat**

____**Diarrhea continues**

____**Child has chest indrawing**

____**Vomiting begins or continues**

____**Child unable to drink**

____**Child has convulsions**

____**Child has difficulty breathing**

____**Blood in stool**

____**Other (specify):**_____

C. Caretaker knows at least two signs of child getting worse at home?……	**Y N**

4. Which diseases will be prevented by the immunizations you or your child has received? (Check all that apply.)

____**Doesn't know**
____**Diphtheria**
____**Tetanus**
____**Whooping cough (specify):**_____

____**Measles**
____**Tuberculosis**
____**Polio**
____**Other**

5.a **Do you know what might happen as a side effect after the immunization?**
.....…….. **Y N**

.b If YES, **what were you told? (Check all that apply.)**

____**Fever**

____**Irritability/crying**

____ **Pain at injection site**

____ **Swelling**

____ **Other (specify):**_____

6. How many vaccination visits does a child need in the first year of life to complete the series of vaccinations?_____

__1. Correct __2. Incorrect __8. Doesn't know

7.a **Did your child receive an immunization today? .....** **Y N**

.b If NO, **(Prompted question. Check a single response.)**

_ 1. Referred for vaccination another day
_ 2. Was not given or referred for vaccination
_ 3. Up to date

8. Do you have your child's vaccination card?
____1.Yes ___ 2.Lost ___3. Never received ___4. Left at home

If the caretaker has the card, record the dates of ALL VACCINES GIVEN, both today and in the past, and the child's birth date and age.

Birth date:____/____/____

Age:_____Months

Immunisation	Received		Date de vac.
POLIO.O (naissance)	Y	N	
BCG	Y	N	
DPT – 1	Y	N	
POLIO – 1	Y	N	
DPT – 2	Y	N	
POLIO – 2	Y	N	
DPT – 3	Y	N	
POLIO – 3	Y	N	
MEASLES	Y	N	

D. Child is up to date?	Y N

9. **Do you have your own vaccination card?**

____1. Yes ____2.Lost ____3.Never received ____4.Left at home ____5. N/A

If YES, copy the caretaker's tetanus toxoid vaccinations in the table below. If the caretaker's TT doses are recorded on the child's vaccination card, copy them here also.

Immunisation	Received		Date de vac.
TT – 1	**Y**	N	
TT – 2	**Y**	N	
TT – 3	**Y**	N	
TT – 4	**Y**	N	
TT – 5	**Y**	N	

E. Caretaker has received at least TT-2?	**Y N**

10.a **Did you receive a tetanus vaccination today? .....** **N/A Y N**
.b If NO, **(Prompted question. Check a single response.)**

__1. Referred for vaccination another day
__2. Was not given or referred for tetanus vaccination
__3.Up to date

11.a **Were you prescribed any oral medication at your last visit?**
Y N

.b **Were you able to get the medication? .....**
If YES, **where did you go to get your medication?** **Y N**

____**The health facility** ____**Mission hospital**

____**Private pharmacy** ____**Drug vendor**

.c If NO, **why not?**

____**No drugs available** ____**No money/could not afford**

____**No source** ____**Other**

Thank the caretaker for answering your questions and ask if he/she has any questions. Be sure that the caretaker knows how to prepare ORS for a child with diarrhea, when to return for vaccination, how to give the prescribed medications, and when to return if the child becomes worse at home.

CONTINUE THE INTERVIEW IN NEXT PAGE WITH THE HEALTH STAFF WHO TOOK CARE OF THE CHILD

HW Category :_____ Date: ___/___/_____

1. Do you have a regular supervisor? ..... Y N
If NO, go to question 9.

2. Do you have a schedule for supervisory visits? ..... Y N

3. How many times have you had a visit from a supervisor ____

- In the last 6 months ..... _____ (number of times)

- In the last 12 months ..... _____ (number of times)

- Supervisor works here and sees worker daily…… Y N

4. How many child-health-related training sessions have you received in the last 12 months?
_____

If NO training received, go to question 14.

5. What type of training was it (give the course title) _____

6. Did your *last* training involve clinical practice? ..... Y N

END OF INTERVIEW

Annex 2 THE RAPID CATCH QUESTIONNAIRE

MODULE 1
EXCLUSIVE BREASTFEEDING AND NUTRITION CHILDREN 0-5 MONTHS

1. Program Unit :	
3. Health Area:	
5. Village:	
7. Name of the surveyor:	

2. Health District	
4. LQAS #	
6. Interview date:	

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD LESS THAN 6 MONTHS

8. Name of the respondent: _____

9. Name of the child: _____. Age of the child in __ __months:

No	QUESTION	ANSWER	SKIP GO TO
10.	**I would like to ask you about the types of liquids and foods that (NAME) consumed yesterday during the day or at night.** ***Check any item listed from the list.***	**LIQUID/FOOD** **A Breastmilk?** **B Plain water?** **C Commercially produced infant formula?** **D Any other milk such as tinned, powdered, or fresh animal milk?** **E Fruit juice?** **F Any other liquids such as sugar water, tea, coffee, carbonated drinks,** **or soup broth?** **G Solid / semi liquid** **Specify _____**	

No	QUESTION	ANSWER	SKIP GO TO
11.	In the first eight weeks after delivery, did you receive a vitamin A dose like this?	1. YES 2. NO →	Module 4 sick children
12.	IF YES how many times	1. One time → 2. Two times or more	Module 4 sick children
13.	How many days after the first capsule did you take the second one?	__ __ (number of days)	

GO TO MODULE 3 – SICK CHILDREN
0-23 months

MODULE 2 VITAMIN A SUPPEMENTATION CHILDREN 6-23

Interview date: __/__/__

Name of the respondent: _____

Name of the child: _____

Age of the child in months: __ __

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD AGE 6-23 MONTHS

No	QUESTION	ANSWER	SKIP GO TO
14.	**Did (NAME) take a vitamin A dose like this during the last 6 months?[1]** **SHOW AMPULE/CAPSULE/SYRUP.**	**YES ..... 1** **NO ..... 2** **DON'T KNOW……8**	

GO TO MODULE 4 – SICK CHILDREN 0-23 months

MODULE 3 VACCINATION

Interview date: __/__/__

Name of the respondent: _____

Name of the child: _____

Age of the child in months: __ __

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD AGE 12-23 MONTHS

No	QUESTION	ANSWER	SKIP GO TO
15.	Do you have a card or any other document where (NAME'S) vaccinations are written down? IF 'YES'ASK 'May I see it please?'	1 YES, SEEN BY INTERVIEWER 2 NOT AVAILABLE (lost/misplaced, not in home) → 3 NEVER HAD A CARD → 8 DON'T KNOW →	 Q.17 Q.17 Q.17
16.	IF document available, record the dates for measles and DPT-HepB-Hib 3	Antigen / Date: DD, MM, YYYY DPT-HepB-Hib 3: ___ ___ ___ Measles: ___ ___ ___	
17.	**IF document not seen or nothing found in the document continue asking.** "Has (NAME) received any vaccinations that are not recorded on this card, including vaccinations given during immunization campaigns?	1. Yes 2. No → 3. I don't' know →	 Module 4 sick children Module 4 Sick children
18.	"DTP Hep B, Hib vaccination, that is, an injection given in the thigh, at the same time as polio drops?"	1. Yes 2. No →	 Q.20

No	QUESTION	ANSWER	SKIP GO TO
		3. I don't' know →	Q.20
19.	How many times	1. One 2. Two 3. Three or more 8. I don't know	
20.	"Measles vaccine?"	1. Yes 2. No 3. I don't' know	

GO TO MODULE 4
Sick children 0-23 months

MODULE 4 SICK CHILDREN 0-23 MONTHS

ALL SUBSEQUENT QUESTIONS PERTAIN TO ANY CHILD LESS THAN 24 MONTHS WHO WAS SICK IN THE PAST TWO WEEKS

Interview date: __/__/__

Name of the respondent: _____

Name of the child: _____

No	QUESTION	ANSWER		SKIP GO TO
21.	Did (NAME) experience any of the following in the past two weeks? *READ CHOICES ALOUD AND CIRCLE ALL MENTIONED BY RESPONDENT.*	A	DIARRHEA	
		B	COUGH	
		C	FAST BREATHING/SHORT, QUICK BREATHS	
		D	MALARIA	
		E	BLOOD IN STOOL	
		F	DIFFICULT BREATHING	
		G	FEVER	
		H	CONVULSIONS	
		OTHER	_____	
22.	*IF ONE OPTION AT LEAST FROM A to H is mentioned, continue asking,* "When (NAME) was sick, was he/she offered less than usual to drink, about the same amount, or more than usual to drink?" (breast for the child 0-6 months)	1.	LESS THAN USUAL	
		2.	SAME AMOUNT	
		3.	MORE THAN USUAL	
23.	"When (NAME) was sick, was he/she offered less than usual to eat, about the same amount, or more than usual to eat? "	1.	LESS THAN USUAL	
		2.	SAME AMOUNT	
		3.	MORE THAN USUAL	

24.	**If "A" is circled in question 17 ask:** **" What did you give to the child to treat that diarrhea?"**	**1** **2** **3**	**ORS** **Other fluids** **Other**	

GO TO MODULE 5 children 0-23 months

MODULE 5 GENERAL FOR CHILDREN 0-23 MONTHS

ALL SUBSEQUENT QUESTIONS PERTAIN TO THE YOUNGEST CHILD UNDER AGE TWO

No	QUESTION	ANSWER	SKIP GO TO
25.	Do you have a vaccination card or another document where the vaccinations for (Name) are recorded?	1. YES 2. NO →	Find the information in the community register
26.	If the mother provides the vaccination card, look at the growth monitoring section and Fill the table You can also fill the table based on informations in the community register		

	Apr 09	May 09	Jun 09
Age in months			
Weight			

No	QUESTION	ANSWER	SKIP GO TO
27.	Before you gave birth to (NAME) did you receive an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?	1. YES 2. NO → 3. DON'T KNOW →	 Q.29 Q.29
28.	How many times did you receive such an injection?	1. ONCE 2. TWICE 3. MORE THAN TWO TIMES 8. DON'T' KNOW	

No	QUESTION	ANSWER	SKIP GO TO
29.	Sometimes children get sick and need to receive care or treatment for illnesses.	A. DON'T KNOW B. LOOKS UNWELL OR NOT PLAYING	

No	QUESTION	ANSWER	SKIP GO TO
	What are the signs of illness that would indicate your child needs treatment?	NORMALLY C. NOT EATING OR DRINKING D. LETHARGIC OR DIFFICULT TO WAKE E. HIGH FEVER F. FAST OR DIFFICULT BREATHING G. VOMITS EVERYTHING H. CONVULSIONS I. OTHER _____ J. OTHER _____ K. OTHER _____	
30.	Do you have any bednets in your house?	1. YES 2. NO →	Q.35
31.	Who slept under a bednet last night? CIRCLE ALL THAT APPLY.	A. CHILD (NAME) B. RESPONDENT → C. OTHER INDIVIDUAL(S) → D. NOBODY →	If "A" Child name is not mentioned go to question 35.
32.	When did you receive or buy the mosquito net (name) used last night?	A. LESS THAN TWO YEARS → B. MORE THAN TWO YEARS	Q.31
33.	Was the bednet ever soaked or dipped in a liquid to repel mosquitoes or bugs?	a. YES b. NO → c. DON'T KNOW →	 Q.31 Q.31
34.	How long ago was the bednet last soaked or dipped?	_____ Months	

No	QUESTION	ANSWER	SKIP GO TO
35.	**I'd like to ask one more question. When do you wash your hands with soap/ash?**	**A. NEVER** **B. BEFORE FOOD PREPARATION** **C. BEFORE FEEDING CHILDREN** **D. AFTER DEFECATION** **E. AFTER ATTENDING TO A CHILD WHO HAS DEFECATED** **X. OTHER _____ (SPECIFY)**	

MODULE COMPLETION CHECKLIST

THIS SHEET TO MAKE SURE THAT ALL THE SECTIONS OF THEQUESTIONNAIRE ARE COMPLETE.

1. **PLEASE CHECK ALL THE MODULES AND CIRCLE "YES" FOR A MODULE THAT IS COMPLETE AND LEAVE THE NON COMPLETED MODULE BLANK**

Module 1 **is completed**	**1. YES**	**2. NO**
Module 2 **is completed**	**1. YES**	**2. NO**
Module 3 **is completed**	**1. YES**	**2. NO**
Module 4 **is completed**	**1. YES**	**2. NO**

2. **FOR ANY MODULE NON COMPLETED, PLEASE RANDOMLY SELECT AN ELIGIBLE CHILD IN THE COMMUNITY, ASK THE QUESTIONS, FILL THE QUESTIONNAIRE AND CHECK "YES". REPEAT THIS UNTILL ALL THE MODULES ARE COMPLETE BEFORE TAKING ANOTHER SET OF QUESTIONNAIRES.**

3. **I, _____ declare that all the sections of this set of questionnaires were filled as per the training and random sampling.**

Date ___/__/2009 Signature