

PLAN INTERNATIONAL USA, INC
d/b/a CHILDREACH

Annual Report
Senegal Child Survival XIV Project

Cooperative Agreement No FAO-A-00-98-00025-00

IMPLEMENTING AGENCY

Plan International
Senegal Country Office
in partnership with
The Ministry of Health of Senegal and FORM' ACTION

LOCATION:

Districts of Nioro and Louga, Senegal

CONTACT PERSON

Mr Samuel Worthington
National Executive Director,
PLAN International USA, Inc
d/b/a Childreach
155 Plan Way, Warwick, Rhode Island 02886

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ACRONYMS

APC	Assistant Project Coordinator
CBO	Community Based Organization
CCB	Community Capacity Building
CCF	Christian Children Fund
CHE	Community Health Educators
CHT	Community Health Team
CHW	Child Health Worker
CS	Child Survival
CSP	Country Strategic Plan
DCM	Diarrhea Case Management
DIP	Detail Implementation Plan
FHS	Field Health Supervisor
HCs	Health Centers
HH	Health Huts
HIS	Health Information System
HFA	Health Facility Assessment
HP	Health Posts
HSP	Health Service Points
IEC	Information Education Communication
IRD	Institut pour la Recherche et le Developpement (Research and Development Institute)
ITN	Insecticide Treated Nets
KPCs	Knowledge Practice Coverage
MC	Mothers clubs
MCM	Maternal Case Management
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non Governmental Organization
NHA	National Health Advisor
NHC	National Health Coordinator
NTMES	National Training Monitoring and Evaluation Supervisor
ORS	Oral Rehydration Sachet
PHN	Public Health Nurse
PVC	Private Voluntary Organization
PC	Project Coordinator
PU	Program Unit
RGY	Radio Guneyi
SANAS	Service Alimentation et Nutrition au Senegal
SCM	Standard Case Management
TBA	Traditional Birth Attendants
USAID	United States Agency for International Development
WCA	Women of Childbearing Age
WVI	World Vision

Executive Summary

PLAN International's Child Survival Project in Senegal has initiated implementation in two rural areas, Koalack and Louga. The project aims to reduce mortality and the risks to child survival, through the appropriate management of diarrhea, pneumonia, malaria, and malnutrition and the prevention of vaccine preventable illnesses. The project aims to reach children under five and women of childbearing age. Within this group children under two are prioritized, since the under two mortality accounts for more than 50% of the infant mortality rate in rural Senegal.

The first year of implementation succeeded in the completion of most start up activities. It also involved planning workshops with all stakeholders to review and refine the implementation plan, using data generated from the baseline survey and lessons learned from initial activities. The year ended with staff hired, oriented and trained, the NGO partnership formalized and functional, baseline assessments completed, the DIP documented, assets procured, and field implementation initiated. Staff, partners, and the community are motivated for the successful implementation of this program as planned.

PLAN has a good and long standing reputation in Senegal. The project enjoys supportive and productive relationships with the Ministry of Health, the partnering NGO, and community based organizations. These factors will facilitate PLAN's ability to respond to the health needs of the population, and make a significant contribution to child survival.

This annual report summarizes the key achievements of the first performance year, notes changes in the original project plan, and responds to the comments of the DIP reviewers. The process of completing this report helped staff reflect of what has been done, what still needs to be done, and how best to do it.

1. Accomplishments and constraints

1.1 Accomplishments

In accordance with the project plan, PLAN and collaborating partners successfully completed the preparatory and start-up activities for the first year. These key activities are listed below.

1.1.1 Hired Staff

Following the recruitment and review of qualified candidates, PLAN hired, oriented, and placed the following key personnel:

- 1 Project Coordinator
- 1 Assistant Project Coordinator, for training, monitoring and evaluation
- 1 Assistant Project Coordinator, for Community Capacity Building and Organizational Development
- 2 Health Information System Assistants, who also provide administrative support
- 15 Community Health Educators (8 for Louga and 7 for Kaolack, contracted and paid with project funds by the collaborating partner NGO, Form'Action)

1.1.2 Trained and oriented staff and partners

- **Community Health Educators and Community Health Teams** (CHWs, TBAs, IEC Relays) associated with the 61 health huts already operational, received initial training and orientation. Other health service points will be enrolled and the personnel trained in the next performance year. The Community Health Educators received training in census taking, health information systems and monitoring tools, and conducting a community assessment of capacity building needs. These skills were immediately applied and refined through the job supervision.
- **Public Health Nurses** (10) were trained in *Training of Trainers* methodology in preparation for their role as trainers and supervisors of the community health team.
- **Health Authorities** at every level were oriented to the goals and activities of the project to solicit full cooperation and support.
- **Staff** were oriented and trained in the key areas listed below, and the skills gained were applied immediately for the implementation of the project:
 - Child survival, a general overview of the grant, etc (project staff)
 - Grant Administration (administrative and management staff)
 - Epi-Info and setting up of the children's registers (Health Information System Assistants and the Project Coordinator in charge of training)

Training in the following areas is planned for the next performance year:

- Supervisory skills using the monitoring tools. This will be done after the pre-testing and final revision of the monitoring tools.
- Community empowerment and capacity building. This will be done after finalizing curricula of community empowerment and capacity building in collaboration with World Vision International and Christian Children's Fund.

1 1 3 Conducted Baseline Assessments

A number of baseline assessments were completed in collaboration with partners at various levels, to understand the current health situation and operating environment. The results of these assessments were used to refine the project plan and develop context specific approaches. These assessments include the following:

- A *Knowledge, Practice, and Coverage Survey* was completed during the first quarter. This involved a survey of households with children under 5 years of age, using the standard child survival survey methodology. The survey assessed knowledge, health practice, and baseline coverage rates. The results were shared with the Ministry of Health, NGOs, and communities.
- A *Census* of children under 5 and pregnant and lactating women was completed in the fourth quarter. The results were used to generate registers of eligible women and children and update the numbers of project beneficiaries.
- A *Training Needs Assessment* was completed during the third quarter to identify the training needs of health promoters and providers. This included members of mothers' committees, community health teams, and the District Management team, as well as Health Officials, Public Health Nurses, and Project Staff.
- A *Capacity Building Needs Assessment* of Community Based Organizations was completed in 16 pilot villages (8 in Sakal and 8 in Wack-Ngouna). This involved interviews and discussions with members of Mothers' Committees, Women's Groups, and Village Health Committees. This assessment was done by community health workers, under the supervision of the Assistant Project Coordinator of Capacity Building, using a methodology developed by Form'Action. The Assistant Project Coordinator for Monitoring and Evaluation also participated in the assessment to ensure optimal monitoring and evaluation of capacity building activities.

The KPC survey revealed specific areas where the project will place special attention. The following are examples of key findings and how the project is responding:

- The KPC revealed a low level of exclusive breastfeeding before 4 months, which may contribute to the high rate of diarrheal disease in children under 3 months of age (51.2%). IEC messages will promote exclusive breastfeeding up to 4 months of age.
- Survey findings confirmed concern about Nutrition and Micro-Nutrient deficiencies. The project will focus on community owned interventions such as growth monitoring and treatment of faltering children and referral to health posts of children with moderate to severe malnutrition. Vit A supplementation will be promoted at health centers and during immunization activities.
- Immunization coverage for both Children less than 2 and women of reproductive age was low (30.8% and 55.3%). The project will work with the MOH to establish outreach activities in order to increase these figures.
- Malaria is very common in the area, with 57.7% of mothers interviewed indicating that their children had fever during the previous two weeks. Of these women only 30.6% had given their children Chloroquine and only 2% reported having an insecticide treated mosquito bednet. The project will emphasize quality treatment (right dose and right length of time),

encourage use of impregnated bednets, prophylactic treatment of pregnant women and appropriate referral

Key findings from the Capacity Building Needs Assessment designed by Form' Action revealed the following key points

The Community Management Committees (Village Health Committees and Mothers' Committees) had the following strengths

- Members are very dynamic and engaged in Child Survival activities and recognize their benefit
- Membership criteria are uniform within both project sites Member must be married and living in the village)
- Community Based Organizations (CBO) management procedures and tools do exist and are well known by all members
- Several support and income-generating activities (literacy classes, micro-credit schemes) exist in PLAN villages

The following weakness were found

- Mother Committees and Women's' Group members do not consider Child Survival activities as part of their regular day to day activities and do not link them to the existence of the project
- CS activities are not regularly held, management tools are not well filled out, high illiteracy rate among group members
- Lack of documentation of achievements and lessons learned
- Ignorance of leaders and member's roles and responsibilities in the CBO management, and leaders have been in position since the creation of the CBOs

Form' Action is using the results from this assessment to initiate participatory planning for capacity building of these groups

1 1 4 Planning Workshops Held

Planning workshops with staff and partners, generated outputs which were used to finalize the Detailed Implementation Plan, and a common understanding among collaborating partners

- The *Detailed Implementation Plan Workshop* involved key members of the PLAN-Senegal and Form' Action staff, and the PLAN-Ghana Country Health Advisor DIP sections were developed by one or more workshop participants and finalized after consultation with the team
- A *Start-Up Workshop* held with participants from MOH, NGOs, and Communities generated further input into the DIP
- *Community workshops* held in both sub-districts proved a forum to share the results of the DIP and Start-up workshops and KPC Survey with community members Their feedback was used to develop the project work plan (see Annex 1)

1 1 5 Signed Memorandum of Understanding

A Memoranda of Understanding (MOU) with Form'Action and MOH was signed in the second and third quarters respectfully. This formalized PLAN's working relationship with these partners for the implementation of this project. The MOU with Form'Action involved the disbursement of funds to activate and organize community based organizations to implement Child Survival activities.

1 1 6 Procured assets, supplies, and materials

Standard procedures were followed for procurement, with expenses charged as planned in the DIP budget to either USAID or to the match generated by PLAN.

- **Capital assets**, including 2 vehicles, 4 computers, 3 printers, and office furniture for all project staff have been procured and are in use since the second quarter. Capital assets were procured following a review of competitive quotes, however this delayed the procurement of vehicles, which were bought in Senegal in June 1999.
- **Health supplies**, such as Insecticide Treated Mosquito Nets, Health Hut Supplies, Health Registers, and IEC materials is in process of being procured or requires on-going procurement. There is a stock shortage of insecticide treated bed nets from the least expensive vender, and the current budget is insufficient to allow procurement for other vendors. PLAN is in the process of investigating other suppliers. Essential drugs (chloroquine, iron, ORS, etc.) have already been procured, and Vitamin A is in process. The procurement of health cards and weighing scales is also in process. Procurement of drugs and insecticide is from the PLAN matching budget.
- **Registers and IEC materials**, will be procured only in the next performance year. The procurement of Monitoring registers will be done only after pre-testing the registers designed during the Health Information System Workshop. Existing IEC materials have been identified, and are in the process of being reviewed and ordered. A cloth flip-chart is being designed with attractive pictures, and is intended to be durable beyond the life of this project. A training manual has been prepared by PLAN and partners and will be shared. The manual will be finalized with the incorporation of illustrations.

1 1 7 Initiated coordination and supervision

Coordination and supervisory systems, if established early, facilitate the implementation of the project and sharing of information.

- **NGOs** receiving Child Survival Grants, including World Vision and Christian Children's Fund, held workshops to discuss the goals and priorities of CS projects, variation in their strategies, implementation constraints and solutions, management issues, and the role of communities, CBOs, government authorities, collectives, and health service providers. These meetings have been very useful and will continue. On several fronts joint actions are being planned at this forum.
- The **project team** coordinates its activities through mail, telephone, and meetings. The two Field Supervisors, Assistant Project Coordinator, and Project Coordinator meet at least monthly to discuss their work plan. Routine supervision of project staff and activities has been initiated and will be strengthened when the monitoring system is initiated. A supervisory schedule and checklist for project activities is finalized.
- A **Project Coordination and Steering Committee** was established, and a schedule for regular meetings finalized.

1 1 8 Initiated Implementation Activities

- The project has concentrated on organization and preparation activities before initiating community education. Project personnel concentrated on community diagnosis and census, developing the health tracking system which will allow follow up of individuals, developing supervisory tools and developing IEC material. Community education was performed for Malaria, but will be implemented early in year 2 for other intervention areas.
- Procurement of bednets for the entire project area was delayed because of shortages of this product from the original supplier. Cost from alternative suppliers were too high for this project. Project staff continued to explore solutions to this problem and expect it to be solved early in project year 2. PLAN did distribute 840 bednets in the project area using sponsorship funds. The project will distribute bednets to other families following the procurement of additional bednets.
- Health Huts provide information, services, supplies, and referral for the prevention and management of malaria, diarrhea, pneumonia, and growth faltering. Public Health Nurses provide immunizations at Health Posts. However, reports of services provided are not available due to the Public Health Nurses Information Withholding Strike. The project is currently organizing outreach activities in which immunization and other health services will be available at health huts and health service points.
- Negotiations are in process with Radio Guneyı and local radio stations to broadcast health messages (See Annex 2).

The following pages have charts that indicate achievement against plan, by intervention. These charts also indicate any changes made in the objectives, indicators, or activity plan.

1 1 8 a Immunization

To reduce mortality from vaccine-preventable illness, through universal immunization coverage

Objective (with indicator)	Planned activities	FY1 Achievement or Comment
1 70% of children 12 to 23 months are fully immunized by age 1 BL 30 8%	Promote retention of immunization cards, and check cards at all encounters	Registers of children and pregnant women have been developed based on community census The monitoring system has been developed The EPI missed opportunity study planned for year 1 is now planned for first quarter of year 2
2 70% of children 12 to 23 months receive DPT3 by age 1 BL 30 8	Establish and maintain registers of all children under 5 and pregnant women, with check list of those who received and did not receive immunizations (Staff)	
3 70% of children 12 to 23 months receive measles vaccine by age 1 BL 37%	Remind pregnant women to get TT, and mothers to immunize children (CHWs)	
4 80% of women with children 0 to 23 months received TT2 during their last pregnancy BL 55 3%	Follow-up with IEC strategies to complete immunization series Monitor vaccine coverage (PHNs and CHT) Promote immunization through monthly growth promotion sessions Increase frequent access to vaccines, through mobile vaccination efforts, outreach, and logistic support Support social mobilization for planning immunization days (CHTs and MCs)	

Notable changes

- The objectives have been reduced from 6 to 4
- Process objectives / indicators have been removed, such as % with cards
- Goal statement has been modified to reflect child survival goal
- Single use disposable auto-destruct syringes and disposable containers are not available for this project
- Periodic interviews with mothers on their knowledge and practice have been incorporated into the health facility assessments

1 1 8 b Diarrhea Case Management

To reduce diarrhea-associated mortality and malnutrition, through prompt and appropriate case management and referral

Objective (with indicator)	Planned activities	FY1 Achievement or Comment
1 80 % of mothers with children 0 to 23 months, can name without prompting, at least three danger signs that require medical referral and treatment for diarrhea	IEC focus on home management of diarrhea	ORS packets have been produced
2 80% of mothers with children under 2 can demonstrate or explain how to prepare ORS correctly	Provide and distribute ORS packages from the health huts	IEC materials have been developed
3 40% of children under 2 with diarrhea in the past 15 days, received ORS	Educate mothers through group sessions and individual counseling (CHTs and MCs)	CHTs have received initial training on DCM
4 70% of children under 2 with diarrhea in the past 15 days, receive as much or more fluids and food	Train CHT on management and referral of diarrhea	
5 70% of children under 2 with diarrhea in the past 15 days, and currently breast feeding, receive as much or more breast milk	Train of health centers on severe case management and provisioning of ORS	
6 90% of health huts and centers are equipped and staffed to manage severe cases of diarrhea	Promote breast feeding and increased liquids and foods during diarrhea	

Notable changes

- Some of objectives have be separated into more than one objective, but essentially the list of performance indicators remains the same as before
- Knowledge and process indicators are combined with practice indicators, since it is difficult to assess achievement in CDD
- More precise and standard measures of practice have been incorporated

1 1 8 c Pneumonia Case Management

Goal To reduce pneumonia associated mortality through prompt and quality case management and referral

Objective (with indicator)	Planned activities	FYI Achievement or Comment
1 70% of mothers with children 0 to 23 months recognize at least two signs of pneumonia BL 33 9%	Plan and implement community based IEC activities Train CHT and MC on the danger signs that indicate referral	CHT have been trained on danger signs that indicate referral
2 80% of children 0 to 23 months with danger signs referred to health post	Train CHEs who will train CHT an MCs on danger signs indicating referral	Project has approached MOH about use of antibiotics at the Health Hut and HSP level
3 70% of health posts have adequate and current stock of antibiotics to treat pneumonia	Train MOH staff, CHT, and MCs on prompt referral Equip health posts with initial antibiotics	MOH is uncomfortable about this action and denied permission

Notable changes

- In accordance with AID DIP comments, the number of objectives and indicators have been reduced from 4 to 3, process indicators, such as the percentage trained have been dropped, and the service quality indicator which is difficult to measure has been dropped
- Ethnographic studies will not be conducted by this project

1 1 8 d Malaria

Goal To reduce malaria associated mortality related in children and pregnant women by improved Malaria Case Management, Antenatal Prophylaxis, and treatment

Objective (with indicator)	Planned activities	FYI Achievement or Comment
1 90% of mothers with children under 2 prescribed an anti-malarial drug during their last pregnancy	Educate mothers and other household members with IEC on malaria prevention, using impregnated bed nets for pregnant women and children under 2	CHT initiated IEC activities 840 bednets were distributed with sponsorship funds
2 60% of suspected cases of acute malaria in children 0 to 23 months will be treated presumptively with an effective and appropriate anti-malarial drug and given supportive care	Educate pregnant women on the use of anti-malarial drugs during pregnancy to prevent malaria Organize MCs and CHT to purchase, distribute, and re-treat bed nets	
3 20% of children under 2 and 30% of pregnant women will use impregnated bed net at least 4 nights each week BL 32%	Train CHWs and CHEs, on the management of acute cases, febrile episodes, appropriate support, referral, provision of Chloroquine and paracetamol, health education and counseling Insure supplies of anti-malarial drugs	

Notable changes

- The number of objectives /indicators were reduced in accordance with AID comments
- Objectives now focus on practices Process, knowledge, and activity indicators were removed
- A supply related activity was added availability of antibiotics is required for performance
- Some target rates of coverage were modified, after considering base line data
- Store keepers will not be trained (see AID comments)
- Mothers' committees (instead of CHWs) will do bed net dipping in health huts
- Insecticides will be stored in health huts and posts, where safe storage is possible
- Every case of anemia detected will be treated with an anti-malarial drug

1 1 8 e Malnutrition

Goal To reduce growth faltering, malnutrition, and consequent vulnerability to death from infection, by promoting optimal infant feeding and growth

Objective (with indicator)	Planned activities	FY1 Achievement or Comment
1 40% of children 6 to 24 months were given only breast milk, on demand, for the first 4 months BL 3 tp 25%	Monitor and record weights, and promote growth at least once a month for children under 2	The registers have been established to track individual children for follow up
2 80% of children 12 to 24 months continue to be breast fed	Train MCs on growth monitoring and promotion, food preparation, nutrition, optimal breast feeding, and growth faltering	
3 60% children 6 to 23 months received semi-solid and solid foods in addition to breast milk by the time they were 6 months of age	Set up registers to track children's growth and provide tool for individual follow-up	
4 80% of children 12 to 23 months received Vitamin A before 12 months of age	Ensure supply of Vitamin A at all immunization events and mobile outreach units Provide IEC on optimal breast feeding and complementary feeding practices	

Notable Changes

- The number of objectives have been reduced to a core few related to healthy practice, in accordance with USAID comments
- Target rates were reduced for exclusive breast feeding in accordance with AID comments

1 1 8 f Sustainability

Goal To enable community groups to continue the process of health promotion and practice

Objective (with indicator)	Planned activities (by Form' Action)	FYI Achievement or Comment
1 100% of HSP and HH are linked to Community Management Committees (Village Health Committees, Mothers' Committees, Women's Groups) that are democratically elected, which are in charge of income generating activities, which are keeping accounting books, which are managing documents properly and which are financing health activities	Initial assessment of community management committees Develop action plan with each committee Elaborate management documents Participative diagnosis and democratic restructuring of committees Participative plan for maintaining culinary demonstrations and impregnated bednets at a price that allows sustainability	The initial diagnosis has been performed for the community management committees
2 ___ % of communities with HSPs able to finance Child Survival Activities	Follow up evaluations of committees	
3 ___ % of committees able to motivate CHT members to perform health activities	- Train managers of committees in simple book keeping and accounting principles	

Notes

This sustainability matrix is added in response to USAID comments Specific goals will be set as activities proceed

1 2 Enabling and Constraining factors for Project Implementation

1 2 1 Enabling factors

A number of factors enabled the initiation of the project to be successful, despite constraints. These include the following:

- Competent, experienced, and motivated staff
- Team spirit and orientation
- Participatory processes that reinforced collaboration and coordination
- Participatory and detailed planning, involving partners and communities. This built a strong common understanding of the project goals and the role of each player to achieve it
- Commitment and involvement of the Public Health Nurses in Nioro District
- Existence of already functional health huts
- A sustainability strategy established at project initiation

1 2 2 Constraining Factors and Actions taken to overcome constraints

- Delay in hiring key personnel. All key personnel have now been hired
- Delay in signing a MOU and Sub-grant agreement with the collaborating NGO, *Form'Action*, delayed the hire of Community Health Workers (CHWs) by *Form'Action*, which consequently delayed the census and other start-up activities implemented by CHWs. The contract is now signed, CHWs, hired, and the census completed
- Delay in vehicle procurement contributed to the delay in completing the census, and adequate field supervision. Vehicles have been procured and are used as planned
- Initial budget under-estimated the costs for supervision, the KPC survey, and DIP preparation, and was not in full compliance with USAID and PLAN guidelines. The budget has been revised and is attached
- Public Health Nurses, especially in Louga district, continue to withhold provider-based service and coverage data key to monitoring the project performance. The project staff are in the process of negotiating improved information sharing at the district, regional, and national levels
- Remote villages especially near the Gambian border were difficult to access due to distance, rivers, heavy rains, or poor transportation. In response to the transportation problem, Community Health Educators were transported to inaccessible sites using the project vehicle as an interim solution. Meanwhile *Form'Action* explores the possibility of procuring motorcycles for Community Health Workers and Public Health Nurses. In addition, the project plans to develop strong health teams in these communities to provide health education and select essential drugs
- There is a stock shortage of insecticide treated bed nets from the least expensive vendor, and procurement from other vendors would exceed the current budget. PLAN is in the process of investigating other suppliers

2 Substantial Changes in Project Design

There are no substantial changes in the project design or DIP that would require a modification to the approved cooperative agreement. Changes in the project design which do not require modification to the cooperative agreement are noted below.

2.1 Changes in the beneficiary population

In order to set up the health information tracking system, a census was performed on the target population of children less than 5 years and reproductive age women. These revised figures indicate that the actual beneficiary population of women and children is 57,906 which is 14% (50,776) greater than the figure cited in the DIP. A census was not performed on population not included as beneficiaries so the project still relies on estimated data for total population figures.

Total and Beneficiary Population Numbers

	Sakal (Louga)		Wachngouna(Nioro)		Combined	
	DIP Est	Actual	DIP Est	Actual	DIP Est	Actual
U5	7,904	13,122	15,586	11,962	23,490	25,084
Women 15-49	9,181	15,558	18,105	13,668	27,286	29,226
Total beneficiary population	17,085	28,680	33,691	25,630	50,776	54,310

2.2 Changes in the site

No changes in the project site were made since the DIP. Project staff decided to implement project activities in areas where there are established health huts first and then expand into HSP. HH are better organized around health activities and will serve as models for expanding into HSP areas. We will be working in 313 villages in Sakal, 12 of which have begun activities and 188 villages in Wachngouna, of which 49 have begun activities.

2.3 Changes in the interventions

The project has maintained the key interventions specified in the DIP since it represents a direct response to the principle causes of under-five mortality in the area. The project will incorporate Senegal's national IMCI strategy into program activities. PLAN is active on the national IMCI committee. The project will train PHNs who work at health posts in IMCI and will coordinate with national efforts to develop community IMCI.

2.4 Changes in the objectives, indicators, and activities

In response to USAID's comments that the goals and objectives be collapsed into fewer objectives, and these objectives focus more on coverage rates of healthy practice rather than process and activities completed, PLAN has modified the goals and objectives matrix.

In section 1.1.8 above revised matrices are presented. The changes in goals, objectives, and activities are noted in the third column and at the bottom of the page. Please refer to this section.

2.5 Changes in human resources or their roles, and organizational structure

The addition of two other projects (funded by DFID and Dutch Lottery grants) also focused on child survival presents an opportunity to share ideas, lessons learned, human resources and expertise. The key changes in staff and structure are noted below.

- The Assistant Project Coordinator for Training, Monitoring and Evaluation will be based at the national level, dedicating 40% of his time to the USAID funded child survival project
- The Project Coordinator is now based in the field with more direct and frequent involvement with project implementation at the community level
- Field Health Supervisors now dedicate more time to project implementation and monitoring
- Form'Action will focus on organizing and strengthening Community Based Organizations, and introducing health financing and cost recovery mechanisms. They will also train CHEs in participatory diagnosis, management, monitoring, and evaluation involving community members and leaders. Form'Action will do this instead of playing a leadership role in IEC
- Two additional PVOs, Christian Children's Fund and World Vision International, are working with PLAN to develop a participatory training methodology (see Annex 3)
- A district-based consultant will train MCs and other groups in promoting, purchase, distribution, and use of insecticide treated bed nets
- The ratio of health workers to beneficiaries has been changed from 1 to 174 (312 community health team members to a population of 54,301)
- Please see Annex 4 to see changes in the organizational structure

2.6 Changes in the Budget

The budget has been revised to reflect the activities and lessons learned in the first year. USAID funds were underspent but activities were funded with PLAN funds, and the PLAN share was overspent. Overall, project activities were met. Next year's budget and activity will be adjusted to compensate for the USAID – PLAN shares.

3.0 Responses to USAID DIP Review Comments

PLAN found the review to be thorough and helpful in considering issues and clarifying various components of the implementation plan. All comments were taken very seriously. For each issue raised in the BHR/PVC review and each written suggestion made by the DIP reviewers, a response is provided below. Unfortunately, PLAN did not receive the summary review comments in time for this report writing and has thus responded to review comments by category.

PLAN's focus will be to establish the project on solid ground, by implementing the core program well before incorporating larger numbers of objectives, indicators, and activities. Nonetheless, many of the suggestions were incorporated as secondary objectives or activities, while others are incorporated as core objectives. All the comments were carefully considered, and the project modified to reflect comments that were critical to shape the project.

We received the USAID Summary comments on the 26th of October 1999 and had already compiled specific responses to specific comments by category. These are included below – comments in bold italics and PLAN response in regular type. Here are the answers to the summary comments.

AID identified 4 comments which are important for the project to respond to as part of the Annual Report Responses to these points is summarized in the following table

DIP Review Comment	Project Response
Revise goals, objective, indicators including institutional strengthening, capacity building and sustainability	Goals and objectives were revised, see objective tables for each intervention in section 1 1 8 Capacity building and sustainability indicators were developed based on Form' Actions capacity building plan and on Form' Action's Community Management Committee analysis
Protocol for Form' Action	The Form' Action protocol has been translated into English and is included as Annex 5
Report on revisions after discussion of suggestions from DIP review	Section 3 1 provides details on responses to individual reviewer comments
Report on cross community and cross committee sharing	The project will be implemented in Health Huts first and these systems will serve as models for systems developed at Health Service Points There will be exchange visits between the model areas and the newer areas to allow for sharing of experiences

3 1 Objectives, indicators, and measuring performance – general comments

3 1 1 Comments on what to measure

Reduce the number of objectives

Project has too many goals, objectives and indicators These can be collapsed into fewer objectives Some objectives reflect process not final product or practice Some objectives are hard to measure

The Annual Report presents matrices with a fewer number of objectives Where possible practice level indicators which can be measured using the KPC survey are used In some cases process and output level indicators are also included The changes made are noted on each page

Add objective and activities on anemia

There is a growing recognition of the importance of malaria, anemia, and micronutrients The project team leader is a nutritionist, and should see how the project can increase the nutrition interventions for malaria There is iron for anemia, Vitamin A, and Zinc which the project may consider (Macdonald) Consider elevating the issue of anemia and malaria (Macdonald)

Anemia among women and young children presents a very important public health problem, and supplementation presents a simple and economical solution Anemia control will continue as a part of the overall MOH program in the country, and PLAN will support these efforts to the extent possible However it will not be included as a specific indicator or objective at this time, since it is important for the project and the staff to now focus on accomplishing a few things well

Measure coverage, outcomes, outputs, process, performance

Add objectives and indicators related to outputs, process, and performance, in addition to practice (see below under monitoring and evaluation) Measure the results of each project goal, measure outcomes at community and health service level, service quality and capacity, coverage, health worker performance, and process toward reaching the goals (Bertoli)

The project does plan to measure and monitor performance at various levels. However, outputs and process may be changed periodically to better meet coverage rates of health practices. To keep staff and partners focused on achieving healthy practices associated with child survival emphasis will be on measuring and monitoring practice level indicators.

Measure capacity building of community groups

How will functioning of mothers' clubs and village health committees be tracked? Are there milestones and a baseline against which you can report progress? (Bertoli)

Some objectives need to measure capacity building of community groups (Bertoli)

Include indicators and objectives for capacity building and sustainability (Davis)

The project is in the process of developing objectives and measures for sustainability and capacity building, and systems to track the capacity and functioning of community based organizations. A sustainability and capacity building matrix is included in this annual report. The work of Form'Action will lead the process of doing this.

Measure IEC

Will the effectiveness of IEC be monitored routinely? The impact on caretakers will be assessed through periodic exit interviews at immunization services and through KPCs (Bertoli) How will PLAN know if key messages and IEC strategy are effective? (Luna)

Focus group discussions conducted every two years will also generate qualitative information on IEC messages.

Measure perceived quality

Monitoring and evaluation system seems top down Consider including a indicator of mothers' perception of quality of services (Bertoli)

Mothers' perception of the quality of services will be included in the Health Facility Assessment, and can also be included in the mid-term and final surveys. However, the project will initially concentrate on generating good monitoring data on coverage rates of healthy practices, before attempting to add and generate quality of service indicators. This stepped approach to establishing a monitoring system will allow PLAN to establish a HIS that generates good data for decision making.

Measure health facility

Can health facility assessment be performed earlier? (Luna)

The health facility assessment is planned for the first quarter of the second fiscal year.

3 1 2 Comments on Analysis, Documentation, and Use of information

Separate the baseline survey results for the two areas, and formulate different approaches as appropriate Report separately for Louga and Kaolack (Ventimiglia)

The data are presented separately and combined, and context-specific approaches are developed to reflect each context.

*Consider documenting the process of working with Rural Health Steering Committees (Ventimiglia)
Consider documenting the context where men have migrated and women have opportunity to improve family health with money sent by men (Luna's notes)*

To the extent possible, PLAN will try to document these and other ideas either directly or through the help of consultants, especially where documentation can facilitate the sharing of lessons learned. The study about the out migration may be incorporated into the qualitative research of mother's comprehension of messages. However, the main focus of staff will be on the implementing the core project and striving to achieve the principle project goals.

Will health information data be computerized? By whom? (Haggarty)

Health information data will be computerized using Epi-Info. An MIS assistant will be responsible for this.

All the supervision, indicators, and checklists are from the top-down Household surveys can be conducted and information managed by Village health and Mothers' committees. It would be stimulating for project beneficiaries to review vital events, morbidity, and quality of services" (Macdonald)

In response to this suggestions, PLAN has incorporated processes which involve village health and mothers' committees in the process of monitoring, analysis and use. PLAN is seeking further guidance on tested methods to do this.

What kind of decisions are CHEs making based on the information that they collect?

The use of data for decision making will be key to implementing and sustaining this project. CHEs will use the children's and mother's registers to identify which individuals need follow-up support to practice healthy behaviors, such as immunizations. The registers are check lists, which indicate those individuals who practice the intervention, and those who need follow-up support to practice. CHEs will share consolidated information with the community, to increase community involvement in identifying problems and solutions.

3.2 Sustainability, including health financing and financial sustainability

3.2.1 Building capacity to continue child survival activities

Who will perform the functions of the CHEs once the project ends? Facilitate direct contact between the nurses and CHTs, and build the capacity of the nurses and the communities, to support the CHT functions. Otherwise who will play the role of CHEs at the end of the project? (Ventimiglia) By having CHEs participate in VHC meetings will community capacity to analyze and articulate health concerns and innovations be built? (Bertoli)

PLAN strives to enable and empower communities to identify health problems and solutions, and plan and take actions to implement these solutions. CHEs are selected from the same community where they work. PLAN in partnership with Form Action is exploring the creation of Groupement d'Interet Economique (GIE) to generate that can sustain the CHE and their work. PLAN is also working closely to strengthen the links between PHCs, CHTs, and CHEs, and defining a sustainable role for each of them. CHEs already participate in VHC meetings to facilitate the process of analyzing health problems and concerns and developing innovative solutions to them.

Mothers' committees can train other mothers' committees These committees can supervise each other to increase sustainability

Mothers' committees, as a part of village health committees, can be supervised by village health committees to plan actions, and schedule follow-up Community health educators and Public Health Nurses will supervise the technical content of actions taken

What is the literacy rate among CHTs? Will plan link TBAs / CHT members with a literacy program? (Davis)

The literacy rate of CHTs is 96% in Louga, while the literacy of CHTs in Kaolack are in the process of being assessed By design, each Community Health Team will have at least one literate and numerate member, and PLAN has started work with these literate CHT members PLAN does have a literacy program, which illiterate CHT members will be encouraged to access

Implications of PLAN inputs on sustainability

If PLAN pays salaries for PHNs at the 10 project posts, what are the implications for sustainability? Are these PHNs on leave from MOH? If so, what are the implications for sustainability of their performance after the project ends? If CHEs perform some responsibilities of PHNs, because PHNs do not have sufficient time, what are implications of sustainability after the project ends? Will PLAN pay Form'Action supervisors? (Haggerty) Supplies for culinary demonstration and IEC will be provided by the project What are the implications for sustainability? (Haggarty)

The project is not paying salary to PHNs posted in the 10 projects health posts Rather, the project is paying salary to the two Health Supervisors one in each project site with the responsibility of overseeing the project implementation in their respective site

As regard to CHEs, the project is approaching the decentralized municipalities to convince them to take over their salaries, as it is the case for primary school teachers Also income generation activities will be initiated in favor of the CHEs in the context of others PLAN activities

Strengthen links with private sector commercial marketing

"Chemical sellers" can be tied in to products for the appropriate management of diarrhea and malaria Maybe there could be a closer relationship between IEC on the one hand and commercial marketing on the other The shop keeper can distribute 4 products soap, ORS, insecticide and nets The shop want to sell, and PLAN wants people to use more of these products (Macdonald)

This issue will be reviewed over the life of the grant

3 2 2 Health financing and cost recovery

Is vaccination a service paid for by the community?(Ventimiglia)

No The vaccination service and supplies are provided free of charge through the MOH PLAN supports MOH staff to provide vaccines monthly at outreach points closer to the communities However, community members pay a small fee for vaccinations, consistent with the Bamako Health Initiative

Will bed nets be affordable to this population without some subsidy? (Davis)

The results from bed net project evaluations and research projects indicates that if bed nets are initially subsidized, subsequent purchase and impregnation at the market price is unlikely, as the community will wait for a future subsidy Bed net projects without subsidy have demonstrated

success in other developing country contexts, and therefore the project will try to implement without subsidy. In addition, PLAN will work to link this with other activities in the livelihood area taking into consideration cultural traditions.

Fabricating nets for income generating schemes usually does not work. It is cheaper to buy ready made nets than to set up a cut and sew operation. PLAN should coordinate with the large scale bed nets project now being planned by the World Bank and MOH – Dr Sambou (Macdonald). If the project makes its own nets and import mesh to do so, be sure the openings are small so anopheles mosquitoes cannot pass through it (Davis)

The project will not pursue income generation through bed net manufacturing, especially since large scale manufacturing and distribution are likely within the life of this project.

VHCs/MCs can be involved in bed net dipping, potentially as an income generating possibility, in stead or in addition to CHWs (Ventumiglia)

Will you train VHCs in the management of revolving funds?(Ventumiglia)

Form'Action will identify appropriate health financing mechanisms with the communities. If revolving health funds are selected to be implemented, Form'Action, with support and assistance from PLAN will train village based groups in the management of these funds.

How successful has MOH been to set up community-level health huts, CHTs, VHCs, and community cost recovery schemes?(Haggerty)

The success of community-level health huts, CHTs, VHCs, and cost recovery depends on the motivation and support of staff and communities. There is a great deal of variation from community to community, depending on the inputs and people involved in each. The MOH is successful in setting up the overarching infrastructure and staff to implement these schemes, and is committed to improving access to health services and supplies in rural Senegal. The MOH is supportive of activities that improve their own schemes and innovations that advance national health goals. This Child Survival Project presents an opportunity to demonstrate successful models where community-level health huts improve outreach, coverage, and health status. This is consistent with the general tendency in Senegal where the NGOs and CBOs play a key role in ensuring health services at the rural community level.

It is necessary to track community data bases and cost recovery schemes in order to verify if this is working. How will plan do this?

PLAN will coordinate closely with Form'Action to track cost recovery schemes on a quarterly basis. PLAN will adopt methods and formats from other community based cost recovery schemes to do this.

3 2 3 Roles and Capacities

The link and interaction between mothers' committees and village health committees is not clear. Would it be more effective to focus on one? (T Ventumiglia)

The mothers' committees are a part of the village health committees. In each committee Form'Action and PLAN will focus on a community group or subgroup that is active, motivated, and committed to advancing community health. The activities of this community group will be supervised and monitored by some form of community self governance. The exact mechanism may vary from community to community.

The role of the three types of community volunteers – CHWs, TBAs, and IEC relays - is not clear (Ventimiglia)

Health Workers	Specific Functions
CHEs	1) backstop the Community Health Team (CHWs, TBAs, IEC Relay) at the community level and also to provide linkage in communications and other activities between the Health Posts and the community, 2) assist with training and supervision of the CHWs, TBAs, IEC relays, 3) assist with monthly report writing, 4) provide linkage with the MOH and the workers at the community level
TBAs	One TBA/village with large villages having two Provide antenatal care and childbirth services including referring at risk pregnancies to health facilities and postnatal care including fostering breastfeeding Provide folic acid and iron tablets supplementation to pregnant women. Distributes/sells condoms
IEC Relay	They are responsible for health education at the community level and will demonstrate the preparation of nutritionally rich foods They assist MOH outreach staff in growth monitoring and data recording at the field level since they are more literate than the other community health team members
CHWs	They carry out malaria prevention and treatment, provide PCM, and sell malaria bednets and insecticides Also, they carry out DCM, immunizations, and nutrition interventions promoting exclusive breastfeeding and use of ORS and Home Made Solutions for the treatment of diarrhea They undertake diseases surveillance, compile, maintain, and update community registers including births and deaths registrations

Who will supervise CHWs? If Health Post Nurses provide supervisory support to CHTs and VHCs, then will they be trained in supervision? (Ventimiglia)

Health Post Nurses will receive training in supervision and support This training will focus on both what information to use to evaluate performance, and more importantly communication and management skills to motivate improved performance Building a sense of team effect and collaboration in striving for common goals with CHWs, VHCs, and CHTs, will also be included in this training On the job feedback on supportive supervision will be ongoing

How consistent is MOH in providing staff for health posts and huts? How will project deal with vacancies, if this is a problem? (Haggerty)

In the Child Survival Project sites, 10 of the 10 positions for Health Post Nurses, and 2 of the 2 positions for Doctors are currently filled PLAN will initiate work in the sites where staff are in place PLAN will also work at the national and district levels, along with others NGOs, to influence the government in ensuring posts are filled

Who will form VHCs if they do not exist? (Davis)

In almost every community there is a village committee or group Form'Action will identify these groups or individuals who are interested in working on health issues, and work with these

groups to strengthen their skills to identify health problems and solutions and take appropriate action

Are CHEs recruited from the area where they are working? (Bertoli)

Yes, CHEs are generally recruited from the same areas where they work. In this way they come to the job well versed with the local context, culture, language, and people. They are also more likely to continue as a community resource after the end of the project.

Are CHT members literate? Are there plans to link them to literacy programs? (Davis)

As mentioned earlier, there is at least 1 CHT member who is literate in each CHT. PLAN motivates illiterate members to enroll in literacy programs available in the area.

The need for emergency transport is ever present – especially when there are no men around to make decisions (Davis)

This is taken care of in PLAN livelihood domain where credits from micro-credit projects are made available in partner villages for people or groups to buy a local transportation mean (horse or donkey carts). These transportation means are managed as income generation activities and are used for all type of transportation including medical emergencies.

Project needs to insist that CHTs are located in inaccessible areas and can do simple curative functions, such as treat malaria, pneumonia, diarrhea, and give first aid, as well as prevention (Davis)

PLAN will work with local health authorities to sanction simple curative functions at the community level by CHTs. In addition, the project does educate mothers and CHT members, as consumers, on the protocols for treatment of malaria, pneumonia, and diarrhea, which provides information to seek appropriate treatment from other sources that can dispense drugs.

Will salary differentials between project paid staff and MOH staff pose problems of motivation and partnership? (Bertoli)

Although PLAN salaries, especially at the district and local levels, are set not to exceed the market rates, there is a salary differential between project paid staff and MOH staff. However, to date it has not posed any problems of motivation and partnership. MOH staff have perks and benefits, status and job security, not available to staff, though project staff may have higher salary and other benefits. Project staff and MOH counterparts work closely together as colleagues and respect the contribution each is making.

How will PLAN improve their own capacity through this grant? How will this experience be replicated within PLAN? (DIP review summary)

This Child Survival Grant provides an opportunity to pilot innovations that can be shared and scaled up to other projects and sites where PLAN is operational. The DFID and Lottery Grants are examples of how this USAID grant was used to leverage financial, human, and other resources (see Annex 4). PLAN has been able to attract expertise to the organization, and gain experience in community based health programming through this grant.

3 4 Collaboration and coordination

How will the data be sent to the Ministry of Health and District Management Team? (Ventumiglia)
How will the data flow to the district management committee? (Haggarty) *How will MOH use the health information generated? (Bertoli)*

MOH and DMT will receive quarterly project reports from Field Health Supervisors and the Project Coordinator, which contain consolidated information on project performance. These reports will be discussed with the officials to motivate their involvement support for the implementation of the project.

How will you learn from World Vision? (Ventumiglia) *Can PLAN, CSF, and World Vision work together to help MOH document Chloroquine resistance?*

PLAN has held a number of meetings with PLAN, CSF, and WV to share project goals, strategies, problems, and solutions. PLAN is working with these other US PVOs to share or design IEC materials, adapt lessons learned, and take joint action to influence government policies and programs.

3 5 Intervention-Specific Comments

3 5a Immunizations

Will PLAN be able to supply lower dose vaccine vial? (Davis)

PLAN will not provide lower dose vaccine vial.

If vaccines are provided at the markets, how will you prepare mothers to bring the road to health card to the market? (Davis)

By reminding them to bring their cards in their money bags during community events, home visits, and education and counseling sessions.

Re Single use / Autodestruct needles and syringe 1) what is the policy? 2) Consider the economic cost, sustainability, and standardization Will the project areas be able to obtain these after the project ends? Consider the environmental concerns do the health centers and posts have incinerators to dispose the syringes? Will PHN bury the syringes according to the correct depth? (Davis)

Single use disposable auto-destruct syringes and disposable containers are not available for this project. Hence the concerns raised above are no longer relevant.

Why can't PHN vaccinate mothers at the growth monitoring sessions, rather than refer them to the health posts? (Davis)

PLAN will explore the possibility of having TT vaccines for pregnant women available at growth monitoring sessions in addition to health posts, to take advantage of this missed opportunity. Because the nurses are so busy with weighing, monitoring, and vaccinating children, it is sometimes difficult to also provide counseling and services, such as TT vaccines for pregnant women at the same time. TT vaccinations provided at the growth monitoring events will miss women who are pregnant for the first time.

3 5 b Diarrhea case management

How did project / mothers define prolonged diarrhea – 18% reported prolonged diarrhea? (Haggerty)
Prolonged diarrhea was defined as 3 or more loose or watery stools for more than 3 days

For indicator on preparation of ORS, I suggest direct observation (Haggerty)

The objective and indicator have been modified to reflect this suggestion. In the evaluation of correct preparation, the project will ask a sub-set of mothers to demonstrate ORS preparation for observation, and another sub-set to explain the steps without prompting.

In some villages there will be a need to “sterilize” water with bleach, since ORS mixed with unclean water would not be appropriate. Louga has particularly scarce water resources (Davis)

This is already incorporated in the steps to preparation of ORS.

For indicator on quality of diarrhea case management, I suggest you add quality indicator at health posts and oral rehydration units

A indicator of quality of case management is difficult to measure, given the variation of cases, the number of cases of each type, poor written records, etc. For the time being the project will not monitor the quality of diarrhea or ARI case management, but will identify a way to evaluate this during the evaluations.

Will project set up oral rehydration units? Who will staff these? (Haggerty)

The project does not plan to set up oral rehydration units. The health posts and centers will also provide oral rehydration and guidance to families on how to rehydrate a child. The project will train providers at all levels in the guidelines for rehydration.

Hygiene promotion will include hand washing but there is no mention of how the project will promote soap

Though this does not feature as a separate objective, the project promotes hand washing with soap after using the toilet, before preparing meals, before preparing ORS, etc. to reinforce this practice. This message is incorporated in the curricula and IEC materials. Soap availability and affordability is not a problem in the project area, with most families using either traditional or modern soaps. The project will not measure the use of soaps or the effectiveness of promoting its use at this time.

ORS packages need to be distributed at the Health Hut level (in addition to the health post) as soon as CHTs are trained (Davis)

This already features as part of the strategy.

Mothers should be trained in the appropriate response to treat diarrhea (Davis)

Chemist should receive training in the appropriate use of ORS and antibiotics (Davis)

The training of care providers at all levels, from mothers, to health workers, to chemists, is already incorporated in the project strategy.

Does Senegal manufacture smaller packets that are mixed using standard pint measures, in stead of the WHO standards that are mixed using the standard liter measure? (Davis)

Although there are a number of ORS options available in the market, the Child Survival Project promotes the standard package distributed through the government, which used the liter measure

3 5 c Pneumonia Case Management

KPC shows that a high percentage of mothers do not seek treatment for pneumonia signs and symptoms When distance and cost may be primary reasons, such as in Louga, the CHW should be authorized to give antibiotics (Davis)

A number of studies show that antibiotics can be dispensed appropriately by low-literate community health workers (Dullaie, 88) PLAN will work with local health authorities to sanction simple curative functions at the community level by CHTs and CHWs In addition, the project does educate mothers and CHT members, as consumers, on the protocols for treatment of malaria, pneumonia, and diarrhea, which provides information to seek appropriate treatment from other sources that can dispense drugs This will be done with caution and care, so that antibiotics are properly dispensed

The use of exit interviews to assess whether clients have adequate counseling on treatment is valid, but it may be difficult to find enough cases to do the evaluation (Davis)

A indicator of quality of case management is difficult to measure, given the variation of cases, the number of cases of each type, poor written records, etc For the time being the project will not monitor the quality of ARI case management, but will identify a way to evaluate this during the evaluations

You state that children will receive directly observed treatment when given anti-bacterial drugs Isn't better for the CHW to visit the child at home, then to move the sick child to the post twice a day? (Davis)

Yes it is, and the project will promote that

3 5 d Malaria

MOH objectives are more modest than the PLAN objectives for malaria control (Macdonald)

Based on this and other comments made by the USAID technical reviewers several of the malaria-specific target rates have been lowered to be more realistic Nonetheless the project strives to make the greatest impact possible on malaria control with child survival resources, given the seriousness and prevalence of this problem

Comments related to treatment

It is important to train venders on the quality of care and to provide consumer education on appropriate treatment (DIP Summary)

If private drug venders are identified as the source of supply by a significant portion of the population, they will be identified and trained on the quality of care and protocols for treatment The baseline survey indicates that mothers generally seek treatment and drugs from health facilities rather than private venders The project already has a component that educates families on the appropriate treatment of malaria, so that the consumer is educated when seeking treatment

How will IEC address context-specific distinction between the treatment of simple malaria (treated with pills) and severe malaria (treated through traditional healers) – (DIP Summary)? There is no mention of traditional healers – but the earlier discussion of “Danu Crises” should be included in the strategy (Macdonald)

Through qualitative discussions with key informants, project staff will confirm if the population does in fact make this distinction in the treatment of severe and simple malaria, and seek traditional healers for severe cases. If this is the case, like private providers, traditional healers will also be trained and oriented to the appropriate management of malaria. Studies such as those recently completed by ENDA Tiers Monde will be used to develop a strategy to do this.

Caretakers should know what to do with chloroquine resistant malaria – where the drug protocol has been followed but the person does not get better (Ventimiglia)

Caretakers will be instructed to return to the health post for medical support if the drug does not seem to improve the condition within 2 days, in accordance with standard protocols. Moreover, a discussion on chloroquine resistant malaria will be included in the community-level health education sessions on malaria.

Can song about chloroquine treatment be developed? (Summary of DIP mtg)

The use of song, pictures, and plays to communicate key information about the management of malaria will be utilized by the project as appropriate. This will determine in each context by committees and health workers.

It is worrisome that antimalarials such as amodiaquine, artemisinin, and halofantrine are available in the private shops. This means that drug resistance will be rising (Davis)

Like most health professionals PLAN staff also share this same concern. In the education sessions with families and providers a discussion of chloroquine resistance and drug resistance is incorporated to reduce irrational therapies. It is difficult however to control the practices of local chemists and drug sellers, whose profits are greater from a number of these drugs.

In the survey 30% of the children were treated at home with chloroquine – was it adequate dose or were the pills left over from previous, incomplete, courses? (Macdonald)

It is very difficult, or rather impossible, to get an accurate assessment of this at this point. During the malaria education sessions, the importance of completing a course of drugs is included.

One suggestion for treating severe malaria in children who are too sick to take pills is to use rectal quinine while they are in the community and to transport them to an appropriate health facility as soon as possible. The use of rectal quinine helps children survive until they reach a health facility

The decision to use rectal quinine will depend on 1) cost, 2) availability, 3) government policy, and 3) if it will require refrigeration. These issues are now being explored.

Comments on Antenatal prevention

Ante-natal prevention and treatment presents a challenge because it is too difficult to ensure chloroquine compliance and women who are on their first or second pregnancy more likely to be at risk for severe cases, but also the most difficult to reach (Macdonald)

Project activities include identifying all pregnant women, and promoting the use of chloroquine to prevent malaria. Health workers will ask to see the packages during their contacts with the

women to observe the pills that remain, in addition to asking if they have consumed the tablets. Pill compliance studies indicate that follow-up monitoring by asking and by doing a pill count of remaining pills improves compliance. In addition, the project will include influential family members, such as mothers and mothers-in-law, in health education sessions.

Comments related to prevention using bed nets

Project should collaborate with big national strategies for the promotion of insecticide treated materials (Macdonald)

This is planned, with discussions already initiated.

How will the impact of distribution and use of bed nets be evaluated? (Bertoli)

The distribution and use of bed nets will be evaluated through the mid-term and end-line KPC survey where families will be asked, 1) if they have a net, and 3) how many nights a week does each family member sleep under a net. To evaluate impact, blood slides are required at baseline and end-line, which is not planned as part of this project.

Gambia leads the world in operations research on bed nets and on a national strategy to promote the use of bed nets. If there are similar linguistic groups in Wackngouna, which borders Gambia, there may be very good IEC and training materials available for PLAN to use (Macdonald)

PLAN is in the process of collecting IEC materials from the region and country for use or adaptation for this project.

70% re-impregnation rates are too high. Even under the best circumstance, it is difficult to reach more than 30% (Macdonald)

We have modified this target rate, after considering your comment, the baseline, and the results of other projects promoting re-impregnation at a cost.

It would be important to know the sleeping patterns of the three ethnic groups (Davis)

Project staff will investigate this.

Don't bother with long sleeve shirts in the evening. The particular malaria vector in Senegal is late-night biting – usually after midnight. Fumigating the living room with coils is expensive and will have no impact on malaria (Davis)

These messages have been deleted from the strategy.

Extreme caution should be employed in handling Deltamethrin. Though its toxicity is low to warm blooded animals, it is absorbed into the body by inhalation ingestion. It is combustible, and when combusted gives off toxic fumes. If inhaled it causes burning sensation, cough, dizziness, headache, nausea. It may cause effects on the nervous system. It may be hazardous to the environment, fish, and honey bees. Use protective gloves and clothes. Who will be trained to reimpregnate nets? Under what safety conditions? What guidelines will be used for the storage of Delthamethrin? A senior project supervisor should ensure all safety procedures (Davis)

Bed net dipping will be done by mothers' committees, and supervised by CHWs, following training and supervised practice in this procedure. They will also receive training in the safe disposal of the chemical. Insecticides will be stored in health huts and posts, where safe storage is possible.

The wettable powder (WP) formulation of deltamethrin is meant to be sprayed on walls and will quickly flake off the nets. The suspension concentrate and single dose tablet are so much better, that the project should not consider WP. The emulsifiable concentrate (EC) is toxic to humans because of the other solvents used (Macdonald)

The project will use the suspension concentrate and not the wettable powder

Comments related to Operations Research

It is good that the project plans to collaborate with MOH to do malarimetric, morbidity and mortality, and chlorquine sensitivity surveys. It would be extremely useful if the project can do in vivo monitoring of sulfadoxine-pyremethamine as well. It would be useful to contact Orstam about drug resistance testing. PLAN project can provide valuable information through better systematic documentation of treatment failures of both drugs (Macdonald). Chlorquine sensitivity studies are quite specialized. Why is the NGO and not the malaria department conducting these studies? (Davis). The PLAN project can also be very helpful in trying to improve compliance for the three-day course of chloroquine, through packaging, colored cards, etc (Macdonald)

The project does not intend to do a clinical or field trials, or chlorquine sensitivity studies, not does it have the human and financial resources to do so. The primary intention of the project is to implement a malaria control strategy and protocol, based on successful models which already exist. The project will also document through baseline, mid-term, and end-line measures, project achievements in the key indicators of performance noted for this intervention. However, we are open to collaborating with others who would like to conduct these studies, if the opportunity arises and does not pose distractions and delays to project implementation or risks to the beneficiary population.

3.5 e Malnutrition

The estimates for PEM is quite old (1985), what about DHS estimate (Haggerty)

The 1985 study is the last national study that was available at the time of the AR. However, PLAN has conducted its own study in the two project areas in 1997, which is available.

Why is height not included in growth monitoring (Haggerty)?

Height does not change quickly from month to month, nor does it signal recent illness and growth faltering (by more long term growth faltering). Weight for age changes more quickly, and monthly change or lack of change, can be used to congratulate or counsel mothers on feeding and caring practices. Since growth monitoring is intended primarily for growth promotion and counseling, we will not incorporate height for age at this point, but continue with weight for age, which serves as a more appropriate indicator of acute malnutrition.

What is the quality control for the weighing equipment brought by the public health nurses to the health huts (Haggerty)?

Weighing machines are checked and calibrated before use, using standard protocols. Nurses are trained and experienced in doing this.

How recent is the protocol for management of mild and moderate malnutrition? (Haggerty)

PLAN will use updated protocols for the management of mild and moderate malnutrition available through WHO and UNICEF, as well as the protocols being developed for IMCI.

How will the project deal with getting mothers to come to growth monitoring sessions once the measles vaccine is completed at 9 months? (Haggerty) What enticement will keep mothers returning to the growth monitoring sessions after last vaccine of measles at 9 months? (Davis)

Follow-up visits will be made to mothers that do not come. And additional program activities related to the health problems of older children will be developed to attract the continued attendance of older children.

The project needs to verify the supply and distribution of Vitamin A (Davis)

The project will provide the initial vitamin A stock for the health posts, and the cost recovery scheme will allow PHNs to maintain it. Distribution will be during immunization and growth monitoring and promotion events.

Has PHN received special training in nutrition? The mother needs as much training in proper food preparation and feeding, as the child needs a special diet to recuperate (Davis)

Yes, the PHNs will receive special training in nutrition, and in how to counsel and educate mothers in nutrition.

Infant feeding

"For mild and moderate cases for children under 4 months if breast milk is insufficient. How will MC/CHW determine if it is inadequate? (Haggerty)

Mothers of all children under 4 months of age presenting with illness or malnutrition will be encouraged to nurse exclusively and frequently. For children above 4 months of age, mothers will be encouraged to give breast milk, liquids, and foods, as much or more than usual. Mothers who feel that their breast milk is insufficient will be counseled on the importance of frequent suckling to increase milk production.

How have you incorporated the influence of grandmothers and peers in feeding practices in your approach? (Ventimiglia)

Yes, mothers and grandmothers are also included for health education and counseling.

The target for exclusive breast feeding of 50% is very ambitious (Ventimiglia), given the widespread practice of giving water, and the low baseline rate of 3% to 25% (Haggerty) How will project handle long standing traditional practice of giving holy water as a pre-lacteal feed to the newborn? (Haggerty) TBAs should be encouraged to place the baby at the mother's breast immediately. This also helps bleeding.

There are a number of key breast feeding practices which are required for optimal breast feeding.

- immediate post partum breast feeding
- discouraging pre-lacteal feeds
- exclusive breast feeding, (including no water) for the first 4 to 6 months
- complementing breast milk with complementary foods by 6 months

All deviations from these practices have deep rooted beliefs in the culture. The project will approach these in a stepped manner. For example, rather than discourage the giving of holy water from the beginning, before credibility is established, the project will first work on promoting immediate post partum feeding and exclusive breast feeding. The target for exclusive breast feeding has been lowered to reflect your comment. The project will not compromise on the definition of exclusive breast feeding, and will discourage mothers from giving water or any other liquid or food during the first four months.

Will there be IEC for breast feeding at the maternity clinics? (Haggerty)

Yes, breast feeding promotion will be included for pregnant women and various events and points of contact

Have you given any thought to influencing the MOH policy of exclusive breast feeding to 4 months, with an aim at revising it to 6 months? (Haggerty)

At the present time, the MOH is not open to changing the protocol in accordance with international standards

Obstacles to exclusive breast feeding will come largely from health staff. If mothers-in-law and TBAs can be influenced, they can re-enforce rather than block project efforts (Davis)

The project will educate mothers and health providers at all levels on the optimal breast feeding practices detailed above. In this process, mothers-in-law will also be included

Micronutrients

I think the project should elevate the focus on anemia (Macdonald)

The project will support existing efforts for anemia control, and will incorporate this as a separate objective following demonstrated capacity to improve the core interventions already sited in this project. Anemia control is recognized by the health team as an important area, with implications on all other child survival interventions



ANNEX 1

Follow-up Visits for Start-Up Workshop

ANNEX 1

Report on the Meetings for Follow Up of the Workshop to the Sakal Communities

1 JUSTIFICATION

In March 1999, Plan International Senegal organized a startup workshop for its Child Survival Project in the Louga and Nioro health districts. Among the recommendations was a plan for restoration to non-present workers. One of the strategies of the plan was the organization of community meetings. This is the reason for the restoration meetings that have begun in the Nioro zone.

2 SCHEDULE

The following schedule was set by the Health Supervisor

[Top row illegible]		
June 10, 1999	-	SAKAL
June 11, 1999	LEONA	NGUEUNE SARR

3 PARTICIPANTS

Plan International was represented by the CSP staff: the CSP Coordinator, the Louga Health Supervisor, the Training, Monitoring and Evaluation Assistant (TMEA), the Community Development Assistant (CDA), and the Community Health Educators (CHEs). From among the people, a total of 59 people participated in the meetings. Nearly all occupations were represented: village chiefs, members of the health committees of the aid stations and health centers (chairpersons, [list ends here, a page appears to be missing]).

REPORT ON THE MEETING OF MAY 25-28, 1999, REGARDING FOLLOW UP REVIEW OF THE WORKSHOP TO THE WACK N'GOUNA COMMUNITY

1 JUSTIFICATION

In March 1999, Plan International Senegal organized a startup workshop for its Child Survival Project in the Louga and Nioro health districts. Among the recommendations was a plan for restoration to non-present workers. One of the strategies of the plan was the organization of community meetings. This is the reason for the restoration meetings.

2 SCHEDULE

The following schedule was set by the Health Supervisor

May 25, 1999	Saboya	Keur Tapha
May 26, 1999	Wack N'gouna	Ndrame Escale
May 27, 1999	CLD	Keur Maba Diakhou
May 28, 1999	Thilla Grand	Keur Madiabel

3 PARTICIPANTS

Plan International was represented by the CSP staff: the CSP Coordinator, the Kaolack Health Supervisor, the Training, Monitoring and Evaluation Assistant (TMEA), the Community Development Assistant (CDA), and the Community Health Educators (CHEs). From among the people, a total of 267 people participated in the meetings, with a minimum of 27 at Thilla Grand and a maximum of 70 at Ndrame Escale. Nearly all occupations were represented: village chiefs, imams, members of the health committees of the aid stations and health centers (chairpersons, treasurers, auditors), members of Mother Committees, committees

History

In early 1999, three NGOs—Christian Children’s Fund (CCF), World Vision (WV) and Plan International (PI)—decided to form a consortium to pursue certain activities of mutual benefit. A top priority within the consortium is to develop a strategy for training in child survival (CS). To begin this task, the consortium requested support from a consultant specializing in community health, health education and adult education.

The task was begun during an initial three-day consultation in April 1999. It was organized around “Steps in the Development of a Training Program” (see appendix A) as suggested by the consultant. The first step (clarifying the goals and objectives of CS projects and programs) was completed in April. Through a participatory process, the three NGOs presented the goals of their respective projects, and together they formulated goals reflecting the priorities of each organization. The goals concern people involved with the promotion of CS at all levels, namely community workers, social/health workers, local and administrative authorities, and other NGOs working in the same area.

In April, the group also made a preliminary consideration of the second step (clarification and definition of the development concepts underlying CS projects and programs). This step is rarely tackled before the training activities are developed. It was begun, but not finished, in April.

Objective of Consultation

Based on the twelve steps identified as necessary for development of the training program, the objective of the consultation discussed in this report was to facilitate completion of the following steps in developing the basic elements of training strategy. According to the planning done August 18, the consultant was to support the consortium members in the completion of steps 2-7.

Accomplishments During Consultation

In the early phase (August 18-25), the consultant worked with a small group of staff members from the NGOs to finalize the “development concepts” that were to underlie the training strategy (step 2). The same working group also began a list of “roles of the various institutional and community workers” (step 3).

Later (August 30-September 2), a planning workshop was held in Mbour, in which eight staff members from the three NGOs participated (see Appendix B: List of Participants in Mbour Workshop). This workshop addressed the following tasks:

1. Validation of the development concepts worked out by the small group
2. Validation of the roles worked out by the small group
3. Further development of the tasks required of each category of workers involved in the CSP in order to accomplish each of the roles
4. Identification of the tasks that must be addressed either during training or at meetings of the various levels of workers

The order of work done during the consultation followed the plan developed with the consultant on August 18. However, it turned out that the time allotted to the various tasks had been underestimated. Namely, the small group finished step three (definition of roles) but not step four (definition of tasks). Additionally, during the workshop, validation of the initial work done by the small group also took longer than expected.

As a result, the working group reached only step four (defining the tasks corresponding to each role) during the Mbour workshop. Given that steps 5-7 were not begun, it was not possible for the consultant to develop a time schedule for completion of steps 9-12 as planned. This was also the reason that the length of the consultation

Importance of confident relationships between the development agents and the communities

Another key concept accepted by the group, and which should constitute a fundamental component of training strategy, relates to the relationship that should exist between the social/health agents and the members of the community. This relationship forms the basis for the partnership between the development agencies and the communities. It should be based on confidence and mutual respect.

Promoting changes in the social norms linked to CS

Given the influence of social norms on individual behavior, it was decided that the training program should focus on CS promotional strategies that target firstly, changing social norms, rather than changing individual behavior. This suggests the importance of using strategies that attempt to identify and involve people who are influential in the community in the promotion of new practices linked to CS.

Individual and Community Empowerment

A final concept that should be systematically developed in the training strategy is individual and community empowerment. This concept implies that efforts ought to be made to increase the knowledge base, competence and confidence of individuals and communities so that they can take their health into their own hands. It also suggests the importance of relationships based on exchange and negotiation between members of the community and social/health agents, as well as the progressive transfer of responsibility to the communities.

Pedagogical Approach, Adult Education

There is a consensus among the consortium members that the training strategy should be developed based on the principles of adult education, in order to increase the relevance and possible impact of training activities. Although adult education is often talked about in Senegal, it is rare to see training modules that are systematically developed based on adult education methodology.

Adoption of this methodology in the training strategy has two important implications. First, all of the training activities developed for the training strategy should be based on the principles of adult education and on experiential training. This approach allows the adult learners to

systematically analyze their own attitudes and practices and to consider how to put new concepts into practice

Second, the educational abilities of the adults, social/health agents, government, and NGOs ought to be developed and strengthened so that these people can use this methodology in the training activities they facilitate. This suggests that the development of the training strategy should include development of an adult-education training workshop for these development agents

Suggestion Concerning the Organization of the Training Manual

Often, training manuals are organized as workshops that define three-day training programs, five-day programs, etc. Since the training needs of the three projects are not identical, it would be preferable that the training manual not be so structured, but rather that it be organized, by topic, as individual exercises that could be used alone or together with other exercises as the need arose. For example, the manual could contain a series of exercises on “improving teamwork” that could be used with social/health agents, NGO staff members, or community organizations. This approach to organizing the training material would also allow training exercises to be used not only in “training workshops,” but also any time during the “working meetings” of the various levels of the programs

Choice of Consultant to Develop CS Curriculum

The consortium members should follow the development of the CS curriculum, and participate occasionally. However, this task requires a significant investment of time and expertise. The consortium members plan to select one or more consultants who can take primary responsibility for this task

Given the innovative nature of the strategy to be used, in terms of both content and pedagogical methodology, the consultant(s) should be carefully chosen. Some important criteria are the consultant should have undertaken advanced study (masters or doctorate level) in adult/non-formal education, and should have extensive experience in community-health programs based on community participation, experience with developing adult-education and experiential-training curricula, and experience with participatory approaches to communication/adult education based on dialogue and negotiation

Next Steps

While awaiting the recruitment of a consultant or consultants who will take on the primary responsibility for developing the curriculum, it is desirable that each NGO present and discuss the proposed roles of the various workers with these latter, namely, social/health agents, community workers, and local and administrative authorities, in order to obtain their observations and assent on this issue

It is suggested that these discussions be limited to the CSP goals and to the roles suggested for the various workers. The other elements of the strategy, such as the concepts, tasks, and attitudes, can be addressed during training. Insofar as the training strategy contains a certain number of innovative elements, which challenge some conventional approaches, it might be difficult to gain acceptance of these elements before going into them in depth during the training



ANNEX 2

PLAN Child Survival Project
and
Radio Guneyi Senegal Collaboration

Radio Gune Yi in Senegal wins an award at the International New York Festivals

Radio Gune Yi (RGY) (Radio Youth) is a unique radio program for children in Senegal. It is unique because it is the only weekly radio broadcast in Senegal done by children for children. Initiated in 1995 by PLAN International Senegal, RGY's objective is to offer Senegal's children the experience of preparing and broadcasting a radio program for their peers, while promoting the Rights of the Child, especially that of freedom of expression.

Last June, Radio Gune Yi won the prestigious "Finalist Award" at the International New York Festivals. This award was presented "in recognition of an outstanding achievement in the International Competition for Radio Advertising and Programming." This year, 1297 entries from 31 countries, all categories included, were submitted to the competition of which approximately 25% were selected for the short list. Only three finalists were selected in each category, RGY was part of the finalists in the children's programs category. Winnie Tay, PLAN Senegal's Director, is really proud of this achievement. "The Radio Gune Yi team and the children have worked very hard and should be proud. It is great to be recognized, not only for doing an innovative and successful development project, but also a high quality radio program."

Apart from the recognition for doing a high quality radio show, RGY has received a very good evaluation, after three years of operation, by *The Center for Development Communication*, an external agency specialized in Radio projects' evaluation. The agency was commended to evaluate the adequacy of Radio Gune Yi's program in training, educating and entertaining the targeted Senegalese children, whether it efficiently promotes the Rights of the Child, and the pertinence of the concepts "children speaking to children" and "learning by doing".

Since its inception, Radio Gune Yi has visited more than 100 villages, trained more than a thousand kids and entertained hundreds of thousand children and adults on the radio. According to *The Center for Development Communications'* report, the recording of a RGY program is not only a radio broadcast, but a rare local event which has an impact both on the children who participate and their parents, other spectators and decision-makers. Speaking into the mike during a RGY recording is clearly a unique experience for the Senegalese child. It gives them the rare opportunity to express themselves in public, to learn by doing, to show those close to them their capacities and to make themselves heard throughout the country. The moment of the recording is a special event for those who are present to witness the children's performance. This sentiment is very strong in rural communities where children have fewer opportunities to obtain information and exchange ideas.

The changes in attitude and behavior are such that RGY and the activities that go with it encourage new local associations. In villages where RGY has been, RGY clubs are formed and attended by children to organize new initiatives. First, these centers serve as a place for collective listening. But in certain communities, the children have also set up theatre troupes and door to door sensitization activities. The children take new initiatives in the domain of information and sensitization. The children become not only agents of change, but actors influencing the development of their communities.

The results of the qualitative and quantitative surveys show that RGY fulfils its mandate to educate, inform and entertain the children. Better, it also does so for adults. The majority of RGY's listeners say that the program entertains and informs them, and that they learn from it.

In Senegal, 90% of child respondents and 95% of adult respondents listen to radio. To the question "Do you now RGY,?" 73% of the children and 70% of adults said, "yes". But even more interesting is the fact that 49% of the children and 29% of the adults spontaneously cited RGY as their favorite children's program. Obviously, those children who participated actively in the production of the program or were present during its recording listen to RGY more persistently than those who did not. But still, one out of two children and adults living in villages or neighbourhoods that never hosted RGY have heard about this program.

The evaluation stated that RGY is a project which has obtained remarkable results in terms of promotion of the Rights of the Child, communication of PLAN's activities, and radio quality. The quality of the program is up to professional standards. The results in the field and among the audience are clear and significant. Communication of PLAN International's activities profits from this project. The objectives set at its launching have been attained and sometimes exceeded.



ANNEX 3

CCF-WVI-PLAN Training Manual
(First Step)

Consulting Report

Support for the preparation of basic elements of a
training strategy on the subject of child survival

Judi Aibel, PhD, MPH
Public Health Consultant

With The Consortium of NGO's working
in the area of Child Survival
Christian Children's Fund, World Vision, Plan International

Sept 3, 1999

Background

In the beginning of 1999, three NGO's- Christian Children's Fund (CCF) World Vision (WV) and Plan International (PI)- decided to organize themselves as a consortium so to carry out certain activities of common interest together. Within the framework of the consortium, one priority activity is the preparation of a training strategy on the subject of Child Survival [Survie de l'Enfant] (SE). To undertake this work, the consortium requested the support of a consultant specialized in community health, health education and adult education.

Work was begun during an initial three-day consultation in April 1999. The work was organized around "Stages in the preparation of a training program" (See Appendix A) as proposed by the consultant. In April the first stage (Clarify the goals and objectives of the SE projects / programs) was realized. Through a participatory process, the three NGOs presented the goals of their respective projects and together they formulated goals that reflect the priorities of each organization. These goals target the involvement by individuals in the promotion of SE at several levels as follows: community participants, social/health participants, local and administrative authorities, and the other NGOs working in the same zone.

In April, a first group consultation was also held relative to the second stage (Clarify / define the development concepts supporting the SE projects / programs). This stage has only rarely been approached prior to the preparation of training activities. This stage was started, but not finished in April.

Objective of the Consultation

Based on the twelve stages identified as necessary for the preparation of the training program, the goal of the consulting, which is the object of this report, has been to facilitate the realization of the next stages in the preparation of basic elements of the training strategy. Following the planning carried out on August 18, the consultant must support the members of the consortium in the realization of Stages 2 to 7.

Achievements during the consultation

In an initial period (from August 18 to 25) the consultant worked with a limited number of staff members of the NGOs to finalize the "development concepts" which will support the training strategy (Stage 2). The same work group also made a rough outline of the "roles of the various institutional and community participants" (Stage 3).

In a second period (from August 30 to September 2) a planning workshop has been organized in Mbour in which eight staff members from the three NGOs participated (See Appendix B: list of participants at the Mbour workshop). During this workshop the following tasks were discussed:

- 1) validation of the development concepts prepared by the limited group
- 2) validation of the roles prepared by the limited group
- 3) preparation of the tasks required by each category of participants in the SE program in order to carry out each of the roles
- 4) identification of the tasks that must be dealt with, either in the training, at the time of the meetings or encounters with the various levels of participants

The organization of the works at the time of consultation followed the plan prepared with the consultant on August 18. However, it has been shown that the time devoted to the various tasks has been underestimated. More particularly, the limited group finished Stage three (the definition of roles), but they did not reach Stage four (the definition of the tasks). In addition, during the workshop the validation of the first works realized by the limited group also took longer than had been anticipated.

As a result, during the Mbour workshop the work group only got to Stage four (the definition of the tasks corresponding to each role). Since Stages 5 to 7 had not been approached, it was impossible for the consultant to prepare a timetable for the implementation of Stages 9 to 12 as

planned. It is also for this reason that the consultation (planned for 13 days at the beginning) only lasted for 12 days.

Conclusions and recommendations

Systematization of the experiences of the NGO's working within the area of Child Survival (SE)

The collaborative work of the three NGO's besides the preparation of a training strategy allows them to share their experiences within the SE area and systematize the teaching materials drawn from their programs for the purpose of their future reinforcement.

Training strategies targeting four categories of persons

Given that the ultimate goal of the three SE projects is to improve the well-being of children within the community, the training strategy targets the four following categories of persons involved in the promotion of SE: the communities, social/health agents, local authorities, administrative authorities and on-site staff of the NGO's. The objective of the training strategy shall be to reinforce knowledge and aptitude linked to the promotion of SE at several levels of society.

Description of the development concepts

An important stage in the preparation of the first elements of the training strategy by the members of the consortium has been to define the development concepts that support the goals of the three SE projects. At this stage the group's comments allowed for the review of certain frequently used concepts as well as other concepts. The concepts ultimately adopted by the group, as a basis for the training strategy, suggest an orientation toward promoting SE that significantly differs from the conventional approach. Several of these key concepts adopted by the group are described herein.

Promotion of SE based on the integration of key SE concepts from the Ministry of Health [Ministere de la Sante] (MS) and values, practices and resources of the communities.

The conventional approach to the promotion of SE consists of informing the communities of the behaviors / practices linked to SE, as preconceived by the MS, and attempting to convince them to adopt them. In this approach, the existing values and practices of the communities are not systematically taken into account.

A cornerstone of the training strategy is the approach that consists of systematically attempting to integrate, on the one hand, the values, practices and resources available to the communities and, on the other, the key concepts promoted by the MS. The integration concept must be applied at several levels: in the contents of the training activities, in the contents of the health education activities [activites d'education pour la sante] (EPS), in the contents of the EPS material, and in interpersonal communication among health workers and community members.

Dialog and negotiation

In the conventional approach to communication on subjects of SE, stress is placed on the "transmission of messages", so as to create "behavioral changes". This approach, often called "IEC", tends to be a one-way, top-to-bottom, vertical process, from the social/health worker to community members.

The concept of communication proposed for the training strategy stresses dialog and negotiation between community members and social/health workers. Compared to the conventional approach, this process is more participatory, and suggests a horizontal, two-way relationship between the social/health worker and community members. This concept is intimately linked to the above concept of integration.

Importance of trusting relationships between development workers and communities

Another key concept retained by the group, which must constitute a fundamental element in the training strategy, deals with the kind of relationships that must exist between social/health workers and community members. These relationships make up the basis for the partnership between development workers and the communities, which must be based on trust and mutual respect.

Promote changes in the social norms linked to SE

Given the influence of social norms on the behavior of individuals, it was decided that in the training program stress must be laid on SE training strategies that target in the first place change in social norms rather than change in behavior by individuals. This suggests the importance of using strategies that seek to identify and involve influential people in the heart of the community in the promotion of new practices linked to SE.

Individual and community empowerment

A final concept that must be developed systematically in the training strategy is the individual and community empowerment strategy. This concept involves efforts that must be made to increase knowledge, competence and trust on the part of individuals and communities, so they may take charge of their own health. This concept also suggests the importance of relationships based on exchange and negotiation between community members and social/health workers, as well as the progressive transfer of responsibility toward the communities.

Pedagogical approach: Adult Education (Extension courses)

There is consensus among consortium members that the training strategy must be prepared based on principles of adult education (extension), so as to increase the pertinence and possible impact of the training activities. Although one often hears of extension courses in Senegal it is unusual to see training modules that are systematically prepared on the basis of adult education methodology.

The adoption of this methodology in the training strategy has two important implications. First, all learning activities prepared for the training strategy must be based on the principles of adult education and on the experiential learning circle. This approach allows adult learners to analyze their own attitudes and practices systematically and reflect on how new ideas can be integrated into their own practices.

In the second place, competence in adult education must be developed / reinforced by social/health workers, the government and the NGO's so they may use this methodology in the training activities they facilitate. This suggests that the preparation of the training strategy must include the development of a training workshop by extension course for these development workers

Suggestion on the organization of a training manual

Training manuals are often set up as a series of workshops that define training programs that last three to five days, or so. As much as possible, whenever the training needs of the three projects differ, it would be preferable if the training manual were not organized in such a structured manner, but rather took the form of individual learning exercises, organized by topic, which can be used alone or in combination with other exercises, according to need. For example, the manual could contain a series of exercises that target, "the reinforcement of teamwork", that could be used with the social/health workers, the staff of the NGOs or with community organizations. This approach to the organization of training materials will also allow the use of learning exercises, not only within the framework of "training workshops", but also during the "work meetings" organized at the various levels of the programs.

The choice of consultant for the preparation of the SE curriculum

The members of the consortium must follow the preparation of the curriculum on the subject of SE and be involved from time to time. However, this task requires a significant investment in time as well as specialized competence. The members of the consortium must identify one or several consultants who shall bear the main responsibility for the task.

Given the innovative nature of the strategy anticipated, both in terms of the contents and in terms of pedagogic methodology, the choice of consultant(-s) must be made carefully. Some important criteria for the choice of such persons are: a background in advanced studies in adult education / non-formal education at the master's or doctoral level, extensive experience in community health programs based on community participation, experience in the development of a curriculum based on adult education and the experiential learning circle, experience in participatory approaches to adult communication / education based on dialog and negotiation.

Next Stages

While awaiting the recruiting of the consultant(-s) who shall assume the main responsibility for the preparation of the curriculum, it is desirable that each NGO present and discuss the roles proposed for the various participants, with the following persons: social/health workers, community participants, and local and administrative authorities. This will allow their observations and approval to be obtained on the subject.



ANNEX 4

Management Structures

ANNEX 4

PLAN NEW MANAGEMENT STRUCTURE FOR CHILD SURVIVAL PROJECTS

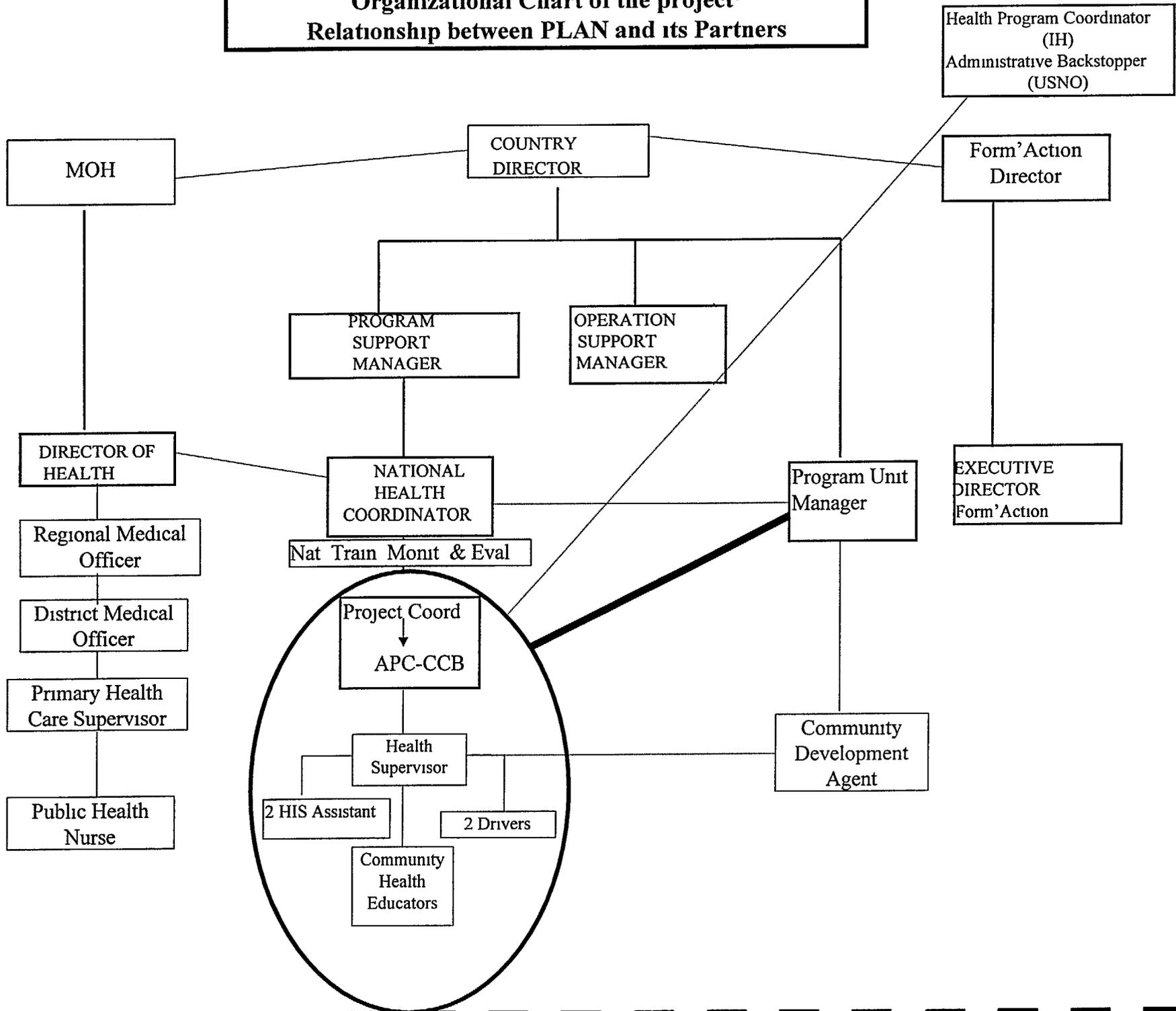
A new management structure for CS project in PLAN Senegal has been designed and is summarized for technical positions (which are under the administrative supervision of PLAN International line managers (Program Support Manager and Program Unit Managers) as follows

National Health Coordinator (Technical) (Administrative)			Grant Administrator	
<i>DfID & LOTTERY GRANTS</i>			<i>USAID GRANT</i>	
DfID/Lottery Child Survival Project Coordinator			USAID Child Survival Project Coordinator	
			Assist PC for Community Capacity Building	
National Training, Monitoring and Evaluation Supervisor				
<i>DAKAR PU</i>	<i>THIES PU</i>	<i>SAINT LOUIS PU</i>	<i>LOUGA PU</i>	<i>KAOLACK PU</i>
Field Health Supervisor	Field Health Supervisor	Field Health Supervisor	Field Health Supervisor	Field Health Supervisor
HIS Assistant	HIS Assistant	HIS Assistant	HIS Assistant	HIS Assistant
Comm Health Educator	Comm Health Educator	Comm Health Educator	Comm Health Educator	Comm Health Educator

- The **National Health Coordinator (NHC)** based in the country office is responsible for advising the CMT on health programming and policy development, networking with partner at the national and international level, sharing of lessons learnt both within and outside PLAN International and backstopping Project Coordinators to improve the quality of CS interventions
- **Project Coordinators (PC)** are full time project staff based in the field. They are responsible for planning, implementation, monitoring and evaluation of all CS project interventions as well as supervision of technical staff involved in project implementation in a defined area: 546 villages for the USAID-funded project and 471 villages/neighborhoods for the DfID&Lottery-funded project
- The **National Training, Monitoring and Evaluation Supervisor (NTMES)** who is the former Assistant for Training, Monitoring and Evaluation of the USAID-funded CS project) will work closely with both PC to design and implement a training plan including a training needs assessment, design of a training curricula, planning and supervision of training sessions and elaboration of training reports. He will also design monitoring and evaluation tools and train both project staff and MOH/NGO partners for their effective use. His position will ensure that training strategies and messages as well as monitoring/evaluation methodologies are harmonized throughout the country and that lessons learnt in each PU will be shared within the country. His time and salary will be distributed as follows: 40% to the USAID-funded project and 60% to the DfID&Lottery project

- The **Grant Administrator** (to be hired) will be is responsible for grant tracking and financial management S(he) will use information from administration, sponsorship and program departments to draft financial reports and work with PC and NHC for budget monitoring and reallocation S(he) will review quarterly and annual reports to ensure adequacy of financial figures with program implementation S(he) will coordinate the elaboration of grant proposals for other domains or interventions and will work toward integration of grant and sponsorship interventions Her(is) time and salary will be distributed as follows 40 % to the USAID-funded project and 60% to the DfID&Lottery project
- **Field Health Supervisors (HS)** are full time PLAN International staff based in the field, who are responsible for monitoring of project interventions in each PU They will supervise **Community Health Educators** who back-stop PLAN and MOH Public Health Nurses, impulse Child Survival activities at the community level and gather information that will be processed by **Health Information System Assistants** to feed into the monitoring and evaluation System While some of their duties was performed by the former APC for Training, Monitoring and Evaluation of the USAID-funded project, they will now take a more important role and work more closely with both PC and the NTMES to plan and monitor project field implementation Skill transfer from PC and NTMES to HS will help ensure quality of Child Survival projects in PLAN International Senegal, even after the end of the grants

**Organizational Chart of the project:
Relationship between PLAN and its Partners**



67

PLAN INTERNATIONAL USA

TECHNICAL BACKSTOPPING
Dr P M METANGMO/ Ms J LUNA

ADMINISTRATIVE BACKSTOPPING
Ms K STEELE / Ms K CRABTREE

STEERING COMMITTEE . Meeting every six months

PLAN INTERNATIONAL SENEGAL
Country Director
Program Support Manager

**Executive Director of
Form'action**

**Ministry of Health
National level**

COORDINATION COMMITTEE: Meetings every three months

PLAN INTERNATIONAL SENEGAL
Program Unit Managers (Louga, Kaolack)
National Health Advisor
NTME Supervisor
Project Coordinator
PLAN Health Supervisor (Louga, Kaolack)

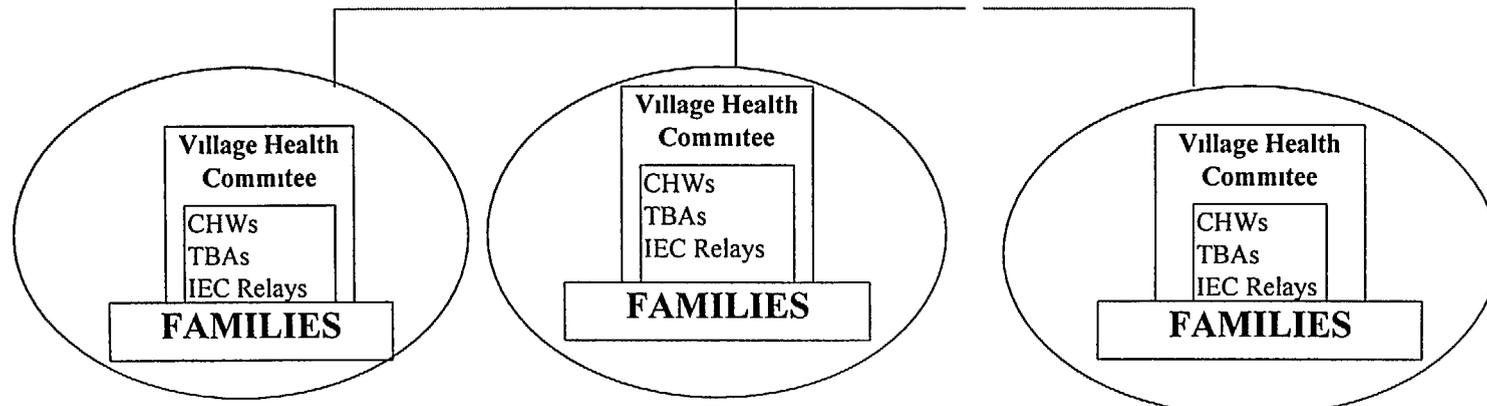
FORM'ACTION
Ass Project Coordinator for
Com Capacity Building

Ministry of Health
Region Level
District level
(Louga, Kaolack)

Project Team

Project coordinator
Ass Project Coordinator for Com Capacity Building
2 PLAN Health Supervisors
2 Health Information System Assistants
2 Drivers

8 Community Health Educators (Louga)
7 Community Health Educators (Kaolack)





ANNEX 5

Form'Action Activities Report
and
Protocols and Subgrant

SUMMARY OF FORM'ACTION ACTIVITIES FOR CBO ORGANIZATION

- Community Capacity Building Needs Assessment an Organizational Assessment of Community Based Organizations (Mother Committees, Women's Groups, Village Health Committees) has been performed following Form'Action methodology in 16 pilot villages (8 in Sakal and 8 in Wack N'gouna) This activity was conducted by CHEs who were trained and supervised by the APC for Community Capacity Building (CCB) The APC for Training, Monitoring & Evaluation also participated to create a link between child survival and organizational development activities The methodology consists of a participatory institutional diagnosis of the community-based organization (CBO) to assess its strengths and weaknesses in terms of associative life, vision, mission, objectives, planned activities and results, management structure and functioning, institutional environment, financial means and other resources of the CBO Techniques used for the 2-day investigation include focus group discussions, interviews with leaders, document review and direct observation After data collection on all these topics, an analysis is performed and results are shared with CBO members and communities and validated through their feedback Main results and lessons learned are presented in annexed documents from Form'Action (*Annex V*) but can be summarized as follows
 - * Strengths
 - Mother Committee and Women Group's members are very dynamic and engaged in Child Survival activities and recognize their benefit
 - Adhesion criteria are uniform within both project sites (being married and living in the village)
 - CBO management procedures and tools do exist and are well known by all members
 - Several support and income-generating activities (literacy classes, micro-credit schemes) exist in Plan International villages
 - * Weaknesses
 - Mother Committee and Women Group's members do not consider Child Survival activities as their regular day-to-day routine and link them to the existence of the project
 - CS activities are not regularly held, management tools are not well filled out, high illiteracy rate among group members
 - Lack of documentation of achievements and lessons learned
 - Ignorance of leaders' and members' roles and responsibilities in the CBO management, and leaders have been in position since the creation of the CBOs

Finally, strategies to reinforce strengths and address weaknesses are proposed by population and discussed with the project team and other local partners This diagnosis allowed us to draft a plan of action for each site that will be closely monitored by CHEs and APC for CCB

A) Diagnostic Procedure for the 15 Pilot Sites in Louga and Kaolack

Plan International Senegal, in collaboration with the NGO Form'Action, intends to undertake a Child Survival Project (CSP), co-financed by USAID Washington, in the Louga and Kaolack regions

This five-year project covers all *arrondissements* [districts] of Sakal and Wack N'gouna. Its goal is to improve the health of children under five years of age and their mothers. It involves the following:

- expanding the vaccination program,
- fighting diarrheal diseases,
- controlling cases of acute respiratory infection,
- preventing and treating malaria,
- monitoring nutrition

Within the context of the partnership between Plan International and Form'Action, the latter is to lead the organizational development of beneficiary communities with continuation of the project's activities in mind.

The methodological approach taken by Form'Action involves completion of the following steps:

- completing a community diagnosis providing information about the current status of community management structures (Mother Committee, Management Committee, Group Committee, Health Committee, etc.) with the goal of taking stock, identifying operational and management weaknesses,
- structuring or restructuring of community management structures with the goal of correcting any dysfunction of income-generating or associative activities,
- implementing income-generating activities with the goal of mobilizing financial resources for effective support of the community health effort,
- implementing a system of adjustments at each health center to balance the list of resources used by the centers based on the economic surplus produced by the various workers within the community.

In addition to the project start-up workshop, motivation of ASCs and community personnel has been identified as a key factor for the project's success, and has been the subject of analysis and planning by the participants.

This is why 15 pilot sites (one site per community-health educator) were chosen in Sakal and Wack N'gouna and the diagnostic was performed in these areas.

By undertaking the diagnostic, we were attempting to sow seeds of curiosity from which the project could grow through example and organized visits.

This summary covers most of the activities accomplished within the scope of this diagnostic. It consists of two parts:

I Presentation of Methodology

II Results and Outlook

I Diagnostic Methodology

The method involved completion of the following three phases

1.1 Data Collection

This involved collection of key information or criteria for evaluation of an organization, as identified in the data-collection guide. The data dealt with seven organizational aspects, namely identity cards, associative life, mission or goals, activities and results, structure, environment, resources, and operational mode. Four tools were used for this phase

- Focus groups, individual interviews, review of documents, and direct observation

1.2 Data Analysis and Diagnosis

This phase consisted of

- compilation of notes taken by each team member (information from focus groups, individual interviews, review of documents and direct observation),
- analysis of data collected for each organizational aspect, using pre-defined criteria,
- classification of key information into two categories
 - Strengths things that exist, are known and well used or well done,
 - Weaknesses things that do not exist, are not known, are not well used or well done

1.3 Release/Validation of Diagnosis and Negotiation for Support

The operations for this phase are as follows

- release/validation of the diagnosis, consisting of
 - presentation of the diagnosis results to the people,
 - collection of participants' opinions (critiques, additional information, etc), in order to share the diagnosis with the various workers for their confirmation or validation of it
- negotiation for support. The task during this phase was to negotiate with the people to find solutions (in the form of an action plan) for any dysfunction identified and presented in the diagnoses ("Weaknesses")

II Results and Outlook of the Diagnosis

Diagnosis occurred between July 9 and 23 for Wack N'gouna and August 9 and 26 for Sakal. Fifteen sites, or one site per CHE, were involved

The selection criteria adopted when choosing the sites were as follows

- existence of a Plan International service point (except in the Potou zone),
 - existence of a health committee or any basic organization,
 - existence of (community) income-generating activities,
 - enthusiasm of the people for CS activities,
- etc

Field work was to be done by a team of CHEs working within a single area, but the interest shown by the CHEs led nearly all of them to participate in the diagnoses for all sites selected

Schedule of Visits in Sakal

TEAM	ECS	DATES	PLACE
Sakal rural community	Modou Seck, Adama Fall, Fama Diouf	Aug 9-10, 11-12, 13-14	Roye Dièye Ndiaguène Wolof Rimbax Sylla
Ngueune Sarr rural community	Abdoulaye Tall, Sophie Niang Diop	Aug 16-17, 18-19	*Pallene Diadji Boumack
Leona rural community	Fama Cissé, Daouda Kebe, El Hadji Faye	Aug 20-21, 22-23, 25-26	Medina Thiolome Tare (Potou)** Batlamine

N B *Diadji Boumack and Batlamine changed their date because the Diadji CHE was ill

* Tare is a non-Plan International village in the Potou zone

* Except for Tare, all of the targeted villages have a health center

Schedule of Visits in Wack N'gouna

DIAGNOSTIC TEAM	DATES	PLACE
Penda N'Diaye, Mariama Kitane	July 19-20, 21-22	Saboya Fetto
Marietou Diao, Amath Thiam	July 17-18, 15-16	Niassene Walo Thilla Grand
Makame Cisse, Babou Thiam, Daniel Lopez	July 13-14, 11-12, 9-10	Pane Sader / Keur Ndiaga Dialle Keur Mandongo Bowe

2.1 Findings and Lessons Learned in the Field

- a) With regard to the Women's Groups and Mother Committees diagnosed
- *The following findings were made concerning Women's Groups*

Strengths and Weaknesses

Committed and dynamic women Membership criteria for the groups are well defined and are similar nearly everywhere (members must be a married woman in the village) Membership fees are paid by the husband on the day of the marriage Rules of operation and management procedures exist and are well known to the members The mission is clear and shared by all All income-generating activities and facilities are already in place There is a very clear perception by the women of the relevance of CS activities The groups generally have their own resources There are management tools for the financial resources Decisions are generally by consent The villages are very clean Most of the groups have reporting meetings Additionally, the focus groups organized during the diagnostic process allowed information to be gathered and allowed the people to become more aware of and familiar with the project The diagnostic process provided the impetus for all groups to take their organization in hand

Ignorance of roles and responsibilities on the part of all members of the office staff The focus is on income-generating activities to the detriment of health activities In nearly all groups, there is no secretary CS activities do not occur on a regular basis Some CS facilities are incomplete Almost none of the groups have implemented annual dues No formalization or written support No office's staff has changed since the creation of the group Illiteracy rates remain high Most groups have no bank account, leading to the problem of keeping resources safe The rare instances of management support that have been implemented are poorly kept up or not used at all

- The current status of Mother Committees varies according to the following parameters origin, status, focal villages, variety of activities relationship to health committee, and existence or non-existence of resource persons

Strengths and Weaknesses

Committed, dynamic, and transparent Mother Committees The goals and activities are well known Responsibility and involvement of satellite villages in the Mother Committee office Rules of operation exist and the members abide by them The basic documents creating Mother Committees already exist Mother Committees have already been trained in CS The facilities or income-generating activities are already in place There is a very clear sense by the Mother Committees of the relevance of CS activities In general, CS activities are done correctly

High rate of illiteracy Lack of formalization and written documentation Ignorance of roles and responsibilities The focus is on income-generating activities to the detriment of health activities No office's staff has changed since the creation of the Mother Committee The rare instances of management support that have been implemented are poorly kept up

- b) Regarding the methodology used
- Based on experience, the methodology was judged to be relevant to the study's objectives
 - For future diagnoses, it would be best to work with teams of at least three persons during the process, and to make a better choice of dates based on the people's occupations
 - The data collection guide should be detailed and the concepts translated, harmonized and validated to ensure that the same practices are followed
 - The diagnostic process' goals should be clearly explained when the people are told about it, and also during the focus groups
 - The preliminary phase during which information about the diagnostic process is provided is as important as the diagnostic phase itself

2.2 Training Needs

The expected result of the diagnostic process for community organizations is "the re-energizing of community management structures for health activities (basic health care, child survival) and income-generating activities in the 15 villages diagnosed in order to make the villages capable of taking over the community health effort on a permanent basis"

CHEs are the agents who should support this dynamic, and so should be equipped to achieve this result

The need also exists for improvements in financial-management capabilities, group dynamics, roles and responsibilities of office staff, identification of income-generating activities, and continuous self-evaluation of activities by visualization

2.3 Priority Actions to be Taken Immediately

Based on those negotiated with the people, and considering the expected result (see "Training Needs"), an action plan for priority actions to be taken immediately was drawn up for the period from September through the end of 1999 for the CHEs in Wack and Sakal

ACTION PLAN FOR LOUGA CHEs

ACTIONS	DEADLINES	RESPONSIBLE	NOTES
1 List CSP service points (aid stations, health centers, and others)	Sept 15, 1999 at the latest	CHEs	For each service point add the focal villages specifying whether they are Plan International villages or not
2 Identify resource persons literate in French or Wolof	Sept 15, 1999 at the latest	Groups concerned with support of CHEs	To help the groups from their villages maintain management support while waiting for those involved to be trained
3 Restore workshop at N'gueune Sarr	during Sept 1999	CSP and ICP	Ensure broad-based and good representation from the groups in the area
4 Validate the new CSP service points	during Sept 1999	CSP/NHC	Validation should begin with ICP's agreement to cover these points
5 Clarify relationship between Plan International and the ICPs in Louga	during Sept 1999	CSP, Plan International and ICP	For effective implementation of CSP activities by the ICPs
6 Obtain additional information about the groups diagnosed	during Sept 1999	Groups, with supervision by the CHEs	Groups represented only a little or not at all during the focus groups
7 Compile a roster of group members so that membership registries can be created	during Sept 1999	Groups, with supervision by the CHEs	Groups diagnosed (central and focal villages)
8 Inventory existing CSP equipment and supplies and determine needs	during Sept 1999	Groups, with supervision by the CHEs	Groups diagnosed (central and focal villages)
9 Ask the groups for their ideas for income-generating activities	before Jan 2000	Groups, with supervision by the CHEs and CDA	For study by CSP before negotiation and possible financing
10 List and formalize the rules of operation in force at the group level	before Jan 2000	Groups, with supervision by the CHEs and CDA	These rules will be supplemented later when procedural errors are corrected
11 Restructure groups	before Jan 2000	CHEs with support from CDA (CDA support optional)	Create decision-making and managing entities (office, management commission or committees for income-generating activities)
12 Supervise reporting meetings or meetings to re-launch activities after restructuring	before Jan 2000	CHEs	For at least two CSP and/or associative activities
13 Open bank accounts	before Jan 2000	Groups with supervision by the CHEs and CDA	Groups with income-generating activities (mill, shop, etc)

ACTION PLAN FOR KAOLACK CHEs

ACTIONS	DEADLINES	RESPONSIBLE	NOTES
1 Clean up detailed information collected on the Mother Committees during the focus groups	before end of Aug 1999	CHEs	As a report following the model in the information-collecting guide
2 Compile a roster of Mother Committee members so that membership registries common to all members (central and focal villages) can be created or updated	before end of Sept 1999	Mother Committee offices supported by CHEs	Also specify dates that members joined the Mother Committee and the amount paid as membership fees
3 Identify resource persons likely to be able to support management in the villages whose CM was diagnosed	before end of Aug 1999	Mother Committee offices with supervision by CHEs	These persons, either men or women, must come from the villages concerned and have enough training to be able to give support
4 Compile all rules of operation and membership criteria determined by the Mother Committees themselves	before end of Sept 1999	Mother Committee offices with supervision by CHEs	As necessary, supplement information on this subject received during the focus groups for the diagnostic
8 Identify activities currently underway or to be implemented that will require support from Plan International/CSP	before Jan 2000	Mother Committee offices with supervision by CHEs and CDA	Compile list of income-generating activities underway and those desired (for study) by the Mother Committees
9 Inventory existing facilities and material resources and determine needs (of Mother Committees)	before Sept 1999	Mother Committee offices with supervision by CHEs	All existing facilities (moveable property and real estate) and supplies furnished by Plan International (for CS and other purposes)
10 Make a participatory institutional diagnosis of health committees and other structures (those receiving financial support from Plan International)	before Jan 2000	CHEs, using the guide used for the Mother Committee detailed implementation plan	Only in the villages whose CMs have been diagnosed
11 Set meeting schedules for the various levels—offices, working committees, management committees for income-generating activities and general assemblies (all members)	before Jan 2000	All Mother Committee members with the support of the CHEs and (possibly) ICPs	At staff meeting, draft a schedule to be negotiated with the general assembly before the general assembly meets
12 Design and implement management support	before Jan 2000	CSP, ICP	Based on CM activities
13 Design and implement support for visualization of results	before Jan 2000	CM, CSP, ICP	Based on pictorial representations of the goals by the people
14 Train resource persons to use support	before Jan 2000	CSP	Prior training of CHEs, who will be the trainers

IV CONCLUSION

The main results of diagnosis of the 15 selected pilot sites at Wack N'gouna and Sakal were as presented above (Results and Outlook, Training Needs, Priority Actions to be Taken Immediately)

Completion of this operation constitutes the first step toward reaching the overall goal, namely perpetuating CSP and basic health-care activities at the community level

It also implies implementation of prerequisites, challenges to be undertaken by both Plan International and Form'Action

a) Plan International

The following actions should be taken

- Define clear rules with the ICPs (Sakal zone) in order to guarantee the credibility of the community personnel through regular supervision and to ensure good attendance at the health center by effectively carrying through with all planned activities
- Finance income-generating activities for Women's Groups and Mother Committees with the goal of generating revenues that can support community health and other costs
- Implement a micro-credit system that will allow women to increase their personal income and pay the costs of health care, and which will also serve as a strong incentive to carry out planned CSP activities
- Develop and implement incentives at the community level to effectively implement the action plans for structuring the CBOs
- Ensure that CS women's groups (weighing) are trained, to make them more independent of government structures
- Improve functional literacy of women in order to accelerate the structural reorganization process (maintain support)

b) Form'Action

The challenges will be as follows

- Seek collaboration and support from the Plan International CDAs to harmonize approaches and community intervention strategies as action plans for structuring are implemented
- In order to support a dynamic of change, the CHEs' needs for improved capabilities must be met so that they can carry out their mission
- In order to remain in line with the stages of the proposed continuation process, the health committees in the pilot villages should be diagnosed soon

A In Summary

- Develop CHE contracts for May-September 1999
- Restore Start Up Workshop to non-present workers at Wack N'gouna and Sakal
- Train 15 CHEs in the CBOs' detailed implementation plan
- Detailed implementation plan DE 16 CBOs (8 at Wack N'gouna and 8 at Sakal)
- Develop 15 action plans to re-energize the CBOs
- Develop action plans covering September-December, 1999 for the 15 CHEs

LIST OF GOALS AND INDICATORS OF IMPROVED CAPABILITIES ON THE PART OF FORM'ACTION AND PLAN INTERNATIONAL

GOAL	INDICATOR
Form'Action	
Implement an institutional development plan for Form'Action, facilitated by Plan International	An institutional development plan is worked up and presented to Plan International Form'Action is assigned an overhead as financial support for the action plan
Improve Form'Action's planning, implementation and evaluation capabilities for a CS project	At the end of the project's four years, the person responsible for monitoring and evaluation is capable of developing, planning, implementing and evaluating a CSP according to Plan International/AID procedures
Improve Form'Action's ability to manage a central accounting system for auditing balance sheets and developing a budget	A procedural manual for a centralized accounting system is available and is used beginning in year 3
Plan International	
Improve CBO functioning in Plan International zones affected by the CSP	Percentage of CBOs that have turned over their office [staff] Percentage of CBOs carrying out activities (income-generating activities, basic health care, CS) Percentage of CBOs having a membership registry
Implement mechanisms for appropriation and continuation of CSP activities by the beneficiaries	Percentage of villages with HSCs capable of financing CS activities Percentage of communities capable of independently motivating service providers

FORM'ACTION'S ACTION PLAN IN THE CONTEXT OF THE CSP FOR OCTOBER 1999-SEPTEMBER 2000

- Detailed implementation plans for the health committees and other CBOs benefitting from Plan International support for the 15 PPS affected in 1999
- Putting in place of management structures and financing of health activities in the 15 PPS diagnosed
- Identification of income-generating activities to be supported by Plan International at the CBO level
- Evaluation of training needs for CBOs
- Training of CHEs in group dynamics, income-generating activity management, organization of work
- Structuring of detailed implementation plans/restructuring of CBO (committees, groups, etc) in 117 HSCs
- Supervision of CBO training in group dynamics and income-generating activity management by the CHEs
- Design and implementation of management support for CBOs and their activities
- Design and implementation of followup plan for D O activities



PLAN
INTERNATIONAL
SENEGAL

Child Survival Project

PROTOCOL AGREEMENT
PLAN INTERNATIONAL
SENEGAL / FORM' ACTION

March 1999

Preamble

PLAN International has initiated a project called "Child Survival" in the purpose of improving the health of under 5 years old children as well as their mothers. This project has been conducted in the Medical District of Nioro and Louga, in support of the management, and carrying out of the Senegalese National Programs

- The Extended Program Immunization
- The Control of Diarrheal Diseases
- Pneumonia Case Management
- The Prevention and Treatment of Malaria
- The Nutritional (Growth) Monitoring

For that purpose PLAN has requested the collaboration of the Ministry of Health as well as Form 'Action, a local NGO, which reference was given to PLAN by the NGO support project

As part of this program, it was agreed and ordered the following,

Between :

PLAN International Senegal, hereafter designated by **PLAN**, represented by his National Director D' Winnie TAY on the one Hand,

And,

On the other Hand, the **NGO Form'Action**, hereafter designated as **Form'Action** represented by his Executive Director M' Jean BASSENE

I - Purpose :

The present protocol agreement aims at defining the clauses of the partnership between PLAN and Form'Action within the project "Child Survival"

II - Concerned Domains .

This present protocol covers the following domains

- ⇒ the organization and the management of the Child Survival Project
- ⇒ the organizational development of the beneficiary communities of the project
- ⇒ the institutional reinforcement of Form'Action

III - Responsibilities:

In so far as the project initiator and subscriber with the USAID of its financing contract, Plan is responsible of its technical and financial management

Form'Action is delegatee for PLAN, and is, as it stands, responsible, before him (PLAN)

IV - Commitments on both sides.

4. 1. Organization and Administrative management

4 1 1 PLAN and Form'Action contract to organize and manage the Child Survival Project's activities according to the basic document of the project

4 1 2 Form'Action contracts to

- ⇒ participate to the recruitment process of the personnel of the project
- ⇒ sit at the level of the board of managers, or wherever needed
- ⇒ second in the project team his Agent in charge of the monitoring and evaluation, as an assistant to the Project Coordinator
- ⇒ to be bound by any auditing and checking of accounts, from PLAN,

regarding funds provided by PLAN within this partnership

4 1 3 PLAN contracts to grant every year to Form'Action for its indirect costs resulting from this partnership, 40 % of indirect cost granted to PLAN Senegal by USAID

This amount will be paid in October at the beginning of USAID fiscal year, all the vouchers will have to be established according to USAID rules and procedures

4 1 4 PLAN contracts to take in charge for the duration of the project the remuneration of the Form'Action officer who seconds the Coordinator as an Assistant, in charge of the Community Based Organization development

4 2 Community Organization Development

4 2 1 PLAN and Form'Action contract to negotiate every year or when needed a contract, relating to the financing of a community organization plan, through operational plans of action aimed at the project's attainments sustainability

This contract will be attached to this present protocol as a **codicil**

4 2 2 Form'Action contracts to execute all the clauses stipulated in the plans of action which will be assigned to him

4 2 3 PLAN contracts to ensure the financing of the elaborated and approved plans of action

4 - 3 - Form'Action institutional reinforcement

4 3 1 PLAN and Form'Action contracts to
⇒ work for the Form'Action Institutional Reinforcement

4 3 2 PLAN contracts to
⇒ give all the necessary assistance to Form'Action in the elaboration of its institutional development plan as well as in the search of the financing, necessary for its implementation

4 3 3 Form'Action contracts to
⇒ Submit to PLAN a diagnosis report on its position as well as an institutional development plan
⇒ Manage the institutional support provided by PLAN according to its

procedures

⇒ To be submitted to any evaluation or Auditing of accounts requested by PLAN

V - Term of the protocol:

The term of this agreement shall commence on the date the two parties sign it, and it will last as long as the duration of the Child Survival Project as indicated in the project base document

VI - Disengagement of Responsibilities

The relations between PLAN International and Form'Action proceeding from this present protocol can't in no way and any right of, commit its responsibility towards any corporate body or natural person of public or private law

However, in the hypothesis such a situation would arise out, Form'Action will substitute itself to PLAN International, undertake its defence, and hold him harmless from and against all claims, expenses, and any responsibility of a conviction in principal, and legal interest, as well as any damages which could be pronounced against PLAN

VII - Termination of the contract

Each of the contracting parties can terminate this protocol on a 90 days notice in writing to the other side

VIII - Settlement of litigation.

Any litigation proceeding from this present protocol, for lack of an amicable arrangement, will be submitted to the territorially court of competent jurisdiction

Dakar, March 30th 1999

For PLAN

WINNIE L. TAY

For Form'Action

JEAN BASSENE

SUB GRANT FOR The RESTRUCTURING OF VILLAGES ORGANIZATIONS

Partners of the Child Survival Project

VORP / CSP

I - Context:

Within the outline of its partnership with Plan international / Senegal for the Child Survival Project (CSP), two Form'action agents have escorted the team project for four days, successively in the sanitary district of Nioko du Rip and Louga. In these two districts, which are in other respects, project sites, PLAN has brought his support to the Ministry of Health for many years in its population sanitary protection in general and child in particular.

The goal of this mission for Form'action was to establish a first evaluation of the situation in the project zone in order to measure the level of its contribution to reach their goal.

Four days we spent on the field, are definitely too insufficient to apprehend the realities. However, all the partnership implementation process between the two organizations, formalized by numerous meetings, workshops (reorientation workshop) and written documents, have helped us to have a global view of the strengths and weaknesses of the existing system.

It appears to us that the weak point of the system is the unsatisfactory management of the community structures and equipment.

Form'action then, proposed to Plan to take over the restructuring of the village organizations in the project sites while the Child Survival Project in which we are partners is still executed.

II - Description of the Under-project

2 1 Justification.

The analysis of the current situation indicates that

- Some HCW and matrons are demobilized either because they received no compensation or because the villagers did not help them in their work

- The Mothers Committees (MC) is a good idea to help mobilise the mothers over child survival questions Unfortunately, experience has shown that like, health committees, their activities were very limited mainly because of management deficiencies
- The impregnated mosquito nets don't sell well because the population find them too expensive

- The 100 000 F CFA cash flow which is used for the culinary shows is not always balanced in receipts and expenditures

- Most of all al has equipped most of the key villages with instruments which can generate incomes like Millet mills, shops cereal storing , warehouse, and bovine food and all that to the profit of the "mixed" group

Besides that point, a 500 000 F CFA revolving fund is at disposal of the women grouping so that they can individually do some small retail business

As a matter of fact, most of those means are under the control of few people, essentially men who have an opaque management style of the fund with no accounting book-keeping, and no diffusion of informations to the population concerned As the result the villagers have conspicuously disengaged themselves from all community activities, which is very harmful to the social progress of the village

The CSP aims during these four years assure perennality of the structures and the activities set up

A number of conditions have to be met to assure the perennality of the structures

- the HCW, the matrons as well as the community health educators will have to be motivated financially

- a continual supply by PLAN or by the project in products and medicine
- a well balanced fund for culinary demonstration
- impregnated nets must be sold at a price, villagers can afford, so that a perennality can be assured to this activity
- the maintenance, renewal, or the reinforcement of the equipment set up for the project or already set up by PLAN

The means to assure perennality to the structures and activities of the CSP do exist, the real challenge is organizational and Form'action has decided to take it up

The restructuration is a prerequisite to the CSP intervention to the CSP intervention and an essential condition to assure the durability of its effects

2. 2. Localization - Duration - Recipient

2 2. 1 Localisation

The VORP / CSP concerns 348 villages in the district of Sakal, sanitary region of Louga and 197 villages in the district of Wack N'Gouna, sanitary region of Niore du Rip

The project will first start in the villages chosen by the CSP before it spreads to the others Plan villages of the district

2. 2 2 Duration

VORP /CSP will last three years and seven months, 30 months will be devoted to the restructuration of the organizations and community activities, as well as the training of the managers, and the remaining period for the (follow up - evaluation - strengthening) of the reorganized structures in the management of their activities

2 2. 3 Beneficiaries

The ultimate beneficiaries of the project are the children targeted by PLAN in its child protection mission

Thanks to a better management of the activities which generate income, one part of the resources will be allocated to assure the perennality of the child's diseases taken in charge by PLAN

The intermediary beneficiaries are the parents who by assuring control and approbation of the management committees will appreciate the community activities fall out over the health of the children

2. 3. Child Survival Project goal

Improve durably the health of the children between 0 and 5 years and women in age of procreation (15 - 49 years), living in the sanitary districts of Louga and Nioro du Rip

2. 5 VORP / CSP expected results

- 1) Installation of Management Committees according to the nature of their activities and functioning in accordance with the required standards
- 2) The committees are sensibilized and are involved in the financing of the health cost
- 3) Identification and setting up in the communities (Mutual, Support fund) of health costs self-financing mechanisms

Indicators:

- Number of management committees per activity financed by PLAN and which members are democratically elected
- Number of Health Committees reorganized and functional
- Number of Restructurized mothers committees equipped with a manual of procedure adapted to the receipts and management control
- Number of management committees trained in management procedures
- Number of Restructurized village groupings, with democratically elected members, in charge of the co-ordination of the different committees and informing the beneficiaries
- Number of mothers committees selling impregnated mosquito nets at an affordable price, prime condition of perennality for this activity
- Number of mothers committees capable of reconstituting the (100 000 F CFA) cash flow allotted by PLAN for the culinary demonstrations

- Number of management committees in charge of the activities which can generate income, and keeping accounting books and management documents properly
- Number of management committees and groupies which are regularly controlled by the inhabitants
- Number of health support funds set up

2. 6. Intermediary Results.

year 1 (September 1999)•

Fifteen committees (of mothers or health) are restructurized and have adopted democratic standards

Year 2 (September 2000)•

R₁ 117 others mothers committees or health are restructurized and function according to democratic standards

R₂ Financial resources mobilization mechanisms are set up within (30) committees

Year 3. (September 2001)•

R₁ Financial resources mobilization mechanisms are set up in 102 others committees

R₂ Support funds for the health programs are set up in 20 committees

Year 4 (September 2002)

Support funds to health programs are set up in 40 others committees

2 5 3. Activities:

Contact all the groupings, health committees, mothers committees, already existing or to be created resources generating management committees and inform them of the goal of the VORP / CSP and the approach considered for its implementation

- work out in conjunction with the groupies and committees in each village, an execution calendar of his under-project, including in one hand a diagnosis of existing organs and their management style and on the other hand the set up of new structures and procedures (organizational development)

- elaboration of management documents for the various activities

- proceed to a participative diagnosis, and to democratic restructuration of groupies and committees as well as their activities

- proceed to a participative examination of the means and ways of maintaining the cash flow for the culinary show, and apply a right price, for the impregnated nets, so to assure a perennality to that service

- ensure the follow up and proceed to a periodical evaluation of committees, groupies and their activities once restructurized

- train managers of various committees to simple book keeping and accounting principles (disbursement, receipts, etc) of productive activities

2 6 Methodological approach

An effective and large adherence of the villagers to this objectives, is the key, for a success of the under-project As well as those who actually use the equipments

The idea is to bring them with a lot of tact, to accept the approach in the interest of the community in general and the children in particular For all theses reasons the first meeting with the villagers is crucial It will have to be well prepared All the surrounding villages will be informed well ahead of the time, we shall emphasize on the main aim which is to assure a lasting protection to the child

During the first meeting, a date will be fixed for participative planning of the diagnosis and restructurization sessions

Those diagnosis and restructurizations sessions will start with the villages which show more interest to the program and which don't have too many organizational problems. It is important to achieve successfully the first restructurization since those sites will be used as references, for exchange visits, for the villages not yet organized or to invite their leaders to participate to others restructurization programs

The VORP / CSP will be extended initially in the villages involved in the CSP, before it is spread to other PLAN villages. It is difficult to forecast the time to spend in each village. It depends on the social and the political relations. Anyhow, the restructurization process will be executed in three phases

The first will concern an extensive participative diagnosis of the social situation, of the existing community structures and the way they are manage

The second phase will concern the restructurization in itself with the installation of new structures, the democratic election of managers and persons in charge, as well as a large information of the villagers regarding their duties, obligations and prerogatives

Theses two phases will be monitored by the supervision team

The third phase concerns the training of the community activities managers, which will start on a date fixed by the supervision team

The restructurization sessions in every key village, will be conducted in presence of the supervisor in organizational development of HDW from PLAN

The restructurization program in the small surrounding villages concerns mainly mothers under-committees and will be conducted by the HCE¹

¹ Make sure that the local leader who is unanimously recognized as such by the villagers assist to all the first meetings

The diagnosis in view of the VO restructurization will require the displacement of a team of 3 persons minimum who will stay during 3 days in each of the fifteen communities concerned by the under-project

2 7. Execution calendar (see operation plan)

The project team will try to reduce the period of time between the information session on the project objectives, and the organizational development session. Therefore, while some villages will be at the step of the diagnosis, others will be in the planning and some others are involved with information process. All these steps will be conducted during the 45 first days of the project.

2 8 Continuation of activities after the VORP / CSP Termination

The last year of the project will concern the accompaniment of the restructurized village organizations. This accompaniment will consist of regular management control in committees and groupies, and additional training when necessary, and in support of population to exercise their power control and their power sanction.

The elected account commissioners will be largely associated in this approach so that they can have the reflex and the legitimacy.

In that same time, the HCE will be trained in organizational development techniques and in the management of activities, which can generate income, so that they can continue the accompanying mission during 43 months of the under-project.

III - Project manager of the VORP /CSP (see Form'action institutional diagnosis)

Form'action Plan / Senegal partner in the Child Survival Project will assure the managerial of this under-project.

IV - Under-project impacts, hypotheses and risks in the objectives achievement.

4 1. Expected impacts

4 1 1 Micro-economic effects

A democratic management of activities generating income will allow a better redistribution of the profits and as the result a substantial improvement in the villagers living conditions

A better access of women to the income of these production units will surely help the activities of the village particularly the women with their "little business"

4.1 2 Socio-cultural effects

The confrontation of the villagers with the democratic management of community structures will involve a change in their behaviour Therefore people in charge will have to show more strictness in the management of the means entrusted to them The villagers will assure their duties of control and sanctions and therefore stand as a real counter-power

With the decentralization process, a number of functions which used to be executed in town, have been transferred to local communities along with their own budget As the result of good management of village structures, local committees will face a democratization in their management

The more, the village women will get involve in community activities, the more they will be emancipated, and will have access to economic resources of the village

An increase in the women's purchasing power will contribute to the well being of the children since the women reinvest most of their incomes in (clothing's, food and health)

The HCW and matrons having a good compensation and beneficiary of necessary means to conduct their activities, will be more available for the health of the population

The rate of child and mother morbidity and mortality will be kept low durably thanks to the activities of the mothers committees

4 2. Hypothesis and risks

One can reasonably assume that a respected local notable won't be against the restructurization of village organizations

A devaluation of CFA francs will not compromise the expected results of the activities generating income and increase the cost of services offered by health committees and mothers committees

V - Services and means

5.1 Human means

CSP team supported by Form'action executive Director is in charge of the project execution. She will use the services of HDW from PLAN and will have these main tasks

- Animate in all the key villages, information meeting of the objectives and the stakes of the VORP / CSP
- Plan, organize, and execute all the participative diagnosis and the restructurization of all the village organizations and their activities in key villages
- Conceive management documents of the various community activities
- Plan and execute the training of all the managers in 10 key villages in Sakal and in Wack N'Gouna
- Plan and proceed to the participative examination of the means to keep the funds intended to the culinary demonstrations, and impregnated mosquito nets at levels which will give perennality to these activities
- Assure the training of HCE in group dynamic and organizational development in the management of community activities, and assure the follow up and evaluation of their application in 3 key villages
- Assure the follow up of the restructurized village organs and offer additional training when needed

- Help villagers be more aware of the power they can exercise when needed, by assuring a control and eventual sanctions against people they elected

The HCE will receive a monthly 92 000 CFA francs allowance detailed as follow

70 000 salary out of which a 5% tax will be deducted

22 000 transportation costs

Form'action executive Director will have to help organize, co-ordinate and counsel the various activities therefore he should

- Assure the follow up and evaluation of the services offered by the under-project team, by evaluating its impact over the village structures functioning
- Adapt regularly the operations plan according to field informations
- Make sure that there is the best synergy between the VORP / CSP activities and the ones of CSP

5.2 Material means

5.2.1 Vehicle

A vehicle 4X4 is necessary in order to give a total autonomy to Form'action, in his mission of supervision of the activities conducted in the under-project PLAN will provide the vehicle every time it is needed

In order to assure a proper follow up in the field 04 camp-beds equipped with mosquito nets and canopy will be bought at 50 000 F piece

As well as 02 trunks gaz lamps will be bought at 40 000 F CFA piece

5.2.2. Institutional support of village organizations

Form'action, after a diagnosis study and field study will transmit to PLAN a bank of projects to the benefice of village communities, those projects could be financed by the program unit budget. Those projects will be conceived in collaboration with PLAN's HDW

ANNEX 6

Work Plan for Years 1 and 2

ANNEX 6

**Child Survival USAID funded project
Activities report October 1998 to
September 1999**

ACTIVITIES YEAR ONE	First quarter			Second quarter			Third quarter			Fourth quarter			Total		
	Oct98-Dec98			Janv99-Mar99			Apr - Jun 99			Jul - Sep 99			Oct 98-Sep 99		
	Plan	Ach	%	Plan	Ach	%	Plan	Ach	%	Plan	Ach	%	Plan	Ach	%
1 PREPARATORY ACTIVITIES															
1 1 Hiring of personnel															
1 1 1 Hiring of Project staff															
1 1 1 1 Project coordinator	1	1	100%										1	1	100%
1 1 1 2 Assit Project coordinator	2	1	100%										2	2	100%
1 1 1 3 Secretary	2	2	100%										2	2	100%
1 1 2 Hiring of field personel															
1 1 2 1 Hiring of drivers				2	0	0%					2		2	2	100%
1 1 2 2 Hiring of CHEs				15	0	0%		15					15	15	100%
1 2 Baseline assessments															
1 2 1 Baseline KPC Survey				1	1	100							1	1	100

1 2 2 Target population sensus						%	1	0	0%		1		1	1	100%
1 2 3 Training needs assessment							2	1	50%		1		2	2	100%
1 2 4 CBO assessment							2	0	0%		2		2	2	100%
1 3 Partnership/MU/ PLAN health team work															
1 3 1 DIP Development				1	1	100%							2	2	100%
1 3 2 Grant Project Start-up workshop				1	1	100%							1	1	100%
1 3 3 Signature of MU with MOH & F'A				2	0	0%		2					2	2	100%
1 3 4 KPC results and Start Up WS restitution							12	9	75%		3		12	12	100%
1 4 Financial & procurement procedures															
1 4 1 Grant Administrative procedure Workshop				1	1	100%							1	1	100%
1 4 3 Procurements of office furniture				2	0	100%		2							
1 4 4 Procurement of computers/printers				6	0	0%		6					6	6	100%
1 4 5 Procurements of vehicles				2	0	0%					2		2	2	100%
1 4 6 Procurement of ITNs										2	X	X	2	X	X
1 4 7 Procurement of essential drugs / scale for GM										2	1	100%	2	1	100%
1 4 5 Procurements of registers (M & E)										61	0	100%	61	0	100%
1 4 6 Procurement of training & IEC material										1	0	0%	1	0	0%
2 TRAINING ACTIVITIES															
2 1 Training at comunity level															
2 1 1 Initial Training of CHWs, TBA										2	2	X	2	2	X
2 1 2 Initial training of IEC relays										2	2	X	2	2	X
2 1 5 Initial training of mother commitees in ITNs										X	X	X	X	X	X

2 2 Training at project and MOH level							1	1	100%				1	1	100%
2 2 1 Initial training of CHE							1	1	100%				1	1	100%
2 2 2 Basic Computer Skills training for Project staff							1	1	100%				1	1	100%
2 2 3 Training in community base diagnosis										2	2	100%	2	2	100%
2 2 4 Management and Supervisory Skills training for Project staff (EPI, Malaria)										1	0	0%	1	0	0%
2 2 5 Training of trainers in Child Survival							2	1	50%		1		2	2	100%
3 COORDINATION ACTIVITIES															
3 1 Project Coordination Committee meeting				1	1	0%	1	1	0%	1	1	0%	3	0	0%
3 2 Steering Committee meeting										1	0	0%	1	0	0%
3 3 Meetings with MOH Health facility staff							6	6	100%	6	6	100%	18	18	100%
4 SUPERVISORY ACTIVITIES															
4 1 Supervision of Community Health Teams(Louga)				X	X	X	X	X	X	X	X	X	X	X	X
4 1 Supervision of Community Health Teams(KLK)				X	X	X	X	X	X	X	X	X	X	X	X
4 2 Supervision of MOH Health facility staff				X	X	X	X	X	X	X	X	X	X	X	X
4 3 Supervision of Project Field staff										3	0	0%	3	0	0%
5 IMPLEMENTATION															
5 1 Mothers Health education & counselling															
5 1 1 Malaria (number)										X	X	X	X	X	X
5 1 2 Diarrhea (number)										X	X	X	X	X	X
5 1 3 A R I (number)										X	X	X	X	X	X
5 1 4 E P I (number)										X	X	X	X	X	X
5 1 5 Nutrition (number)										X	X	X	X	X	X
5 2 ITN activities															
5 2 1 Dipping of Bednets by MCs										X	X	X	X	X	X
5 2 2 Distribution of bednets by MCs										X	X	X	X	X	X
5 3 Health hut level activities															
5 3 1 Malaria case management by CHWs															
5 3 1 1 Chloroquine										X	X	X	X	X	X

5 3 1 2 Referral										X	X	X	X	X	X
5 3 2 Diarrhea case management															
5 3 2 1 ORS packet distributed										X	X	X	X	X	X
5 3 2 2 Referral										X	X	X	X	X	X
5 3 3 Pneumonia case management															
5 3 3 1 Referral										X	X	X	X	X	X
5 3 4 EPI															
5 3 4 1 Outreach strategies										61	X	X	61	X	X
5 3 4 2 Fixed strategies										61	X	X	61	X	X
5 3 5 Nutrition															
5 3 5 1 Growth monitoring sessions										61	X	X	61	X	X
5 3 5 2 Culinary demonstrations										61	X	X	61	X	X
5 4 Other health education activities															
5 4 1 Dusk/Dawn health Education Broadcasts										24	0	0%	24	0	0%

X = Activities which cannot be assessed because of information withholding or activities realized under PU budgetary line instead of project budgetary line

PLAN International Senegal Child Survival Project Louga/Nioro
 Work Plan Year two October 99 to September 2000

Activities Year Two	Responsible	Milestone	First quarter			Second Quarter			Third Quarter			Fourth Quarter	
			O	N	D	J	F	M	A	M	Jul	J	A
1 Preparatory activities (finalization of year one)													
1 1 Baseline assessments													
1 1 3 Health Facility Assessments /Missed opportunity EPI	Consultant												
		HFA report written											
1 1 2 CBO assessments	Form Action												

2 1 7 Initial training of CBO in Child Survival	NRME / Consultant																		
2 1 8 Initial training of CBO in management and cost recovery	Form Action																		
		All trainings completed																	
2 2 Training at project and MOH level																			
2 2 Basic Computer Skills training for Project staff	NRME / Consultant																		
2 2 Management & supervisory skills training for project staff	NRME																		
2 2 Project staff training in qualitative survey	Consultant																		
2 2 Project staff training in Health facility Assessment	Consultant																		
2 2 Management & supervisory skills training for CHEs	NRME																		
2 2 Team Building training for CHEs	Form Action																		
2 2 Training of CHEs in qualitative survey & participatory research	NRME / Form Action																		
2 2 Training of trainers in new approach in CS (Vit A Malaria)	NRME																		
		All trainings completed																	
3 COORDINATION ACTIVITIES																			
3 1 Project level																			
3 1 1 Project Staff coordinating meeting (monthly)	Project Coordinator																		
3 1 2 PLAN's Health Team coordinating meeting (monthly)	Project Coordinator																		
3 1 3 Project Coordination Committee meeting (quaterly)	Project Coordinator																		

3 1 4 Steering Committee meeting (every 6 months)	Project Coordinator																		
3 1 5 Annual workshop for Program Unit activities planning & assessment (once a year)	National Health Advisor																		
3 2 MOH level																			
3 2 1 Meetings with MOH Health Facilities staff (monthly)																			
3 3 Community Level																			
3 1 5 Annual workshop for community activities planning & assessment (once a year)																			
5 IMPLEMENTATION																			
5 1 Mothers Health education & counselling																			
5 1 1 Malaria (number of sessions)	CHEs / CHTs																		
5 1 2 Diarrhea (number of sessions)	CHEs / CHTs																		
5 1 3 A R I (number of sessions)	CHEs / CHTs																		
5 1 4 E P I (number of sessions)	CHEs / CHTs																		
5 1 5 Nutrition (number of sessions)	CHEs / CHTs																		
5 2 ITN activities																			
5 2 1 Dipping / Re-dipping of Bednets by MCs	Consultants / MCs																		
5 2 2 Distribution of bednets by MCs	MCs																		
		All community receiving bednets																	
5 3 Health hut level activities																			
5 3 1 Malaria case management by CHWs	CHWs																		
5 3 1 1 Chloroquine																			
5 3 1 2 Referral																			
5 3 2 Diarrhea case management	CHWs																		
5 3 2 1 ORS packet distributed																			

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ANNEX 6

PLAN International Senegal Child Survival Project Louga/Nioro
 Work Plan Year two October 99 to September 2000'
 (This Work Plan is integrating PU activities not included in project budget)

Activities Year Two(SEP 99 to OCT 2000)	Responsible	Milestone	First quater			Second Quater			Third Quater			Fourth Quater		
			O	N	D	J	F	M	A	M	Jun	Jul	A	S
1 Preparatory activities (finalization of year one)														
1 1 Baseline assessments														
1 1 1 Health Facility Assessments /Missed opportunity EPI	PC				■									
		H F A report available				■								
1 1 2 CBO assessments	Form Action					■	■	■	■	■	■	■	■	■
1 1 3 Village Health Commity assessment (pilot settings of year one)	Form Action			■	■									
		All assesements achieved							■					
1 2 Financial & Procurement procedures														
1 2 1 Procurement of ITNs	Project Coordinator		■	■	■									
1 2 2 Procurement of health huts supplies	Project Coordinator		■	■	■									
1 2 3 Procurements of registers (M & E)	Project Coordinator		■	■	■									
1 2 4 Procurement of training & IEC material	Project Coordinator		■	■	■									
1 2 5 Hygien materiel (PU budget)	Project Coordinator		■	■	■	■	■	■	■	■	■	■	■	■
1 2 6 Office supplies	Project Coordinator		■	■	■	■	■	■	■	■	■	■	■	■
		All sites equiped				■								
2 Training Activities														
2 1 Training at community level (Health Service Points)														
2 1 1 Initial Training of CHWs TBA (Louga)	FHS					■	■	■						
2 1 2 Initial training of IEC relays (Louga)	FHS					■	■	■						
2 1 3 Initial Training of CHWs TBAs (Kaolack)	FHS													
2 1 4 IEC relays (Kaolack)	FHS													
2 1 5 Initial training of MCs in ITNs (LGA)	FHS								■					
2 1 6 Initial training of MCs in ITNs (KLK)	FHS								■					
2 1 7 Initial training of CBO in Child Survival (Health Comitees)	FHS								■					

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Activities Year Two(SEP 99 to OCT 2000)	Responsible	Milestone	First quarter			Second Quarter			Third Quarter			Fourth Quarter		
			O	N	D	J	F	M	A	M	Jun	Jul	A	S
4 1 3 A R I (number of sessions)	CHEs / CHTs													
4 1 4 E P I (number of sessions)	CHEs / CHTs													
4 1 5 Nutrition (number of sessions)	CHEs / CHTs													
4 2 ITN activities														
4 2 1 Dipping / Re-dipping of Bednets by MCs	MCs / FHS													
4 2 2 Distribution of bednets by MCs	MCs / Form Action													
		All community receiving bednets												
4 3 Health hut level activities														
4 3 1 Malaria case management by CHWs	CHTs													
4 3 2 Diarrhea case management	CHTs													
4 3 3 Pneumonia case management	CHTs													
4 3 4 EPI														
4 3 4 1 Outreach strategies	PHN													
4 3 4 2 Fixed strategies	PHN													
4 3 5 Nutrition														
4 3 5 1 Growth monitoring sessions	PHN / MCs													
4 3 5 2 Culinary demonstrations	PHN / MCs													
		All communities receiving CS services												
4 4 Other health education activities														
4 4 1 Health Education Broadcasts	PC/ FHS													
4 5 Empowerment and Capacity Building Activities														
4 5 1 Setting up of income generative activities (PU budget)	Form Action													
5 SUPERVISORY ACTIVITIES														
5 1 Community level														
5 1 1 Supervision of Community Health Teams(LGA & KLK)	CHEs / PHN													
5 1 2 Supervision of CBOs	CHEs / Form Action													
5 2 Project and MOH level														
5 2 1 Supervision of MOH Health facility staff (health post)	DHMTs / NTMES													
5 2 2 Supervision of Proj staff	NHC													

Activities Year Two(SEP 99 to OCT 2000)	Responsible	Milestone	First quater			Second Quater			Third Quater			Fourth Quater		
			O	N	D	J	F	M	A	M	Jun	Jul	A	S
5 2 3 Supervision of project field personnel	PC/ FHS													
6 RESEARCH ACTIVITIES														
6 1 Operational research in Malaria	PC / MOH / Other partner (IRD)													
6 2 Qualitative surveys in Child Survival	Consultant / PC													
7 Construction (PU budget)														
7 1 Health hut / Construction (PU budget)	FHS													
7 2 ORT/Nutrition construction (PU budget)	FHS													
8 Other Health Activities not included in the CS grant														
8 1 Training of Trainers in STD/ HIV (PU budget)														
8 2 Training of relays (Club Guneyi) (PU budget)														
8 3 Support Program for CHWs, TBAs IEC Relays (PU budget)														

' A more detailed plan have to be set up at the beginning of each quater This plan is in french for a better understanding by the whole Plan health team This strategy will allow each actor to do a self assessment of his work



ANNEX 7

Training Needs Assessment

ANNEX 7

TRAINING ACTIVITES (for year two and following training needs assessments)

ACTIVITIES YEAR TWO	RESPONSIBLE	Number to be trained	O	N	D	J	F	A	M	J	J	A	S
TRAINING ACTIVITIES													
Training at community level (Focal Healrh Points)													
Initial Training of CHWs, TBA (Louga)	PC / FHS	56 (2 pers x 28 HSP)				■	■						
Initial Training of IEC relays (Louga)	PC / FHS	28 (1 pers x 28 HSP)				■	■						
Initial Training of CHWs, TBA (Kaolack)	PC / FHS	30 (2 pers x 15 HSP)				■	■						
Initial Training of IEC relays (Kaolack)	PC / FHS	15 (1 pers x 15 HSP)				■	■						
Initial Training of Mcs in ITNs (Louga)	PC / FHS	56 (2 pers x 28 HSP)							■				
Initial Training of Mcs in ITNs (Kaolack)	PC / FHS	30 (2 pers x 15 HSP)							■				
Initial Training of CBO in Child Survival	PC / FHS	129 (3 pers x 43 HSP)						■					
Initial Training of CBO in Management and cost recovery	Form'Action	45 (3 pers x 15 HSP)						■					
Training at Project level													
Basic Computer training for Project staff	PC/NSTME	07		■									
Management and Supervisory skills training for Project staff	PC / NTMES	07			■								
Project staff training in qualitative survey	PC	07							■				
Project staff training in Health facility assessment	PC	07			■								
Management and Supervisory skills training for CHES	PC / FHS	15			■								
Team Building training for CHES	Form'Action	15			■								
Training of CHES in qualitative survey and participatory resarch	NSTME / Form'Action	15							■				
Training at MOH level													
Training of trainers in new approch in CS (Vit A, Malaria)	PC / FHS	17				■							
Training in Supervisory skills	PC /FHS	17				■							



ANNEX 8

Concept Paper about Project Activities

Village Census and Enrollment Methodology
Concept paper by Dr Ndeye Fatou Ndiaye/CSP Coordinator
1998-1999

Part 1 – Census and coding

This work was done by Community Health Educators with the support of ICPs and all resource persons who could be identified at the community level

- **Step I Establish an identity card for each village**

The task is to identify villages that are focal points [for health] thanks to their aid station and health centers and to create a sort of “identity card” for each village by collecting specific, previously-defined data

- **Step II Establish a code for each CHE**

The code consists of the first letter of the *arrondissement* [district] and a number assigned to each CHE (See list in Appendix)

Example W1, W2, W3, , W7 for Wack N’gouna
 S1, S2, S3, , S8 for Sakal

- **Step III Establish a database for followup on individual children**

Step IIIa For each CHE, assign a number to each village identified, beginning with number 1

Step IIIb Assign a number to each concession in each village (note the name of the concession supervisor)

Step IIIc Assign a number to each mother in each concession (note that the name of the mother corresponds to the household, each mother being considered as a household)

Step IIId Assign a number to each mother’s children aged 0-5 years, always beginning with number 1 The oldest child is first, etc Note the last name and first name of each child

Step IIIe Create a code for each child in this order

- 1 CHE code (see list in Appendix),
- 2 first letter of the rural community If the first letters of different communities are the same, use the next letter to tell them apart
Example For Keur Madiabel and Keur Maba Diaxu, use “D” for Keur Madiabel and “B” for Keur Maba Diaxu,
- 3 the village number,
- 4 the concession number,
- 5 the household number,
- 6 the child’s number

This gives, in order (see example in Appendix),

CHE code/first letter of rural community/village number/concession number/household number/child number

For villages where the census was recently done but the code system is not yet in place, the code system will be created as weighings are completed at the community level, based on existing

registries Additional information regarding coding will be progressively incorporated before the first computer analysis (maximum three months)

Part 2 – Creation of Computer Database For Individual Followup on Children Aged 0-36 Months

The input screen uses Epi Info version 6 (see documentation in Appendix)

Each child aged 0-36 months will have a computer file that will allow quarterly monitoring of SNP, vaccination[, and] oral case history, and monitoring every six months for vitamin A, treated mosquito net

The study will be carried out with a computer analysis program created using the Epi Info software, version 6 (see Appendix) The program is started up each quarter by the assistant responsible for the management information system

At the same time, we will use group followup based on monthly collection of data on 0- to 5-year-old children for all CSP activities, which is the classic public-health approach and will allow us to detect monthly trends

Regardless of the advantages and disadvantages [of each approach], the benefit lies in the combination of the two approaches

Comparison of Group and Individual Followup

	Group Followup	Computerized Individual Followup
Advantages	Easy Requires few resources Classic approach with monthly checks allowing overall trends to be detected Allows quick decision-making	Allows correlated cross-analysis Allows articles to be written Based on the individual followup system that already exists at the community level (Mother Committee roster, expanded vaccination program, etc) <ul style="list-style-type: none"> • Facilitates analysis (gives group and individual results) • More accurate results • Allows for combination of community and clinical approaches (use of oral case history) • Quicker, easier analysis using a computer program • Innovative approach that can be shared and that permits exchange of experiences and lessons learned More specific explanations of the trends revealed <ul style="list-style-type: none"> • Provides a way to keep explicit archives when the project has ended • Uses the individual followup system that already exists at the community registry level (SNP followup)

	Group Followup	Computerized Individual Followup
Disadvantages	<ul style="list-style-type: none"> • Documentation and analysis of information not very accurate (need for surveys, focus groups, etc) • No clinical approach possible 	<ul style="list-style-type: none"> • New approach that may encounter resistance from public health workers used to the classic system • Requires computer hardware and software training

This table, which is not comprehensive, gives an overview of the two approaches and how they complement each other. This last point emphasizes the need for integration useful for monitoring and evaluation of CSP activities.

Part 3 – Village Enrollment Strategies for Conducting Activities

1 Health Service Centers (HSCs), Mosquito Net Treatment Centers, Continuation Mechanisms

Activities will begin in health centers that are already operational, in order to provide time to introduce the community structures needed for the smooth functioning of the HSCs or for the existence of health centers (Mother Committee, ASCs/intermediaries/midwives)

We think that four to five months after the beginning of health center activities will be sufficient time to make the rest of the HSCs operational

To introduce mosquito net treatment centers, given the toxicity of the product, we will use the Plan International health centers and aid stations, as these sites have infrastructure that allows them safely to store the products. These structures have facilities that allow them to store poisonous products. In conjunction with this, we will implement a system of advanced [mosquito-net] treatment strategy based on specific needs and insisting on the treatment of curtains. Additionally, certain HSCs may serve as points of sale for treated mosquito nets.

Another important point is to consider a system allowing one intermediary per village to be put in place. This choice will be made at the community level with the CHEs as a catalyst. The CHEs will be responsible for initiating the idea at the community level, but the choice of intermediary will be made by the communities.

It is necessary to organize the CHEs for continuation of activities in order to furnish a lasting revenue source for them (economic interest group or other body). This will be studied by Form'Action in collaboration with the CHEs.

Under the Plan International policy in effect in Senegal, each ICP is reimbursed for supervisory visits to health centers. The problem can be stated in terms of "Plan International villages" and "non-Plan-International villages." To avoid creating a process that cannot be continued at the end of the project, supervisory visits to health centers in Plan International villages will be linked with visits to HSCs in non-Plan International villages. The reimbursement will be made per supervisory visit and not per center visited. The possibility of implementing a lasting ICP incentive system for each visit to the non-Plan International sites and health centers should also be considered. This could be taken over by the communities (cash or in kind), for example Form'Action will play an important role in this process.

ANNEX 9

CHE Training Report

PLAN
INTERNATIONAL
SENEGAL

TRAINING COMMUNITY HEALTH
EDUCATORS IN
CHILD SURVIVAL
(Louga June 14 - 18, 1999)

By
Diagully KOITA, Assistant to the Child Survival Project Coordinator
In charge of Training, Follow-up and Evaluation

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1 DESCRIPTION OF THE WORKSHOP

1.1 Introduction

The PLAN International Senegal's health program contains a component 'Child Survival', which is being implemented out in all its zones of activity, among which the health programs for the Kaolack and Louga zones", specifically referred to as "Child Survival Project", benefit from the support of USAID and the collaboration of the Non-governmental organization, Form'Action. Community Health Educators (ECS) are recruited within the framework of this project. Training the various participants, among which the ECS is among the strategies employed for reaching the set goals. Thus it is that the seven (07) and eight (08) ECS of Louga and Kaolack have been brought together at the Louga training center to take part in this workshop.

1.2 Goals of the Workshop

- to reinforce the knowledge of the Community Health Educators on PLAN International Senegal and its Child Survival Project
- to develop the Community Health Educators' theoretical and practical knowledge of the technical activities of Child Survival programs
- to develop competence among Community Health Educators in the management of the information system

1.3 Participants

Participants include Community Health Educators involved in carrying out the activities of the Child Survival Project in Kaolack and Louga, with the support of PLAN, particularly at the mobilization level, with PSE staff members as facilitators. The list of participants is indicated in Appendix 1.

1 4 The Program

DAY 1 Monday, June 14

08 00 – 08 30	Pre-test
09 00 – 10 00	Opening Introduction of participants
10 00 – 10 30	Administrative Information / Goals of the training Information on the course of the workshop
10 30 – 10 45	Coffee Break
10 45 – 11 30	Group work (knowledge of PSE)
11 30 – 12 30	Recapitulation – meeting
12 30 – 14 30	Lunch Break
14 30 – 15 30	Group work (members role)
15 30 – 16 30	Recapitulation
16 30 – 17 00	Evaluation
17 00	End of work

DAY 2 Tuesday, June 15

08 30	Recapitulate Day 1
09 00 – 10 00	SNP
10 00 – 10 15	Coffee Break
10 15 – 11 15	LMD
11 15 – 12 15	Group work
12 15 – 13 00	Recapitulation
13 00 – 14 00	Lunch Break
14 00 – 15 00	PALU
15 00 – 15 30	PEV
15 30 – 16 30	Group work
16 30 – 17 00	Evaluation of Day 2
17 00	End of the day

DAY 3 Wednesday, June 16

08 30	Recapitulate Day 2
09 00 – 10 00	IRA
10 00 – 10 15	Coffee Break
10 15 – 11 15	Group work
11 15 – 12 15	Return
12 15 – 13 00	Summary of teaching

13 00 – 14 00	Lunch Break
14 00 – 15 00	SIG PSE presentation
15 00 – 15 15	Break
15 15 – 16 30	Group work
16 30 – 17 00	Evaluation of Day 3
17 00	End of the day

DAY 4 Thursday, June 17

08 00 – 8 30	Recapitulate Day 3
08 30 – 13 00	CLD in SAKAL
13 00 – 14 00	Lunch Break
14 00 – 15 00	SIG Group work
15 00 – 15 15	Break
15 15 – 16 30	Return to work group on SIG
16 30 – 17 00	Evaluation Day 3
17 00	End of the day

DAY 5 Friday, June 18

08 00 – 8 30	Return Day 4
08 30 – 13 15	Planning ECS activities
13 15 – 13 45	Final evaluation
13 45	Closing

1 5 Methodology

The workshop unfolds in four phases

Phase 1

Knowledge of PLAN and the Child Survival Project

The purpose of this stage is, on the one hand, to lead participants to understand PLAN's motivations, strategies and activities, through questions and answers, and to use work groups to reconstruct the organizational diagram of PSE within PLAN. In particular, two Community Development workers (ACS) have lived up the topic, 'Familiarity with PLAN'

Phase 2

Knowledge of the areas of activity of the PSE

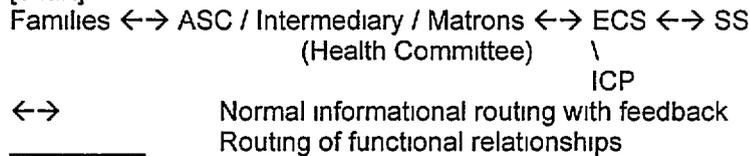
This phase concerns looking into, as group work, the five (5) areas and the ten (10) modules of the PSE

Phase 3

Use of a health information system for management purposes (SIG)

In this phase, the participants assembled the various management tools to be used by Community Health Workers at the outpost level and at the service points- a model for their monthly reports. These tools are more or less identical to those already in existence on-site in particular the Package of Integrated Activities in Nutrition (PAIN) registers. The main distinction is the insertion of a "Vit A" column. Furthermore, the informational routing was determined to include feedback.

[chart]



It was proposed that monthly sessions be held between the ECS and the health committees while the monthly meetings would be organized with the team at the level of each zone. However, there is also the possibility of a quarterly meeting with all members of the two zones. Moreover, a coding system for each ECS and each eligible child in the PSE has been defined by the Coordinator of the PSE, with practical exercises for better understanding.

Coding of the ECS by Number

WackNgouna Zone

- W1 Makam CISSE
- W2 Mariama KITANE
- W3 El Hadji Babou THIAM
- W4 Penda NDIAYE
- W5 Mariétou DIAO

- W6 Daniel LOPEZ
- W7 Amath THIAM

Sakal Zone

- S1 Adama FALL
- S2 Sophie Niang DIOP
- S3 Fama DIOUF
- S4 El Hadj FAYE
- S5 Daouda KEBE
- S6 Abdoulaye TALL
- S7 Modou SECK
- S8 Fama CISSE

Children's Code

- ECS Number
- First letter of the rural community (except for Keur Madiabel and Keur Maba Diakhou use D for the first letter, B for the second)
- Village Number
- Concession Number
- Household Number
- Child Number (0 – 5 years, considering the eldest as No 1)

Example The code W3 D 8 12 4 2 means that

This is the 2nd-eldest child of 0 – 5 years of age, from the 4th woman living in Concession No 12 at the level of the 8th village of the rural community of Keur MaDiabel, under the responsibility of the ECS El Hadj Babou THIAM

Phase 4

ECS Activity Planning for June – July

During the course of this phase, the PSE Coordinator planned activities with the ECS for the months of June and July 1999, which essentially have to do with the gathering of basic data, consciousness-raising for the service points and centers for impregnating mosquito nets

II RESULTS OF THE WORKSHOP

2 1 Evaluation of the workshop by participants

The 15 participants all filled out an anonymous, final evaluation form yielding the following responses

- 1) The general level of satisfaction is 100%
- 2) The level of goals reached is 100%
- 3) The participants' level of satisfaction is 100% with regard to the competence of the trainers in explaining the topics, dispelling any doubts and responding to the participants training needs
- 4) The participants' level of satisfaction with regard to time spent at the workshop is 47%
- 5) The level of satisfaction with regard to the pedagogic organization of the workshop is 80%
- 6) The level of satisfaction with regard to the locations where the training was held is 1%
- 7) The level of satisfaction with regard to resources and training aids used is 67%
- 8) 100% of the participants judge themselves capable of explaining the new knowledge and competence acquired during the workshop at the time of the decentralized sessions and in their supervisory duties
- 9) The most useful activities and characteristics are
 - the group projects
 - the content of the modules
(Management tools, SNP, IEC vaccinations SIG, Malaria, IRA)
 - Coding of children
- 10) 93% of participants judged everything useful
One participant judged the model of the financial report to be the least useful
- 11) The coding of children, the use and application of the registers, the group spirit the IEC the technical content of the modules, the SNP, the PSE, the assumption of responsibility for health by the community, anticipated on-site work and the SIG make up the most significant things the participants learned

- 12) Comments made about the trainers include open mastery of subject, pedagogic competence, clear, not nervous friendly simple, respect their work and schedules wish the project to succeed, "Big hurrah"
- 13) The sections that should be more thoroughly explored or given more time are
 - table on taking chloroquine
 - SNP
 - monthly report
 - SIG
 - reports between ECS and SS, ECS and ICP
 - IRA
 - coding
- 14) Suggestions or recommendations for future workshops include
 - move the training location
 - increase the amount of time
 - change the zone
 - provide the documents during training
 - manage time well

2.2 Comments made by Facilitators

The ECS are involved in the success of the project more than could justify their presence in the heart of the PSE. Thus, each person contributed his utmost, both in the technical plan and the overall management plan for the project. Contributions made by various people can teach us a lot. However, almost everyone regretted the pokiness of the accommodations and the no-show of the Local Development Committee (CLD), due to delay by the PSE members. In addition, an important follow-up and supervisory task of the ECS must be done on-site, so that they may fully fulfill their role as agents for social mobilization for achieving the PSE goals.

III APPENDICES

APPENDIX 1 List of participants

	Name	[illegible]	[illegible]	Place
1	Daniel LOPEZ	ECS	Ndrame Escale	Kaolack
2	Marietou DIAO	ECS	Keur Maba	Kaolack
3	Mariama KITANE	ECS	Keur Tapha	Kaolack
4	Makam CISSE	ECS	Wack Ngouna	Kaolack
5	Abdoulaye TALL	ECS	Ngueune Sarr	Louga
6	Daouda KEBE	ECS	Leona	Louga
7	Penda NDIAYE	ECS	Saboya	Kaolack
8	El Hadji Babou THIAM	ECS	Keur Madiabel	Kaolack
9	Amath THIAM	ECS	Thilla Grand	Kaolack
10	Sophie Yamar Niang DIOP	ECS	Ngeune Sarr	Louga
11	Fama CISSE	ECS	Leona	Louga
12	El Hadji FAYE	ECS	Leona	Louga
13	Fama DIOUF	ECS	Sakal	Louga
14	Modou SECK	ECS	Sakal	Louga
15	Adama FALL	ECS	Sakal	Louga
16	Dr Ndeye Fatou NDIAYE	CPSE	PLAN	Louga
17	Gnagna GUEYE	Ass SIG	PLAN	Louga
18	Guineth FALL	Health Sup	PLAN	Louga
19	Amadou GAYE	Health Sup	PLAN	Kaolack
20	Oumi GUEYE	Ass SIG	PLAN	Kaolack
21	Diaguily KOITA	A Forma/follow-up/Eva	PLAN	Kaolack

APPENDIX 2 Daily Evaluation Form

DAILY EVALUATION OF THE WORKSHOP

Day _____

Strong points	
Weak points	

Suggestions	
-------------	--

APPENDIX 3 Final Evaluation Form

FINAL EVALUATION FORM ON THE WORKSHOP

		Not at all Satisfied	Very Satisfied
1	In general, how satisfied are you with the workshop?		1 2 3 4 5
2	Do you think that the workshop reached the goals it had set for itself?		1 2 3 4 5
3	How satisfied are you with the ability of the trainers to explain the topics, dispel any doubts and respond to the participants' training needs?		1 2 3 4 5
4	How satisfied are you with the time devoted to this workshop?		1 2 3 4 5
5	How satisfied are you with the organization of this training? (for example, presentations vs group work vs case studies vs role play)		1 2 3 4 5
6	How satisfied are you with the locations used for this workshop?		1 2 3 4 5
7	How satisfied are you with the resource materials and aids used?		1 2 3 4 5
8	How capable do you think you would be of applying the new knowledge and competence acquired during this workshop in your everyday work?		
9	What are the activities and characteristics you have found most useful?		

- 10 What was the least useful thing?
- 11 What was the most significant thing you learned?
- 12 What comments or suggestions do you have for the trainers?
- 13 Is there any part of the workshop, in your opinion, that should be more thoroughly explored or given more time? If so indicate exactly which topic or session

APPENDIX 4 Daily Report

Summary of the Daily Work for June 14, 1999

The opening of the daily work which was supposed to be done by the PUM from Louga, Ousmane BA- sadly prevented from doing so- was carried out by the Project Coordinator at around 09 00 a m , who took advantage of the opportunity to welcome everyone and apologize for the delay in the work

The welcome address was followed by a pretest on the Child Survival Project, which lasted around 20 min

Then, we moved on to the introduction of the participants in pairs- to get to know each other better Around 10 30, after having gone over all administrative questions the course of the workshop and the goals of the training, there was a 15-min coffee break

Workshops on the recapitulation of the organizational diagrams on the structure and function of the Project followed, until the lunch break at 13 30

When work began anew at 15 00, reporters from each group recapitulated the various works At that time there were so many interjections on PLAN s activities that the ADC from Louga were kind enough to explain to us PLAN s system of sponsorship, its vision and mission for the country's children

Work ended at 17 15

Reporter Daniel LOPEZ, ECS Ndrame Escale

Summary of the Daily Work for June 15, 1999

The workshop began at 09 00 with the presentation of the report on Day 1, by one of the ECS
The evaluation of Day 1 was carried out by the facilitator who thereafter presented the various areas of the PSE, as well as the various modules

Around 10 00 we received a visit from the PUM Ousmane BA who welcomed us He was brought up to date on the activities of the preceding day so he could be better involved in the course of the workshop

The group work on the SNP and the LMD started at 11 30 after a 15-min coffee break
The recapitulation by work groups on the SNP ran from 13 00 until 14 00 time for the lunch break When work began again at 15 30 the facilitator presented the feeding schedule for a child of 0 – 36 months This was followed by a recapitulation on the LMD followed at 17 00
The group works on the PEV and malaria at 17 15 were followed by their recapitulation from 17 45 until 18 30

The day ended with an evaluation of the day at 19 00

Reporter Daouda KEBE, ECS Potou

Summary of the Daily Work for June 16, 1999

Work began earlier than usual, at 8 10 The facilitator provided a summary on primary health care while stressing its components

He also gave a brief synopsis of the IEC

At 9 27, as an exception to the preceding days, the daily work was not opened with a reading of the report Therefore, an ECS participant from Louga presented his report from Day 2

At 9 30, the facilitator moved on to the evaluation of Day 2, while highlighting the strong points and those needing improvement and providing clarifications on certain points brought up by the participants

At 10 10 the facilitator went over the IRA, where one subject had been submitted from each of the three respective groups for reflection Plenary meetings followed the coffee break
It is thus that explanations and data were provided on the rapid breathing of a child of 0 to 5 years of age as well as the percentage of associated deaths alarm signs, the advice for the ASC mothers and PAIN

At 13 57 the lunch break began After lunch, at 16 00 the facilitator went into the definition and importance of the SIG, while discussing management tools The group work ended the day at 18 30, while reports were made on the plenary sessions on the following day
Nonetheless, group work continued until late at night

However, the presence of the Health Supervisor from the PU in Louga in the afternoon should be noted He tried in his own way to provide explanations after the facilitator, to further everyone's understanding

Reporter **Mariama KITANE, ECS Keur Tapha**

Summary of the Daily Work for June 17, 1999

The workshop was opened at 8 25 with the presentation of the report on the preceding day
Then the facilitator read the evaluation of Day 3 A discussion on the PSE work framework was held

At around 10 00 we went to Sakal to attend the CLD, as planned, but unfortunately it did not take place

At 10 40, all the ECS were introduced to the Executive Director of Form'Action who had come to the CLD for the occasion and to bring the salaries for the month of May Salaries were handed out afterwards The lunch break started at 13 45

At 16 45 the participants reassembled in the meeting room for a presentation on the various management documents (weight, prescriptions expenses, inventory list orders deliveries)

At 19 05 the facilitator explained the coding of the SIG tools, which allow for a better follow-up of the child

The workshop ended at 19 45 However, group work continued until late at night

Reporter **El Hadji Babou THIAM, ECS Keur Madiabel**

APPENDIX 5 PRE- / POST-TEST TRAINING OF THE ECS

June 14 – 18, 1999

Name and given name of the ECS

Origin

I Circle the correct answer

<u>Kind of vaccination</u>	<u>Time of administration</u>
1 Measles / Yellow Fever	a) 4 ½ months b) 9 months c) 3 ½ months
2 BCG	d) 8 months e) 2 ½ months f) 0 months
3 DTCP 1	g) 1 month h) 3 ½ months i) 2 ½ months
4 DTCP 2	j) 1 ½ months k) 3 ½ months l) 2 ½ months
5 DTCP 3	m) 1 ½ months n) 3 ½ months o) 2 ½ months

II For what period of time should a baby exclusively receive mother's milk?

Circle one answer

0 – 8 months

0 – 1 months

0 – 3 months

0 – 2 months

0 – 6 months

0 – 4 months

III Anti-malarial chemical prophylaxis is no longer applied to children

Circle one

TRUE FALSE

IV A cold is not a sign of the seriousness of Acute Respiratory Infections

Circle one

TRUE FALSE

V Name the three (3) rules for controlling diarrhea at home

VI A pregnant woman must have at least two (2) prenatal consultations before her delivery

Circle one

TRUE FALSE

VII Name four kinds of information that are necessary for you to include in your monthly report from a Community Health Educator

VIII Chatting is an interpersonal communication technique

Circle the right answer

TRUE FALSE

IX The participation made by the people within the framework of Primary Health Care is limited to financial contributions

Circle one

TRUE **FALSE**

X Among the following populations, which is not part of the area of intervention of the Child Survival Project?

Circle one answer

- 1** Fight against diarrhea
- 2** Fight against malaria
- 3** Fight against Acute Respiratory Infections
- 4** Information, education, communication
- 5** Vaccinations

PLAN
INTERNATIONAL
SENEGAL

DATE June 29, 1999

To Louis SAGNA PUM Kaolack

Cc Dr Ndeye Fatou NDIAYE, CSPC
Ousmane BA, PUM Louga
Dr Adja DIACK MBAYA, NHC

From Diaguily KOITA, APC

Sub Report on the training of Community Health Educators

Dear Colleagues,

Attached you will find the report on the Community Health Educators training session, held in Louga during the month of June 1999

Thank you for your help



ANNEX 10

Health Information System Workshop Report

Plan
International
KAOLACK

**INFORMATION SYSTEM VALIDATION WORKSHOP
FOR MANAGEMENT PURPOSES
(Kaolack, August 26 – 27, 1999)**

By Diagully KOITA
Assistant to the Coordinator of the Child Survival Project,
Entrusted with Training, Follow-up and Evaluation
And by
Dr Ndeye Fatou NDIAYE PSE Coordinator

September 1999

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- 2-2 RECOMMENDATIONS
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- APPENDIX 5 Composition of the work groups

1 DESCRIPTION OF THE WORKSHOP

1 1 Introduction

The Information System for Management (SIG) of the Child Survival Project (PSE) of PLAN International Senegal has as its objective the collection and use of pertinent information on activities and results, for decision-making purposes on the subject of health. To this end, validation by the partners at the Ministry of Health has proven indispensable. This is the justification for this workshop.

1 2 Objectives of the workshop

- to adopt management tools at the community level
- to determine the informational route
- to adopt supervisory tools

1 3 Date August 26, 27, 1999

1 4 Place Kaolack – Centre des Oeuvres catholiques

1 5 Participants

Eighteen people took part in this workshop, among which were present: one representative of the Study, Research and Planning Administration, two representatives from the Health Administration (SNGE – SNAN), one representative of the Medical Region of Kaolack, two station head nurses of the District of WackNgouna (Ndrame Escale and Keur Madiabel) and the ten members of the health team of Plan International Senegal. The Louga team was absent due to a local workshop.

1 6 Methodology

- reminder to PSE

STRATEGIES

- Increase basic community capabilities (Form'Action)
- Partnership (MS, private structures)
- IEC

WORK CARRIED OUT

- Basic investigation
- Workshop launch
- Sign agreement
- Detailed intervention plan for the Project
- Return to the communities
- Train trainers
- Decentralized training
- Monographic study
- Participation in the District / Regional coordination meetings
- Institutional diagnostics of community health organizations

- Group work

The workshop has essentially been carried out in the form of group work followed by a return to meetings

II RESULTS OF THE WORKSHOP

2.1 Synopsis of the meetings

COORDINATION GROUP / FOLLOW-UP

Composition of the group

Ms Adja DIACK MBAYE, CNS PLAN International
Malamine SARR, BRAN Kaolack
Moussa SARR, SS PLAN Thies
Lamine GUEYE, SSP Supervisor, Nioro District
Boubou NIANE, ICP Ndrame Escale
Ms Aissatou KANE MBAYE, SS PLAN Dakar

Thoughts on Coordination and Supervision

* Definition of the concepts

Coordination

An exchange of information which facilitates communication and allows conflicts to be handled
Basic Goal Follow-up on the correct execution of a plan of action
Coordination is an aspect of the follow-up

Supervision

Intended to further training and motivation, it is directed at individuals and not activities

* Coordination

1 Formal coordinating bodies

SUPERVISION

LEVEL	PERSONS TO SUPERVISE	PERSON IN CHARGE OF SUPERVISION		FREQUENCY	MEANS OF SUPERVISION
		Health Ministry	PLAN/F A		
Village / neighborhood (case of health of PPS)	Members of health committees	ICP	SS/F'A-ECS	Complete supervision bimonthly	Existing
	Members of mothers' committees/ GPF	ICP	SS/F'A-ECS	Complete supervision bimonthly	Existing
	Public health committee members	ICP/AH	SS/E/CS	Complete supervision bimonthly	Existing
	ASC / Matrons	ICP	ECS	Complete supervision bimonthly	Existing
	Intermediary / IEC	ICP	ECS	Complete supervision bimonthly	Existing
Rural Community (Community district, health station)	ICP	ECD	Not Applicable	Monthly supervision	Existing
	Wise-woman	ECD	Not Applicable	Monthly supervision	Existing
	ECS	ICP	SS/F'A	Monthly supervision	To be prepared
District / Region (PU health center)	ECD	ECR	Not Applicable	Quarterly	Existing
	SMI contractors (doctors, SF, nurses)	ECD/DS/E CR	Not Applicable	Quarterly	Existing
	SS	Not Applicable	CPSE / RNFSE	Monthly	To be prepared
	SIG Assistant	Not Applicable	RNFSE / SS	Monthly	To be prepared
National	CPSE	Not Applicable	CNS	Quarterly	To be prepared
	RNFSE	Not Applicable	CNS	Quarterly	To be prepared
	CNS	Not Applicable	PSM	Quarterly	To be prepared

COORDINATION PROCEDURES TO BE PUT INTO PLACE BY THE PSE
(Scheduling to be made each year See year 99-00 attached)

[Chart]

[top row]

Coordination procedures [months are listed]

[left column]

- 1 Annual balance / planning workshop PU
1 Lg/l Kik/l Th/1 St-L/ 1 Dkr
 - 2 Monthly coordination meetings of PSE AID
2 Ass SIG / CPSE / RNFSE / SS
Kik Lgs / ECS*
 - 3 Monthly coordination meetings of PSE DFID/ Lottery
CPSE DFID – Lott / RNFSE / SS
Dkr , Th, St-L
 - 4 Monthly coordination meetings of the health team
 - 5 Quarterly coordination meetings at the community level
 - 6 Quarterly coordination meetings
 - 7 Quarterly coordination meetings of steering committees
- * 1 ECS per P U

COORDINATION

LEVEL	AGENCY	MINISTRY OF HEALTH	PLAN INTERNATIONAL	COMMUNITY
COMMUNITY		<ul style="list-style-type: none"> • APB • Monthly coordination meeting of the health station (ICP, health committees, GPF, Matrons' committees, ASC / Matrons / Intermediary, Partners for development, OCB, Associations, Local collectives) 	<ul style="list-style-type: none"> • Annual PB / PSE workshop • Meeting _____ of coordination of PSE at the community level (ICP, ECS ADC SS, CS CM GPF, ASC / Matrons / Intermediary, Form'Action PCR) 	<p>Annual Budgetary Meeting of the Rural Council (CR)</p> <p>CLD Meetings</p>
DISTRICT		<ul style="list-style-type: none"> • APB • Monthly coordination meeting of the district (ECD, Partners of the ONG, ICP, Local collectives) 	<ul style="list-style-type: none"> • Annual workshop of PB of PSE • Monthly PSE coordination team meeting (PUM, CPSE, RNFSE, ADC) 	CDD Meetings
REGION		<ul style="list-style-type: none"> • APB • Quarterly coordination meeting (ECR, ECD, Partners, Local collectives, Social partners) 	<ul style="list-style-type: none"> • SS, ECS, Ass SIG, Form'Action • Quarterly PSE coordination committee meeting (ECR, ECD, CPSE, SS, PUM Rep ICF Form'Action, CS District, RNFSE) 	CRD Meetings
NATIONAL		<ul style="list-style-type: none"> • APB • Quarterly meeting of the health administration (DS, MCR, _____ PDIS, Partners for development) 	<ul style="list-style-type: none"> • Half-yearly steering committee meetings (DS, DERF, Partners for development, expanded CMT, CNS, CPSE RNFSE) • Monthly coordination meetings 	CR Meetings

Health Team (CNS, CPSE, RNFSE, SS)

GROUP INFORMATION PROCESS**1 Comment on the goal of a SI**

'Reliable information in an opportune time for planning, management and decision-making on the subject of health'

- Reliable = true, in conformance with reality, verifiable
- Collects info in an opportune time (within a period of time in which it is supposed to take reality into account) = ideal moment
- Aim to make a decision based on the situation

2 Parties responsible for collection by level

Level 1 Community

PPS, health cases

- ASC / Matrons / Intermediary
- ECS – ADC

Level 2 Health Station

- ICP

Level 3 District

- SSP
- SS

Level 4 Regional

- SS / PU / CPSE

Level 5 Inter-regional

CPSE

Level 5 [6?] National

- CNS / RSFSE

3 Destination of the information collected

Each higher level is the addressee of the information with regard to the level immediately lower with feedback

4 Level and distribution procedures

NB Level and distribution procedures are being cut again

Community level**a) Village**

- Health Committee Meetings (CM, Salubrite)
- CDV
- GPF

b) Rural Community

- Rural Council Meeting

c) City district

- CLD

District level

Management Committee

- Mayor
- President of Rural Council
- President of District Health Commission
- MCD

(Management of resources allocated to health within the framework of decentralization)

5 To which end?Community level

- Better management of community health at the village level
- Planning on that basis
- Decision-making
- Preparation of PLDS

Health system level

- Master epidemiological situation
- Decision-making with regard to situation
- Evaluation of the impact of specific programs
- Preparation of PDDS / PRDS / PNDS

NGO level

- Research / publications
- Marketing of the organization
- Evaluation and preparation of operational plans

Level	Body	MSP	PLAN	F Action
		PARTICIPANTS	PARTICIPANTS	PARTICIPANTS
National		DERF / Var Stat	CNS / RNFSE (CO)	DE/FA
Inter-regional			CPSE	ACPSE // ADOC
Regional		SSF / ECR (Region)	SS PLAN (PU)	
Sanitary District		SSF / ECD (District)	SS PLAN (PU)	
City District / Rural Community		ICP / SFE (Health station)	ECS (OCB Resp)	ECS (OCB Resp)
Village		ASC / Matrons / IEC Intermediary, Health Cases, PPS)	Idem	Idem

*GROUP WORK TOOLS***SNF REGISTER of the child readapted to the needs of the SE Project (Follow-up on children)****Administrative Part**

[table, top row]

No

Given and family names

Sex

Date of Birth

Name of the concession director

Given and family names of the mother

Address

Code

Instructions for filling out Refer to the PAIN manual**For new variables**

- **No** Indicate the ID number of the child with regard to the structure
- **Given and family names** Indicate the given and family names of the child
- **Sex** Indicate the sex of the child (M, F)
- **Date of Birth** Specify the date of birth (day/month/year if lacking give the month and year)
- **Name of the concession director** Place here the family and given names of the concession director instead of the given name of the father
- **Given and family names of the mother** Indicate the given and family names of the mother to maintain
- **Address** Specify the name of the village or sector in writing
- **Code** Section reserved for the Community Health Educator of the Child Survival Project

Technical Part

[table, top row]

Age in months

Weight

Arrow (Evolution of growth)

Color (nutritional state)

Impregnated mosquito nets

Vit A

PEV

Advice

Observations

[second row]

> 6 months

< 6 months

Re-impregnated

Instructions for filling out Refer to the PAIN manual

- Indicate the age of the child in months, as of the month following birth
- Indicate the weight in kilos and grams
- Use an arrow to indicate the corresponding nutritional state of the child
- Indicate the first letter of the color of the nutritional state (V = green [vert], R = red, J = [jaune] yellow)
- Insert a column for impregnated mosquito nets, subdivided into three sub-columns Mark an X in the column that best matches the situation
- Indicate the dose of Vitamin A received
- Specify advice given to the mother
- Indicate all useful information in the observations

MONTHLY IEC ACTIVITIES

[table]

Date	Activities	Place	Participants	Observations
------	------------	-------	--------------	--------------

PLAN
INTERNATIONAL
SENEGAL

LOUGA AND KAOLACK CHILD SURVIVAL PROJECT

MONTHLY REPORT FROM THE COMMUNITY HEALTH EDUCATOR

Monthly Activities

Name of the ECS

Month of

Date	Activities	Place	KM	Observations

Observations (Summarize key points observed during the month in ten lines or less)

OUTPOST AND STATION ACTIVITIES

City district of
 Health district of
 Health station of
 Name of the ECS

MORBIDITY

[table]

[top row]

Age bracket [left column]	0-1 year	1-2 years	3-5 years	Total
------------------------------	----------	-----------	-----------	-------

Complaints

Fever

Fever + cough

Diarrhea

Other

Total

REFERENCES

[table]

[top row]

Age bracket [left column]	0-1 year	1-2 years	3-5 years	Total
------------------------------	----------	-----------	-----------	-------

References

Fever reference

Fever + cough reference

Diarrhea reference

Other references

Total reference

MORTALITY

[table]

[top row]

Age bracket [left column]	0-1 year	1-2 years	3-5 years	Total
------------------------------	----------	-----------	-----------	-------

References

Fever deaths

Fever + cough deaths

Diarrhea deaths

Other deaths

Total deaths

INFORMATION – EDUCATION – COMMUNICATION

[table]

[top row]	Topics	No IEC meetings	No Participants	Observations
-----------	--------	-----------------	-----------------	--------------

No of radio broadcasts

NUTRITIONAL AND WEIGHT MONITORING

[table]

[top row] 0-11 months 12-13 months 24-36 months TOTAL

[left column]

green

yellow

red

Total

No of weighing sessions

No of cooking demonstrations

Impregnated mosquito nets

- No of mosquito nets sold
- No of impregnated mosquito nets

EXPANDED VACCINATION PROGRAM

[Table]

[top rows]	0-11 months		12-13 months		Total by sex		Overall total
	M	F	M	F	M	F	

[left column]

BCGp

DTC1

DTC2

DTC3

RVX

FJ

EV

ECV

NUTRITIONAL MONITORING FORM Information on Vitamin A

Insert a table in the "Observations" part of the nutritional monitoring form

Dosage \ Administration Date	Date of 1 st dose	Date of 2 nd dose
Dosage 1 st dose		
Dosage 2 nd dose		

2.2 Recommendations

- List the supervision models (conclusion = end of Oct 99)
- Favor the integration of the SS into the ECD for supervision
- Prepare and test the supervision model for ECS
- Test the proposed workbook, "Follow-up on Children"
- For mortality / morbidity, make two tables of which 1 indicates morbidity + reference and 1 mortality
- For the SNP form, insert a table for Vit A in the space for "Observations", while taking into account the date of administration, the age in months and the dose administered
- Specify the transmission routing of the work reports in diagram form
- Respect the procedures for internal mail delivery to the organization

2.3 Evaluation of the workshop by participants

Before closing the workshop, a final, anonymous evaluation form was filled out by the participants. The following answers were obtained:

- 1) The general level of satisfaction is 100%
- 2) The level of goals reached is 100%

- 3) The participants' level of satisfaction with regard to the time spent at the workshop is 78%
- 4) The level of satisfaction with regard to the organization of the workshop is 100%
- 5) The level of satisfaction with regard to the locations is 78%
- 6) The level of satisfaction with regard to resource materials used is 89%
- 7) General suggestions and recommendations prepared are
 - Ensure the follow-up to the measures taken
 - Apply the measures relative to the partners
 - Better respect the time allocated to each group work and recapitulation
 - Better involvement by all participants
 - Take the period into account
 - Involve the Ministry at each meeting
 - Send the support information on final reports in the shortest possible time
 - Increase the length of time
 - First make explanations on the PLAN organizational diagram
 - Find more suitable locations
 - Finalize the staff supervision models (CNS, CPSE, SS, ECS) on the basis of the existing model
 - Simplify the mechanisms for sharing information while respecting the procedures in effect at PLAN
 - Better prepare the documents on the work so that discussions are limited to the minimum necessary

III APPENDICES

APPENDIX I *Agenda*

DAYS	TIMES	ACTIVITIES
DAY 1 08/26/99	08 30	Opening
	08 30 – 08 40	Administrative questions
	08 40 – 08 50	Presentation of Objectives / Agenda
	08 50 – 09 00	Methodology and work norms
	09 00 – 09 45	Reminder of PSE
	09 45 – 10 00	Setup of work groups and Terms of reference
	10 00 – 10 15	COFFEE BREAK
10 15 – 13 30	Group work (management tools – informational routing – coordination, follow-up)	
13 30 – 14 30	LUNCH PAUSE	
14 30 – 17 30	Recapitulation Evaluation of day's activities End of the day	
DAY 2 08/27/99	08 30	Reading of account of Day 1 and results – evaluation
	09 00 – 10 00	Recapitulation (Continuation)
	10 00 – 10 15	COFFEE BREAK
	10 15 – 15 00	Return (Cont) Amendments - Adoption - Recommendations - Closure
	15 00	- Meal

APPENDIX 2 List of Participants

Name	[illegible]	[illegible]	Location
Medoune NDIAYE	Var Stat	DERF /MS	Dakar
Houleye TOBE	SNAN	DS/MS	Dakar
Dr Issa MBAYE	Head SGB KK	SNGE	Kaolack
Malamine NDIAYE	BRAN	RM Kaolack	Kaolack
Lamine GUEYE	SSP	Nioro District	Nioro
Ms Rokhy Drame DIALLO	SMI	Nioro District	Nioro
Amadou DIOP	ICP	Keur Madiabel	Keur Madiabel
Boubou NIANE	ICP	Ndrané Escale	Ndrané Escale
Dr Adja Diack MBAYE	CNS	PLAN Int	Dakar
Dr Ndeye Fatou NDIAYE	CPSE	PLAN Int	Louga
Gnagna GUEYE	A/SIG	PLAN Int	Louga
Moussa SARR	SS	PLAN Int	Thies
Guineth FALL	SS	PLAN Int	Louga
Amadou GAYE	SS	PLAN Int	Kaolack
Babacar DIOUF	SS	PLAN Int	St Louis
Ouni GUEYE	A/SIG	PLAN Int	Kaolack
Diaguily KOITA	ACPSE	PLAN Int	Kaolack
Ms Aissatou Kane MBAYE	SS	PLAN Int	Dakar

APPENDIX 3 TERMS OF REFERENCE GROUP MANAGEMENT TOOLS

- Analyze the register of Nutritional and Weight Monitoring (SNP)
- Analyze the model for the monthly report from the Community Health Educator (ECS)
- Analyze the Nutritional and Weight Monitoring (SNP) Form
- Make proposals with regard to these tools keeping Vitamin A

TERMS OF REFERENCE INFORMATIONAL ROUTING

- Comment on the objective of an Informational System (*Reliable information in an opportune time for planning, management and decision-making on the subject of health*)
- Identify parties responsible for collection by level
- Specify the addressee of the information collected (Handling and use)
- Determine the levels of dispersal of the information
- Cite procedures for recapitulation at the community level
- Specify to which end the data from the PSE will be used, by level Community Health system, PLAN

TERMS OF REFERENCE COORDINATION / FOLLOW-UP

- Determine the formal coordination authorities
- Propose a meeting schedule
- Identify levels of supervision
- Propose a monthly supervision schedule for a health station with 12 outposts, with the most distant at 12 km
- Analyze supervision instruments

MANAGEMENT TOOLS (SUPPORT FOR DATA COLLECTION)

ASC / Matrons / Intermediary
 PAIN Register
 CPN Handbook
 PEV Handbook
 Delivery Handbook
 Consultation Handbook

Product and Medicine Management Handbook
Discussion Handbook
'Set Sétal" Handbook
Financial Management Handbook
Medicine Ordering Handbook

ECS

Activity Handbook
Monthly Report

HEALTH SUPPLEMENT – ACPSE – CPSE

Quarterly Report

SUPERVISION

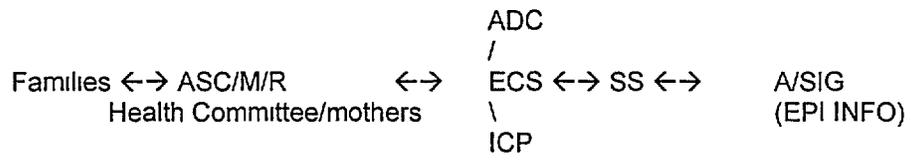
Instrument Supervision Models, Checklist
Level ASC / M / R – ECS – SS

COORDINATING AUTHORITIES

- Monthly coordination meetings
- Quarterly coordination meetings
- Steering Committee

INFORMATIONAL ROUTING
(With returned information)

[box]



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APPENDIX 4 FINAL EVALUATION FORM FOR THE SIG VALIDATION WORKSHOP
 WITHIN THE FRAMEWORK OF THE 'PSE'
 August 26 - 27, 1999

(For questions No 1 through 6, circle the number you find most appropriate from 1 to 5, respectively, from Not at All Satisfied to Very Satisfied)

	Not at all Satisfied	Very Satisfied
1	In general, how satisfied are you with the workshop?	1 2 3 4 5
2	Do you think that the workshop reached the goals it had set for itself?	1 2 3 4 5
3	How satisfied are you with the time devoted to this workshop?	1 2 3 4 5
4	How satisfied are you with the organization of this workshop? (for example, group work,)	1 2 3 4 5
5	How satisfied are you with the locations used for this workshop?	1 2 3 4 5
6	How satisfied are you with the resource materials used?	1 2 3 4 5
7	What are your suggestions and general recommendations?	

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Makeup of the Group MANAGEMENT TOOLS

Medoune NDIAYE
Amadou DIOP
Houleye TOBE
Ndeye Fatou NDIAYE
Oumi GUEYE
Gnagna GUEYE

Makeup of the Group INFORMATIONAL ROUTING

Dr Issa MBAYE
Diaguly KOITA
Amadou GAYE
Guineth FALL
Rokhy DIALLO
Babacar DIOUF

Makeup of the Group COORDINATION / FOLLOW-UP

Ms Adja DIACK MBAYE, CNS PLAN International
Malamine SARR, BRAN Kaolack
Moussa SARR, SS PLAN Thies
Lamine GUEYE, SSP Supervisor, Nioro District
Boubou NIANE, ICP Ndrané Escale
Ms Aissatou KANE MBAYE, SS PLAN Dakar



ANNEX 11

Coordination Schedule for Year Two

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ANNEX 11

**SCHEDULE OF COORDINATION MEETINGS OF THE PLAN INTERNATIONAL SENEGAL HEALTH TEAM
1999-2000**

Coordination Meeting	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jly	Aug	Sep
Annual PU assessment/planning workshop 1 Lg/1 Klk/1 Th/1 St L /1 Dkr		Nov 2 Start up Workshop										
Monthly coordination meetings for AID CSP 2 Ass SIG/CPSE/RNFSE/SS Klk-Lga/2 CHEs*	Oct 1 Louga	Nov 10 KLK	Dec 1 Louga	Jan 3 KLK	Feb 1 Louga	Mar 1 KLK	Apr 3 Louga	May 2 KLK	Jun 5 Louga	Jly 3 KLK	Aug 1 Louga	Sep 1 KLK
Monthly coordination meetings for CSP DFID/Lottery CPSE DFID-Lottery/RNFSE/SS Dkr, Th, St L	Oct 6 Thies	Nov 12 St Louis	X	X	X	X	X	X	X	X	X	X
Monthly coordination meetings for the Health Team	Oct 11 CO	Nov 16 CO	Dec 8 CO	Jan 7 CO	Feb 8 CO	Mar 8 CO	Apr 7 CO	May 8 CO	Jun 8 CO	Jly 7 CO	Aug 8 CO	Sep 8 CO
Quarterly coordination meetings at community level			X			X			X			X
Quarterly coordination meetings	Postponed to Nov 2			X			X			X		
Semi-annual meetings of steering committees	Postponed to Nov						X					

LG = Louga
 KLK = Kaolack
 Th = Thies
 St L = St Louis
 Dkr = Dakar
 CO = Country Office



ANNEX 12

Health Huts and Health Service Points List

ANNEX 12

List of Health Service Points (HSP) and Health Hut in WackNgouna

Health Post	Health hut	HSP
Maba Diakhou	<ul style="list-style-type: none"> • Ndiagne Walo • Keur Malick Ranet • Velingara • Keur Amath Seydou • Niassène Walo • Gorja • Ndiobène Walo • Thuarène Matar 	<ul style="list-style-type: none"> • Ndenenene • Keur Ousmane Coumba (Loumène Ousmane) • Keur Massar Ba
Thilla Grand	<ul style="list-style-type: none"> • Ndrame Ndimba • Pane Ablaye Diop • Keur Fode 	<ul style="list-style-type: none"> • Bouledje
Keur Madiabel	<ul style="list-style-type: none"> • Keur Mandongo • Taiba Mbayène • Ndiago II • Ndienguène Ibra • Thiamène Ousmane • Ndeme • Keur Maniebe • Keur Abdou Dieffe 	<ul style="list-style-type: none"> • Thioyène • Koudame • Ndiougouty Malick • Missirah Dine • Ndouboul
Wack Ngouna	<ul style="list-style-type: none"> • Ndiago I • Keur Yoro Khoudia • Thuarène Alassane • Keur Mady Yacine • Soucoutou • Pane Sader • Keur Ndiaga Diale • Samonko Toucouleur • Medina Thiamène • Thiamène Diogo 	<ul style="list-style-type: none"> • Mbayène • Keur Mamour Coumba • Nguer Babou • MBadiène
Saboya	<ul style="list-style-type: none"> • Darou Salam Mouride • Samboumba • Thiwalo 	<ul style="list-style-type: none"> • Ndiayène Poste • Kouranko
Keur Tapha	<ul style="list-style-type: none"> • Fetto • Keur Samba Ka • Keur Sa Rokhy • Ndiba • Keur Matar Faty (Darou Matar) 	
Ndamé Escale	<ul style="list-style-type: none"> • Keur Gaye • Ndiaguène Mody • Ndienfory • Thiamène Maka • Bowe • Touba II • Thioyène Matar • Thuarène Guissa • Keur Layène Sakho • Keur Momath Anta • Keur Birane Ndoupi • Keur Fasso Boury 	

List of Health Service Points (HSP) and Health Hut in Sakal

CHE name	Health Post	Health hut	HSP
Abdoulaye TALL	• Ngueune Sarr	• Pallène • Gouyar Sarr	• Ndiock Sall
Sophie NIANG	• Ngueune Sarr	• Diadjï Bou Mag	• Yarouwaye • Bangath
Modou SECK	• Sakal	• Roye Dieye	• Thiar Diop • Ndakhar • Mbekheul ou Nguit
Fama DIOUF	• Sakal	• Ndiouffene • Rimbax Syll	• Dungour • Keur Ibra Niang • Mbande Peulh • Ngadjï Sarr • Windou • Ndiobene Ndiamath
Adama FALL	• Sakal	• Santhiou Merina • Ndiaguene	• Massar Diop • Ndawass • Kadiar Peulh • Nianguène • Ngomène
El Hadj FAYE	• Leona	• Batlamine	• Batlamine • Keur Ndary ou Boudouwoula
Fama CISSE	• Léona	• Medina Thiolom • Mbaye Mbaye Mapathe	• Santhiou Diadjï • Bayakh Gaye • Wokhale Diam
Daouda KEBE	• Leona		• Potou • Keur Koura • Sague Sathuel • Tare • Gnayam



ANNEX 13

Monitoring Instruments

ANNEX 13A

CHILD SURVIVAL PROJECT, LOUGA AND KAOLACK

MONTHLY REPORT OF THE COMMUNITY HEALTH EDUCATOR

1999-2000
Month of

MONITORING OF NUTRITION AND WEIGHT

	0-11 months	12-23 months	24-36 months	TOTAL
Green				
Yellow				
Red				
Total				

Number of weighings

Number of food-preparation demonstrations

Treated Mosquito Nets

- Number of mosquito nets sold
- Number of mosquito nets treated

EXPANDED VACCINATION PROGRAM

	0-11 months		12-23 months		Total by gender		Overall Total
	M	F	M	F	M	F	
BCGp*							
DTP1**							
DTP2							
DTP3							
RVX							
Yellow fever							
EV							
ECV							

* Anti-tuberculosis [Translator]

**DTP = Diphtheria, tetanus, pertussis [Translator]

ANNEX 13 B

Date
Health hut
Community Health Team
Community Health Educator

**COMMUNITY HEALTH TEAM SUPERVISION FORM
FOR GROWTH MONITORING**

ITEMS	APPRECIATION			OBSERVATIONS
	Completely satisfied	Not completely satisfied	Not realized	

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1- Welcome

2- Checking Scale

3- Checking Health cards

4- Checking Register

5- Undress the child

6- Put the child on scale

7- Write weight on register and health card

8- Draw up the growth curve

9- Interpret growth curve

10- Counselling mothers

11- Give next appointments for weighing

SUMMARY

SIGNATURE

ANNEX 13C

SUPERVISION

NIVEAU	PERSONNES A SUPERVISER	RESPONSABLE DE LA SUPERVISION		PERIODICITE	INSTRUMENTS DE SUPERVISION	DATE
		Ministère Santé	PLAN/F A			
Village / Quartier (case de santé ou PPS)	Membres Comités de santé	ICP	SS/F A-ECS	Supervision Bimestrielle Intégrée	Existe	NOV DEC JANV
	Membres Comités de Mamans/GPF	ICP	SS/F A-ECS	Supervision Bimestrielle Intégrée	Existe	NOV JANV MARS
	Membres Comités de salubrité	ICP/AH	SS/ECS	Supervision Bimestrielle Intégrée	Existe	NOV JANV MARS AV-JU-AOUT
	ASC/Matrones	ICP	ECS	Supervision Bimestrielle Intégrée	Existe	NOV JANV MARS AV JU-AOUT
	Relais/IEC	ICP	ECS	Supervision Bimestrielle Intégrée	Existe	NOV- JANV -MARS AV JU AOUT
Communauté Rurale (Commune d'arrondissement, Poste de Santé)	ICP	ECD	Non Applicable	Supervision mensuelle	Existe	
	Sage Femme	ECD	Non Applicable	Supervision mensuelle	Existe	
	ECS	ICP	SS/F A	Supervision mensuelle	A Elaborer	NOV DEC JANV FEV MARS AV MAI JU JUI AOUT SEPT OCT
District / Région (Centre de Santé PU)	ECD	ECR	Non Applicable	Trimestrielle	Existe	
	Prestataires SMI (Médecins SF Infirmiers)	ECD/DS/ECR	Non Applicable	Trimestrielle	Existe	
	SS	Non Applicable	CPSE / RNFSE	Mensuelle	A Elaborer	NOV DEC JANV FEV MARS AV MAI JU JUI AOUT-SEPT OCT
	Assistante SIG	Non Applicable	RNFSE/SS	Mensuelle	A Elaborer	NOV DEC JANV FEV MARS AV MAI JU JUI AOUT SEPT OCT
National	CPSE	Non Applicable	CNS	Trimestrielle	A Elaborer	NOV-FEV-MAI-AOUT
	RNFSE	Non Applicable	CNS	Trimestrielle	A Elaborer	NOV-FEV-MAI-AOUT
	CNS	Non Applicable	PSM	Trimestrielle	A Elaborer	NOV-FEV-MAI-AOUT

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Date
 Health hut
 Community Health Team

CHECKLIST - MEETINGS WITH MOTHERS (IEC)

STEPS	RATING					OBSERVATIONS
	5	4	3	2	1	
1- Setting up of the site						
2- Greets						
3- Objectives of meetings						
4- Speak clearly et loudly						
5- Facilitate all attendees participation						
6- Answer to questions						
7- Essential points repeated						
8- Make a sumary of the meeting						
9- Thanks						

Recommendation

Signature

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SUPERVISORY CHECKLIST FOR COMMUNITY HEALTH EDUCATOR

ITEMS	RATING			OBSERVATIONS
	3	2	1	
<ul style="list-style-type: none"> - Planning of technical and participatory institutional diagnosis activities - Cheeking registers - Recording health huts and comitees data - Meeting with Public Health Nurse - Meeting with health comitees - Review activites - Sending data - Evaluate performance - Plan for the future 				

Recommendation

Signature

ANNEX 13D

Example of Community register for individual follow up Adaptation of Growth monitoring register at MCs and Health hut level (In french)

REGISTRE SNP de l'enfant réadapté aux besoins du Projet SE (Survie des enfants)

Partie Administrative

N°	Prenom & Nom	Sexe	Date de naissance	Nom du chef de concession	Prenom & Nom de la mere	Adresse	Code

Instructions de Remplissage Referer au Manuel du PAIN

Pour les nouvelles variables

- **N°** Inscire le numero d'identification de l'enfant par rapport a la structure
- **Prenom & Nom** Inscire le prénom et nom de l'enfant
- **Sexe** Inscire le sexe de l'enfant (M, F)
- **Date de naissance** Préciser la date de naissance (jour/mois/année, a défaut insérer le mois et l'année)
- **Nom du chef de concession** Mettre nom et prénom du chef de concession a la place de prenom du pere
- **Prénom et nom de la mère** inscrire le prénom et nom de la mère à maintenir
- **Adresse** Préciser le nom du village ou quartier en inscrivant
- **Code** Partie réservée a l'Educateur Communautaire de Sante du Projet Survie de l'Enfant

Partie Technique

Age en mois	Poids	Flèche (Evolution croissance)	Couleur (Etat nutritionnel)	Moustiquaires impregnees			Vit A	PEV	Conseils	Observations
				> 6 mois	< 6 mois	reimp-regnees				

Instructions de Remplissage Referer au Manuel du PAIN

- Inscrire l'âge de l'enfant en mois, a partir du mois suivant la naissance
- Inscrire le poids en Kilo et en Gramme
- Inscrire une flèche correspondante a l'etat nutritionnel de l'enfant
- Inscrire la premiere lettre de la couleur de l'etat nutritionnel (V = vert, R = rouge et J = jaune)
- Insérer colonne moustiquaire impregnee subdivisee en trois sous colonnes Inscrire une croix dans la colonne correspondante a la situation actuelle de la moustiquaire
- Inscrire la dose de Vit A reçue
-
- PEV inscrire le nombre de contacts reçus
- Préciser les conseils donnés a la mere
- Inscrire toutes les informations jugees utiles dans les observations

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Individual children follow up
Example of few variables analysis with Epi Info data base ¹

Quarterly analysis for Vaccinal Status among (the age choice depend on what we are looking for)

Month **October 99**

Record #	Code ²	Age	BCG	POLIO	DPT1	DPT2	DPT3	Measle	Yellow fev
1	cw13345	16	Y	Y	Y	Y	N	Y	Y
2	cw32489	13	Y	Y	Y	N	N	N	N

Month **November 99**

Record #	Code	Age	BCG	POLIO	DPT1	DPT2	DPT3	Measle	Yellow fev
1	cw13345	16	Y	Y	Y	Y	N	Y	Y
2	cw32489	13	Y	Y	Y	N	N	N	N

Month **December 99**

Record #	Code	Age	BCG	POLIO	DPT1	DPT2	DPT3	Measle	Yellow fev
1	cw13345	16	Y	Y	Y	Y	Y	Y	Y
2	cw32489	13	Y	Y	Y	N	N	N	N

Growth monitoring follow up Weighing

Year two first quarter October to December 99 (Analyzis made in December 99)

Record #	CODE	EXIT	Exit reason	Death cause	October Weighted	November Weighted	December Weighted
1	cw13345	N			N	Y	Y
2	cw32489	Y	Death	Diarrhea	Y	N	N

Growth monitoring follow up Curve Orientation

Year two first quarter October to December 99 (Analyzis made in December 99)

Record #	CODE	EXIT	Exit reason	Death cause	October curve	November curve	December curve
1	cw13345	N				down	down
2	cw32489	Y	Death	Diarrhea	down		

Growth monitoring follow up Color

Year two first quarter October to December 99 (Analyzis made in December 99)

Record #	CODE	EXIT	Exit reason	Death cause	October color	November color	December color
1	cw13345	N				yellow	red
2	cw32489	Y	Death	Diarrhea	red		

¹ Other variables can be analyzed for example Vitamine A every six month, Impregnated net every six months etc Two children are concerned by this example but we can have results for the whole children Many other combinations are also possible The analysis is made by a program run following needs

² The code signification is explained in the concept paper CHES, HIS assistant and project staff are already trained

ANNEX 13 E

Example of table for monthly data entry by the HIS assistant in Excel'

Quantification des activites et cibles atteintes mensuellement																	
Activites	Oct	Nov	Déc	Tot tri	Janv	Févr	Mars	Tot tri	Avr	Mar	Juin	Tot tri	Juil	Aout	Sept	Tot tri	Total
SNP																	
poste	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
case/ CMs	0	0	0	0	0	34	0	34	0	0	0	0	0	0	56	56	90
Demonstr Culinaire	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Nombre 0 36 peses	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Vaccinations																	
Stratégie avancee	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Stratégie fixe	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
BCG	0	0	0	0	0	0	0	0	0	2	0	2	0	0	0	0	2
DTC1	8	0	12	20	0	0	32	32	0	0	0	0	0	52	0	52	104
Polio 1	#REF!	#REF!	#REF!	#REF!	#####	####	#REF!	#REF!	#REF!	###	####	#REF!	#####	###	###	####	#REF!
DTC2	0	0	0	0	0	45	0	45	0	0	36	36	0	0	0	0	81
Polio 2	#REF!	#REF!	#REF!	#REF!	#####	####	#REF!	#REF!	#REF!	###	####	#REF!	#####	###	###	####	#REF!
DTC3	90	2	68	160	0	54	0	54	0	0	0	0	0	110	0	110	324
Polio 3	#REF!	#REF!	#REF!	#REF!	#####	####	#REF!	#REF!	#REF!	###	####	#REF!	#####	###	###	####	#REF!
Rougeole	0	43	0	43	0	0	0	0	0	0	0	0	0	0	0	0	43
Fievre jaune	#REF!	#REF!	#REF!	#REF!	#####	####	#REF!	#REF!	#REF!	###	####	#REF!	#####	###	###	####	#REF!
IEC																	
	0																
LMD	3	0	0	3	0	4	6	10	0	4	0	4	0	2	0	2	19
Nutrition	0	24	0	24	0	0	0	0	0	3	4	7	0	0	2	2	33
PEV	0	0	0	0	0	0	4	4	0	0	0	0	3	0	3	6	10
IRA	0	0	2	2	0	4	0	4	0	0	6	6	0	0	5	5	17

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Paludisme	0	3	0	3	0	4	0	4	0	0	0	0	0	0	0	0	7
CLINIQUE																	
Palu simpl	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	2
Palu ref	0	2	0	2	0	0	0	0	0	0	2	2	0	0	0	0	4
Diarr simpl	0	0	0	0	0	0	0	0	2	0	0	2	0	0	2	2	4
Diarr ref	0	0	0	0	0	2	0	2	0	0	0	0	0	0	0	0	2
IRA ref	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	2	2

' The table is based on the monthly report given by the CHEs Data entry is done by the HIS assistant for each CHEs There are two tables one for combined result per site and one for combined results for the project These tables are filled automatically as measure data are entered in the tables by CHEs Their is a total of 8 (Louga) and 7 (Kaolack) tables to be filled each month by the assistant Insertion of formula permit to make addition systematically