

PLAN INTERNATIONAL/USA

PLAN SENEGAL FIELD OFFICE

CHILD SURVIVAL XIV

FINAL EVALUATION REPORT

**Implementing Agency
Plan International Senegal
In partnership with
The Ministry of Health and
Form'Action**

Location: Districts of Nioro and Louga, Senegal

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Despite the best efforts of the Senegal Country Office and the project staff, factual errors may persist in the report. They must be considered the responsibility of the principal author who tried to understand the complexity of the environment within a short period of time.

The principal author is Sandra Wilcox, Consultant. Claire Boswell, Plan Health Associate, also contributed to the report.

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ACRONYMS

APC	Assistant Project Coordinator
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
BCC	Behavior Change Communication
CBO	Community-Based Organization
CHE	Community Health Educator
CHT	Community Health Team
CHW	Community Health Worker
CMT	Country Management Team
CS	Child Survival
DHMT	District Health Management Team
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, and Tetanus
EPI	Expanded Program on Immunizations
HFA	Health Facility Assessment
HH	Health Hut
HIS	Health Information System
HP	Health Post
HPN	Health Post Nurse
IMCI	Integrated Management of Childhood Illness
IR	Intermediate Result
ITN	Insecticide-Treated Net
KPC	Knowledge, Practice, and Coverage
MC	Mothers' Committee
MOH	Ministry of Health
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
PAIN	Integration Packet of Nutrition Activities
PC	Project Coordinator
PUM	Program Unit Manager
PVO	Private Voluntary Organization
SDP	Service Delivery Point
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization
WRA	Women of Reproductive Age

INTRODUCTION

The Senegal Child Survival (CS)XIV final evaluation fieldwork was conducted between September 1 to September 15, 2002 in the regions of Dakar, Kaolack and Louga, Senegal. The team consisted of Sandra Wilcox, team leader, and Claire Boswell, the Plan headquarters representative. In addition, the project staff participated in the evaluation, assisting with field interviews, organizing schedules and logistics and reviewing findings. The staff from Plan and Form'Action who participated include Dr. Etienne Dioh, the Plan CS Project Coordinator, Diaguily Koita, the CS Assistant Coordinator for Training, Monitoring and Evaluation, Jean Bassene, Director of Form'Action and Assistant Coordinator for Community Capacity Building, Touty Cisse, the Assistant Coordinator for Community Capacity Building, Amadou Gaye, Kaolack Field Health Supervisor, Guineth Fall, Louga Field Health Supervisor, Mbalo Ndiaye, Plan Senegal Program Support Manager, and Dr. Thidiane Ndoeye, Plan Senegal Health Coordinator.

The schedule followed by the team consisted of spending the first two days in Dakar at the Plan country office receiving a briefing from the project team, reviewing documents and interviewing Plan field office staff. The team also reviewed and revised evaluation tools during this time. The team then spent the next seven days interviewing field staff, visiting sites in the project areas, and interviewing community groups and agencies involved in project activities, in the regions.

The evaluation team spent the last four days writing up preliminary findings for the report and conducting both internal and external debriefings of findings to Plan and USAID Senegal.

A. Summary

The goal of the Plan Senegal CSXIV project is to improve the health status of children under 5 years of age and their mothers in two *arrondissements* (sub-districts) in Senegal (Wack Ngouna and Sakal). At the final KPC, the total beneficiary population was 58,075, composed of 26,871 children under five and 31,204 women of reproductive age. This figure for the total beneficiary population (based on the census carried out in the project) is considerably higher than the estimated target population stated in the Detailed Implementation Plan (DIP) (50,776 women and children) and has increased since the mid-term evaluation (54,310). In Wack Ngouna, there are seven Health Posts (HPs), whereas in Sakal there are three HPs.

The project strategy addresses five key child survival issues which impact the high infant mortality rate in the two project areas and which are of priority concern to the MOH: immunizations of women and children, diarrhea disease control, pneumonia case management, malaria control, and nutrition.

The broad objectives of the program strategy are to: 1) empower existing community-based organizations (Village Health Committees, Community Health Workers and women's groups) to offer services of higher quality with equity and a cost-recovery system for sustainability; 2) promote Ministry Of Health (MOH) institutional capacity to improve the quality of Child Survival services delivered in the project sites; 3) sensitize and educate child caretakers, as well as influential community members, on child survival interventions and promote increased use of appropriate services.

The field visits for the final evaluation of this project were conducted between September 1 – 14th 2002 in the two project sites at the Plan Program Units of Kaolak and Louga. Members of the evaluation team included: Pierre-Marie Metangmo, the Plan US based Child Survival Coordinator, Claire Boswell, the Plan US Health Associate, Etienne Dioh, the Plan CS Project Coordinator (PC), Diaguily Koita, the CS Assistant Coordinator for Training, Monitoring and Evaluation, and Touty Cisse and Jean Bassene, the Assistant Coordinators for Community Capacity Building.

The following are the key project achievements, issues, challenges and recommendations noted during the evaluation.

Achievements

- The project has created strong community organization strategies that have continued to improve through out the project and resulted in fortified community decision-making in support of project goals. Examples of empowering activities include the following:
 - Strengthening of Village Health Committees (VHCs)
 - Creation and strengthening of Mothers' Committees (MCs)
 - Strengthening skills and performance of Community Health Team personnel (CHT)
 - Strengthening involvement of village leaders in health committees and activities

- Development and management of community health funds allowing revolving drug supply, revolving bednets, micro credit loans and large savings for community designated projects in addition to incentives for CHTs
- Development and follow-up of community-determined quarterly activity plans
- Health Huts (HHs) and Service Delivery Points (SDPs) are fully stocked with equipment and supplies necessary for completion of essential medical treatment and preventive activities.
- Ministry of Health personnel at HP levels and below are fully trained in the management of child survival intervention areas except for Acute Respiratory Infection (ARI) in Kaolack where MOH training is not available in this area.
- The project trained and supported Community Health Education (CHE) staff has successfully linked services between the community level structures and the health facilities in the project areas.
- The project has achieved significant success in its immunization intervention activities. It met or surpassed all its behavioral and knowledge target objectives.
- The project has made significant progress in malaria treatment and prevention activities, having met the bulk of its objectives.
- The CS project has implemented a thorough and well managed community based Health Information System (HIS). This system has been used effectively by community committees to understand health status and program health activities. The information has also been used and followed by project management to make intervention decisions and resolve problems.
- Plan and Form'Action have provided high quality training in project intervention areas, data management, community organization, follow-up and supervision to CHTs, MOH staff and project staff.
- There is good evidence of excellent teamwork in the project. This is demonstrated by the good working relationship between Plan project staff and Form'Action staff and the strong team of CHes.
- The supervision system is strong. The staff and community personnel interviewed during the evaluation demonstrated good knowledge of the project intervention areas and reporting abilities. They also reported that they were very satisfied with the supervision that they have received.
- The project has made good progress on its work plan. It has completed most of the activities programmed for the final year of the project.
- The community committees and health teams interviewed demonstrate good technical

capacity. They have the knowledge and skills and a good understanding of the key messages for most intervention areas.

Issues

- A major issue concerns the sustainability of the CHEs . Currently they have individual contracts with Form'Action and no benefits. They have fulfilled a pivotal role in assuring project success in bridging the service gap between community and MOH health structures, but there is no provision for their continuation after the project ends.
- Due to mid-term recommendations recognizing the importance of the CHE roles in developing community health structures, the project increased the number of CHEs. However, the project has not been able to resolve the issue of travel support to adequately supervise community activities. Many of them supervise as many as 40 villages. Project vehicles, also not sufficient for the workload, are used for multiple activities and the transportation allowance provided to CHEs is not sufficient for them to carry out programmed activities. This often necessitates that project staff walks 10 to 15 kilometers to reach village destinations, especially in Louga where villages are far away from one another.
- Although there has been substantial progress through the project's partnership between Plan and Form'Action, there are concerns regarding the existing structure. Project staff and Form'Action believe they have not been treated as equal partners. They believe this is because they are not permanent Plan staff.
- The project has not been able to respond completely to the mid-term recommendations advocating implementation of more varied IEC mass media approaches. They have lacked sufficient time, technical expertise and resources. The evaluators noted that there was a lack of sufficient print media for community education activities. There has been low compliance in implementation of planned community IEC talks.

Challenges

- Although there have been significant improvements since the mid-term review, there are still challenges in the project's relationship with the MOH staff. The relationship with the Health Post Nurses (HPNs) has improved significantly. However, there are still concerns expressed by the District Health staff that the project staff does not adequately coordinate with them.
- A common problem mentioned by Form'Action and Plan management staff is the difficulty of coordinating a project in two geographic areas that are more than 300 kilometers apart. Both areas have significant project management challenges that require regular attention and are difficult to address when coordinators are stretched between the two areas.

- Plan will need to carefully think through its relationship with Form'Action and the CHEs in the design of follow-on activities. Both groups have expressed concern regarding future potential roles.

Recommendations

- Regarding a follow-on project, Plan should try to focus on one geographic area or seek to set up separate project management structures in each area. Plan should also consider scaling up to the district level in at least one of the areas. A district level intervention would facilitate and enhance relationships with MOH staff.
- If there is a follow-on project, Plan needs to work with Form'Action in the development of a mutually satisfactory partnership. Form'Action has shown its administrative capacity to operate independently and it has proven itself to be a very capable partner technically in the area of community organization. Form'Action's grass roots development strategies nicely complement Plan's organizational and technical development strengths.
- In a follow-on project, Plan needs to carefully think through strategies for sustaining the CHE staff. These staff positions are integral to the success of project activities because of their pivotal role in mobilizing communities around health priorities. In addition, Plan needs to resolve the transportation issue for these staff. Without adequate transportation they can not be expected to fulfill their job requirements.
- The next project should work with technical assistance to develop a project-wide IEC strategy. This strategy should include development or adaptation of print and media materials for non-literate audiences. They should also continue development of entertaining mass media education formats such as songs, dances, stories, street theater, puppetry, etc. It may be useful to contact a local agency with expertise in this area that can provide technical assistance and training in these methodologies.
- The project should extend its current exclusive breastfeeding recommendation for infants from four months to six months of age in order to coincide with the World Health Organization (WHO) recommendations.
- The project may want to consider adding family planning as an intervention area as several communities visited by the evaluators specifically asked for information about contraception and some had already acquired these services.

B. Assessment of Results and Impact of the Program**B.1. Results Summary Chart**

Plan Senegal AID Child Survival Project

Comparison of baseline KPC, project objectives and Final KPC

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
MALARIA	Reduce mortality and morbidity due to malaria among children and pregnant women by improving prevention, home treatment, and referrals.	Percentage of households using at least one impregnated mosquito net	4.4%	30%	42%	
		Percentage of households where an U5 child uses an impregnated mosquito net	3.2%	30%	33%	* 1,6%
		Percentage of impregnated or re-impregnated mosquito nets within 6 to 9 months following their purchase or first impregnation	0.1 %	70%	71%	
		Percentage of suspected cases of malaria among U5 children and pregnant women, who received efficient and appropriate presumptive care	30.6%	80%	57%	36*

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		Percentage of malaria cases requiring referrals according to set criteria and which have been referred to health clinics	17.7%	80%	Not measured, but 86% of interviewed mothers can identify at least one manifestation of the illness at home	
		Percent of pregnant women who received appropriate anti-malaria preventive care	70.2%	90%	64%	
		Percent of education sessions on malaria held at HHs and SDPs		At least one meeting per month at each HH and SDP	45%	

* UNICEF : Rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance MICS décembre 2000

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
NUTRITION	Monitor growth of children 0-36 months by educating their mothers about the need for weighing their children and in exclusive breastfeeding for children 0-4 months	Percentage of children 0-23 months whose weight is monitored on a monthly basis, and their weight for age ration reported in registers in the last three months.	14.8%	90%	61% among 3-23 children	
		Percent of mothers who exclusively breastfeed their children until the age of 4 months	25.7%	50%	40%	* 23.5%
		Percentage of mothers who introduced a complementary food for children 4 to 6 months	41.8%	60%	62%	
		Percentage of severely malnourished children identified and referred to a health facility for appropriate treatment		70%	Not measured	

* UNICEF: Rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance MICS décembre 2002

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
NUTRITION	Monitor growth of children 0-36 months by educating their mothers of the need for weighing their children and of exclusive breastfeeding for children 0-4 months	Percentage of 12-23 children who received Vit. A supplementation after they were 6 months old		80%	80%	
		Percentage of breastfeeding mothers who received Vit. A within two months following the birth of their child	0%	50%	9%	
		Percentage of mothers who know and can explain the need to include complementary food in the child's diet		100%	71% of mothers know when food should be included into the child's diet	
		Percentage of educational sessions on nutritional issues held at HHs and SDPs		At least one meeting per month at each HH and SDP	50%	

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
DIARRHEA	Reduce malnutrition and mortality rate due to diarrhea by timely care including referral	Percentage of mothers who know theoretically how to prepare sugar/salt oral rehydration solutions	20.4%	80%	78%	
		Percentage of mothers who can mention at least three diarrhea signs requiring referrals	30%	60%	57%	
		Percentage of educational sessions on diarrhea held at HHs and SDPs		At least one meeting per month at each HH and SDP	38%	

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
DIARRHEA	Reduce malnutrition and mortality rate due to diarrhea by timely care including referral	Percentage of children 0 to 23 months who received the same quantity or more of food, breast milk/fluids during their latest diarrhea episode	38.5%	68%	63%	
		Percentage of health facilities equipped, supplied, and staffed with personnel for the treatment of severe cases		90%	100%	
		Percentage of children 0-23 months referred to the HH then to the HP for treatment of severe diarrhea		100%	Not measured	

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
VACCINATION	Achieve total immunization coverage in project area for all children before their first birthday, and at least two Tetanus Toxoid (TT) for the Women of Reproductive Age (WRA), especially mothers of children 0-23 months	Percentage of children 0-23 with a vaccination booklet	70.1%	90%	95%	
		Percentage of children 12-23 months fully vaccinated	30.8%	70%	82%	*** 40%
		Percentage of children 12-23 months vaccinated against measles	37.1%	70%	87%	
		Percentage of children 12-23 who received the DPT3 vaccine	31.2%	70%	90%	

*** Ministère de la Santé et de la Prévention Direction de la Santé Division des Soins de Santé Primaires – **Présentation des résultats du monitoring 2ème semestre 2001 mai 2002**

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
VACCINATION	Achieve total immunization coverage in project area for all children before their first birthday, and at least two for especially mothers of children 0-23 month old	Percentage of children 12-23 months who received DPT1 but not DPT3	47%	10%	10%	
		Percentage of HPs with a functioning cold chain		100%	100%	
		Percentage of educational sessions on vaccination held at HHs and SDPs		At least one meeting per month at each HH and SDP	36%	
		Percentage of mothers of children 0-23 months who received at least two TT	53.3%	80%	75%	

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
ACUTE RESPIRATORY INFECTIONS	Reduce mortality rate due to pneumonia through early and improved quality treatment	Percentage of mothers of children 0-23 months who can identify at least one symptom of serious ARI	33.9%	70%	63%	
		Percentage of children 0-23 months presenting one symptom of serious ARI, who has been referred to a health clinic	40.3%	80%	70%	

Plan Senegal, CS X1V, Final Evaluation, October, 2002

Health Problem	Project Goal	Indicators	Initial KPC Findings February 99	Target	Final KPC Findings July 02	National Situation
ACUTE RESPIRATORY INFECTIONS	Reduce mortality rate due to pneumonia through early and improved quality treatment	Percentage of HP and Health Center personnel trained on ARI care		80%	30%	
		Percentage of HPs with enough stock of antibiotic drugs for the treatment of ARI		70%	100%	
		Percentage of educational sessions on ARI held at HHs and SDPs		At least one meeting per month at each HH and SDP	23%	

B.2. RESULTS: TECHNICAL APPROACH

B.2.a. Overview

Goals and Objectives of CS XIV

The goal of the project is to improve the health status of children under 5 years of age and their mothers in two sub-districts in Senegal (Wack Ngouna and Sakal).

The project strategy addresses five key child survival issues which impact the high infant mortality rate in the two project areas and which are of priority concern to the MOH: immunizations of women and children, diarrheal disease control, pneumonia case management, malaria control, and nutrition.

The broad objectives of the program strategy are to: 1) empower existing community-based organizations (VHCs, Community Health Workers (CHWs) and MCs) to offer services of higher quality with equity and a cost-recovery system for sustainability; 2) promote MOH institutional capacity to improve the quality of Child Survival services delivered in the project sites; 3) sensitize and educate child caretakers, as well as influential community members, on child survival interventions and promote increased use of appropriate services.

Project location

The project is implemented in two different regions in Senegal, approximately 300 km. apart, Kaolack and Louga in a total of 466 villages¹. In Kaolack, the project is located in the district of Nioro, in one of the sub-districts, Wack Ngouna, in a total of 190 villages in four rural communities. Similarly, in Louga the project targets 276 villages in three rural communities in the sub-district of Sakal, district of Louga. At the final KPC, the total beneficiary population was 58,075, composed of 26,871 children under five and 31,204 women of reproductive age. This figure for the total beneficiary population (based on the census carried out in the project) is considerably higher than the estimated target population stated in the DIP (50,776 women and children) and has increased since the mid-term evaluation (54,310). In Wack Ngouna, there are seven HPs, whereas in Sakal there are three HPs.

¹ This number of villages is different from the one announced in the DIP (349 in Louga and 197 in Kaolack, for a total of 546) and year one Annual Report (313 in Louga and 188 in Kaolack, for a total of 501). These differences are due to migration and other sociological factors, i.e. some villages that were made of only 3 homes do not exist any more.

Overall program strategy

The project's strategy has been to strengthen the household promotion of Child Survival and home management of the above described key childhood illnesses, as well as their use of both community level health services and MOH facilities, when referrals are required. In addition, the strategy aimed to sensitize and educate influential community members on the Child Survival interventions and use of appropriate health services. At the community level, the program has sought to strengthen the quality and use of community health services by increasing the ability of community organizations to manage those services and promote their use. Lastly, the project has tried to strengthen the ability of MOH staff to carry out community outreach activities. At all levels, the project has attempted to identify and support approaches, which can be sustained by community actors and MOH staff after the Child Survival project ends.

The implementation of the project is based on a partnership between Plan International, the MOH and Form'Action, a local NGO specializing in community development and capacity-building.

B.2.b. Progress Report by Intervention Area

Progress toward accomplishment of DIP intervention objectives

In addition to the KPC survey that was repeated at the final evaluation to provide quantitative information about the outcomes of DIP intervention objectives, it is also possible to report on the extent to which the activities planned for each intervention have been carried out.

Effectiveness of five child survival interventions

Based on the quantitative results, qualitative group interviews conducted at the community level during the final evaluation, and on project staff reports, the following observations are made regarding the effectiveness of the five child survival interventions.

Immunization coverage of children 0-23 months and women with children 0-23 months

According to the KPC results listed in section B.1., immunization coverage is the area that improved the most during the project period. 82 percent of children 0 – 23 months were fully vaccinated, which is well beyond the baseline level of 30.8 percent and the targeted level of 70 percent. In addition, 87 percent were vaccinated against measles (baseline-37%, target 70%). Also the percentage of children receiving the third DPT vaccine increased from 31 percent to 90 percent, while the percentage who dropped out after receiving the first DPT vaccination dropped from 47 percent to 10 percent. The percentage of children with a vaccination booklet increased from 70 to 95 percent. The percentage of mothers of children 0 – 23 months who had received at least two TT increased from 53 percent at baseline to 75 percent at the final. This was slightly below the 80 percent target but still a significant improvement.

Qualitative interview data collected during the final evaluation suggest that virtually all women with young children are convinced of the importance of vaccinating their children. Vaccination coverage rates have increased due to increased participation of HPNs in outreach vaccination days and increased community mobilization by community organizations, which, in turn, has contributed to increased participation of women and children targeted by these activities. At the time of the mid-term there had been problems with frequent vaccine shortages brought about by a lack of coordination between the MOH and the Ministry of Finance. This problem has been resolved with the change in government and better administrative procedures. The HPs now order vaccines 6 months in advance and the MOH is able to program vaccinations accordingly. Factors, which contribute to inadequate coverage of TT2 amongst pregnant women, include, socio-cultural beliefs, which encourage women to conceal their pregnancy for several months before attending pre-natal clinics. This, in turn, contributes to fewer women receiving the recommended vaccination.

Diarrhea case management

The final KPC results show that significant gains were made in the area of diarrhea knowledge and practice. Although they did not exactly meet their targets the achievements were very close. For example, knowledge of how to prepare salt/sugar solutions went from 20.4 percent at baseline to 78 percent at the final (target-80%). The percent of mothers who can name three diarrhea risk factors requiring referral increased from 30 percent at baseline to 57 percent at the final evaluation (target-60%). Likewise, the percent of children receiving the same or more quantities of food, breast milk/fluids during diarrhea increased from 38.5 percent at baseline to 63 percent at the final survey (target-68%).

Home treatment of simple diarrhea: The training provided to the CHEs and CHTs focused on the MOH's revised prescribed treatment plan for "diarrhea without dehydration" based on home fluids and ORS, if available. ORS packets are not available at the community/HH level and in some cases are not regularly available at the HP level either. Project staff also explained that children do not like the taste of the ORS salts so people prefer not to buy them. For this reason, the HPs often have ORS packets with expired dates on them. Although the CHTs taught to promote home fluids for early treatment of diarrhea, the mid-term review team found that when women with young children were asked what priority action they take when their child initially has diarrhea, the majority stated that they would prepare Sugar/Salt Solution SSS. For many years the MOH has promoted the use of SSS and clearly it will not be easy for mothers to change their practices, in line with the revised WHO and MOH policy which gives priority to home fluids. Despite this the project has reinforced the importance of using home fluids as a first recourse in all training and CHE activities conducted by the project. Some of the home fluids include juice from the baobab tree, guava juice, amri water and diru water.

Referral of severe cases of diarrhea: According to both women with young children and grandmothers interviewed during the final evaluation, it appears that most of them know that they should take a child with more severe diarrhea to the HP as quickly as possible. This awareness is validated by the KPC finding of increase in knowledge of risk factors requiring referrals. But the actual numbers of referrals were not measured. During the mid-term community groups identified two constraints that sometimes impede them from going to the

health center: first, the difficulty and/or cost of transport; and second, the cost of drugs prescribed by health personnel. The final evaluators did not hear these concerns voiced strongly. This is probably because of the improved community managed drug supply systems and funds for transport.

Acute Respiratory Infections/ Pneumonia Case Management

According to the KPC results, there has been significant improvement in knowledge and practice related to ARI though they did not completely meet their targets. The percentage of mothers of children 0 – 23 months who could identify at least one serious symptom of pneumonia rose from 34 percent at baseline to 63 percent at the final evaluation (target-70%). Likewise the percentage of children 0-23 months who were referred for serious ARI symptoms rose from 40.3 percent at baseline to 70 percent at the final evaluation (target-80%).

One of the interesting KPC findings was that only 30 percent of HP and health center personnel had been trained in the management of ARI. This is because the MOH has not implemented this kind of training in these regions. This training is included in the Integrated Management of Childhood Illnesses (IMCI) training but so far IMCI has only been implemented in select districts and has not reached the project regions. However, the Louga MOH district office has implemented ARI and tuberculosis training for its staff. This has not been done in the Kaolack region and may contribute to why the project has not reached all its targets in this area.

Another finding was that the project only met 23 percent of its objectives for the provision of CHE on ARI. When asked about this the staff indicated that it was difficult to teach community personnel diagnostic techniques for pneumonia. They indicated that they needed better materials and models for this instruction.

The mid-term review stated that the younger and older women interviewed indicated that they take children with ARI directly to the HH or HP. They also told the mid-term staff that they were sometimes deterred from going to the HP by the cost and/or difficulties associated with transport and with the cost of drugs that are prescribed. Again the final evaluators did not find that people complained about the cost of drugs. Drugs were available through revolving drug supplies at the HH levels, which community members were very pleased about. They also had established funds for transport to HPs and centers. Interviewees did not discuss the use of traditional healers and remedies, but it is probable that the use of these services/remedies also constitutes a constraint to early referral and should be addressed in health education activities.

Prevention and treatment of malaria

According to the final KPC results, the project has met or surpassed most of its malaria control objectives. The percentage of houses using at least one impregnated bednet rose from 4.4 at baseline to 42 at the final (target-30%). Likewise the percentage of households where an under 5 child uses an impregnated bednet rose from 3.2 at baseline to 33 at the final evaluation (target-30%, national average-1.6%). The percentage of impregnation or reimpregnation of bednets within 6 – 9 months of purchase or first impregnation rose from 0.1 at baseline to 71 at the final? The percentage of suspected malaria cases among U5 children and pregnant women who

received appropriate care rose from 30.6 at baseline to 57 percent at the final (target-80%). The percentage of pregnant women who received appropriate anti-malarial care dropped from 70 at baseline to 64 at the final but staff believes this is due to reporting errors on the maternal health cards.

Bednet use: The mid-term review concluded through community level interviews that virtually all women knew that it was important for pregnant women and young children to sleep under a bednet as a preventive measure. This was also shown to be true at the final KPC evaluation through the increased use of bednets. The impregnation and sale of bednets by women's groups and health committees has been very successful. The mid-term review indicated that the nets were too expensive for most families (6,000 CFA) but as was also noted the government did drop the price and sell them to communities at 3,500 CFAs per net. There was a limited supply from the government, and communities were concerned about continued availability. So in order to set up a sustainable system, the project staff and communities established community revolving funds for nets by buying at the government price and selling for 4,000 CFAs. Bednets are sold through health committees in Louga and through mothers committees in Kaolak. The mid-term noted finding that in some cases, at the household level, preference for bednet use is given to the husband or mother-in-law instead of the mothers and children but the final found that at least a third of the U5 target population was using the nets. So there continues to be progress in this area.

Chloroquine use as a prophylactic and as treatment: Chloroquine is sold by women's groups and mothers committees in a cost recovery scheme set up by the Child Survival Programs. The mid-term review team found in interviews with women with young children that although they were convinced that it is important for pregnant women to take chloroquine, it was not possible to determine exactly how many actually followed the recommended prophylactic protocol during pregnancy. As noted above, the KPC showed a higher percentage of women taking prophylaxis at the baseline (70 percent) than at the final evaluation (64 percent). The staff explained this discrepancy to be a recording error since medications are not always noted on the maternal health cards. However, from the KPC and interviews it does appear that the majority of pregnant women are taking the chloroquine. The mid-term also notes that in interviews many women stated that they were less vigilant about treating cases of acute malaria in children with chloroquine, as recommended. The final KPC notes a definite increase over baseline in this area (31 to 57 percent). However, it still falls short of the target (80 percent). Many stated that they do not do so because of "negligence" on their part. This issue should have been further explored/discussed at the community level in the context of health education activities, however, as in other intervention areas the project only completed 45 percent of its planned education activities.

Nutrition Promotion

According to the final KPC survey, there have been significant improvements in the area of nutrition, though again they did not meet all their targets. The percentage of children 0-23 months whose weight is monitored monthly and reported in their booklets increased from 14.8 at baseline to 63 at the final evaluation (target 90 percent). Staff believes this percentage is actually higher but that the figures may not have been recorded in the cards. The percentage of mothers who exclusively breastfed for four months went from 26 at baseline to 40 at the final (target was 50 percent). The percentage of mothers who introduced complementary food for children 4 to 6 months of age increased from 42 at baseline to 62 at the final evaluation (target 60 percent). 80 percent of children 12-23 months received Vitamin A supplements after 6 months of age (target 80 percent). But only 9 percent of breastfeeding mothers received Vitamin A within 2 months after the birth of their child. The staff and community members explained that the Integration Packet of Nutrition Activities (PAIN) recommendations are for 200 mgs of Vitamin A to be distributed at the HP after the birth of the child. The KPC found that MOH personnel attended 37 percent of births but according to project staff, the HPs either did not always have Vitamin A available for them or forgot to give it to them at delivery.

Growth monitoring: The mid-term review and the final evaluation found when talking to community and CSP interviewees, that growth monitoring sessions have become more frequent and a greater percentage of women are now having their children weighed on a monthly basis. This observation is validated by the KPC data noted above. Two constraints associated with women's participation in this activity are: in some cases HPNs are not willing to delegate the baby-weighing task to community women and in these cases when HPNs do not show up for outreach activities, no growth monitoring is carried out. Shortly after the mid-term review, the Nutrition Program of Senegal authorized community level personnel and committees to do growth monitoring. In Kaolak, the MCs are able to weigh the children but in Louga only the HPNs are permitted to do this. To resolve this situation, the PC has invited representatives from the National Nutrition Program to come to Louga and train the district MOH staff. In both the mid-term review and the final evaluation it was not possible to determine either the accuracy of the weighing done by community members or the quality of the nutritional counseling provided to women. It is important that these two parameters related to the quality of this service continue to be monitored, possibly using observations/interviews and Lot Quality Assessment Sampling (LQAS). Only 50 percent of the planned nutrition educational sessions were executed. The final evaluators were concerned when staff mentioned that particularly in Kaolak, many children stayed in the yellow zone of the weighing cards and did not improve. Staff attributes this to the fact that more families in Kaolak are polygamous, births are closely spaced and the young children often lose out in the group eating sessions. The evaluators also wondered about the quality of the nutrition counseling and education. Perhaps an assessment of these activities together with more emphasis on education would improve this condition.

Exclusive breastfeeding: Virtually women/mothers interviewed during the mid-term review and final evaluation said that they know about the advantages of exclusive breastfeeding and the majority said they have practiced it. However, a constraint identified by some of them during the mid-term, which limits their ability to put it into practice, is the opposition to the idea on the part of some grandmothers/mother-in-laws. During the final evaluation, this constraint was not as

evident. In fact following a mid-term review recommendation, most communities have now formed ‘grandmothers’ support groups that are educated about all project intervention areas including breastfeeding.

Vitamin A supplementation: The mid-term review indicated that most women did not know why it is important for their young children to periodically receive this micronutrient. Obviously this situation has improved since 80 percent of children 12 to 24 months have received Vitamin A. The problem, as discussed above, is that only a small percentage of women are receiving it after delivery.

2.C. New Approaches and Operational Research

Four innovative and important approaches/activities which were developed in the Child Survival Program are: 1) the recruitment, training and supervision of CHEs; 2) the development of the partnership between Plan and Form-Action (local NGO); 3) the rapid assessment of the CSP-supported HHs to identify factors which contribute to the relatively limited use of these structures by community members; and 4) the development of a consortium with World Vision and Christian Children’s Fund to develop community health empowerment training strategies and materials.

Involvement of CHEs:

An innovative and quite effective strategy adopted in the CSP was the recruitment of CHEs. The strategy involves the recruitment, training and supervision of CHEs who are expected to work closely with communities to strengthen their capacity to manage and finance CS activities at that level. Criteria for recruitment of the CHEs were: residence in the project area; secondary school diploma; and some experience in community development and health education in rural communities. During the initial planning for the project it was assumed that these educators would come from the rural communities where they would be working and be given training and a small stipend. However, as it worked out they received so many qualified applicants when they advertised that the majority of CHEs had more education than required and most were not from the project area communities. Initially the role of the CHEs (defined in the DIP) was primarily to supervise the CHTs. However, as the importance of strengthening the capacity of community-based organizations (MC and VHC) to promote and manage Child Survival activities became clearer to CSP staff, the role of the CHE was expanded to include ongoing capacity building and supervision of the community-based organizations (CBOs).

While a number of operational constraints related to CHE’s activities were identified during the mid-term review and final evaluation, they have played a critical role in community capacity building and in strengthening links between communities and HPNs.

The community capacity-building activities are very labor-intensive and it is clear that MOH staff do not have time to be involved in these activities in an ongoing and substantive way. Furthermore, most MOH do not have in-depth skills in community development and empowerment approaches for working with communities. The role of the CHE responds to the need for meeting the community capacity-building/empowerment objectives. Because of this

critical role, it would be useful for the CSP to document and evaluate the work of the CHE. This documentation could then be presented to donors and government authorities in order to lobby for personnel at this intermediary level that could further MOH health objectives. As regards the prospects for perpetuating the role of the CHEs, negotiations have started and CHEs are beginning to organize themselves into a local service provider NGO. The thinking is that these CHEs would make themselves available to be contracted out to various organizations seeking to conduct work with local communities. However, discussions with the CHEs revealed that so far they have not investigated what opportunities exist for their services and have not developed a strategy for marketing themselves or determining where the needs are .

Partnership with local NGO for community capacity building

The implementation of Child Survival Programs, which aim to empower communities and strengthen their ability to manage their own health initiatives, requires two types of expertise. The first relates to the technical aspects of Child Survival programming and the second to participatory/community development methods. Community capacity-building involves strengthening existing organizational structures or creating new ones. The Child Survival Programming works to reinforce existing VHCs, CHTs and MCs. While Plan CS staff has a solid background in the technical aspects of Child Survival Programming, a partnership with a local NGO, Form'Action was established to benefit from their experience in helping communities effectively manage their own development activities. An additional objective of the partnership was for Plan to assist Form'Action in strengthening its institutional capacity to develop and implement a CS program.

In spite of several problems encountered in the operationalization of the Plan-Form'Action partnership, overall the collaboration between the two organizations has been useful. It has allowed for cross-fertilization between the technical CS expertise of Plan staff and the community development expertise of Form'Action staff. A major weakness in many CS projects is the absence of skills in community development/empowerment approaches in working with community actors. Because of this weakness, many of the CS project communities are unable to continue on their own once the projects end. The Plan- Form'Action partnership is a significant strength in the overall project and should be systematically documented to serve as an example for other CS projects in the future.

Study on under-utilization of health huts

With the support of an intern from Emory University, Rollins School of Public Health, a small, operational study was carried out in July 2000 to identify factors that can explain the relatively limited use of the HHs at the community level. The study was conducted in 10 villages in the Kaolack zone of the CS project area and in the same number of villages in the Thies zone of the CS/DFID-Lottery-United Kingdom project area. The study revealed a number of factors which apparently contribute to the limited use of the HHs including: the lack of community support and motivation of the CHW/Traditional Birth Attendant (TBA)/IEC relays; limited involvement of outlying villages in central village activities; and the lack of community confidence in the ability/skills of the CHT members. This information was useful for program planning and for the development of community health strategies by project personnel.

NGO Consortium on Community Empowerment Training

Based on a common need for training materials/modules in French to use with both MOH and community partners to promote community empowerment in health programs, a consortium was established with Plan, World Vision and Christian Children's Fund in 1999. Two six-day workshops were held, facilitated by an outside consultant specializing in participatory/non-formal health education, to define the basis for this work. Since then additional work has not been done in this regard, though Plan is still committed to continuing this effort. In fact Plan did develop a training manual based on the training received. In Senegal, as elsewhere in West Africa, there is a need for training materials to promote empowerment for health and development. Systematically addressing this need, however, would require considerable time and resources, including expertise in non-formal education curriculum development. The consortium approached BASICS Senegal (at the beginning of BASICS II) to seek their help in funding this activity. While BASICS staff informally expressed their interest in this activity, there has subsequently been no formal commitment on BASICS' behalf to support it.

Literacy Assessment

In collaboration with Plan's National Coordinator for Training and Evaluation, the Learning staff designed a questionnaire to assess literacy levels of community service providers and CBO leaders (health committees, MGs etc.). These surveys were conducted in the two project areas and completed just prior to the final evaluation. Plan intends to use this information to develop literacy training for illiterate community service providers (CHWs, TBAs, IEC relays) since lack of literacy skills is a major impediment to their continued management of community health services.

3. RESULTS: CROSS-CUTTING APPROACHES

3.a. Community Mobilization

The overall project goals at the community level are to empower existing community-based organizations (VHCs, CHTs and MCs) to offer services of higher quality with equity and a cost-recovery system for sustainability and to sensitize and educate child caretakers, as well as influential community members, on child survival interventions and promote increased use of appropriate services.

In this section, the main accomplishments and constraints related to each of the key components and categories of actors involved in the CS project are discussed. Lessons learned by evaluation team members are also presented.

Community Health Teams and Village Health Committees

The project's objective has been to develop the capacity of communities to promote Child Survival activities through CHTs and VHCs. The project is working with HHs in 15 central villages in Kaolack and 15 central villages in Louga. In each central village there is a community health team composed of a CHW, TBA and an IEC relay and a VHC composed of approximately five members. Basic equipment (weighing scales, table and chairs) and an initial supply of drugs were provided to each HH. In addition, in the Kaolack area outreach activities are regularly carried out at 33 service delivery points, places where monthly outreach activities are carried out under a tree. In Louga outreach activities were initiated at 28 SDPs in the third year of the project.

Renewal/restructuring of CHTs and VHCs: The initial project assessment of the CHTs and VHCs revealed a number of issues associated with the status and viability of these individuals and groups. In most cases, the CHT and VHC members were chosen and trained many years ago, in some cases twenty years ago, and most were barely functional when the project started. Therefore, the CS project decided to undertake the major task of encouraging communities to select new CHTs and VHCs, to retrain them and to focus on strengthening their organizational and management capacity.

Efforts to revive the CHTs and VHCs were spearheaded by Form'Action and carried out in collaboration with the CHEs, field health supervisors and CS PC. This was done using the Participatory Institutional Diagnosis (PID) tool and took between one and two days per site. The PID process was carried out in Kaolack with 48 VHCs (in 15 central villages and at 33SDPs) and in Louga with 30 VHCs (12 central villages and 28 service delivery points). A second step in this process, which was carried out only with the VHCs in the central villages was the restructuring of those committees to clarify their roles and responsibilities.

One of the lessons learned through this process was that the development of community health activities, which involve village committees and volunteers requires that community members chosen for these positions of responsibility be democratically selected. This assures that

communities will continue to support them over time. For any CS project the renewal/restructuring and training of these human resources/organizations requires time and specialized community development methods. These efforts are justified in that they contribute to building a solid foundation from which technical Child Survival activities can later be developed and managed.

- **Current status of village health committees:** In all of the central villages, the VHCs have been restructured and trained and appear to be functional. Their training was postponed until after the restructuring had taken place. Training of committees has continued into year four with such topics as 'evaluation of the CHTs. In addition, quarterly action plans are developed by the communities and followed up on at monthly meetings under the supervision of the CHEs.
- **Training of CHWs/TBAs/IEC relays:** In the first year of the project an initial group of 40 CHWs, 40 TBAs and 24 IEC relays were trained. At the end of year two, a second group was trained in Louga consisting of 26 TBAs and 30 CHWs. In Kaolack the second group of CHT members was also trained. Additional training for community staff in nutrition or PAIN (Paquet d'Activites Integrees de Nutrition) was provided during year three of the project. This training was imparted to 5 (Louga) health center teams, 75 CHWs, and 346 IEC relays.
- **Health hut revolving drug fund:** The HHs are supposed to replenish their basic drug supplies through the closest HP. Early in the project a major problem was that the HPs often did not have drug supplies to dispense. This constraint usually required communities to travel to the district level drug warehouses to replenish their supplies, which adds to the cost of the drugs. In the past two years there have been improvements in the management of revolving funds and drug supplies due to improved management by the VHCs. HPNs are collaborating by including HH drug orders in the HP orders sent to the district level. The project was able to assist in the organization of the drug ordering process and now all the communities interviewed commented on the fact that medicines were available.

Working with the District Health Management Teams (DHMTs) to assure a sustained system for community drug supplies has been an important lesson learned by the project.

- **Motivation of community health teams:** The mid-term review indicated that the majority of the CHWs/TBAs/IEC relays were discouraged in their work, mainly because of the fact that their communities initially promised to give them either a financial or other type of incentive for the services they provide and failed to keep their promises. The final evaluation team felt that this was still a problem in some areas but not in all of them. In fact there have been advances in this area. The project has employed three strategies to increase financial support for health activities. These are: 1) acquiring HH revenues from services rendered by the CHT, 2) financial contributions from the participating population and 3) support from income generating activities and interest from credit/loans. Only the first of these is constant and is usually not sufficient. However, several of the communities visited during the final evaluation are taxing community members in order to establish a payment fund for the CHTs. In addition, it seems that about 25 percent of the project communities are using their health funds as a basis for credit and loans and this is increasing their levels of funding

available to support the CHTs. The mid-term also made note of other factors that discouraged the CHTs in their work, such as the lack of confidence in their skills and services on the part of community members and limited use of the services they provided. The final evaluation did not find these problems. In general the communities and CHTs felt confident of their skills and abilities and appreciated by their communities. There were some CHT members who were not literate and felt that this impeded their abilities to successfully manage the local health system and they were looking forward to receiving literacy training from Plan.

- Supervision and evaluation of the community health teams: In order to continuously reinforce the quality of services provided by the community health teams and to motivate them in their work, it is important that the HPNs supervise their work. At the mid-term, this was a problem because the HP nurses were not providing the supervision required. Apparently they were on strike over payment and had refused to travel or provide outreach services unless someone paid their costs. Since the mid-term, this issue has been resolved and through the work and support of the CS project, most of the HP nurses are actively involved in supervising the CHTs. Almost all the CHTs interviewed had strong positive relationships with the HPNs. In turn the HPNs praised the support of the project, particularly the CHEs in strengthening the communities' abilities to provide services.
- Previously, although community members stated that the community health teams "work for the community," communities did not play a role in supervising or evaluating their work. However, since the mid-term, this has changed. The project began training the CBOs in simple participatory methods for evaluating the work of the CHTs during year three and by the time of the final evaluation, it was clear that the communities regularly evaluate their activities through the quarterly action planning process. The CHEs oversee this process through preparatory meetings followed by a general assembly of validation of the quarterly action plans, which are evaluated at the end of each month.

The strengthening of the role of the HPN in the on-going supervision of the CHTs has been an important lesson learned by the project management staff. The concern is whether the nurses will be able to continue this supervision after the project ends. Both the HPN and the CHT teams expressed concern about this during the final evaluation.

Before the mid-term review there was limited use of the HHs and this was believed to be related to a lack of confidence in the services provided by community members (many wish the CHWs would give injections and provide drugs that they are not allowed to prescribe), transport difficulties for people in the satellite villages, lack of support by community leaders for CHT services; drug shortages, and the fact that drugs can be purchased in markets and shops. Since the mid-term there has, however, been an increase in the use of these services. This increased utilization appears to be related to better mobilization of women to use the services by the CHTs and VHWs since they were re-chosen and restructured, considerable effort made by the CHEs to sensitize community members on the importance of using the community services, discussions and advocacy with leaders from both the central and satellite villages, and greater participation of the HPNs in community outreach activities as compared with the beginning of the project. In

addition there has been a tremendous amount of progress in strengthening the community drug systems and funds for sustaining them. All the communities interviewed commented on how readily accessible services and drugs were to them through the community structures.

Factors which appear to contribute to greater use of HH services are dynamic VHCs and MCs which encourage people to use the community services and strong encouragement from village leaders, both in the center and satellite villages, to use these community services. One of the key lessons learned here is that the use of community health services, both now and after the project ends, depends to a great extent on community ownership and support for the CHTs. One step towards creating this sense of community ownership that has occurred since the mid-term is the way the CHEs have organized the communities to progressively take more responsibility for motivating, supervising and evaluating the services provided by their own CHTs through monthly and quarterly meetings.

Involvement of Women's Groups in Child Survival Activities

The Detailed Implementation Plan (DIP) describes the important role that existing community women's groups were expected to play in helping to organize community Child Survival activities and in mobilizing community members to participate in them. Initial assessments of the women's groups by project staff revealed that both in the Kaolack and Louga the women's groups were less well organized and weaker than originally thought. As with the VHCs, it was decided that these groups needed to be restructured and strengthened if the project expected them to effectively carry out Child Survival promoting activities during the life of the project and beyond.

Based on this reasoning, the same participatory institutional diagnosis process (used with the VHCs) was carried out with 48 women's groups in Kaolack and 15 women's groups in Louga. According to community members the technical assistance and restructuring have had several beneficial effects on the women's groups: they now have representatives from the satellite villages as well as the central village; roles and responsibilities of the officers and committees are clearer; meetings are held more regularly; and their management is more transparent. Women's group members identify several positive effects which these organizational changes have had on community-level Child Survival activities: more regular communication of information regarding Child Survival activities; increased use of services provided at the HHs; greater regularity in carrying out community-organized Child Survival activities; and greater involvement by women from the satellite villages in the activities held in the central village.

One of the weaknesses identified by the mid-term review was that there was a lack of communication between the women's groups and the VHCs, which could have facilitated resolution of many of the problems encountered by the Women's Groups (WGs) in carrying out their activities. These problems included absence of a regular meeting schedule and a dependency mentality on the part of WGs to allow the CHEs to solve problems that they could have resolved themselves. Since the mid-term, this situation has improved. Through the work of the CHEs and project staff, the groups now have regular meeting schedules and have received training in the five project intervention areas. This has led to their greater involvement in the execution of project activities.

An important lesson learned by the project was that it was necessary for all women's group leaders to have a clear understanding of the five priority Child Survival interventions and of the project objectives for each one in order to enable them to promote these interventions in the most effective way possible.

- Child survival activities carried out by the WG: In most cases the WGs take full responsibility for organizing health activities themselves (village cleanliness campaigns, growth-monitoring, cooking demonstrations, sale of chloroquine, impregnation and sale of bednets), and in other cases their role is to mobilize women to participate in activities carried out by the HPN (vaccination sessions and pre-natal consultations). As mentioned above, nationally, the Nutrition Program allows communities to do weighing and monitoring of children's growth and this has occurred in the Kaolak communities. However, in Louga, the nurses have not relinquished this responsibility to the communities, so the project is arranging training for the Louga district MOH nurses for this to be addressed.

Project staff have noted that an important lesson learned here is that in almost all communities WGs are generally very motivated to participate in organizing and managing CS activities and there have been significant improvements in their ability to organize these activities. While in most cases WGs are motivated to carry out these activities, their organization and management skills needs to continue to be reinforced. Although there has been a substantial strengthening of their abilities there is still a need for ongoing follow-up and supervision. Most of the committees interviewed during the final evaluation stated that they would like some kind of continuing supervision and support.

3.b. Communication for Behavior Change

In the DIP two types of BCC/IEC activities were planned such as home visits to target Child Survival service defaulters and group activities. The DIP recommended the use of participatory IEC approaches such as songs, stories and role-plays that engage community members in enjoyable and active learning experiences.

Targeted home visits: It was anticipated in the DIP that the community health teams would carry out home visits in both the central and satellite villages to follow-up specific women/children who did not attend a vaccination or growth monitoring session. The mid-term review showed that home visits were rarely carried out and when they did take place it was usually the CHEs that did them. In almost all villages the CHTs were not motivated to carry out home visits for several reasons: families did not have confidence in the advice they gave, due to their relatively low level of education and training, general de-motivation of CHTs and the considerable time and effort required to visit homes in central villages and especially in satellite villages.

However, by the time of the final evaluation, this situation had improved considerably. As mentioned above, the CHTs now have much more respect in the communities due to the upgraded training and supervision they have received. In addition, now that the communities are maintaining a census of children who have been immunized, the mothers committees and the health committees follow-up on individuals who have not kept up with their vaccinations or do not come for weighing or other outreach services. The success of this strategy is validated by the

high immunization rates in the project area (82 percent are fully vaccinated). In addition, most of the communities have sub-committees that make home visits and check for hygiene and general health status in the home. So even though the CHTs do not always do home visits, representatives of the committees do follow-up on health intervention activities. This was an important lesson learned by the project, and they adjusted for the lack of home visits by the CHTs by having the community committees take charge of this activity.

Group IEC/social mobilization activities:

The main group IEC activities being carried out in the project-supported communities are health talks and cooking demonstrations accompanied by nutritional advice. The health talks, which are sometimes conducted by the HPN supervisor, but more frequently by the CHTs, deal with all-five priority Child Survival topics. A cloth picture box (boîte à images) or flip chart was also developed on the five topics. These activities/materials are useful in providing community members with information. However, they do not necessarily require active participation and problem solving related to the different Child Survival issues that optimize adult learning. According to the DIP, the CS project was to give priority to the use of simple and participatory learning methods, which communities can easily use on their own, such as songs, stories and role-plays. Since the mid-term review, three communities in the Kaolak region have begun developing songs and stories about women and children's health that they have presented to their communities. One of the WGs developed a role-play and song on malaria prevention and it was shared with several other villages. However, this has been done only recently and these activities have not been done in an organized way with all the project communities. Community interviewees expressed interest in such activities that are well suited to the socio-cultural context.

Conventional health talks being used in the project are useful but not optimal in terms of stimulating problem-solving and adult learning. As noted in the KPC, many of the planned talks have not been given as anticipated. When asked why the CHTs were not providing the education sessions, they indicated that people got bored with the same thing over and over and didn't come. Part of the problem in the past has been that the IEC sessions were only given by the CHEs, who are often constrained by lack of transport etc. Since the mid-term, the CHEs have worked with the IEC relays so that they can provide the community education. Although simple and participatory IEC methods were proposed in the DIP, such as songs, stories and role-plays, such activities have been used to only a limited extent in the project. This is due, in part, to the fact that most CS project team members do not have specialized skills in the development and use of these techniques. The mid-term review recommended that in order to increase community members' participation in IEC activities and the impact these activities have on their behavior, that the CHEs and other CS project staff members be trained in the promotion and use of these techniques. As mentioned above, efforts to expand creative and participatory IEC activities have begun in Kaolak but have not been fully developed. The project staff recently contacted the Christian Children's Fund's (CCF) CS project about assisting them in developing a strategy for this effort. However, it seems clear that developing a successful participatory IEC strategy requires a long-term effort and commitment and since this project is ending in a few months, the staff is thinking about developing this for a follow-on project.

Participation in IEC activities: Participants in the health talks and nutrition education during cooking demonstrations are primarily women with young children. Previously, older women

participated on an irregular basis. Since the mid-term and the formation of ‘grandmothers’ groups, the older women have become much more involved in the cooking sessions as well as other CS activities. This was an important lesson for the project, since older women have much influence on women and children’s health decisions in the home.

Cinebus activities: In the Kaolack area Plan’s mobile video van visits communities several times a year and shows films on health and other development topics which are followed by group discussion. Community members enjoy these sessions and they are widely attended by different community groups. According to Plan staff the use of the Cinebus has not been optimal. There appear to have been difficulties coordinating activities.

Grandmothers’ influence on Child Survival practices:

The mid-term review interviews with women with young children and with grandmothers revealed that in virtually all families grandmothers give advice on the different Child Survival issues: when the newborn baby should be put to breast; whether exclusive breastfeeding should be practiced or not; timing and type of first complementary foods; treatment of ARI, diarrhea, etc. An important lesson learned from this was to involve grandmothers in CS activities. After the mid-term, the CHEs began coordination and sensitization sessions with grandmothers and elderly women to promote CS activities, and increase their involvement in promotion and sustainability of healthy behaviors and sustainability of positive health behaviors. At the final evaluation, many grandmothers talked about their involvement in health and MCs and their contribution in promoting healthy behaviors in their households and among community groups.

3.c. Capacity Building Approach

3.c.(i) Strengthening the Private Voluntary Organization (PVO) Organization

No formal assessment of Plan’s institutional capacity was carried out at the beginning of the project, and a capacity building plan for the PVO itself was not included in the DIP. However, a number of efforts have been made at Headquarters and Plan Senegal levels to strengthen Plan’s capacity to implement Child Survival projects related to data collection, project planning and technical aspects of Child Survival programming.

Plan Senegal staff was trained in both KPC data collection and DIP preparation through the USAID-funded CS project. These skills were subsequently used to develop Child Survival proposals that were submitted to DFID and the National Lottery of the United Kingdom. /In both cases funding was obtained from those organizations to support Child Survival programs in three additional areas where Plan works in Senegal.

The Plan CS project staff participated in two Headquarters organized workshops to share lessons learned in Child Survival projects in 1999 in Nepal and in 2000 in Nairobi. The CS PC also participated in a CORE-organized workshop in Nairobi in 2000 on Safe Motherhood. The Plan West Africa office has also organized annual conferences in which CSP staff have participated: in 1998 in Dakar on KPC data collection; in 1999 in Ghana on micro-finance and health; and in 2000 in Benin on lessons learned in Child Survival programs.

3.c. (ii) Strengthening the Local NGO Partner to Implement Child Survival Programs

Overall, the partnership between Plan and the local NGO, Form-Action has been very beneficial for both organizations. However, several operational constraints have occurred in the partnership, related in part to insufficient clarity regarding the roles and responsibilities of the two organizations.

Progress toward strengthening institutional capacity of Form'Action

The revised capacity-building plan (annexed in the Sept. 1999 annual report) defines the goals of the partnership and stipulates the anticipated institutional capacity-building outcomes and impact. To date, Plan has provided support to Form'Action related to three capacity building goals: 1) to provide support for development of an institutional strategic plan; 2) to improve Form'Action ability to plan, implement and evaluate Child Survival projects; 3) to strengthen Form' Action's accounting system.

The organizational assessment and strategic plan, for which Plan provided Form'Action with the services of consultant, was completed in September 2000. The strategic plan identifies Form'Action's areas of expertise and competitive advantage in the NGO world, and also defines priority areas for the organization's development in the next five years. The plan includes discussion of Form'Action's interest in continuing to be involved in health-related programs and specifies several priority technical areas, namely, reproductive health, environmental health and health education. In addition, one of the areas identified for further development in the coming years is the "development of local and community organizations". The authors of the mid-term review commented that because of the growing demand in Senegal for human resources and methods which can contribute to community capacity-building, they thought it might be more appropriate for Form'Action to further develop its expertise in strengthening community-based organizations involved in health, including health-related cost recovery activities, rather than trying to develop the broader range of technical skills that would be required to develop and implement comprehensive Child Survival projects. They believed that Form'Action could carve out a strong niche for itself by specializing in community organization and empowerment. Despite this observation, Form'Action has recently been awarded a grant from UNICEF to implement broad child survival activities in the southern region of Senegal. Form'Action staff credit their experience with the CS project for having given them the technical expertise to manage other CS projects.

Efforts to strengthen Form'Action's Child Survival programming capacity have included the following strategies: participation of Form'Action staff members in Child Survival technical training sessions organized in the CS program; participation of one Form'Action staff member (Assistant/Country Office) in the child survival technical support workshop on participatory evaluation of Child Survival projects; involvement of the Assistant/Country Office in all periodic CS program meetings and lessons learned sessions; active participation of two Form'Action staff members in the mid-term review and final evaluation.

The third goal in the Form'Action capacity-building plan dealt with strengthening the organization's accounting system. Early in the project Plan's administrative staff carried out an

initial assessment of Form'Action's financial systems and then decided to wait until completion of their institutional development plan before reinforcing/restructuring those systems. This work was conducted after the mid-term review, and Form'Action was also authorized to purchase a computer for their central office activities.

Revised roles and responsibilities of Form'Action

After the DIP, Form'Action's role was revised (September 1999, Annual report) to focus on: 1) strengthening the organization and management of Community Based Organizations (WGs, VHCs ; 2) developing/strengthening the income-generating, cost recovery systems managed by CBOs to finance Child Survival activities; 3) training and follow-up of CHEs in participatory community development approaches and techniques. Based on a reappraisal of Form'Action's expertise, they are no longer expected to play a leading role in IEC and health education strategies, as originally stipulated in the DIP.

Lack of clarity regarding roles, responsibilities and approach used by Form'Action

Interviews with both Form'Action and Plan staff reveal that at the beginning of the partnership there was not sufficient clarity regarding either the respective roles of Form'Action and Plan staff in the project nor the mechanisms of coordination and follow-up of the activities carried out by each of the partners. For example, some Plan staff felt that responsibility for "development and implementation of the sustainability strategy for the project" was totally delegated to Form'Action. After the mid-term review it was made clear to all CSP staff that they must all share responsibility for identifying and implementing strategies that will contribute to community ownership and the potential for sustainability. With the assignment of a new PC (2000), coordination between Plan and Form'Action became much stronger and more unified.

One of the issues that resulted from the mid-term review that may have weakened Form'Action's institutional capacity was the need to provide an additional coordinator who could manage the Louga project sites. It was found that one community development coordinator was not sufficient for both Louga and Kaolak. As a result the Form'Action executive director moved to Louga to supervise field activities. Because of his heavy involvement in daily project activities, he was no longer able to conduct the business development activities that he had previously done in Dakar.

Prospects for sustained impact of Plan assistance to Form'Action:

Plan's support to Form'Action has focused on Form'Action's material and recurrent operating costs and developing the skills of two Form'Action staff members, the Executive Director and Assistant/Country Office director, who are now assigned full-time to the CS project. Support provided for material and recurrent costs will strengthen Form'Action's institutional capacity to manage other projects. In addition, the fact that two key senior staff now have experience implementing Child Survival projects in an in depth and sustained way, has allowed them to gain experience for implementing other CS projects. This acquired expertise is demonstrated by Form'Action's recent acquisition of a new UNICEF-funded CS project.

Issues: Despite the acknowledged benefits that both Plan and Form'Action have acquired through their partnership, Form'Action has expressed some concerns. Despite the fact that Form'Action came into the arrangement with Plan providing a mentoring role and agreeing to

help them develop their corporate capabilities in child health, they believe that Plan has not always recognized their ability. Form'Action believes that it has grown institutionally through its partnership with Plan and that it is able to function as an independent partner. However, they believe that Plan still has doubts about Form'Action's fiscal abilities and therefore, continues to monitor their financial activities very closely requiring financial controls and approvals for every purchase and payment. Form'Action staff also expressed concern about not being invited to participate in various national and international child survival meetings and forums. In addition they expressed concern that their position as a "less than equal" partner may have contributed to the inadequate transportation and salary support being given to the CHEs. Since Form'Action manages the CHEs, when they complained to Plan about needing better salaries and transportation in order for the CHEs to do their jobs, Form'Action did not really feel that they were in a strong enough position to negotiate this with Plan.

It is clear that if Plan and Form'Action are to continue to work together on future projects, then the partnership agreements need to be reevaluated. Clearly, Form'Action has grown and benefited from the partnership with Plan and as a result, will demand more benefits and more decision-making authority in any future joint endeavor. At the same time, it will be of benefit to Plan to continue to work with them since they have provided the community organization skills needed to make the CS health activities work.

3.c.(iii) Health Facilities Strengthening

At the beginning of the project (late 1998) all HPs and HHs were visited by the field health supervisor who carried out a rapid assessment of their services, equipment, and drugs using a tool, which is widely used in West Africa. The BASICS methodology was not used. The information collected in the rapid assessment was used to identify priority needs of each HP and HH, some of which were subsequently addressed using project or other Plan funds. No systematic follow-up assessment has been carried out to evaluate functional changes since the rapid assessment was conducted in 1998. (There was a plan in a cooperative agreement between Plan and the MSH FP/maternal health project to conduct a health facilities assessment in the Louga area, using the BASICS tool).

Based on the results of the Health Facility Assessment (HFA), various types of material support have been provided to the HPs (solar panels for electricity, construction/repair of HPs, refrigerators, and drugs), which have strengthened their capacity to provide quality services at that level. Plan expects the HPs to ensure the maintenance of the equipment provided to them, but the HP nurses believe that Plan should also cover maintenance costs. The mid-term review recommended that this maintenance issue is addressed with the MOH and that the project asks them to set up maintenance fund but it appears that this was not accomplished. The project also equipped HHs and SDPs with beds, scales, cooking utensils, furniture and other necessities noted in the HFA, by the project. Because the HHs have established revolving funds to cover maintenance of drugs and supplies, it is likely that the Huts will continue to be maintained after the project ends.

Community members are very appreciative of the outreach visits made by the HPNs to their communities, given their commitment to having their children and pregnant women vaccinated

and their interest in the other essential services provided by these nurses. During the first year of the project HPN involvement in the monthly outreach activities was very irregular. CS project members have since established closer relationships with the HPNs and during the last two years their presence for the outreach visits has considerably increased.

3.c. (iv) Strengthening Health Workers' Performance

The evaluators assume that this section addresses the health worker's performance issues of the MOH staff working in partnership with the project in Kaolack and Louga areas.

Several strategies have been employed to strengthen the MOH health worker's performance including, coordination activities and training.

Planning, evaluation and coordination of CSP activities with MOH partners takes place through a number of periodically scheduled meetings organized either by the District Health Management Team (DHMT) or by the project.

Annual CSP planning meeting: The objective of this several day planning meeting is to allow project staff and MOH collaborators to review activities carried out in the preceding months and to come to a consensus on project-supported activities to be carried out in the following 12 months. A constraint associated with this attempt to integrate/coordinate the planning of project activities into DHMT planning is the fact that Plan's fiscal year starts several months earlier than the MOH's. DHMTs participation in the planning meeting helps but does not ensure integration of the two planning processes and budget exercises.

The project meetings were held both in the Kaolack and Louga regions. During the first two years, the categories of participants in the Kaolack and Louga meetings differed with a greater participation on the part of community actors in the Kaolack meetings, namely, CHWs, TBAs, IEC relays and VHCs. After the mid-term review, the strategy changed, and instead of inviting large numbers of community level staff and committees to this meeting, the community meetings were conducted individually at each HH, with all key community health actors. Based on these discussions their opinions/priorities were then communicated to project staff and DHMT members.

At both the mid-term and final evaluation, the DHMTs complained that the participation of CS staff members in their project outline planning meetings is insufficient. According to CS staff, they realize the importance of attending the project outline planning sessions but sometimes these meetings are postponed and CS staff is unable to attend due to other prior commitments.

During the first 2 years of the project at least two members of the CS staff attended the monthly coordination meetings organized by the DHMTs in Nioro and Louga. However, the mid-term review team concluded that this is not the best setting in which to deal with CS issues in an in-depth way, given that the majority of the HPNs who attend these monthly meetings work in zones, which are not supported by the project. After the mid-term it appears that regular

attendance at the meetings decreased and the DHT mentioned this lack of regular coordination during the final evaluation.

To improve communication and collaboration with the DHMT, the project decided to hold quarterly evaluation and coordination meetings. Attendees at these meetings include MOH staff such as HPNs, DHMTs and project staff (including CHes and Community Development Agents). So far three of the four planned meetings have been held. The project's quarterly reports are sent regularly to the District Medical Officers and this action has also proven effective in keeping them updated.

In addition to the meetings and collaboration activities described here, the project has also sponsored a number of training activities (Please see training section of this report (3.c.v). For training activities, the project has trained a number of MOH staff to act as trainers and conduct training of trainer's activities in the project areas. These training activities have done a tremendous amount to improve the skills and motivation of the MOH and HP staff. Other factors that have influenced their work is the amount of community organization and development work conducted by the project, particularly by the CHes. This work with CBOs has allowed the communities and CHTs to actively participate in health activities and work jointly with MOH outreach staff to meet MOH health objectives.

The concern is what will happen when the project ends. Most of the HPNs interviewed stated that they would not be able to continue doing their jobs as effectively without the community organization and mobilization work that has been done by the project CHes. They saw their job as being service providers and not community mobilizers. They saw the CHes as filling this needed role that allowed them to conduct effective outreach services. The members of the CHTs that were interviewed indicated that they now felt better prepared to do their jobs, since the project had sponsored their training and encouraged regular supervision on the part of the HPNs. However, they were not sure that all the systems were in place to assure that they would be able to sustain their activities after the project ended. In many communities there were still a lot of tasks being managed by the CHes that the CHTs were not able to do. Many of the CHTs who lacked confidence were not literate. To address this need, Plan is starting to organize literacy training in the region but this may not be enough, given the advanced age and lack of education of many of these individuals. In communities where one of the CHT members is literate, this person can often assume responsibility for the planning and organizing of reports, services, community meetings etc. But in general the CHT staff believed that they needed a little more time with the project before they could assume complete responsibility for their activities. When interviewed, the CHes estimated that 30 to 40 percent of the communities they worked with could sustain activities after they left.

3.c.v) Training

The CS project's training strategy includes activities organized for community and MOH partners. The strategy is based on a training-of-trainers approach in which HPNs and district management team staff are trained as trainers who in turn train the Community Health Teams (CHTs - namely CHWs, TBAs and IEC relays) in collaboration with CSP staff. The training provided to community and MOH actors has clearly provided them with skills to help them carry

out their CS related activities. During the mid-term several constraints were identified in the overall training approach and materials used, some of which were subsequently modified to improve the outcome of later training activities.

Child Survival training manual: In order to train both the HPNs and CHTs a “training manual” was developed by the project based on a number of MOH-developed manuals. Development of the manual involved MOH and CS project staff members as well as World Vision, Christian Children’s Fund (CCF) and Peace Corps. The “manual” includes training objectives and an outline of the training sessions that deal with the 5 Child Survival interventions as well as a session on the project management information system. The manual includes detailed lists of the technical information to be presented on each Child Survival topic and this information accurately reflects MOH priorities. The manual does not, however, follow the standard training curriculum format in which there is a detailed description of the pedagogical activities (to include, for example, copies of handouts to be distributed, of role plays to be used, of questions to be asked in small group activities), estimated time required for each activity, and special instructions to the trainers. When asked about this, the staff gave the final evaluators a copy of the CS training manual being used but it does not appear to have been modified to include participatory activities or copies of handouts.

In the health sector in Senegal, training sessions are frequently carried out using a directive teaching approach, in which pedagogical activities are primarily lectures accompanied by some small group work, which is often not sufficiently well structured to optimize learning. The mid-term review recommended that the project consider developing/using training manuals that include a detailed presentation of participatory, adult learning methods/activities that can contribute both to standardizing and improving the pedagogical quality of the teaching and to greater participant learning. However, the development of more detailed training manuals does require considerable time and expertise. During the mid-term review Plan staff discussed the possibility of borrowing/modifying the CHT training modules already developed by the Christian Children’s Fund/Project in CANAH in Senegal but this does not appear to have taken place. The project did talk to CCF about using some of their IEC strategies but decided to wait until receiving a project extension before implementing them.

CHT participant training materials/guide: A constraint related to the training of community health actors (community health team) is their low-literacy level and the difficulty that many of them have in following and retaining what is presented during the training sessions. Mid-term review participants suggested developing a “participant training guide” for CHT members that they could use during training events and take home with them for reference purposes. It appears that this suggestion was acted on as the final evaluators noted many materials on HH walls that described through pictures how to treat child illnesses or prevent health problems. Some communities also had xeroxed copies of pamphlets that had limited words and lots of pictures. Staff also indicated that they were working with the Learning Domain staff to translate documents into Wolof.

Practical constraints related to training events: A constraint associated with the involvement of MOH staff (district management team & HPN) as trainers in CSP-supported training events stems from the fact that sometimes they are unable to participate in these activities due to

unexpected meetings/training sessions required by their superiors. In order to address this the project arranged for at least three trainers to be present at each training event, so that if one is called away at the last minute, others are able to take on the activity. The project is also better about planning training events in advance and arranging for the events to be included in the MOH planning process.

Other lessons learned through the joint training process included the need to add a chapter on patient follow-up to the training manual. Since this is an important aspect of care that the CHTs are often called upon to provide, this seemed an important addition. The project staff also realized that it was important to include a model or example of the reporting formats for the CMTs monthly and quarterly reports. Information on how to fill out the reporting documents was also included in the training.

In addition to the training provided to the MOH staff and communities, the project also provided training to the project staff, including CHEs on basic child survival interventions, community development and organization, teaching methods, supervision, Integrated Nutrition Activities Package (PAIN), data management and reporting.

The tables included in Annex 5, outline the kinds of training given by the project to staff, CHTs, MOH staff and CHEs.

3.d. Sustainability Strategy

The CS Project has aimed to put in place systems and activities in support of Child Survival that can be sustained by the MOH and communities themselves when Plan support is withdrawn. In the DIP the sustainability goals/strategy focus on community level parameters that are believed to contribute to sustainability of Child Survival activities at that level. The sustainability strategy does not include objectives/indicators related to MOH skills and support for community level activities. Lastly, a widespread dependency mentality at the community level has been a serious challenge to sustainability.

The sustainability strategy at the community level focuses on: developing cost-recovery and income-generating systems to finance Child Survival activities; strengthening the quality of basic services provided by CHTs (CHWs, TBA, IEC relays); strengthening the management systems of women's groups/ MCs and their ability to support Child Survival activities and CHTs. An important dimension of such support involves development of a community-financed system to support/motivate CHT members. In addition, the sustainability strategy included recruitment and training of CHEs who are from the project area, in the hope that they would remain in their communities beyond the life of the project and continue to work with them.

At the community level, significant progress has been made in developing cost-recovery and income-generating systems to finance Child Survival activities. During the past two years efforts were made to encourage Plan-affiliated communities to provide financial support for Child Survival activities from existing community income-generating activities (grinding machines, shops, micro-credit programs). A constraint in this regard is the fact that in the non Plan-

affiliated communities, such well-established income-generating activities do not exist. However, from reports it is clear that 25 to 30 percent of the communities are now managing micro-credit and loan programs from their community funds. The proceeds from the interest on these loans are being used to support community activities. In addition, communities are also setting up systems whereby every family is taxed or asked to contribute a certain amount to cover the costs of the CHTs. A third strategy that has been employed is the generation of revenues from services provided by the CHTs at the HHs. Although these strategies are bringing some level of support for the CHTs, most communities were not able to fully support them at the time of the final evaluation. The most promising strategy is through the income-generating activities but this will take a while longer to fully implement.

A critical variable related to the sustainability of community level activities is the motivation of CHTs to carry out regular and quality services. In the search for sustainable systems, the CS project expects communities to provide primary support for their own CHTs. The mid-term review found only a few cases where communities had put a system in place for ensuring on-going support/motivation for their CHTs. However, after the mid-term review, CS staff put increased emphasis on helping communities define and implement these systems in order to adequately motivate CHTs. As mentioned above, although the systems are there, they are not yet able to provide 100 percent of the support needed.

Another dimension of sustainability not explicitly addressed in the DIP is support from community leaders for child survival activities, CHTs and WGs. The mid-term review pointed out that developing sustainable community support for child survival activities requires support from primary community leadership structures, i.e. traditional male leaders. Lessons learned from community health programs in other regions of Senegal and other countries suggested that support from primary community leadership structures is one factor that contributes to community ownership, involvement and sustainability of those programs. In line with this suggestion, the project systematically identified all the leaders and resource people in the project villages. Next they began sensitizing and educating them about the importance of project activities and discussed the difficulties they were having in implementation. This sensitization helped to mobilize the leaders who used their skills to improve the management and functioning of the community committees and local organizations.

While the DIP includes discussion of the need to strengthen the skills of MOH staff and their involvement in community-level Child Survival activities, this need is not translated into a goal or objective in the sustainability plan. Clearly, the sustainability of community-level Child Survival activities depends not only on strengthening the “social infrastructure” (community structures and actors) but also on ongoing support from MOH staff, primarily HPNs. It was suggested by the mid-term reviewers that a goal and objective/s be added to the sustainability plan related to periodic and ongoing involvement of HPNs in implementing, supporting and monitoring community Child Survival activities. The reviewers also recommended integrating into the sustainability plan an objective related to DHMT support for HPN involvement in community Child Survival activities, given the constraints in this regard. Regarding monitoring and evaluation activities at the community level, a lesson formulated during the mid-term review recommended that monthly or quarterly monitoring and evaluation sessions be held at the HH level with the CHT, VHC, WGs, CHEs and HPNs. Although new sustainability objectives were

not added to the project, these recommendations were followed. The project began conducting quarterly planning and evaluation meetings in the communities that were supervised by the CHEs. Participants included VHCs, MCs, service providers, HPNs and CBO leaders. These participants draw up quarterly activity plans with roles and responsibilities divided among the various community actors. The activities are then followed up at monthly meetings with the VHCs, MCs and service providers. Also after the mid-term, the CHEs received additional training in capacity building to help develop the CBOs and committee structures.

Dependency mentality: An additional concern mentioned in the mid-term review was the widespread “dependency mentality” existing in the majority of the project villages. The reviewers felt that this was a major constraint to the sustainability of the Plan-supported Child Survival activities. Evidence of this dependency was based on information gathered during mid-term review interviews and from CSP staff experiences at the community level. This blatant sense of dependency on Plan was articulated many times in statements made by community members wherein they stated that they were expecting and waiting for Plan to solve even very basic problems/needs for them such as: construction of an enclosure around their HH, which was primarily Plan-financed; purchase of spoons and additional pots for cooking demonstrations; purchase of tweezers and alcohol for the village health worker and material for the matrone’s birthing kit (even though the VHC has money in the bank); purchase of additional mats for Child Survival activity gatherings; and repair of the literacy hut. In spite of the efforts made in all Plan programs to develop a sense of community ownership of Plan-supported activities by requiring communities to participate in projects developed in their area, the dependency mentality appears to be widespread. This type of dependency spirit exists, to a greater or lesser degree, in many places in Senegal, as in other countries, and especially in places where NGOs have worked for many years. The mid-term review recommended that there be continued and more in depth work on this issue within Plan and with its MOH, Form’Action and community partners. The final evaluators found that despite this history, when community representatives were asked if they could continue on their own after the project ended, a surprising number felt that they could. They did not think they could manage things as well but they did think they could continue some of the basic activities such as the planning meetings and committee activities. Not all of them were sure they could handle all the accounting responsibilities involved in managing the community funds. Likewise the CHTs were mixed regarding whether they could independently sustain all their activities despite the training and sense of empowerment they had received. Those that were literate or whose communities were supporting them financially were more confident. As the community structures are becoming stronger and local members are assuming more responsibilities, there is some evidence that the project is beginning to reverse this sense of dependency, which is incompatible with project objectives of community ownership and sustained responsibility for their own health and development.

In general, the project has made tremendous progress in the development of organized community structures in a relatively short period. There now exist community committees that meet, plan, carry out, and manage CS activities on a regular basis. These communities have also established their own funds and credit programs and are able to maintain services, supplies and drugs at the Health Hut level. In general, when asked about the sustainability of these structures, most staff and community members feel that 30 – 40 percent of the communities could continue without further support. They probably would not be able to function at the level of services

being provided now but they could continue to function at some level. However, it is believed that most are not ready to sustain their health activities without any support. The USAID/DCHA/PVC office in Washington is aware that years is too short a period to set up a sustainable health system and this project is a good example. Although Plan was not awarded an extension project for 2002-2007, Plan is actively seeking funding to continue support of project activities and allow these communities additional time to assume responsibility for them.

One of the big concerns is the sustainability of the CHEs, who have been key to the whole community development component of the project. They are also fulfilling a key role in bridging the gap between communities and the MOH health services staff. As mentioned above, the original intent of the project was to recruit CHEs from local communities whose support would later be assumed by these local communities after the project ended. Unfortunately, this strategy proved unworkable. It was difficult to recruit appropriate candidates from the local communities and even when they did, these individuals were not effective in their jobs. The project found that people from outside the local areas where they worked were more effective. Several strategies have been discussed regarding how to sustain the CHEs (such as community support, approaching the MOH about making them permanent MOH staff, etc.), but so far nothing has been put in place. One action that the project has encouraged them to do was for the CHEs to form an independent association and offer themselves out to development agencies on a contractual basis. The CHEs are in the process of incorporating themselves, but when discussing this with the evaluators, it was clear that they had not thought about whom they might work for or how they were going to market themselves. In the meantime, given their excellent community organization skills and their health knowledge, some of them are already being offered jobs by other organizations. So if Plan and Form'Action do not come up with a viable strategy for them soon, it is likely that they will leave and go to work for someone else.

C. PROGRAM MANAGEMENT

C.1. Planning

In general, the project staff believes that the Detailed Implementation Planning process was helpful in setting up the technical strategies and parameters for the project. The objectives were developed based on the results of the baseline KPC survey and these objectives served as the measurement standards from which to judge technical achievement. An area that was not as clearly developed in the DIP were the community organization activities that the partner, Form'Action was chiefly responsible for. These activities have proven to be considerable and of great importance to the success of the project. This is because it would have been impossible to have strengthened the local services teams without the corresponding involvement of the local community health committees, women's committees, mother's groups and local leaders, who actively manage and participate in the delivery of these services. In addition the CHEs, who were responsible for carrying out and supervising the community organization and empowerment activities, were also employed by Form'Action. Much of the planning and organization of their work occurred through regular planning and supervision activities carried out by the Form'Action coordinators in the field. In addition, the participative mid-term review looked at many of the community organization strategies and made numerous recommendations to the project. Many of these recommendations were followed and brought significant

improvements to the project. (These recommendations are discussed in other sections of this report).

In addition to the various planning and coordination meetings held between the project and the MOH district staff and HPNs that are discussed in section 3.c.(iv) of this report (Strengthening Health Worker Performance), the Project Coordinator also conducts monthly staff meetings during which the staff report on activities conducted during the previous month and make plans for the next month's activities. The CHEs also submit monthly reports of community activities in their respective areas. These reports include activities completed by the MCs and health committees, financial accounting statements regarding money collected and spent by their respective communities, numbers and kinds of outreach activities conducted with the HPN and CHTs and supervisory activities completed. During the monthly staff meetings, the CHEs also program the next month's activities.

C. 2 Staff Training

As can be seen from the training tables in Annex 5, the project staff has received training on a number of subjects between 1999 and 2001. Topics include "basic technical training on child survival interventions," "participative evaluation skills," "Epi Info," "data management," and specific "child survival training for the Community Development Agents" in Kaolak and Louga. In addition, the CHEs received training in 1999, 2001 and 2002 on different topics related to community organization. These courses included "Participative Institutional Diagnosis of Community Based Organizations," "Group Dynamics Skills," "Operational Planning Skills," and "Elaboration of Community Budgets."

Some highlights about some of the formal and informal staff training and development opportunities that have been provided to CS project staff (CSP coordinator, field health supervisor, assistant/Country Office, community health educator) include the following:

- The two field health supervisors participated in a training course on district level monitoring and evaluation. This has strengthened their involvement in monitoring and evaluation activities at the HP/district level.
- Five Plan staff members involved in the CSP participated in a one-week workshop on participatory evaluation methods organized by Child Survival Technical Support. The mid-term review was conducted using the methodology presented in the workshop. All the CSP staff that participated in the Child Survival Technical Support workshop was involved in the mid-term review and applied the acquired knowledge/skills.
- Twice a year a two to three-day meeting is organized with the staff from both the USAID and DFID/Lottery Child Survival projects in order to share lessons learned between projects.
- Once a month the CS PCUSAID and CSP coordinator/DFID/Lottery meet for a one-day meeting to share concerns and lessons learned.
- Since June 1998 a system of cross-visits between Plan staff working in different Program Units is organized to share successes, challenges, and lessons learned.
- Formal training was provided to the CHEs that dealt with the technical aspects of the five Child Survival interventions addressed in the project. The role/tasks of the CHEs in community development and capacity building were not addressed in their initial

- training. They also received informal training on strategies for working with community individuals and groups during health supervisor visits and meetings, and through activities carried out with Form'Action staff. Form'Action has also provided annual courses on community diagnosis and organization as mentioned above.
- Training in community development/empowerment approach: At the community level, the project's overall aim is to promote community capacity to manage Child Survival activities itself. CS staff (CHE, field health supervisor, CSP coordinator) appears to have adequate knowledge and skills regarding the technical aspects of managing Child Survival interventions. Since the mid-term they have further developed their community development and organization skills and have successfully implemented several development/empowerment strategies with CBOs and local committees.
 - Exchange visits for Form'Action staff: The mid-term recommended that Form'Action staff be given the opportunity to take advantage of study trips both within Senegal and with NGOs elsewhere in the West Africa region in order to broaden their exposure to CS and other development programs. The mid-term review noted that while the partnership established with Form'Action derives from their experience in community development and empowerment, this organization is still relatively young (started in 1991) and the skills of its staff still need to be strengthened. Unfortunately, this recommendation was not acted on before the end of the project but should be considered for a future project.

C.3. Supervision of Program Staff

Administrative supervision of the Child Survival PC is provided by the Program Unit Managers in Kaolack and Louga and by the Program Support Manager in Dakar. The National Health Coordinator who is based in Dakar provides technical surveillance. Technical support and follow-up to the coordinator of Child Survival project is ensured through a series of activities including: the preparation and discussion of annual work plans and development and discussion of detailed quarterly work plans. Based on these plans the National Health Coordinator advises the Program Support Manager to approve required resources, provides technical assistance and/or identifies issues that require further discussion. Monthly CSP meetings are held to review progress in project implementation. These are attended either by the National Health Coordinator or the National Training, Monitoring and Evaluation Supervisor. During the mid-term review it was recommended that they hold these meetings quarterly rather than monthly because of the length of time staff was taken away from other project activities. However, there are still small monthly meetings to review progress, collect and review community data, and discuss problems.

The project has developed some successful methodologies in the area of supervision. In an effort to integrate technical and organizational development activities, the project developed some "integrated supervision tools," which enable the different staff members to do more comprehensive supervision at each field visit. This tool reinforces the abilities of the CHEs and assures that all aspects of program activity (technical and community organization) are covered. Previously, the CHEs were only supervised by Form'Action staff but during the last year, the project decided that Plan technical staff should share this responsibility with Form'Action in

order to better take advantage of both areas of expertise. Monthly evaluation meetings are held to present monitoring data such as performance graphs for growth monitoring and immunization. The financial status of community generated funds is also presented and assessed. Project staff and community members attend monthly meetings. The meetings have greatly increased the confidence that the communities have in their leaders and their respective abilities to manage CS generated funds. This process has encouraged community members to become more involved in the CS health and community organization activities and to participate in local decision-making, which greatly increases the likelihood of sustainability.

Other supervision tools developed by project staff include detailed checklists of field activities to be conducted by the CHEs. These lists are developed jointly by the CHEs and their supervisors and are based on the project objectives. They include both technical CS activities and organizational development strategies. At the end of each quarter, these lists are reviewed and the results are discussed, exploring reasons for meeting or failing to meet set objectives. Then the supervisor makes recommendations and works with the CHE to develop strategies for overcoming problems or dealing with issues. Regular reports are made by supervisors in order to keep track of progress.

Another interesting tool is a supervision book kept in each community. In this notebook each supervisor documents the results of his/her findings when reviewing the work of the CHTs, the MCs, VHCs, and the various community sub-committees activities. The evaluators were able to see where the CHEs, PC, Form'Action staff and HPNs had all made notations in these books with observations and recommendations for the communities. Later the CHE follows up on the recommendations to see what has been done regarding the different issues.

3.C.4. Human Resources and Staff Management

Personnel policies, procedures and job descriptions

Job descriptions were developed for all project field positions, for Form'Action partners and for Plan headquarters staff that supports the project. The CHEs are only paid a stipend and do not receive benefits, the project has been pretty flexible about granting them leave when needed, as long as they provide advanced notice. As mentioned above, a fair amount of attention has been given to supervising and strengthening the skills of the staff in recognition of their vital role.

Morale and working relations amongst CSP staff

Since the appointment of the new CS PC, the working relationship between CS project staff has improved. It appears that project relationships are also more cordial since the new Health Advisor took over. The new Health Advisor has been very hands off though, probably as a reaction to the problems created by the previous Health Advisor who, according to the staff, was over involved with the project's management. Form'Action stated during the final evaluation that their working relationship with Plan staff and integration into the CS program has improved dramatically since the new PC arrived. They indicated that the previous coordinator did not have a good understanding of community organization and its relevance to the CS project. Apparently she did not include them in meetings or ask their opinions about project implementation.

The major morale issue has to deal with the status of the CHEs. Their role is so important to the project's success and yet they feel undervalued by the project because they are paid low salaries with no benefits. They also have problems in completing their assigned tasks, which requires traveling to numerous communities during the month because they lack adequate transportation. The project vehicles are apparently used by the two Program Unit offices for multiple project activities, so they are not always available for use by CHEs. The project does pay them an allowance for transportation but according to the CHEs, it is not enough. As mentioned in other sections of this report, part of the problem here is that the original intent in developing the CHE position was for these individuals to come from the local communities where they would be working and, therefore, would not require large transportation allowances or professional salaries. Hopefully this problem will be remedied if the project is extended.

Staff turnover

As discussed above a major change in project staff took place at the end of the first year when the PC left. Within two months she was replaced with a new CS Coordinator. Though it took some time to catch up, it was relatively easy for the second PC to take over given his familiarity with the area and his previous work in similar NGO-supported community health projects. A second change was when the Health Advisor left in year three of the project and was replaced. Although staff has had to adjust to these changes, in general they are satisfied with the changes and pleased with the new PC and Health Advisor.

There has also been turnover among the CHEs. Because of the difficulty and community organization skills needed to do the job, some individuals are unable to adequately manage these tasks. In addition, salaries are low and there are no benefits. For these reasons four staff members from Louga and one from Kaolak have either left or been asked to leave.

Staff transition to other jobs when the project ends

Most of the project staff consists of Plan employees so they will continue to be employed by the organization when the USAID grant ends. Furthermore, Plan is seriously considering continuing the CSP when USAID funding ends. Plan Senegal sees child survival as a country priority so it will actively seek more funding for projects in this area. The CHEs were hired in collaboration with Form'Action, which is responsible for administratively managing them, while Plan is responsible for their technical management. As mentioned above, Form'Action has been working with the CHEs to organize them into an association or Non-Governmental Organization (NGO). They are presently in the process of creating this entity and hope to be able to contract themselves out to other health and development projects in the future.

C.5. Financial Management

Plan staff monitors the budget with input and advice from HQ technical advisors and the US-based administrative and grants accounting team. Project staff in each site holds annual budget meetings in order to project expenses for planned activities (and review expenses in subsequent years). The PC consolidates monthly financial reports. These reports are submitted quarterly to

the Program Unit Managers (PUM) who then review the reports and afterwards pass them on to the Operations Support Manager (OSM).

The program tracks costs incurred using Plan Senegal's established financial system. Expenditures are broken down using specific codes for labor, equipment, supplies, and facilities. Project expenditure reports are sent directly from Plan Senegal to Plan's US office where they are reviewed for USAID compliance and submitted to USAID. The budget is adjusted as necessary based upon the DIP and periodic reviews by the PC and US-based administrative team. Plan's corporate general ledger system assigns a project ID number to enable accurate tracking of project expenditures. After the US office submits reports to USAID and receives the reimbursement, funding transfers are made on a monthly basis from the US office to the CS project to reimburse project expenditures. Plan's organizational finance system enables Plan USA to separately track donations from USAID and non-USAID sources.

As the responsible partner, Plan monitors Form'Action's management of project related funds. During the past two years there do not appear to have been many problems with spending and accountability and expenditures are on track with both Plan and Form'Action. However, during the first part of the project, staff did have problems accessing funds and accounting for expenditures to Plan Dakar's satisfaction. The delay in hiring a Grant Administrator contributed to this problem. However, after the administrator was hired and the new PC received training in how to program and access project funds, things began to run more smoothly. Although the CS project funding ends September 30th, Plan has agreed to continue funding project activities until the end of 2002. During this period, Plan will be seeking continued funding for project activities.

C.6. Logistics

The CS project was provided with necessary equipment, supplies and vehicles to facilitate their work. At the time of the mid-term review a number of gaps were identified in terms of equipment and supplies and these were addressed during years two and three. In order to ensure that the HHs and HPs are fully functional they have been provided with all basic equipment required for implementation of Child Survival activities.

Logistical support to DHMTs and HPNs: Since the beginning of the project logistical support has been provided to the DHMTs and HPNs for special events (for example, National Vaccination Days) and during joint community visits with MOH partners. MOH partners expressed their appreciation for this support that enables them to reinforce their activities at the community level.

Logistical support to CHEs: The CHEs receive a monthly transport allowance to enable them to pay for local transport (taxis, horse-drawn carriages) to their target villages. The evaluation clearly shows the inadequacies with the present logistical support they receive. In some cases local transport is not available at all and in other cases it is exorbitantly expensive. In many cases the CHEs walk for many kilometers from one village to the next in order to do their work. In the two project zones the terrain differs, and while motorbikes can be used in the Kaolack area they are not practical in the very sandy Louga area. The mid-term review team concluded that it was

urgent either that more appropriate logistical support be provided to the CHEs or that their zones of responsibility be decreased by increasing their number. The project did reduce the size of the zones that the CHEs were responsible for after the mid-term and they added more CHEs, in line with MTE recommendations. However, they have not been able to satisfactorily address the transport issue and it has continued to hamper CHE efforts throughout the project period. In fact, the lack of transportation has frustrated the staff and impacted morale.

C.7. Information Management

The Monitoring and Evaluation system consists of a series of registers and other records kept at the community (Health Hut) level and reports of activities generated by the CHEs. The registers include a list of all children in the catchment area of the Health Hut and their immunization and growth monitoring status. Additionally, other registers track the sale of mosquito nets and other medications, cases treated at the Health Hut, and other activities, such as prenatal consultations, deliveries, and culinary demonstrations. The CHEs work closely with the community to maintain these registers properly and to ensure good quality data.

CHEs generate monthly reports, which include information on vaccination; growth monitoring; IEC sessions; sale, treatment, and re-treatment of bednets; prenatal consultations; assisted deliveries; postnatal consultations; cases treated; cases referred; and deaths. After the information is reviewed by the PC and Assistant Project Coordinators (APC), the HIS Assistants enter this information into the computer, where it is kept in a database.

Measuring Progress Towards Program Objectives

Since the CHEs are the key implementers of project activities, their reports are very useful in monitoring outputs. The CS team uses these outputs to verify that project activities are on schedule.

The collection and use of data is strongest at the community level, where it is used by CHTs, Mothers' Committees, VHCs, and other community members to ensure that all eligible beneficiaries are utilizing the available services. However, information has not been systematically compiled to calculate indicators at the project management level until very recently (last six months of the project). Coverage estimation (particularly for vaccinations and growth monitoring) is stronger than monitoring of knowledge and practice indicators.

Collecting, Reporting, and Using Data

The registers maintained in the HHs are regularly updated with the assistance of the CHEs. The communities are using this data in various ways. For example, the vaccination registers are used to identify children who are not up-to-date on their immunizations, and community members will make visits to the family to ensure that the child comes for the next vaccination session. CHEs turn in their reports monthly to the Assistant Coordinators and this data is reviewed and discussed.

Data is reported and used at many different levels. Every month, the project staff and the CHEs hold review meetings to monitor the work plan and current activities and to plan for the next month. Quarterly review meetings are held at the HH level between the nurses, the CHEs, the

CHT, and the CBOs to develop the action plan and discuss activities from the last quarter. The CBOs also meet monthly to review their activities and community data, find solutions to problems, and follow-up on the action plan. All of the CBOs interviewed said they met at least once a month, and several meet even more frequently.

At the project management level, data has been used in various ways to improve the project's impact. For example, after the mid-term evaluation, the team identified the need to increase the number of CHEs since not all communities were being covered. In another case, the team noticed that a very high number of children were being identified as moderately malnourished in Koalack. After some discussion and investigation, the team concluded that food security was an issue due to polygamy and the large number of children per man. They then went to the local government authorities and are now preparing to utilize the HHs to link women and children to the government supplementary food program.

The financial reporting of the CBOs also helped the team identify the need to look for sources of income for the CHT members. By negotiating with the District Management Team, the project succeeded in obtaining a share of the money collected by nurses for vaccination services to be shared with the community volunteers.

Lastly, inventories in the Health Huts revealed that Oral Rehydration Solution (ORS) packets were not being distributed. When CHEs questioned the community members, the CHT and mothers explained that the children disliked the taste and would not drink it. The project then decided to work more on promotion of Recommended Home Fluids and the Sugar/Salt Solution.

Staff Skills

The staff is sufficiently trained and has been carrying out data collection and analysis without external support for quite some time. The bulk of data collection at the community level is done by the CHEs because of high levels of illiteracy. If the services of the CHE ended, it is doubtful that most communities could continue to maintain their registers without external assistance. Another concern for sustainability is the necessity of two full time HIS Assistants to enter data into the computerized system. The project is collecting immunization and growth monitoring data on each individual child, which requires quite a bit of staff time and effort. For monitoring project objectives, CHEs could do simple coverage calculations at the HH level, which would free the HIS Assistant to complete other duties.

- a) The information system has been very useful to the project in encouraging community ownership and involvement in the project. It has also strengthened the ability of the MOH to accurately keep vaccination records. Before the project began keeping immunization registers at the HHs, mothers frequently lost their children's health cards, and their vaccination status was lost. Now this information is available in case something happens to the health card.
- b) The community, the MOH, and the project staff are all very aware of the achievements that the project has made. Communities articulate decreases in malaria and other childhood illnesses, decreased maternal mortality, increased vaccination, and improved access to services. The MOH recognizes the increased coverage for services and the

decreased morbidity for vaccine-preventable diseases. The project staff is also fully conscious of the progress that they have made during the past four years.

- c) The greatest success of the information system has been the child registers. Plan has begun to use this model in its communities that are not part of the CS Project in order to better track the services that the children need.

C.8. Technical and Administrative Support

In addition to the technical backstopping provided to the project by the National Health Coordinator, the project has benefited from technical assistance both from the Plan Regional Office in Dakar and from Headquarters.

Support from the Regional Office: During most of the project implementation period the Plan Regional Health Advisor position was vacant. For the first three months of the project the previous Regional Health Advisor helped with the design of the CS project management plan and with the hiring of the PC. At that point he was appointed Child Survival technical backstopper in Washington, D.C. A replacement was finally hired in 2001 but he is stationed in Ghana (previously the RHA was stationed in Senegal) and has not been very involved in the CS activities.

Support from Headquarters: A series of technical support activities have been carried out by Headquarters staff since the project was approved, namely: training in Knowledge, Practice, and Coverage (KPC) data collection and analysis; facilitation of startup workshop; assistance with DIP development; participation in DIP review; assistance with preparation of annual reports; review of quarterly project reports; and ongoing provision of documentation to CSP staff for project quality improvement. Headquarters staff has also participated in both the mid-term review and the final evaluation. They are also assisting the Plan Senegal country office in their search for additional project funding.

3.C.9. Management Lessons Learned

Some of the key management related lessons learned or conclusions reached in the project include:

- Community organization and empowerment strategies are as important to project success as implementation of technical child survival activities. In fact, it is recommended that CS projects begin intervening with community organization and mobilization stratagems before introducing the health activities.
- It is critical that the Project Coordinator understand the necessary role of community organization in accomplishing/reaching child survival goals
- Even though a CS project may only be implemented in a part of a district where Plan is actively working, it is necessary to establish a strong partnership with MOH personnel

who can continue to manage project activities after the project ends. In order to do this, it is necessary to have regular meetings, involve them in the implementation of project activities as much as possible and facilitate their being able to comply with their own MOH policies. For this reason it may be important to move project CS activity beyond the Plan communities and work in partnership with the district health office.

- The increased availability of data from project activities and community census has allowed Plan and Form'Action to make better management decisions. An example was that of using project data to justify hiring more CHEs. Also when reviewing community accounting funds, the project staff realized that the HPNs were taking all the funds from payment for community outreach services, so the project stepped in and negotiated for the HPNs to leave 25 percent for the CHTs.

D. CONCLUSIONS AND RECOMMENDATIONS

Based on the final evaluation findings, the evaluators have come up with the following lists of achievements, issues, challenges and recommendations:

Achievements

- The project has created strong community organization strategies that have continued to improve through out the project and resulted in fortified community decision-making in support of project goals. Examples of empowered activities include:
 - strengthened VHCs
 - creation and strengthening of MCs
 - strengthened skills and performance of CHTs personnel
 - strengthened involvement of village leaders in health committees and activities
 - development and management of community health funds allowing revolving drug supply, revolving bednets, micro credit loans and large savings for community designated projects in addition to incentives for CHTs.
 - development and follow-up of community determined quarterly activity plans
- HHs and health points of service are fully stocked with equipment and supplies necessary for completion of essential medical treatment and preventive activities.
- Ministry of Health personnel at HP levels and below are fully trained in the management of child survival intervention areas except for ARI in Kaolak where MOH training is not available in this area.
- The project-trained and-supported CHE staff has successfully linked services between the community level structures and the HP levels in the project areas.
- The project has achieved significant success in its immunization intervention activities. It met or surpassed all its behavioral and knowledge target objectives.

- The project has made significant progress in malaria treatment and prevention activities, having met the bulk of its objectives.
- The CS project has implemented a thorough and well-managed community based HIS. This system has been used effectively by community committees to understand the health status and program health activities. The information has also been used and followed by project management to make intervention decisions and resolve problems.
- Plan and Form'Action have provided high quality training in project intervention areas, data management, community organization, follow-up and supervision to CHTs, MOH staff and project staff.
- There is good evidence of excellent teamwork in the project. This is demonstrated by the good working relationship between Plan project staff and Form'Action staff and the strong team of CHEs.
- Strong supervision system. The staff and community personnel interviewed during the evaluation demonstrated good knowledge of the project intervention areas and reporting abilities. They also reported that they were very satisfied with the supervision that they have received.
- The project has made good progress on its work plan. It has completed most of the activities programmed for the final year of the project.
- The community committees and health teams interviewed demonstrate good technical capacity. They have the knowledge and skills and a good understanding of the key messages for most intervention areas.

Issues

- A major issue concerns the sustainability of the CHEs. Currently they have individual contracts with Form'Action and no benefits. They have fulfilled a pivotal role in assuring project success in bridging the service gap between community and MOH health structures but there is no provision for their continuation after the project ends.
- Due to the recommendations made at the mid-term, which recognized the importance of the role of CHEs in developing community health structures, the project increased the number of CHEs. However, the project has not been able to resolve the issue of travel support to adequately supervise community activities. Many of them supervise as many as 40 villages. Project vehicles are used for multiple activities and the transportation allowance provided to CHEs is not sufficient for them to carry out programmed activities. This often necessitates that project staff walk 10 to 15 kilometers to reach village destinations.
- Although substantial progress has been made through the partnership between Plan and Form'Action, there are concerns regarding the existing structure. Project staff and

Form'Action believe they have not been treated as equal partners. They believe this is because they are not permanent Plan staff.

- The project has not been able to respond completely to the mid-term recommendations, which advocated implementation of more varied IEC mass media approaches. They have lacked sufficient time, technical expertise and resources. The evaluators noted that there was a lack of sufficient print media for community education activities. There has been low compliance in implementation of planned community IEC talks.

Challenges

- Although there have been significant improvements since the mid-term review, there are still challenges in the project's relationship with the Ministry of Health staff. The relationship with the HPNs has improved significantly. However, there are still concerns expressed by the District Health staff that the project staff does not adequately coordinate with them.
- A common problem mentioned by Form'Action and Plan management staff is the difficulty of coordinating a project in two geographic areas that are more than 300 kilometers apart. Both areas have significant project management challenges that require regular attention and are difficult to address when coordinators are stretched between the two areas.
- Plan will need to carefully think through its relationship with Form'Action and the CHEs in the design of follow-on activities. Both groups have expressed concern regarding future potential roles.

Recommendations

- Regarding a follow-on project, Plan should try to focus on one geographic area or seek to set up separate project management structures in each area. Plan should also consider scaling up to the district level in at least one of the areas. A district level intervention would facilitate and enhance relationships with MOH staff.
- If there is a follow-on project, Plan needs to work with Form'Action in the development of a mutually satisfactory partnership. Form'Action has shown its administrative capacity to operate independently and it has proven itself to be a very capable partner technically in the area of community organization. Form'Action's grass roots development strategies nicely complement Plan's organizational and technical development strengths.
- In a follow-on project, Plan needs to carefully think through strategies for sustaining the CHE staff. These staff positions are integral to the success of project activity because of their pivotal role in mobilizing communities around health priorities. In addition, Plan needs to resolve the transportation issue for these staff members. Without adequate transportation they can not be expected to fulfill their job requirements.

- The next project should work with technical assistance to develop a project-wide IEC strategy. This strategy should include development or adaptation of print and media materials for non-literate audiences. They should also continue development of entertaining mass media education formats such as songs, dances, stories, street theater, puppetry etc. It may be useful to contact a local agency with expertise in this area that can provide technical assistance and training in these methodologies.
- The project should extend its current exclusive breastfeeding recommendations for infants from four months to six months of age in order to coincide with the WHO recommendations.
- The project may want to consider adding family planning as an intervention area as several communities visited by the evaluators specifically asked for information about contraception and some had already acquired these services.

Annex 1

Team Members

Evaluation Team Members

Sandra Wilcox	External Consultant
Claire Boswell	Health Associate, Child Survival PLAN/IH
Dr. Pierre-Marie Metangmo	Senior Health Program Coordinator, Child Survival PLAN/ IH
Dr. Etienne DIOH	Child Survival Project Coordinator. Plan Senegal
Diaguily Koita	National Training, Monitoring & Evaluation Supervisor, PLAN Senegal
Jean Bassene	Executive Director of Form' Action. Louga CD Coordinator.
Touty Cisse	Assistant for Organizational Development of Communities. Form' Action.
Guineth Fall	Field Health Supervisor, Plan Senegal, Louga
Amadou Gaye	Field Health Supervisor, Plan Senegal Kaolak
Gnagna Gueye	Health Information System Assistant, PLAN Senegal, Louga
Amsatou Sene	Health Information System Specialist, PLAN Senegal, Kaolak
Thidiane Ndoeye	Health Advisor, PLAN Senegal, Dakar
Mbalo Ndiaye	Program Support Manager, Plan Senegal, Dakar.

ANNEX 2

Assessment Methodology

Assessment Methodology

Four Methods were used to collect information:

- Focus Group Discussions
- Interviews
- Observation
- Documentation Review
- KPC Quantitative Data

The Senegal CSXIV final evaluation fieldwork was conducted between September 1 to September 15, 2002 in the regions of Dakar, Kaolack and Louga, Senegal.

The schedule followed by the team (see Annexes I and 3 for a complete list of team members and persons contacted and interviewed) consisted of spending the first two days in Dakar at the Plan country office receiving a briefing from the project team, reviewing documents and interviewing Plan field office staff. The team also reviewed and revised evaluation tools during this time. The team then spent the next seven days interviewing field staff, visiting sites in the project areas, and interviewing community groups and agencies involved in project activities, in the regions using Focus Group Discussions and Participatory Learning Appraisal Methods. The interview guidelines and questions can be found in Annex III, Field Evaluation Questionnaires. A list of persons contacted and interviewed during the evaluation can be found in Annex 4. The quantitative KPC data collected for the final evaluation is presented in section B.1. (Results Summary Chart) of this report.

The evaluation team spent the last four days writing up preliminary findings for the report and conducting both internal and external debriefings of findings to Plan Senegal and USAID Senegal.

ANNEX 3

Persons Interviewed and Contacted

List of Persons interviewed and Contacted: Kaolak

➤ PUM : (Program Unit Manager

- Falilou SECK

➤ Superviseur Santé

- Amadou Gaye

➤ Superviseur AGR

- Maoudo Ndiaye

➤ Assistante SIG

- Aïssatou Fall

➤ Assistante Administrative

- Yaye Diène Kaloga

➤ ECS : (Educateur Communautaire de Santé)

- Awa Badji Zone de Thilla Grand
- Mariama Kitane Zone de Keur Tapha
- Aïssatou Faye Zone de Keur Mady Yacine
- Makam Cissé Zone de Wack Ngouna
- Mbaye Thiam Zone de Ndienghène Ibra
- El Hadji Babou Thiam Zone de Keur Madiabel
- Daniel Lopez Zone de Ndrané Escalé
- Amath Thiam Zone de Ndiaffory
- Talla Bèye Zone de Keur Maba
- Penda Ndiaye Zone de Saboya
-

➤ Equipe Cadre de District

- Docteur Magaye Diassé Medecin Chef Adjoint de Nioro

- Docteur Aliou Diallo Medecin Chef de District de Nioro
- Lamine Gueye Superviseur SSP Nioro
- Mamadou Sene Chef Sous Brigade d'hygiene Nioro
- Mme Rockhy Drame Diallo Sage Femme SR Nioro

➡ **Infirmier Chef de Poste**

- Boubou Niane Infirmier Chef de Poste de Ndrame Escalé
- Amadou Ba Infirmier Chef de Poste de Saboya
- Arona Gueye Infirmier Chef de Poste de Keur Maba

➡ **Organisations Communautaires de Base (OCB)**

(Comite de Sante, Comite de Mamans, Chef de Village, ASC/Matrones/Relais) de :

- Niassene Walo
- Thiamene Ousmane
- Fetto
- Gorla
- Keur Layine Sakho
- Keur Yoro

Persons Interviewed and Contacted: Louga

PERSONNES ET OCB INTERVIEWES A LOUGA Dans le cadre de l'évaluation finale du projet Survie de l'Enfant

Personnes / OCB	Localité	Fonction	Remarques
Guineth FALL	PU Louga	Superviseur Santé et Acting PUM	
Ousmane FAYE	PU Louga	Agent de développement communautaire	
Aly DIOP	PU Louga	Agent de développement communautaire	
Farmata SECK	PU Louga	Assistante administrative	
Gnagna GUEYE	PU Louga	Assistante chargée de Système d'Information à des fins de Gestion	
Malick Cissé NDIAYE	Centre de santé de Louga	Médecin chef du district de Louga	
Modou SECK	Sakal	Educateur Communautaire de Santé	
Thiafour MBOW	Sakal	Educateur Communautaire de Santé	
El Hadji FAYE	Léona	Educateur Communautaire de Santé	
Ndèye Maty SARRE	Léona	Educateur Communautaire de Santé	
Boubacar BA	Ngueune Sarr	Educateur Communautaire de Santé	
Bitty GUEYE	Ngueune Sarr	Educateur Communautaire de Santé	

Personnes / OCB	Localité	Fonction	Remarques
Membres du Comité de santé Membres du Comité de mamans Chef de village ASC/Matrones/Relais	Ndiock Sall	Membres des instances qui gèrent la santé dans le village	Zone de l'ECS Bitty GUEYE
Membres du Comité de santé Membres du Comité de mamans Chef de village ASC/Matrones/Relais	Ndiouffène	Membres des instances qui gèrent la santé dans le village	Zone de l'ECS Boubacar BA
Membres du Comité de santé Membres du Comité de mamans Chef de village ASC/Matrones/Relais	Bangath	Membres des instances qui gèrent la santé dans le village	Zone de l'ECS Sophie NIANG

ANNEX 4

Field Evaluation Questionnaires

QUESTIONNAIRE EVALUATION FINALE

QUESTIONS POUR LE STAFF DU PROJET

- 1 - Qu'est-ce que ce projet vous a apporté
- 2 – Quelles sont selon vous, les forces et faiblesses de ce projet
- 3 – Qu'est-ce que à votre avis, le projet a apporté à **Plan**, et quelle influence il a eu sur les autres programmes.
 - technique
 - managériale
- 4 - Que pensez-vous de la qualité de l'assistance technique apportée au staff durant la vie du projet
- 5 – Quel est le système de supervision et que pensez-vous de la qualité de cette supervision
- 6 – Qu'auriez-vous changé si vous aviez à mettre en œuvre le même projet
- 7 – Quelles sont les activités ou les aspects du projet qui pourraient continuer sans aide \ extérieure.
- 8 - Avez-vous utilisé le SIG et en quoi il vous a aidé dans le travail
- 9 – Selon vous quelles ont été les forces et les faiblesses du système de transmission des informations techniques et financières.

QUESTIONS POUR LE STAFF DU MINISTERE DE LA SANTE

- 1 – Selon vous, qu'est-ce que le projet a apporté au district
- 2 – Vous sentez-vous capables de continuer l'exécution des activités avec les communautés, sans le projet
- 3 – Que pensez-vous de la collaboration avec Plan
- 4 - Quels changements souhaiteriez-vous si ce projet devait se poursuivre.

QUESTIONS POUR LES ORGANISATIONS COMMUNAUTAIRES DE BASE

- 1 – Quels changements avez-vous noté sur le statut sanitaire de votre communauté durant ce projet
- 2 – A quel niveau du cycle du projet votre communauté a participé et quelle a été la nature de cette participation
- 3 – Sans assistance du projet, quelles sont les activités que vous pensez pouvoir continuer à exécuter
- 4 – Que pensez-vous de la collaboration avec Plan
- 5 – Quelle utilisation faites-vous des fonds générés par les activités du projet et quelle est le système de gestion mise en place
- 6 – Quels sont les mécanismes de prise de décision dans la communauté et y’a-t-il des changements induits par le projet.

QUESTIONS POUR LE PERSONNEL COMMUNAUTAIRE

- 1 – Quel est votre sentiment par rapport au travail que vous faites dans le cadre du projet
- 2 - Etes-vous disposés à continuer vos activités à la fin du projet. Si oui, dans quelles conditions
- 3 – Quel est votre sentiment sur la qualité de la supervision par le MOH et le staff du projet
- 4 – Quel a été l’apport du projet dans le renforcement de vos capacités.

QUESTIONS POUR LES ECS

- 1 – Quelle est selon vous, votre contribution personnelle dans la réalisation des objectifs du projet
- 2 – Quels sont les moyens que le projet a mis à votre disposition et quelles sont les contraintes dont vous avez fait face durant ce projet.
- 3 – Quel sentiment avez-vous de la capacité des communautés à continuer à mener les activités du projet.

QUESTIONS POUR FORM'ACTION

- 1 – Comment le projet a affecté votre organisation
- 2 – Comment ressentez-vous la collaboration avec Plan
- 3 – Au sortir de ce projet, êtes-vous en mesure de gérer vous-même un projet survie de l'enfant. Pourquoi ?
- 4 – Quelles sont selon vous les forces et faiblesses, et quelles sont les améliorations qui peuvent être apportées si ce projet devait continuer
- 5 – Quelle appréciation faites-vous de la gestion administrative des ECS qui vous a été confiée.

ANNEX 5

Training Tables

SYNTHESE DES FORMATIONS PSE/AID KAOLACK								
TITRES FORMATIONS	NOMBRE PARTICIPANTS	TITRE PARTICIPANTS	DUREE	LIEU				ANNEES
				CENTRE SANTE	POSTE	VILLAGE	AUTRES	
Suivi Evaluation des programmes de santé	1	Superviseur santé	21 jours				Dakar	1998
Hygiène/Assainissement	135	Comité de salubrité comités de mamans	3 jours		oui			1999
Gestion Soins de santé primaires Initiative de Bamako	130	Comité de santé	3 jours		oui			1999
Survie de l'enfant	13	ICP/ECD	4 jours				Kaolack	1999
Survie de l'enfant	181	ASC/Matrones	6 jours		oui			1999
Survie de l'enfant	11	ECS	5 jours				Louga	2001
Système d'information	6	Staff projet	2 jours				Kaolack	1999
Supervision	12	ICP/ECD	5 jours				Kaolack	2000
Survie de l'enfant	62	Relais/ASC	3 jours		oui			2000
Imprégnation moustiquaires	134	Comités de mamans	3 jours		oui			2000
Paquet d'Activités Intégrées de Nutrition (PAIN)	48	Relais/ASC	5 jours		oui			2001

Paquet d'Activités Intégrées de Nutrition (PAIN)	11	ECS	10 jours				Centre PLAN Louga	2001
Soins de Santé Primaires /Initiative de Bamako	91	Comité de mamans/comités de santé	4 jours				Local dans un village siège de Poste de santé	2001
Stage pratique ASC	27	ASC	90 jours		oui			2001
Stage pratique Matrones	22	Matrones	90 jours	oui	oui			2001
Paquet d'Activités Intégrées de Nutrition (PAIN)	158	Relais comités de mamans	5 jours		oui			2001
Recyclage gestion case	135	Comités de mamans/comités de santé	3 jours		oui			2001
Stage pratique Matrones	3	Matrones	90 jours	oui				2001
Recyclage pratique ASC	7	ASC	21 jours		oui			2002
Suivi Evaluation	1	MDC Nioro	21 jours				Dakar	2001
Suivi épidémiologique	1	Superviseur Soins de Santé Primaires Nioro					Belgique	2002

SYNTHESE DES FORMATIONS PSE/AID (staff)								
TITRES FORMATIONS	NOMBRE PARTICIPANTS	TITRE PARTICIPANTS	DUREE	LIEU				ANNEES
				CENTRE SANTE	POSTE	VILLAGE	AUTRES	
Suivi Evaluation des programmes santé		3 CPSE RNFSE ADOC	21 jours				Dakar	2001
Evaluation participative		4 CNS CPSE ADOC RNFSE	5 jours				Dakar	2001
EPI INFO		6 Staff PSE	4 jours				Dakar	1999
Logiciel MS PROJECT		6 Staff PSE	4 jours				Mbour	2001
Survie de l'enfant pour les ADC de Kaolack et Louga		16 Agent de développement communautaire PLAN	5 jours				Mbour	2001

SYNTHESE DES FORMATIONS PSE/AID LOUGA

TITRES FORMATIONS	NOMBRE PARTICIPANTS	TITRE PARTICIPANTS	DUREE	LIEU				ANNEES
				CENTRE SANTE	POSTE	VILLAGE	AUTRES	
Suivi Evaluation	1	Superviseur santé	21 jours				Dakar	1999
Comité salubrité	32	Relais	4 jours			oui		2000
Recyclage comité salubrité	30	Relais	4 jours			oui		2001
Comité salubrité	27	Relais	4 jours			oui		2002
Comité de santé	31	Membres du bureau	3 jours			oui		1999
Comité de santé	31	Membres du bureau	3 jours			oui		2000
Comité de santé	31	Membres du bureau	3 jours			oui		2001
Comité de santé	36	Membres du bureau	3 jours			oui		2002
Survie de l'enfant	22	Relais	5 jours		oui			1999
Survie de l'enfant	22	Relais	5 jours		oui			2000
Survie de l'enfant	23	Relais	5 jours		oui			2001
Techniques enseignement	27	ICP	5 jours				Centre PLAN	1999
Supervision	27	ICP	5 jours				Centre PLAN	2001
Paquet d'Activités Intrégréées de Nutrition PAIN	5	Equipe cadre district	3 jours	oui				2001
Formateurs au PAIN	27	ICP	10 jours				Centre PLAN	2001

Formation relais au PAIN	188	Relais	10 jours		oui			2001
Formation ECS au PAIN	10	ECS	5 jours				Centre PLAN	2000
Formation transcriton wolof	49	ICP (27) ADC(8) ECS(9) From'action(1) ECD(4)	3 jours				Louga	2002
Formation en technique d'imprégnation	27	ICP	3 jours				Centre PLAN	2000
Formation en technique d'imprégnation	54	Relais	3 jours			oui		2000
Formation initiale des matrones	24	Matrones	90 jours	oui				2000
Formation initiale des ACS	24	ASC	90 jours		oui			2000

Les formations tenues au niveau des postes de santé ont concerné l'ensemble des postes de santé de la zone PSE (Sakal, Ngeune Sarr, et Léona)

SYNTHESE DES FORMATIONS PSE/AID (Développement organisationnel)									
NUMERO	TITRES FORMATIONS	NOMBRE PARTICIPANTS	TITRE PARTICIPANTS	DUREE	LIEU				ANNEES
					CENTRE SANTE	POSTE	VILLAGE	AUTRES	
1	Diagnostic Institutionnel Participatif des OCB	20	ECS	5 jours				Kaolack Louga	1999
2	Techniques d'animation de groupes	21	ECS	20 jours				Kaolack Louga	2001
3	Technique de planification opérationnelle	21	ECS	1 jour				Kaolack Louga	2001
4	Elaboration budget communautaire	21	ECS	1jour				Kaolack Louga	2002

La formation numéro 1 s'est déroulée en 5 jours à Kaolack et 5 jours à Louga

La formation numéro 2 s'est déroulée en 15 jours de théorie pour les 2 zones ensemble, puis 5 jours de pratiques à Louga et 5 jours de pratiques à Kaolack

La formation numéro 3 s'est déroulée en 1 jour à Louga et 1 jour à Kaolack

La formation numéro 4 s'est déroulée en 1 jour à Louga et 1 jour à Kaolack

Annex 6

Final KPC Results

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PROJET SURVIE DE L'ENFANT
Districts de Louga et Nioro
Arrondissements de Sakal et Wackngouna

ENQUETE KPC FINALE
Knowledge, Practices, and Coverage Survey

Préparé par :
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Responsable National chargé de Formation/Suivi/Evaluation
Programme Santé

Août 2002

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SIGLES ET ACRONYMES

ADC: Agent de développement communautaire
ASC: Agent de Santé Communautaire
ASIG : Assistante chargée du Système d'Information à des fins de Gestion
CCC: Communication pour un Changement de Comportements
CPSE: Coordonnateur du Projet Survie de l'Enfant
ECD : Equipe cadre de district
ECR : Equipe cadre de région
ECS : Educateur Communautaire de Santé
ICP: Infirmier Chef de Poste
IEC: Information Education Communication
IRA: Infections Respiratoires Aiguës
IST: Infections Sexuellement Transmissibles
JNM: Journées Nationales de Micro nutriments
KPC: Knowledge, Practices and Coverage Survey
LMD: Lutte contre les Maladies Diarrhéiques
MAR: Maternité A moindres Risques
MSP: Ministère de la Santé et de la Prévention
OCB: Organisation Communautaire de Base
OMS: Organisation Mondiale de la Santé
PEV: Programme Elargi de Vaccination
PPS : Point de Prestations de Services
PSE: Projet Survie de l'Enfant
PU: Program Unit
PUM: Program Unit Manager
RNFSE: Responsable National chargé de Formation Suivi Evaluation
SE: Survie de l'Enfant
SRO: Sachet de Réhydratation par voie Orale
SS : Superviseur Santé

RESUME

Plan Sénégal, avec l'obtention de USAID/BHR/PVC d'une subvention de quatre ans, a exécuté un PSE dans les arrondissements de Wackngouna et Sakal respectivement dans le district de Nioro dans la région de Kaolack et le district de Louga dans la région de Louga. Le PSE a été mené avec une organisation non gouvernementale locale FORM/ACTION spécialisée dans le développement organisationnel.

Le but du PSE est de réduire la morbidité et la mortalité infanto juvénile à travers le PEV, la lutte contre la malnutrition, la lutte contre le paludisme, la lutte contre les maladies diarrhéiques, la lutte contre les IRA. Cette subvention de l'USAID se proposait de renforcer les interventions de **Plan** Sénégal en SE au sein des deux arrondissements sus-mentionnés pour la période du 30 septembre 1998 au 29 septembre 2002

Situé au centre du Sénégal, l'arrondissement de Wackngouna du district de Nioro est composé de quatre communautés rurales (Keur Madiabel, Wackngouna, Keur Maba Diakhou, Ndrame Escale) et 190 villages au moment de l'enquête finale. Concernant l'arrondissement de Sakal du district de Louga, il est situé au nord du Sénégal avec trois communautés rurales (Leona, Sakal, Ngueune Sarr) et 276 villages lors de la dernière évaluation.

Plan Sénégal dispose de PU à Louga depuis 1998 et Kaolack depuis 1990. Ces deux régions, en plus des taux élevés de mortalité infanto juvénile élevés à l'image de l'ensemble du pays, éprouvent des difficultés d'accès aux services de santé.

La population directement bénéficiaire est estimée à 135 686 au moment de l'enquête finale incluant 82 663 habitants à Wackngouna (16 372 enfants de 0-4 ans et 19 012 femmes âgées de 15-49 ans) et 53 023 habitants pour Sakal (10 499 enfants de 0-4 ans et 12 192 femmes en âgées de 15-49 ans).

Le PSE a été réalisé à travers trois stratégies inter reliées :

1. Encadrer les OCB (comités de santé, groupement des femmes ...) en vue d'améliorer leur pouvoir sur la prise en charge de leur propre état de santé ;
2. Participer au développement durable des capacités d'intervention du MSP;
3. Sensibiliser les membres de la communauté sur la santé à travers des activités d'information éducation communication.

Une enquête KPC de base avait été réalisée en février 1999 sous la conduite de la première coordonnatrice du programme santé de Plan, de la première coordonnatrice du

PSE et son assistant chargé de formation suivi évaluation. L'étude avait porté sur 646 mères d'enfants de moins de 24 mois (322 à Wackngouna et 324 à Sakal). L'assistance technique sur le processus d'échantillonnage et la formation des acteurs était assurée par Dr Pierre Marie Metangmo basé aux USA, Coordonnateur Principal des Programmes de Santé de **Plan**. Il s'est évertué aussi à faire un transfert de compétences en matière de KPC à la coordonnatrice et son assistant.

L'objet de cette enquête était de déterminer les niveaux de connaissances, pratiques et couverture des principales interventions : PEV, nutrition, LMD, lutte contre le paludisme, lutte contre les IRA. C'est en fonction de ces résultats qu'un document de *Programme détaillé des interventions* a été élaboré avec des indicateurs pour chaque type d'interventions.

En août et septembre 2000, une enquête à mi-parcours de type participatif a été réalisée, sous la conduite de Judy AUBEL consultante indépendante, au niveau des deux sites et a porté essentiellement sur les aspects qualitatifs pour mieux orienter les stratégies durant les deux dernières années du projet.

En juillet 2002, l'enquête finale KPC a été réalisée sous la responsabilité administrative de Dr Etienne DIOH Coordonnateur du Projet et la conduite technique de Diaguily KOITA que Dr Pierre Marie Metangmo avait formé lors de l'enquête de base. Les principaux résultats sont les suivants :

1. 50 % des mères (332/667) sont illettrées (en français, arabe et langues nationales) et 42 % ne mènent aucune activité génératrice de revenus.
2. Sur les 431 (65 %) mères qui disposaient de carnets de santé, 230 (53 %) ont effectué 03 consultations pré natales durant leur dernière grossesse, 65 % ont reçu du fer et 64 % de la chloroquine en chimioprophylaxie. 75 % ont reçu au moins 02 doses de vaccin anti tétanique. Cependant, seules 04 % ont effectué au moins deux visites post natales dans les 42 jours après leur dernier accouchement, et 9 % ont bénéficié d'une prescription en vitamine A.
3. Un total de 620 mères sur les 667 (93 %) allaitaient leur enfant de moins de 24 mois. 64 % avaient commencé l'allaitement maternel durant la première heure après leur accouchement. 40 % des mères pratiquaient l'allaitement maternel exclusif de 0-4 mois.
4. Sur les 611 enfants âgés de plus de 02 mois, 61 % ont été pesés chaque mois durant le trimestre qui a précédé l'enquête. Globalement, les enfants consomment des aliments énergétiques, protéiniques et protecteurs.
5. Parmi les 249 enfants ayant présenté une diarrhée dans les 15 jours précédant l'enquête, 76 % ont reçu la même quantité ou plus de lait maternel. Pour les enfants de plus de 04 mois et présentant une diarrhée (213), les 90 % ont reçu une quantité de

liquides égale ou supérieure à celle administrée d'habitude. Les 61 % ont reçu une quantité d'aliments égale ou supérieure à celle consommée d'habitude. Des 249 enfants ayant présenté une diarrhée, 12 % ont reçu des sachets de SRO, 56 % la « solution salée sucrée », 21 % des solutions domestiques.

6. Le taux de couverture vaccinal des enfants de 12-23 mois est de 82 %. Les enfants qui ne disposaient pas de fiche ou de carnet de vaccination sont considérés comme non vaccinés. 10 % n'ont pas terminé leur série vaccinale contre la diphtérie, tétanos, coqueluche (DTC). Par ailleurs, le taux de couverture contre la rougeole est de 87 %, la fièvre jaune 84 %.
7. 30 % des mères ont déclaré que leurs enfants ont présenté une toux ou des difficultés respiratoires dans les 15 jours précédant l'enquête. Parmi elles, 71 % ont cité la toux et 63 % la dyspnée comme signes de gravité. Les postes de santé et centres de santé constituent les principales structures de référence : 70 % des enfants présentant une IRA ont été orientés vers ces lieux.
8. 38 % des mères ont déclaré que leurs enfants ont présenté une fièvre dans les 15 jours précédant l'enquête. 57 % parmi elles (144/253) ont donné de la chloroquine à leur enfant souffrant de fièvre. 42 % (280/667) des mères utilisent des moustiquaires imprégnées. 71 % des moustiquaires (200/280) imprégnées ont été ré imprégnées en moins de 06 mois. 33 % des enfants (218/667) ont dormi sous moustiquaire imprégnée la veille de l'enquête.
9. 69 % des mères lavent leurs mains avec du savon avant de donner à manger à l'enfant et 35 % après avoir fait la toilette des enfants.
10. 23 % des mères ne disposent pas de latrines dans leurs concessions.
11. 19 % des mères qui ont entendu parler du SIDA (117/608) ne connaissent pas un mode de transmission du SIDA.
12. Le préservatif est connu de 15 % des mères comme moyen de protection contre le SIDA.
13. 41 % des mères ne connaissent pas un signe d'infections génitales chez la femme.
14. 24 % des mères ne connaissent pas une méthode de planning familial.

En comparant les deux zones (Kaolack et Louga) au niveau de deux activités clés de la SE que sont : la vaccination exécutée par les partenaires du MSP (ICP et équipes mobiles), et la surveillance nutritionnelle et pondérale exécutée par les mères elles-mêmes, il ressort que : Louga devance Kaolack de 7 points sur le plan vaccination ; Kaolack devance Louga de 6 points sur le plan de la régularité de la pesée des enfants de plus de 2 mois.

RECOMMANDATIONS

Malgré des avancées significatives par rapport à l'enquête de base et au contexte national, il est important de faire des recommandations pour, d'une part maintenir, voire améliorer les acquis ; d'autre part, procéder à des réaménagements pour assurer une bonne couverture de la santé du couple mère-enfant :

1- 36 % des mères ont commencé à allaiter leur enfant plus d'une heure après l'accouchement ; par ailleurs, l'âge concerné par l'allaitement maternel exclusif a évolué au cours du projet : de 04 mois au départ, il a été prolongé à 06 mois selon les normes de l'OMS. Ainsi, il est nécessaire de revoir les supports et messages d'information éducation communication pour améliorer la mise au sein précoce et l'allaitement maternel exclusif jusqu'à 6 mois.

2- Le réflexe de la surveillance nutritionnelle et pondérale est en train d'être adopté par les mères (de 15 % au départ, la pesée régulière est passée à 57 %). Mais les objectifs semblent trop ambitieux (pesée à 90%) par rapport à l'activité communautaire et au contexte national. Le taux d'administration de la vitamine A est dû aux JNM, d'où envisager l'inclusion des femmes allaitantes aux bénéficiaires des JNM ; responsabiliser les matrones dans la systématisation de l'administration de la vitamine A aux accouchées ; promouvoir la disponibilité de la vitamine A au niveau communautaire et sa distribution par le personnel communautaire.

3- Concernant les maladies diarrhéiques, 19 % des mères continuent de donner des médicaments anti diarrhéiques et les sachets de réhydratation par voie orale sont peu utilisés(12%) ainsi que les "liquides maison" (21 %) ; en outre la moitié des mères ne retiennent pas la déshydratation comme signe de gravité. Dès lors, les activités d'IEC/CCC devraient être renforcées pour une utilisation plus accrue des "liquides maison" chez les enfants diarrhéiques, la reconnaissance des signes de gravité, la systématisation du lavage des mains, en un mot mieux vulgariser les comportements clés de prise en charge de la diarrhée à domicile.

4- La vaccination des enfants a été une réussite avec plus de 80 % des enfants effectivement couverts. Toutefois, le challenge est de maintenir le cap à travers la mobilisation sociale continue, l'appui aux activités de vaccination menées par les ICP, la sensibilisation sur les avantages de la vaccination, la conservation des fiches des enfants, la généralisation du pré paiement de la vaccination des enfants. Ainsi. Il faudrait mettre en place une stratégie de pérennisation des acquis (mobilisation sociale, IEC/CCC, recherche active, envisager la promotion de vaccinateurs/agents IEC/CCC à côté des ICP, re dynamiser la vaccination des femmes en âge de reproduction contre le tétanos.

5- Pour la fièvre, près du 1/3 des enfants présentant une fièvre n'ont pas reçu de chloroquine. Il y'a encore 32 % des enfants qui ne dorment pas sous moustiquaire imprégnée (le taux est passé de 3 % à 58 %). Il s'agira de documenter toutes les stratégies mises en oeuvre ; revoir la faisabilité des objectifs très ambitieux ; décentraliser l'activité de services à base communautaire en matière de disponibilité de la chloroquine en utilisant des relais dans tous les villages ; en plus, il faut adapter les supports et les messages au nouveau protocole d'administration de la chloroquine chez l'enfant en cas de fièvre.

6 – Pour les IRA, bien que les mères consultent les structures de santé, il est important de disposer de supports pour animer les séances de sensibilisation sur les IRA, notamment en ce qui concerne la prise en charge des cas de toux / rhume à domicile, les signes de référence des IRA ; de maintenir la participation de **Plan** Sénégal au processus de mise en oeuvre de la Prise en Charge Intégrée des Maladies de l'Enfant (PCIME).

7- Le SIDA, les infections génitales, et le planning familial restent plus ou moins inconnus dans la zone du projet ; il serait intéressant avec les données recueillies de réfléchir sur la diversification des interventions de **Plan** en matière de santé de la mère et de l'enfant. Ainsi, les volets IST/SIDA (surtout les manifestations et les conséquences des IST/SIDA en plus des modes de transmission et des moyens de prévention) seraient introduits dans les séances d'information éducation communication ; les agents de santé communautaires, matrones, relais seraient formés ;

8- Le volet MAR n'a pas été intégré systématiquement aux interventions de base du PSE, bien que les formations dispensées ne l'aient pas occulté ; or la MAR est indissociable à la santé de l'enfant ; il faudrait envisager de systématiser sa prise en compte dans les volets techniques et utiliser les supports d'IEC/CCC disponibles à cet effet. Concrètement, le jeu w3 « wouré wer werlé » serait introduit et vulgarisé ; le staff des PU et les acteurs du PSE seraient formés sur tous les aspects de la MAR (y compris le planning familial).

9-Pour l'Hygiène/Assainissement, les taux de latrinisation semblent satisfaisants ; toutefois, l'accent serait mis sur : l'utilisation et l'entretien des latrines ; le renforcement de la sensibilisation sur l'hygiène alimentaire de l'enfant ; la vulgarisation des règles de potabilisation de l'eau à domicile ; le contrôle de la qualité de l'eau ; la formation du staff de **Plan** et les comités de salubrité au module information éducation communication / salubrité élaboré par le Service National de l'Hygiène..

10- Le PSE a été exécuté en partenariat entre **Plan** Sénégal, le MSP, les communautés, et FORM'ACTION. Cette dernière s'était focalisée (avec deux agents faisant partie intégrante de l'équipe) sur le développement organisationnel des OCB (comités de santé, comités de mamans, groupements de femmes) et la gestion des ECS. Les OCS disposent présentement actuellement d'un système de gestion transparente et de suivi des activités par elles-mêmes ; les ECS qui soutenaient les populations dans la mobilisation sociale et l'encadrement rapproché du personnel communautaire sont en train de se constituer en

groupement d'intérêt économique (GIE) dans un but d'autonomisation ; ainsi, dans un souci de durabilité, il serait souhaitable que ce partenariat entre tous les acteurs se poursuive pour une deuxième phase de consolidation des acquis, d'autant plus que les ICP sont limités quantitativement et happés par le curatif au détriment des activités promotionnelles que les ECS mènent présentement sous leur autorité.

I - INTRODUCTION

A. Rappel

Plan Sénégal est présent depuis 14 ans à Louga et 12 ans à Kaolack pour soutenir le développement communautaire. Le PSE appuyé par l'USAID se proposait de contribuer à la réduction de la morbidité et la mortalité infanto juvénile à travers : la vaccination, la lutte contre le paludisme, les maladies diarrhéiques, la malnutrition, les infections respiratoires aiguës. Le PSE, intégré au domaine "*Grandir en Bonne Santé*" de **Plan** Sénégal, est mis aussi en œuvre avec d'autres ressources dans ses trois autres PU (Dakar, Thiès et Saint-Louis) sous la supervision du Coordonnateur National Santé. Cependant, seuls les arrondissements de Sakal à Louga et Wackngouna à Nioro ont bénéficié de la subvention de USAID/BHR/PVC Washington et d'un appui spécifique de Plan IH (Washington's office) en vue de respecter les exigences de la subvention comme l'étude de base, l'élaboration du programme détaillé des interventions, l'évaluation à mi-parcours et l'évaluation finale.

La situation sanitaire du Sénégal se caractérise par une mortalité infanto juvénile élevée (147 /1000). Parmi les déterminants, figurent des problèmes d'accessibilité à des infections qu'on peut prévenir et guérir comme les maladies diarrhéiques, les infections respiratoires aiguës, le paludisme et la rougeole, le tout sur fond de malnutrition. La mise en œuvre de la stratégie des Soins de Santé Primaires, adoptée à Alma Ata, n'a pas répondu à toutes les attentes pour plusieurs raisons telles que : la faiblesse des prestations de services délivrées au niveau des services de santé les plus périphériques, l'insuffisance d'appropriation et de pouvoir des communautés. Le PSE s'est occupé de ses aspects par : (1) le renforcement des capacités des organisations communautaires de base (comités de santé, comités de mamans, groupements de femmes...) dans les arrondissements de Sakal (dans le district sanitaire de Louga) et Wackngouna (dans le district sanitaire de Nioro) pour délivrer suffisamment de services de qualité avec équité et un système de recouvrement de coûts, (2) le soutien institutionnel au MSP pour améliorer la qualité des services délivrés dans les sites du projet avec un système de gestion performant, (3) sensibiliser et éduquer les gardiens d'enfants et autres leaders communautaires dans l'adoption de comportements clés en SE et la promotion de l'utilisation des services appropriés.

Les interventions du PSE comportent la nutrition (25%), la lutte contre le paludisme (25%), la lutte contre les maladies diarrhéiques (20%), la lutte contre les infections respiratoires aiguës (15%) et la vaccination (15%). La population directement bénéficiaire est estimée à 135 686 au moment de l'enquête finale incluant 82 663 habitants à Wackngouna (16 372 enfants de 0-4 ans et 19 012 femmes âgées de 15-49 ans) et 53 023 habitants pour Sakal (10 499 enfants de 0-4 ans et 12 192 femmes âgées de 15-49 ans).

B. But, Objectifs et Principaux indicateurs :

Pour chaque intervention, des objectifs spécifiques et des indicateurs ont été adoptés dans le document *Programme détaillé des interventions* :

1- Nutrition: Suivre la croissance de tous les enfants de 0-36 mois en éduquant leurs mères dans ce domaine, mais aussi à une référence appropriée, et que tous les enfants de 0-4 mois soient exclusivement allaités au sein

1. Assurer le suivi médical de 90% des enfants âgés de 0 à 2 ans. Une fois par mois il y aura des séances de pesées, ce qui permettra d'enregistrer leurs poids/âge sur la fiche de santé
2. Augmenter de 25,7 à 50% le nombre de mères qui n'ont eu recours qu'à l'allaitement par le sein de leur enfant jusqu'à l'âge de 4 mois
3. Parvenir grâce à un travail de sensibilisation à ce que 60% des mères ajoutent des éléments nutritifs complémentaires dans l'alimentation de leurs nourrissons âgés entre 4 et 6 mois
4. Veiller à ce que 70% des enfants répertoriés à la case de santé et qui souffrent de malnutrition sévère soient suivis pour traitement et supplémentation
5. 80% des enfants de 12 à 23 mois recevront de la vitamine A après avoir atteint l'âge de 6 mois
6. 50% des mères qui ont allaité par le sein leur nouveau-né devront recevoir la vitamine A pendant les 2 mois qui ont suivi l'accouchement

2- Paludisme: Réduire la mortalité et la morbidité liées au paludisme chez les enfants et femmes enceintes en améliorant leur prévention, la prise en charge de la fièvre à domicile ainsi que la référence des cas par une orientation recours

1. Augmenter de 2 à 30% le nombre de ménages qui utilisent au moins une moustiquaire imprégnée
2. Augmenter de 3,2% à 30% le nombre de ménages où un enfant âgé de moins de 5 ans dort 4 nuits sur 7 sous une moustiquaire imprégnée
3. Traiter et ré imprégner 70% des moustiquaires, dans les 6 à 9 mois qui séparent la date d'achat et la date de la dernière ré imprégnation
4. Parvenir à faire soigner par les ASC 80 % de cas aigus de paludisme chez les enfants de 0 à 23 mois et chez les femmes enceintes à qui seront distribués des médicaments et tout le soutien nécessaire
5. Prescrire de la chloroquine à 90% des femmes enceintes

3- Diarrhée : Réduire la malnutrition et la mortalité due à la diarrhée par une prise en charge précoce et appropriée des cas dont la référence

1. 80% des mères devront apprendre à préparer une solution de SRO.

2. Augmenter de 30% le nombre de mères sensibilisées ayant des enfants âgés de 0 à 23 mois et qui peuvent reconnaître les signes de référence de la diarrhée. Exemple : vomissements répétés, déshydratation, fièvre, présence de sang dans les selles ; diarrhée persistante.
3. Augmenter de 30 % le nombre d'enfants âgés de 0 à 23 mois ayant reçu la même quantité ou plus que d'habitude de lait maternel et des aliments depuis leur dernier épisode de diarrhée.
4. Equiper 90 % des services de santé en personnel qualifié et en matériel pour faire face à des cas sévères de diarrhée.

4- Infections respiratoires aiguës (IRA) : Réduire la mortalité due aux IRA par une prise en charge précoce et de qualité des cas

1. Augmenter de 33,9% à 70% le nombre de mères ayant des enfants âgés de 0 à 23 mois et qui sont suffisamment sensibilisées afin de pouvoir déceler au moins un signe avant-coureur d'une infection respiratoire aiguë IRA.
2. Parvenir à faire acheminer à temps au poste de santé 80% des enfants âgés de 0 à 23 mois présentant des signes graves (respiration rapide, tirage)
3. Assurer à hauteur de 80% la formation du personnel des structures de santé dans la prise en charge des IRA
4. Assurer dans 70% des postes de santé un stock d'antibiotiques disponibles pour les IRA.

5-Vaccination: Assurer une couverture vaccinale à tous les enfants avant leur premier anniversaire, et administrer au moins deux doses de vaccin anti-tétanique aux femmes en âge de reproduction qui sont mères d'enfants de 0-23 mois.

1. Augmenter de 70% à 90 % le pourcentage des enfants âgés de 0 à 23 mois qui disposent d'une carte de vaccination.
2. Augmenter de 31,2% à 70% le pourcentage des enfants âgés de 12 à 23 mois qui ont reçu leur 3^{ème} dose de vaccins contre la diphtérie, coqueluche,, tétanos (DTC3)
3. Augmenter de 37% à 70% le nombre d'enfants âgés de 12 à 23 mois vaccinés contre la rougeole
5. Augmenter de 55,3% à 80% le nombre de mères ayant des enfants âgés de 0 à 23 mois et qui ont déjà reçu au moins 2 vaccins antitétaniques.
6. Réduire de 47 % à 10% le pourcentage de perdus de vue au DTC.

C. Sites du Projet

Le Projet Survie de l'Enfant a été mené dans deux arrondissements en milieu rural : l'arrondissement de Wackngouna du district de Nioro dans la région de Kaolack et l'arrondissement de Sakal du district de Louga dans la région de Louga. L'ethnie dominante est le wolof (43% de la population totale). L'économie est basée sur

l'agriculture traditionnelle. Le maraîchage (patates, oignons, carottes...) est aussi intense dans ces zones. Ces deux sites ont été retenus pour abriter le projet en raison de : leurs besoins en matière de santé, la collaboration déjà existante entre les populations et **Plan** Sénégal, le développement d'une nouvelle expérience en matière de santé.

D. But de l'enquête KPC finale

Le processus de l'enquête KPC a été effectué durant la période du 07 juin au 31 juillet 2002 par l'équipe santé de **Plan** Sénégal avec des prestataires indépendants pour la collecte et la saisie des données. La formation des prestataires (superviseurs, enquêteurs, opératrices de saisie) a été assurée par l'équipe du PSE qui a été initiée et formée en début de projet par Dr Pierre Marie Metangmo basé aux USA, Coordonnateur Principal des Programmes de Santé de **Plan**

Le but de l'enquête est de comparer les données de base aux données de fin de projet pour se faire une idée exacte de la situation des indicateurs déterminés en début de projet ; l'enquête a permis aussi, de disposer d'informations de base sur d'autres volets de Survie de l'Enfant notamment la Maternité A Moindres Risques, les IST/SIDA, l'Hygiène et l'assainissement, le planning familial ; en outre, l'enquête a permis de renforcer la collaboration de **Plan** avec le MSP en matière de recherche quantitative et de partager avec les ECD et les ECR le processus du KPC et les résultats qui sont les leurs.

E. Programmation des activités

Les activités de l'enquête ont concerné :

1. Réunion préparatoire du KPC (formation du core team)
2. Elaboration des termes de référence des prestataires (superviseurs, enquêteurs)
3. Finalisation du questionnaire traduit en wolof (51 questions)
4. Choix des villages à visiter
5. Préparation de la logistique et traduction du questionnaire en Wolof.
6. Préparation de la formation des superviseurs et enquêteurs
7. Formation des superviseurs
8. Formation des enquêteurs dans chaque zone (Kaoalack et Louga) avec pré test des questionnaires et feed-back
9. Derniers réajustements du questionnaire et reproduction

10. Collecte des données sur le terrain (quatre jours) avec 30 grappes (villages) par zone.
11. Saisie informatique des données avec le logiciel EPI INFO (quatre jours)
12. Analyse des données avec le staff des PU de Kaolack et Louga et les ECR et ECD responsables sanitaires des zones d'intervention.
13. Finalisation du rapport

II – METHODOLOGIE

A. Le Questionnaire:

Le questionnaire utilisé lors de l'enquête de base a été revu par le core team notamment en ce qui concerne les questions à ajouter avec la Maternité à moindres Risques ; les IST/SIDA ; l'Hygiène, l'assainissement ; le Planning Familial. Ces questions supplémentaires ont été jugées essentielles pour l'équipe Santé de **Plan**. La traduction des questions supplémentaires en wolof a été faite par le core team avec des documents y afférents et déjà traduits, puis les questions ont été validées lors des formations des acteurs, et enfin corrigées et adoptées à la suite du pré test sur le terrain. Le questionnaire est administré aux mères âgées de 15 à 49 ans avec un enfant de moins de 24 mois (qui n'a pas encore fêté son 2^{ème} anniversaire) . Le questionnaire final comporte 51 questions réparties comme suit :

- Questions 1 - 3 : Données socio démographiques
- Questions 4 - 5 : Instruction et occupations des mères
- Questions 6-15 : Suivi de la grossesse et de l'accouchement
- Questions 16-20 : Alimentation de l'enfant
- Questions 21-28 : Diarrhée
- Questions 29-31 : Vaccination et Surveillance pondérale
- Questions 32-35 : Infections respiratoires aiguës
- Questions 36-44 : Paludisme
- Questions 44-46 : Hygiène/Assainissement
- Questions 47-50 : Infections sexuellement transmissibles/SIDA
- Question 51 : Planning familial

B. Echantillonnage

L'échantillonnage a été réalisé à partir de la liste exhaustive de l'ensemble des villages où le projet intervient dans les deux zones en utilisant le modèle des 30 grappes de l'OMS pour le calcul de la couverture vaccinale.

La taille de l'échantillon a été calculée avec la formule suivante :

$$n = z^2(pq)/d^2$$

avec **n** = nombre de l'échantillon

z = degré de précision ; **z** = 1.96 pour un intervalle de confiance de 95%.

p = prévalence estimée du phénomène à étudier fixée par défaut à 50%, (pour disposer d'une taille d'échantillon maximale)

q = probabilité complémentaire **q** = **(1-p)** = **50%**

	p	q	pq
q = (1-p)	0.10	0.90	0.090

Valeur de **p** et **q** pour laquelle **pq** est le plus élevée et la valeur la plus élevée de **n**

0.50 0.50 0.25

0.80 0.20 0.16

0.90 0.10 0.09

d= degré de certitude ou marge d'erreur, **d=0.10** (précision de 10%)

d'où

$$n = (1.96 \times 1.96)(.5 \times .5)/(.1 \times .1)$$

$$n = (3.84)(.25)/.01$$

$$n = 96$$

En général, quand la méthode des 30 grappes est utilisée, il est recommandé de doubler la valeur de **n** . Ce qui donne une valeur de **n= 96x2 = 192** Ainsi : **n /nbre de grappes soit 192 / 30 = 6,4 personnes par grappe**, et si on arrondit on obtient finalement 7 personnes par grappe soit au total **7 x 30 = 210 personnes**, méthodologie dans l'échantillonnage 30 grappes de l'OMS.

Le KPC élaboré par John Hopkins University a suggéré de passer à un échantillonnage de **300 personnes (30 grappes de 10 personnes par grappe)** pour prévoir les déchets qui pourraient arriver au niveau des questionnaires.

C. Sélection aléatoire des grappes (villages)

Elle s'est déroulée comme suit :

- o Listing de la population (estimée pour 2002) de chaque village
- o Calcul de la population cumulée pour chaque village
- o Détermination du **Pas** de sondage : Pas = population totale cumulée des villages divisée par 30 qui correspond au nombre de grappes
- o Tirage d'un nombre au hasard inférieur ou égal au **Pas** en utilisant un billet de banque (le nombre au hasard doit avoir le même de digits que le **Pas**)
- o Choix de la première grappe qui est celle dont la population cumulée est supérieure ou égale au nombre tiré au hasard
- o Notation du numéro **1 (première grappe)** à côté de ce village
- o Addition du **Pas** avec le nombre au hasard pour trouver la **seconde grappe** qui est celle dont la population cumulée est égale ou supérieure à cette somme
- o Addition du **Pas** à la somme trouvée pour déterminer la **troisième grappe** qui est celle dont la population cumulée est égale ou supérieure à cette somme.
- o Continuation de la procédure jusqu'à atteindre les 30 grappes

D. Formation des superviseurs et enquêteurs

La formation s'est déroulée en quatre jours : trois jours en intra muros et un jour de pratique sur le terrain avec pré test du questionnaire et feed-back. Le premier jour de la formation a concerné l'ensemble des 10 superviseurs (indépendants de Plan et recrutés depuis Dakar) pour les deux zones (05 pour Kaolack et 05 pour Louga). Cette formation tenue à Kaolack s'est focalisé sur un rappel du PSE, la méthodologie du KPC, la compréhension du questionnaire.

Les trois autres jours ont été consacrés à la formation séparée des 20 enquêteurs (indépendants de Plan) recrutés au niveau local (10 par zone) avec la participation des superviseurs concernés. Les équipes de facilitation étaient composées pour Kaolack de : SS, CPSE/AID, un membre de l'ECR et un membre de l'ECD ; pour Louga : RNFSE, SS, Médecin-Chef de Région, Superviseur Santé de la Reproduction du district. Le contenu de la formation des enquêteurs portait sur : la méthodologie du KPC, les rôles du superviseur et de l'enquêteur, les techniques d'interview, l'étude du questionnaire, la familiarisation avec le questionnaire traduit en wolof par des jeux de rôle, des éléments du calendrier des événements locaux en cas d'absence de pièces d'identification pour déterminer l'âge, le pré test du questionnaire sur le terrain, le feed-back sur le questionnaire, organisation de la collecte des données sur le terrain. Le pré test s'est déroulé dans des villages non concernés par l'enquête ; une équipe d'un superviseur et de deux enquêteurs a interviewé en moyenne deux mères d'enfants de moins de deux ans.

E. Collecte des données

Simultanément du 1^{er} au 04 juillet 2002 (après la photocopie, durant la semaine du 24 au 28 juin 2002, des questionnaires définitivement adoptés) l'enquête sur le terrain a eu lieu au niveau des villages retenus par hasard lors de l'échantillonnage. La durée de la collecte prévue, au départ pour 05 jours, a été ramenée à 04 jours ; ceci parce que une rencontre de tout le personnel de **Plan** était convoquée le 5^{ème} jour. Une des contraintes

essentielles sur le terrain a été la configuration de la zone de Louga : certains villages situés au bord de la mer sont difficiles d'accès avec beaucoup de cactus qui ont entraîné des enlisements et des détériorations des pneus ; par ailleurs, il faut faire plusieurs villages pour atteindre le nombre de 10 mères au moins par village.

Mais, le processus a été respecté pour chaque zone : les 05 équipes ont fait au moins chacune 10 villages par jour (10 mères enquêtées par village) pour deux jours (soit 100 mères), puis 20 villages par jour pour 02 jours (soit 200 mères), ce qui fait 300 mères d'enfants de moins de 02 ans à enquêter au moins. Ainsi, au niveau de Louga 348 questionnaires de mères d'enfants de moins de deux ans ont été jugés valides par les membres du Core team, contre 319 pour Kaolack.

F. Saisie des données

Quatre opératrices (2 par zone) ont été recrutées (avec un protocole d'accord) avec **Plan** pour appuyer les deux Assistantes chargées du Système d'Information à des fins de Gestion (ASIG) dans la saisie des données. A cet effet, elles ont été initiées le 08 juillet 2002 à Kaolack sur le logiciel EPI INFO et la procédure d'entrée des données à partir du questionnaire par le RNFSE . Du 09 au 12 juillet 2002, à Louga, les opératrices de saisie ainsi que les ASIG ont procédé à la saisie des questionnaires avec le logiciel EPI INFO. Elles ont procédé à une double saisie à partir des questionnaires validés par le core team avec la création d'un minimum de 188 variables par le RNFSE pour l'analyse.

G. Analyse des données

Après une première analyse du RNFSE, les résultats ont été discutés sous forme de réunion de travail, les 30 et 31 juillet 2002 à Dakar. Cette rencontre regroupant le staff des PU et les ECR et ECD impliqués directement durant tout le processus, a abouti aux conclusions suivantes :

- o Le processus adopté pour toutes les étapes s'est déroulé de manière satisfaisante sur le plan de la rigueur scientifique et de l'implication des acteurs concernés.
- o Les résultats analysés, volet technique par volet technique en fonction des indicateurs, sont jugés très satisfaisants eu égard à l'atteinte des objectifs et du contexte national actuel
- o Des recommandations par volet ont été formulées ; et le RNFSE les inclura dans son rapport final
- o Le canevas du rapport final a été discuté et adopté
- o Les SS rempliront les formulaires (qui leur ont été remis sur place par le RNFSE) relatifs à toutes les réalisations durant le projet afin de répondre à toutes les sollicitations du consultant
- o Le staff de **Plan** devra prendre les dispositions nécessaires pour procéder à la restitution à tous les niveaux (depuis le niveau national jusqu'au niveau communautaire)

- o **Plan** devrait disposer d'une deuxième phase pour consolider les résultats obtenus avec le concours des ECS qui ont secondé les ICP dans la mise en œuvre des activités d'IEC/CCC et l'encadrement rapproché des OCB.

III – RESULTATS DE L'ETUDE:

Les réponses concernent 51 questions. 667 questionnaires (348 pour Louga et 319 pour Kaolack) comprenant 51 questions ont été jugés valides et analysés. Les principales réponses sont présentées ci-après :

Identification

1. Les mères sont classées par tranches d'âges de 15 à 49 ans et le total de mères interviewées est de 667 (348 à Sakal de Louga et 319 à Wackngouna de Kaolack). Les grossesses à risques concernent les femmes âgées de moins de 19 ans (9 %) et plus de 34 ans (14 %).

AGE DES MERES EN ANNEES	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
15-18	60	09%	39	12 %	21	06 %
19-34	513	77%	244	76%	269	77 %
35-49	94	14%	36	11%	58	17 %
Total	667	100%	319	100%	348	100%

2. Le pourcentage des enfants de moins de 05ans est de 18 %, et ceux des enfants de 05-11 mois et plus de 11 mois sont identiques 41 %.

AGE DES ENFANTS EN MOIS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
0-4	123	18%	84	26%	41	12%
5-11	273	41%	122	38%	151	43%
12-23	271	41%	113	35%	157	45%
Total	667	100%	319	100%	348	100%

La répartition des enfants selon le sexe est assez équitable avec 49 % de filles et 51 % de garçons. Toutefois, à Kaolack les garçons sont plus nombreux de 3 points.

SEXE DES ENFANTS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Féminin	325	49%	152	48%	174	50%
Masculin	342	51%	167	52%	174	50%
Total	667	100%	319	100%	348	100%

3. L'intervalle inter génésique entre les enfants retenus pour l'enquête et leurs aînés directs (frères/sœurs) est supérieur à 80% dans l'ensemble.

INTERVALLE INTER GENESIQUE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Moins de 23 mois	114	17%	58	18%	74	21%
Plus de 23 mois	253	83%	261	82%	274	79%
Total	667	100%	319	100%	348	100%

Instruction et Occupations des mères

4. Près de 50% (335/667) des mères ne savent ni lire ni écrire aucune langue ; 20% sont instruites en langues nationales ; 8% parlent le français et 28% l'arabe.

EDUCATION DES MERES	Total (n=667)		Kaolack (n=322)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. français	50	8 %	33	10%	17	5%
2. arabe	189	28%	127	40%	61	18%
3. langues nationales	131	20%	31	10%	101	29%
4. Ne savent pas lire	332	50%	141	44%	191	55%

5. Durant l'étude 42% (281/667) des mères n'ont pas d'activités génératrices de revenus. 30% s'occupent d'agriculture. 18% mènent des activités commerciales à domicile.

ACTIVITES DES MERES	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Pas d'activités génératrices de revenus	281	42%	146	46%	143	44%
2. Artisanat	18	3%	10	3%	8	3%
3. Agriculture	198	30%	93	29%	105	30%
4. Commerce à domicile	121	18%	59	19%	55	19%
5. Commerce au marché	46	7%	13	4%	31	9%
6. Autres	46	7%	05	2%	05	2%

Suivi de la grossesse et l'accouchement

6. Des 667 mères interviewées, 65% possédaient un carnet de santé.

POSSESSION DE CARNET DE SANTE PAR LES MERES	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Mères avec carnet	431	65%	176	55%	254	73%
2. Mères sans carnet	236	35%	143	55%	94	27%
Total	667	100%	319	100%	348	100%

7.8.9.10.11. Parmi les 431 mères disposant d'un carnet de santé 53% avaient effectué au moins 03 visites pré natales lors de leur dernière grossesse ; 64% avaient reçu une prescription de chloroquine, 65% du fer, et 9% de la vitamine A. Seules 5% avaient effectué 02 visites post natales dans les 42 jours qui avaient suivi leur accouchement

INFORMATIONS SANITAIRES SELON LES CARNETS	Total (n=431)		Kaolack (n=176)		Louga (n=254)	
	Freq.	%	Freq.	%	Freq.	%
1. 03 consultations pré natales et plus	230	53%	94	53%	133	52%
2. Prescription de fer	281	65%	59	34%	222	87%
3. Prescription de chloroquine	277	64%	57	32%	218	86%
4. 02 vaccinations anti tétaniques et plus	325	75%	138	78%	186	73%
5. 02 visites post natales au moins	18	5%	05	3%	13	5%
6. Prescription de Vit A	37	9%	14	8%	22	9%

12. 93% des mères connaissent le nombre requis de consultations pré natales pour une femme enceinte.

NOMBRE DE CONSULTATIONS PRE NATALES REQUISES POUR UNE FEMME ENCEINTE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Connaissance du nombre de consultations pré natales requises pour une femme enceinte	617	93%	294	92%	323	93%

13. Les céréales constituent l'aliment le plus considéré comme interdit (24%) pour une femme enceinte.

INTERDITS ALIMENTAIRES POUR LA FEMME ENCEINTE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Protéines	27	4%	7	2%	20	6%
Fruits	32	5%	22	7%	10	3%
Légumes	8	1%	1	2%	7	2%
Céréales	159	24%	89	28%	69	20%

14. 77% des accouchements ont été assistés par le personnel de santé ou une matrone

ACCOUCHEMENTS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Personnel santé et matrones	513	77%	246	77%	267	77%
Autres	154	23%	73	23%	81	23%
Total	667	100%	319	100%	348	100%

15. Les 03 principaux facteurs de risques de la grossesse cités par les mères sont

respectivement les consultations pré natales incomplètes ou inexistantes (28%), l'anémie (25%) et la fièvre (23%).

FACTEURS DE RISQUES DE LA GROSSESSE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Consultations pré natales incomplètes /inexistantes	184	28%	64	20%	121	35%
Fièvre	152	23%	42	13%	109	31%
Anémie	165	25%	43	14%	121	35%

Alimentation de l'enfant

16.17 Parmi les mères interviewées, 93% ont affirmé qu'elles continuaient d'allaiter au sein leurs enfants au moment de l'enquête. Cependant sur les 47 qui n'allaitaient plus, les 45 ont affirmé l'avoir fait, ce qui revient à une pratique de l'allaitement maternel avoisinant les 99%. 26% des enfants de plus de 19 mois étaient toujours allaités au sein.

ALLAIEMENT MATERNEL	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Mères qui pratiquent l'allaitement maternel actuellement	620	93%	308	96%	312	90%

ALLITEMENT MATERNEL DES ENFANTS DE 20-23 MOIS	Total (n= 59)		Kaolack (n= 18)		Louga (n=41)	
	Freq.	%	Freq.	%	Freq.	%
Mères qui allaitent leurs enfants de 20-23 mois	26	44%	10	56%	25	61%

18. Parmi les mères interviewées, 64% ont déclaré avoir commencé à allaiter au sein leurs

enfants dans la première heure après leur accouchement.

MISE AU SEIN APRES L'ACCOUCHEMENT	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Durant la première heure	429	64%	196	61%	233	67%
2. Entre 1et 8 heures	161	24%	82	26%	78	22%
3. Plus de 8 heures	74	11%	40	13%	35	10%
4. Ne se rappellent pas	3	1%	1	0%	2	1%
Total	667	100%	322	100%	324	100%

19 a - k. L'allaitement maternel exclusif est de 40% ; 24% reçoivent de la bouillie, 26% du beurre, et 13% de la viande et poisson.

ALIMENTATION DES ENFANTS DE 0-4 MOIS	Total (n=123)		Kaolack (n=84)		Louga (n=39)	
	Freq.	%	Freq.	%	Freq.	%
1. Allaitement maternel exclusif	49	40%	26	31%	16	41%
2. Bouillie	29	24%	24	29%	5	13%
3. Fruits	11	9%	8	10%	3	8%
4. Carotte mangue, papaye	16	13%	12	14%	4	10%
5.Feuilles vertes	7	6%	3	4%	4	10%
6. Viande, poisson	16	13%	12	14%	4	10%
7. Arachide	16	13%	12	14%	4	10%
8. Oeuf, lait caillé	25	20%	19	23%	5	15%
9. Sucre	39	32%	30	36%	9	23%
10. Beurre	32	26%	21	25%	32	26%

ALIMENTATION DES ENFANTS DE 5-11 MOIS	Total (n=273)		Kaolack (n=122)		Louga (n=151)	
	Freq.	%	Freq.	%	Freq.	%
1. Autre lait	109	40%	28	23%	81	54%
2. Bouillie	212	78%	90	74%	120	80%
3. Fruits	155	57%	68	56%	87	58%
4. Carotte mangue, papaye	175	64%	72	59%	103	58%
5. Feuilles vertes	92	34%	41	34%	51	34%
6. Viande, poisson	196	72%	85	70%	111	74%
7. Arachide	171	63%	81	64%	90	60%
8. Oeuf, lait caillé	210	77%	88	72%	122	81%
9. Sucre	230	84%	102	84%	128	85%
10. Beurre	189	69%	83	68%	106	70%

ALIMENTATION DES ENFANTS DE 12-23 MOIS	Total (n=271)		Kaolack (n=113)		Louga (n=158)	
	Freq.	%	Freq.	%	Freq.	%
1. Autre lait	161	59%	35	31%	126	80%
2. Bouillie	243	90%	94	83%	149	94%
3. Fruits	234	86%	94	83%	140	89%
4. Carotte mangue, papaye	253	93%	102	90%	151	96%
5. Feuilles vertes	189	70%	78	70%	111	70%
6. Viande, poisson	255	94%	106	94%	149	94%
7. Arachide	256	95%	109	97%	147	93%
8. Oeuf, lait caillé	262	97%	109	97%	153	97%
9. Sucre	254	94%	101	90%	153	97%
10. Beurre	240	89%	99	90%	141	90%

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CONSOMMATION DE SEL IODE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Ajout sel iodé	456	68%	231	72%	225	65%

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ADMINISTRATION DE LA VITAMINE A CHEZ LES ENFANTS DE PLUS DE 5 MOIS	Total (n=505)		Kaolack (n=215)		Louga (n=290)	
	Freq.	%	Freq.	%	Freq.	%
Administration de la Vitamine A aux enfants de plus de 5 mois	471	93%	207	96%	264	91%

20.

CONNAISSANCE DE L'AGE D'INTRODUCTION DES ALIMENTS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Avant 4 mois	84	13%	46	15%	38	11%
2. Entre 4 et 6 mois	476	71%	221	69%	255	73%
3. Après 6 mois	105	16%	51	16%	54	16%
4. Ne savent pas	02	0%	1	0%	1	0%
Total	667	100%	319	100%	348	100%

Diarrhée

21. 37% des 667 mères interviewées ont déclaré que leurs enfants ont eu de la diarrhée dans les 15 jours précédant l'enquête.

CAS DE DIARRHEE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1.Episode diarrhéique	249	37%	153	48%	96	28%
2. Pas d'épisode diarrhéique	418	63%	166	52%	252	72%

22. Parmi les 249 enfants ayant eu de la diarrhée, 40% ont été allaités au sein plus que

d'habitude, et 36% ont été allaités comme d'habitude.

ALLAITEMENT AU SEIN PENDANT LA DIARRHEE	Total (n=249)		Kaolack (n=153)		Louga (n= 96)	
	Freq.	%	Freq.	%	Freq.	%
1. Plus que d'habitude	100	40%	72	47%	28	29%
2. Comme d'habitude	89	36%	56	37%	33	34%
3. Moins que d'habitude	39	16%	20	13%	19	20%
4. Arrêt allaitement	2	1%	2	1%	0	0%
5. Enfant déjà sevré	19	7%	3	2%	16	17%

23.60% des enfants de plus de 4 mois et qui ont eu la diarrhée ont reçu plus de liquides que d'habitude, 30 % ont reçu la même quantité que d'habitude.

LIQUIDES PENDANT LA DIARRHEE CHEZ LES PLUS DE 4 MOIS	Total (n=213)		Kaolack (n=125)		Louga (n= 88)	
	Freq.	%	Freq.	%	Freq.	%
1. Plus que d'habitude	128	60%	80	64%	48	55%
2. Comme d'habitude	64	30%	36	29%	28	32%
3. Moins que d'habitude	17	8%	7	6%	10	11%
4. Arrêt liquides	0	0%	0	0%	0	0%
5. Allaitement exclusif au sein	4	2%	2	2%	2	2%

24. 63% des enfants de plus de 4 mois avec diarrhée ont reçu des aliments comme et plus que d'habitude.

ALIMENTS PENDANT LA DIARRHEE CHEZ LES PLUS DE 4 MOIS	Total (n= 213)		Kaolack (n=125)		Louga (n=88)	
	Freq.	%	Freq.	%	Freq.	%
1. Plus que d'habitude	81	38%	52	42%	29	33%
2. Comme d'habitude	52	24%	25	20%	27	31%
3. Moins que d'habitude	42	20%	17	14%	25	28%
4. Arrêt aliments	10	5%	9	7%	1	1%
5. Allaitement exclusif au sein	28	13%	22	17%	6	7%

25. Durant leur dernier épisode diarrhéique, parmi les 249 enfants ayant eu une diarrhée 12% ont reçu des sachets RVO, 56% la solution salée sucrée, 21% des “liquides maison”.

TRAITEMENTS PENDANT LA DIARRHEE	Total (n= 249)		Kaolack (n=153)		Louga (n=96)	
	Freq.	%	Freq.	%	Freq.	%
1. Sachet RVO	30	12%	16	11%	14	15%
2. Solution Salée Sucrée	140	56%	99	65%	41	43%
3. Liquides maison	51	21%	33	22%	18	18%

26. Les 39% des mères ayant des enfants diarrhéiques se sont adressées au poste et centre de santé, tandis que 32% n’ont bénéficié d’aucun conseil.

CONSEILS EN CAS DE DIARRHEE	Total (=249)		Kaolack (n=204)		Louga (n=127)	
	Freq.	%	Freq.	%	Freq.	%
1. Hôpital	4	2%	0	0%	4	4%
2. Poste de santé/ centre de santé	98	39%	60	39%	38	40%
3. Pharmacie	1	0%	0	0%	1	1%
4. Personnel communautaire	47	19%	36	24%	11	12%
5. Aucun conseil	80	32%	50	33%	30	31%

27. Par rapport aux signes de danger, 57% des mères ont cité la fièvre et 51% la déshydratation.

SIGNES DE DANGER	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Ne savent pas	7	1%	3	1%	4	1%
2. Vomissements	205	31%	57	18%	148	43%
3. Fièvre	381	57%	118	37%	263	76%
4. Prolongement de la diarrhée au-delà de 3 jours	342	51%	177	56%	165	47%
5. Déshydratation	339	51%	153	48%	186	53%
6. Sang dans les selles	235	35%	78	25%	157	45%
7. Manque d'appétit	100	15%	36	11%	64	18%
8. Fatigue	128	19%	128	19%	48	14%

28. Parmi les mères, 78% connaissent la manière de préparer la solution salée sucrée.

PREPARATION SOLUTION SALEE SUCREE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Connaissent	519	78%	248	78%	271	78%
2. Ne connaissent pas	148	22%	71	22%	77	22%

Vaccination et Surveillance pondérale.

29. 96% des mères possédaient des fiches (ou carnets de santé) de santé des enfants concernés par l'enquête.

POSSESSION DE FICHES DE SANTE POUR LES ENFANTS DE 0-23 MOIS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Fiches de santé	637	96%	308	96%	329	95%

30. Le statut vaccinal des enfants de 12-23 mois est calculé par rapport à l'ensemble des

enfants de ce groupe, en considérant que les enfants qui n'ont pas de fiches de santé n'ont pas été vaccinés. La couverture vaccinale est de 82%. Les perdus de vue au DTC représentent 10%.

VACCINATION DES ENFANTS DE 12-23 MOIS	Total (n=271)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. BCG	260	96%	110	97%	150	95%
2. DTC 1	259	96%	109	97%	150	95%
3. DTC 3	245	90%	101	89%	144	90%
4. Polio1	259	96%	109	97%	150	95%
5. Polio 3	244	90%	101	89%	143	91%
6. Rougeole	235	87%	98	87%	137	87%
7. Fièvre jaune	228	84%	91	81%	137	87%
8. Complètement vaccinés avec ou sans cartes	222	82%	88	78%	134	85%
Perdus de vue au DTC (12-23 mois)	Total (n=245)		Kaolack (n=101)		Louga (n=144)	
DTC1 - DTC3 ----- DTC1	10%		11%		9%	

31. 57% des enfants de 0-23 mois ont été régulièrement pesés durant les 3 derniers mois de l'enquête. Pour les plus de 2 mois, le pourcentage est de 61%.

SUIVI PONDERAL DES ENFANTS DE 0-23 MMOIS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. 3 pesées mensuelles durant le trimestre	377	57%	184	58%	193	56%

SUIVI PONDERAL DES ENFANTS DE 3-23 MOIS	Total (n=611)		Kaolack (n=280)		Louga (n=331)	
	Freq.	%	Freq.	%	Freq.	%
1. 3 pesées mensuelles durant le trimestre	372	61%	180	64%	192	58%

Infections respiratoires aiguës:

32. Parmi les 667 mères interviewées, 30% ont déclaré que leurs plus jeunes enfants ont présenté une toux ou des difficultés respiratoires.

INFECTIONS RESPIRATOIRES AIGUES	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Infections respiratoires aiguës durant les 2 dernières semaines de l'enquête	203	30%	112	35%	91	26%

33. 34. Parmi les 125 enfants atteints d'IRA, 79% ont été emmenés en consultation au poste / centre de santé.

MERES AYANT AYANT FAIT CONSULTER LEURS ENFANTS ATTEINTS D'IRA	Total (n=125)		Kaolack (n=74)		Louga (n=51)	
	Freq.	%	Freq.	%	Freq.	%
1. Hôpital	7	6%	3	4%	4	8%
2. Poste/Centre santé	88	70%	51	69%	37	73%
3. Clinique privée	0	0%	0	0%	0	0%
4. Personnel communautaire	24	19%	20	27%	4	8%
5. Tradi praticien	3	2%	1	1%	2	4%

35. La toux est le signe de référence des IRA le plus cité (71%).

SIGNES DE REFERENCE DES IRA DE L'ENFANT	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Ne savent pas	13	2%	5	2%	8	3%
2. Dyspnée	420	63%	169	53%	251	72%
3. Toux	475	71%	229	72%	240	71%

Paludisme :

36. 38% des mères ont reconnu que leur dernier enfant a eu de la fièvre durant les 15 jours précédant l'enquête.

FIEVRE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
Fièvre durant les 2 dernières semaines	253	38%	139	44%	114	33%

37. 57% des cas de fièvre des enfants ont été traités avec de la chloroquine., 18% emmenées au poste/centre de santé.

TRAITEMENT DES CAS DE FIEVRE DEL'ENFANT	Total (n=253)		Kaolack (n=139)		Louga (n=114)	
	Freq.	%	Freq.	%	Freq.	%
1. Chloroquine	144	57%	91	66%	53	47%
2. Tradi praticien	6	2%	1	1%	5	4%
3. Poste/centre santé	46	18%	27	19%	19	17%
4. Personnel communautaire	25	10%	22	16%	3	3%
6. Rien	26	10%	9	7%	17	15%

38. Par rapport à la prévention du paludisme, 66% des mères ont cité la moustiquaire imprégnée.

PREVENTION DU PALUDISME	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Moustiquaire simple	27	4%	10	3%	17	5%
2. Moustiquaire imprégnée	437	66%	191	60%	246	71%
3. Insecticides	70	11%	23	7%	47	14%
4. Assainissement	549	82%	268	84%	281	81%
5. Chloroquine	195	29%	46	14%	149	43%
6. Ne savent pas	12	2%	8	3%	4	1%

39.40. 41.42 Parmi les 280 moustiquaires imprégnées (soit 85% de l'ensemble des moustiquaires et 42% de possession de moustiquaires imprégnées par rapport à l'ensemble des mères interviewées), les 43% ont été acquises moins de 6 mois, et les 71% ont été ré imprégnées en moins de 6 mois.

POSSESSION DE MOUSTIQUAIRE IMPREGNEE	Total (n=280)		Kaolack (n=107)		Louga (n=173)	
	Freq.	%	Freq.	%	Freq.	%
1. Période d'acquisition moins de 6 mois	119	43%	37	35%	82	47%
2. Dernière imprégnation moins de 6 mois	200	71%	41	38%	159	92%

43. Parmi les 667 enfants concernés par l'enquête, 33% ont dormi sous moustiquaire imprégnée la veille de l'enquête.

UTILISATION DE MOUSTIQUAIRE IMPREGNEE PAR LES ENFANTS	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Enfant enquêté	218	33%	76	24%	142	41%

44. 86% des mères ont cité la forte fièvre comme signe de gravité de la fièvre, 60% les vomissements.

SIGNES DE REFERENCE DES CAS DE FIEVRE CHEZ L'ENFANT	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1.Forte fièvre	574	86%	283	89%	291	84%
2. Fièvre plus de 3 jours	176	26%	76	23%	103	30%
3. Vomissements	401	60%	122	38%	279	80%
4. Refus de manger	196	29%	61	19%	135	39%

Hygiène / Assainissement

45. 69% des mères ont déclaré qu'elles se lavent les mains avec du savon avant de donner à manger aux enfants.

LAVAGE DES MAINS AVEC DU SAVON	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Avant de préparer les repas des enfants	426	64%	185	58%	241	69%
2. Avant de donner à manger aux enfants	463	69%	195	61%	268	77%
3. A la sortie des toilettes	397	60%	112	35%	285	82%
4. Après avoir fait la toilette des enfants	234	35 %	70	22%	164	47%

46. Parmi les mères interviewées, 77% disposent de latrines.

EXISTENCE DE LATRINES	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Oui	513	77%	237	74%	276	79%
2. Non	154	23%	82	26%	72	21%

Infections sexuellement transmissibles / SIDA

47. 48. Parmi les 608 mères qui ont entendu parler du SIDA (soit 91% de l'ensemble des mères interviewées), 76% ont cité la voie sexuelle pour la transmission du SIDA, contre 48% qui ont cité la voie sanguine.

TRANSMISSION DU SIDA	Total (n=608)		Kaolack (n=272)		Louga (n=336)	
	Freq.	%	Freq.	%	Freq.	%
1. Voie sanguine	291	48%	94	35%	197	59%
2. Voie sexuelle	460	76%	163	67%	277	82%
3. Voie placentaire	11	2%	4	2%	7	2%
Voie mammaire	4	1%	1	0%	3	1%

49. Parmi les 608 mères qui ont entendu parler du SIDA (soit 91% de l'ensemble des mères interviewées), 64% ont cité la fidélité comme moyen de protection contre le SIDA, le préservatif a été nommé par 15%.

PROTECTION CONTRE LE SIDA	Total (n=608)		Kaolack (n=272)		Louga (n=336)	
	Freq.	%	Freq.	%	Freq.	%
1. Préservatif	89	15%	21	8%	68	20%
2. Abstinence	250	41%	48	18%	202	60%
3. Fidélité	389	64%	163	69%	226	67%

50. Parmi les 667 mères interviewées, 19% ont cité les pertes comme signe d'infection génitale chez la femme.

SIGNES D'INFECTION GENITALE CHEZ LA FEMME	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Pertes	128	19%	35	11%	93	27%
2. Plaie	91	14%	21	7%	70	20%
3. Prurit (grattage)	86	13%	15	5%	71	20%

Planning Familial

51. La pilule est la méthode de planification familiale la plus connue (68%) par les mères interviewées.

METHODES DE PLANIFICATION FAMILIALE	Total (n=667)		Kaolack (n=319)		Louga (n=348)	
	Freq.	%	Freq.	%	Freq.	%
1. Pilule	459	69%	222	70%	237	68%
2. Dispositif intra utérin	80	12%	23	7%	57	16%
3. Préservatif	71	11%	13	4%	58	17%
4. Dépo (injectable)	318	48%	152	48%	166	48%
5. Norplan (chirurgie)	46	7%	23	7%	23	7%

IV - DISCUSSIONS:

Eu égard aux résultats passés en revue, les points de discussions peuvent concerner:

Distribution de l'âge:

23% des mères ont eu des grossesses et accouchements à risques compte tenu de leur âge. Cet état de fait peut militer en faveur de l'introduction d'activités de sensibilisation pour éviter les grossesses précoces et tardives. D'où la nécessité d'élargir la gamme des interventions du PSE aux différentes composantes de la Maternité A moindres Risques. Pour preuve, plus de la moitié des mères ne connaissent pas un signe d'infections génitales chez la femme

Education /Occupation:

50% des mères ne savent ni lire ni écrire une langue et 42% ne mènent aucune activité génératrice de revenus. Cette situation nécessite l'accélération du processus de responsabilisation des femmes pour mieux asseoir leur pouvoir au sein des communautés. Leur alphabétisation y contribuerait vivement.

Allaitement/Nutrition

L'allaitement maternel exclusif pour les enfants de moins de 5 mois est de 40%. C'est encourageant par rapport au contexte national (il est de 23,5% selon le rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance UNICEF décembre 2000). Toutefois, l'augmentation de l'âge pour l'allaitement maternel exclusif à 5 mois révolus, impose la révision des supports de sensibilisation utilisés présentement (boîte à images). Il faut souligner, par ailleurs, l'aspect multi sectoriel de l'alimentation de l'enfant, d'où la nécessité de la conjugaison des efforts des différents domaines (santé, apprentissage, habitat, moyens d'existences, développement de relations et échanges culturelles).

Contrôle de la diarrhée et des maladies

La Prise en Charge Intégrée des Maladies de l'Enfant (PCIME) constitue la nouvelle stratégie intégratrice du MSP pour améliorer l'état de santé des enfants. A ce sujet, il est important de maintenir **Plan** au sein des instances de conception sur la PCIME ; ainsi, le staff de **Plan** ne sera pas dépassé par rapport aux nouvelles idées relatives à la Survie de l'Enfant et sera plus à l'aise dans l'utilisation des nouveaux supports (manuel de formation, cartes conseils) en cours d'élaboration avec son implication.

Vaccination

La couverture vaccinale de 82% des enfants de 12-23 mois est très motivante (Elle dépasse l'objectif national du pays qui est de 80%), mais le challenge est de maintenir le cap pour ne pas chuter comme c'est le cas actuellement (de 80% en 1987, le taux de couverture vaccinal est estimé aux alentours de 50% présentement). Pour ce faire, adopter la même stratégie en cours : sollicitation de plus en plus accrue de l'équipe mobile pour parer aux occasions manquées dues à l'indisponibilité des infirmiers chefs de poste plus ou moins sollicités, responsabilisation de la communauté pour la recherche directe des enfants absents lors des séances de vaccination, intensification des activités d'IEC/CCC, appui à la stratégie avancée et mobile.

Infections respiratoires aiguës :

C'est le volet qui souffre essentiellement d'une absence de supports de sensibilisation. Heureusement que ces derniers sont en train d'être élaborés dans le cadre de la PCIME, d'ailleurs **Plan** est impliqué dans le processus.

Paludisme :

57% des enfants qui ont la fièvre ont pris de la chloroquine (selon le rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance UNICEF décembre 2000, il est pour le niveau national de 36%). Il faudra maintenir la tendance (à l'enquête de base, 31% des enfants prenaient de la chloroquine en cas de fièvre) avec l'utilisation des moustiquaires imprégnées par les enfants qui est de 33 % (selon le rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance UNICEF décembre 2000 1,6% des enfants de moins de 5 ans dorment sous moustiquaire imprégnée), mais les supports utilisés (boîte à images, dépliants) doivent être adaptés par rapport aux nouvelles normes pour l'administration de la chloroquine chez l'enfant en cas de fièvre.

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ANNEXE 1 : PLANIFICATION DES EQUIPES D'ENQUETE

PLANNING DES JOURS D'ENQUETE KPC FINAL KAOLACK 2002					
EQUIPES	NOMS	JOUR 1	JOUR 2	JOUR 3	JOUR 4
		LUNDI 1ER/07/02	MARDI 02/07/02	MERCREDI 03/07/02	JEUDI 04/07/02
1	Bah FALL	Nguéyène Djim	Nguer Babou	Médina Diané	Ndramé
	Dame SYLLA		Samako Bambara	Touba 2	
	Ndiassé TOURE				
2	Al Assane SENE	Keur Dongo	Keur Maba	Wack Ngouna	Bowé
	Mariama SARR		Thilla Ndiaye	Médina Thiamène	
	Ibou SALL				
3	El Hadji T. MBAYE	Keur Yoro Khodia	Keur Mamour Coumba	Lohène Aly	Niassène Walo
	Ndeye FAYE		Thiamène Diogo		Ndiobène Walo
	Mariétou DIAO				
4	Ibrahima DIA	Keur Abdou Diaffé	Keur Fodé	Keur Mamour Anta	Keur Madiabel 1
	Mbagnick NDIAYE		Tawfékh		Keur Madiabel 2
	Moussa SENE				
5	Thérèse DIOH	Ndioungty Serigne	Keur Modou Bonguel	Kéré Walo	Keur Madiabel 3
	Adama HANNE		Goria		Keur Madiabel 4
	Pape Alioune NDIAYE				

Voiture 1 : Chauffeur :.....

Voiture 2 : Chauffeur :.....

Voiture 3 : Chauffeur :.....

Les noms en style gras représentent les superviseurs

Les noms en style normal représentent les enquêteurs

Équipe 1

Équipe 2

Équipe 3

Voiture 4 : Chauffeur .

Voiture 5 : Chauffeur .

Voiture 6 : Chauffeur .

Équipe 4

Équipe 5

(Core Team)

PLANNING DES JOURS D'ENQUETE K.P.C. FINAL LOUGA 2002

EQUIPES	NOMS	JOUR 1	JOUR 2	JOUR 3	JOUR 4
		01/07/02	02/07/02	03/07/02	04/07/02
1	Mame Keum NDOYE Mounina DIAKHATE Soukeyna FALL	Baïty Rip (Véhicule 1)	Ngueune Sarr Keur Pathé Peulh (Véhicule 2)	Sakal Taïba Ndiaye (Véhicule 5)	Ngondame (Véhicule 4)
2	El Hadj Moussa DIOP Abdoulaye BA Tamsir NDIAYE	Diadji Bou Mag (Véhicule 2)	Thiarène Sarr (Keur Sidy Sarr) Mbaye Mbaye Peulh (Véhicule 3)	Thiarène Sylla Yakhi Niay (Véhicule 1)	Potou 1 (Véhicule 5)
3	Amadou Abib TALL Magatte Dramé DIOP Awa MANE	Gouyar Sarr (Véhicule 3)	Bakhdar Mbengue Ndakhar Ndiaye (Véhicule 1)	Boundouwoula 1 Galdamel (Véhicule 4)	Sague Sathiel (Véhicule 2)
4	Aminata SECK Alioune FALL Abdou Kane GAYE	Keur Sambou 2 (Véhicule 4)	Darou Salam Ndiouffène (Véhicule 5)	Lambath Ndiaye Maka Ndiaye (Véhicule 2)	Taré (Véhicule 3)
5	Djibril KEITA Ndèye Fatou D. DIOP Ousseynou SECK	Mboubène Mbatar (Véhicule 5)	Keur Balla Niass Nianguène (Véhicule 4)	Médina Thiolom Ndialègne (Mbathie) (Véhicule 3)	Thiowor (Véhicule 1)
6	CORE TEAM	Véhicule 6	Véhicule 6	Véhicule 6	Véhicule 6

Véhicule 1 : Mor DIAGNE ; Véhicule 2 Mbaye DRAME ; Véhicule 3 Temporaire ; Véhicule 4 Pape LO ; Véhicule 5 : Abdou FALL ; Véhicule 6 : Alioune NIANG

Les noms en style gras représentent les superviseurs

Les noms en style normal représentent les enquêteurs

ANNEXE 2 : TABLEAU COMPARATIF KPC DE BASE ET KPC FINAL DU PSE /AID

DOMAINES D'INTERVENTION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
PALUDISME	Réduire la mortalité et morbidité liées au paludisme chez les enfants et femmes enceintes en améliorant leur prévention, la prise en charge de la fièvre à domicile ainsi que la référence des cas par une orientation recours	Proportion de ménages qui utilisent au moins une moustiquaire imprégnée	4, 4% des ménages utilisent des moustiquaires imprégnées	30 %	42%	
		Proportion de ménages où un enfant de moins de 5 ans utilise une moustiquaire imprégnée	3,2 % d'enfants de moins de 5 ans dorment sous moustiquaires imprégnées	30 %	33%	* 1,6%
		Proportion de moustiquaires ré imprégnées dans les 6 à 9 mois suivant leur date d'achat ou d'imprégnation	0,1% des moustiquaires sont ré imprégnées tous les 6 mois à 9 mois	70 %	71%	
		Proportion de cas suspects de paludisme chez les enfants de moins de 5 ans et les femmes enceintes ayant reçu un traitement présomptif efficace et approprié	30,6% des fièvres chez les enfants à domicile sont pris en charge par la chloroquine	80%	57%	* 36%

		Proportion de cas de paludisme nécessitant une référence selon les critères établis et qui l'ont été effectivement	17, 7 %	80%	86% <i>connaissent un signe de référence : forte fièvre</i>	
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* UNICEF : Rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance MICS décembre 2000

DOMAINES D'INTERVENTION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJETIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIONALE
PALUDISME	Réduire la mortalité et morbidité liées au paludisme chez les enfants et femmes enceintes en améliorant leur prévention, la prise en charge de la fièvre à domicile ainsi que la référence des cas par une orientation recours	Proportion de femmes enceintes détentrices de carnet de santé à qui on a prescrit en préventif un antipaludique approprié	70,2%	90%	64%	
		Proportion de causeries organisées sur le palu dans les cases et PPS			Non mesuré par KPC	

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
NUTRITION	Suivre la croissance de tous les enfants de 0-36 mois en éduquant leurs mères dans ce domaine mais aussi à une référence appropriée et que tous les enfants de 0-4mois soient allaités exclusivement au sein.	Proportion d'enfants de 12-23 mois ayant reçu de la vit A après qu'ils aient atteint l'âge de 06 mois.		80 %	80%	
		Proportion de mères allaitantes qui ont reçu de la vit A dans les 2 mois suivant leur accouchement.	0 %	50 %	9%	
		Proportion de mères connaissant et pouvant expliquer les bonnes pratiques du sevrage.		100 %	<i>71% des mères connaissent l'âge d'introduction d'aliments chez les enfants</i>	
		Proportion de causeries organisées sur la nutrition dans les cases et PPS.			Non mesuré par KPC	

DOMAINES D'INTERVENTION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJECTIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIONALE
NUTRITION	Suivre la croissance de tous les enfants de 0-36 mois en éduquant leurs mères dans ce domaine mais aussi à une référence appropriée et que tous les enfants de 0-4 mois soient allaités exclusivement au sein	Proportion d'enfants de 0-24 mois qui sont suivis à la pesée une fois par mois et leur Poids/Taille reporté sur leur fiche de croissance	14,8% des enfants de 0-3 ans ont été régulièrement pesés les 3 derniers mois et leurs poids reportés sur la fiche	90%	57% chez les 0-23 mois 61% chez les 3-23 mois	
		Proportion de mères qui allaitent exclusivement au sein leur enfant jusqu'à 4 mois révolus	25,7% des mères allaitent exclusivement leur enfant de la naissance à 4 mois	50 %	40%	* 23,5%
		Proportion de mères qui ont introduit une alimentation complémentaire chez les enfants de 4 à 6 mois	41,8% des mères introduisent une alimentation complémentaire chez l'enfant entre 4 et 6 mois	60%	62%	
		Proportion d'enfants malnutris sévères identifiés et référés pour traitement approprié			Non mesuré par KPC	

* UNICEF : Rapport de l'enquête sur les objectifs de la fin de décennie sur l'enfance MICS décembre 2000

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJECTIF S	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
DIARRHEE	Réduire la malnutrition et la mortalité due à la diarrhée par une prise en charge précoce et appropriée des cas dont la référence	Proportion d'enfants de 0-23 mois ayant reçu la même quantité ou plus d'aliments, de lait maternel / liquides durant leur dernier épisode diarrhéique.	37, 2 %	68 %	63%	
		Proportion de structures de santé dont le matériel et l'équipement sont sur place de même que le personnel pour la PEC des cas sévères de diarrhée.			Non mesuré par KPC	
		Proportion d'enfants de 0-23 mois référés à la case puis au poste de santé chez l'ICP pour diarrhée sévère.			Non mesuré par KPC	

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
DIARRHEE	Réduire la malnutrition et la mortalité due à la diarrhée par une prise en charge précoce et appropriée des cas dont la référence	Proportion de mères sachant verbalement comment préparer la solution de réhydratation par voie orale	20,4%	80%	78%	
		Proportion de mères pouvant citer au moins un signe qui nécessite une référence en cas de diarrhée	30%	60 %	57% <i>Fièvre</i>	
		Proportion des causeries organisées sur la diarrhée dans les cases et PPS.			Non mesuré par KPC	

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
VACCINATION	Achever la couverture infantile en vaccination dans la zone du projet pour tous les enfants avant leur premier anniversaire et au moins deux VAT pour les FAR surtout les mères d'enfants âgés de 0 à 23 mois	Proportion d'enfants de 0-23 mois disposant d'une carte de vaccination	70,1% des enfants de 0-23 mois disposent de carte de vaccination / SNP	90 %	96%	
		proportion d'enfants de 12- 23 mois complètement vaccinés	30,8% des enfants de 12-23 mois sont complètement vaccinés	70%	82%	² 40%
		Proportion d'enfants de 12-23 mois ayant reçu le vaccin anti rougeoleux	37,1% des enfants de 12-23 mois sont vaccinés contre la rougeole	70%	87%	

		Proportion d'enfants de 12-23 mois ayant reçu le vaccin DTCP3	31,2% des enfants de 12-23 mois sont vaccinés au DTCP3	70%	90%	
		Proportion de mères d'enfants de 0-23 mois et détentrices de carnet de santé ayant reçu au moins deux VAT	53,3% des mères d'enfants âgés de 0-23 mois et détentrices de carnet de santé ont reçu au moins deux VAT	80%	75%	
		Proportion d'enfants de 12-23 mois ayant fait leur DTC1 et aussi leur DTC3	47% des enfants âgés de 12-23 mois ne terminent pas leur série de DTC	10 %	10%	
		Proportion de postes de santé disposant d'une chaîne de froid convenable			Non mesuré par KPC	
		Proportion de causeries organisées sur la vaccination dans les cases et PPS			Non mesuré par KPC	

2 Ministère de la Santé et de la Prévention Direction de la Santé Division des Soins de Santé Primaires – **Présentation des résultats du monitoring**
2^{ème} semestre 2001 mai 2002

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
I.R.A	Réduire la mortalité due à la pneumonie par une prise en charge précoce et de qualité des cas	Proportion de femmes ayant des enfants de 0-23 mois et sachant reconnaître au moins un signe de danger pour les infections respiratoires aiguës	33,9%		63% <i>Dyspnée</i>	
		Proportion d'enfants de 0-23 mois présentant un signe de danger pour les infections respiratoires aiguës et référés dans une structure sanitaire	40,3%	80%	70% <i>Poste</i>	

		Proportion du personnel des centres et postes de santé formée à la prise en charge des infections respiratoires aiguës			Non mesuré par KPC	
		Proportion de postes de santé ayant un stock d'antibiotiques disponible pour la prise en charge des infections respiratoires aiguës			Non mesuré par KPC	
		Proportion de causeries organisées sur les infections respiratoires aiguës dans les cases et PPS			Non mesuré par KPC	

DOMAINES D'INTERVENTION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJECTIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIONALE
HYGIENE ET ASSAINISSEMENT	Evaluer le niveau de connaissances des mères sur les bonnes pratiques d'hygiène alimentaire chez l'enfant et le niveau de disponibilité de latrines dans les concessions	Proportion de mères d'enfants de 0-23 mois connaissant au moins une bonne pratique d'hygiène alimentaire à appliquer vis à vis de l'enfant			69% avant de donner à manger aux enfants	
		Proportion de concessions où les habitants disposent de latrines			77%	

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
IST / SIDA	Evaluer le niveau de connaissances des mères sur le SIDA	Proportion de mères d'enfants de 0-23 ayant entendu parler du SIDA			91%	
		Proportion de mères d'enfant de 0-23 mois connaissant au moins un mode de transmission du SIDA			76% voie sexuelle	

		Proportion de mères d'enfant de 0-23 mois connaissant au moins une méthode de protection contre le SIDA			64% <i>Fidélité</i>	
		Proportion de mères d'enfant de 0-23 mois connaissant au moins un signe d'infection génitale chez la femme			19% <i>Pertes</i>	

DOMAINES D'INTERVEN TION	BUTS DU PROJET	INDICATEURS	ENQUETE DE BASE FEVRIER 1999	OBJEC TIFS	ENQUETE FINALE JUILLET 2002	SITUATION NATIO NALE
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MATERNITE A MOINDRES RISQUES	Evaluer le niveau de connaissances des mères sur les grossesses à risques et les différentes méthodes de planning familial	Proportion de mères d'enfants de 0-23 connaissant au moins un facteur de risques.			28% <i>Manque ou insuffisance de consultations pré natales</i>	
		Proportion de mères d'enfants de 0-23 mois ayant bénéficié de l'assistance d'un personnel de santé qualifié ou une matrone.			77% <i>(avec 40% pour les matrones)</i>	
		Proportion de mères d'enfants de 0-23 mois qui connaissent au moins une méthode de planification familiale			69%	
		Proportion de mères d'enfants de 0-23 mois ayant effectué au moins 3 consultations pré natales lors de leur dernière grossesse	47,2%		53%	3 21,02%

3 Ministère de la Santé et de la Prévention Direction de la Santé Division des Soins de Santé Primaires – **Présentation des résultats du monitoring 2ème semestre 2001** mai 2002

ANNEXE 3 : LISTE DES VILLAGES

ZONE DE KAOLACK

NUMERO	COMRUR	LOCALITE	POPTOT 98	POPTOT02	CUMUL	GRAPPE
1	MABA	BOUSSOURA	181	202.72	203	
2	MABA	DAROU	91	101.92	305	
3	MABA	DIAWENE	300	336	641	
4	MABA	FAYENE	150	168	809	
5	MABA	GORIA	774	866.88	1676	1
6	MABA	K. AMATH SEYDOU	474	530.88	2206	
7	MABA	K. DIAMBODJI	193	216.16	2423	
8	MABA	K. MATAR DRAME	80	89.6	2512	
9	MABA	K. SAMBA YACINE	234	262.08	2774	
10	MABA	K.MALICK RAMATA	392	439.04	3213	
11	MABA	K.THIerno DIEYE	510	571.2	3784	
12	MABA	KEUR FODE	523	585.76	4370	2
13	MABA	KEUR GORY	302	338.24	4708	
14	MABA	KEUR GUELADIO	524	586.88	5295	
15	MABA	KEUR HERRY	268	300.16	5596	
16	MABA	KEUR MABA	910	1019.2	6615	3
17	MABA	KEUR MAKONDJI	500	560	7175	
18	MABA	KEUR MASSAMBA	260	291.2	7466	
19	MABA	KEUR MASSAR BA	251	281.12	7747	
20	MABA	KEUR SERIGNE BA	341	381.92	8129	
21	MABA	KOURANKO	153	171.36	8300	
22	MABA	LOUMENE OUSMANE	400	448	8748	
23	MABA	MBOULEDDJA	262	293.44	9042	
24	MABA	MBOWENE	194	217.28	9259	
25	MABA	MODOU BONGUEL	201	225.12	9484	4
26	MABA	NAOULEROU	332	371.84	9856	
27	MABA	NDAME LO	240	268.8	10125	
28	MABA	NDEMENEL	140	156.8	10282	
29	MABA	NDIAGNE WALO	1023	1145.76	11427	
30	MABA	NDIAYENE	284	318.08	11745	
31	MABA	NDIOBENE WALO	900	1008	12753	5
32	MABA	NDRAME DIMB	415	464.8	13218	
33	MABA	NDRAME NGATA	168	188.16	13406	
34	MABA	NGAYENE SINE	356	398.72	13805	
35	MABA	NGUEYENE MAMADY	362	405.44	14211	
36	MABA	NIANGUENE	275	308	14519	
37	MABA	NIASSENE WALO	400	448	14967	6
38	MABA	PANE ABLAYE DIO	861	964.32	15931	
39	MABA	PASSY KHOUR	252	282.24	16213	
40	MABA	SALAOBE	170	190.4	16404	
41	MABA	SANTHIE MAKHA	138	154.56	16558	
42	MABA	SANTHIE MBAYENE	270	302.4	16860	
43	MABA	SANTHIEBAYEMBAY	325	364	17224	

44	MABA	SANTHIENDRAMTAB	152	170.24	17395	
45	MABA	TAMSIR K.KHODIA	79	88.48	17483	
46	MABA	TAW FEEX	172	192.64	17676	7
47	MABA	THIAMBENE	450	504	18180	
48	MABA	THIARENE MATAR	914	1023.68	19204	
49	MABA	THILLA GALO	147	164.64	19368	
50	MABA	THILLA GRAND	825	924	20292	
51	MABA	THILLA NDIAYE	385	431.2	20723	8
52	MABA	THIOYENE	234	262.08	20985	
53	MABA	TONGO	133	148.96	21134	
54	MABA	VELINGARA	1365	1528.8	22663	
55	MADI	ABOU DIAFFE	669	749.28	23412	9
56	MADI	DOUBOUROU	196	219.52	23632	
57	MADI	KEUR MADIABEL	10167	11387.04	35019	10-11-12-13
58	MADI	KEUR MALO	136	152.32	35171	
59	MADI	KEUR MANDOGO	984	1102.08	36273	
60	MADI	KEUR MANIEBE	279	312.48	36586	
61	MADI	KOUDAME	224	250.88	36837	
62	MADI	LOHENE ALY	128	143.36	36980	14
63	MADI	LOHENE BABOU	215	240.8	37221	
64	MADI	MISSIRA DINA	453	507.36	37728	
65	MADI	NDEME	517	579.04	38307	
66	MADI	NDIAGO II	378	423.36	38731	
67	MADI	NDIENGUENE IBRA	417	467.04	39198	
68	MADI	NDIOUGOUTYMALIC	195	218.4	39416	
69	MADI	NDIOUGOUTYSERIG	245	274.4	39691	15
70	MADI	SANTHY YORO	33	36.96	39728	
71	MADI	SANTHYBAYEMBAYE	72	80.64	39808	
72	MADI	TAIBA MBAYENE	642	719.04	40527	
73	MADI	THIAMENEOUSMANE	416	465.92	40993	
74	MADI	THIANDA	32	35.84	41029	
75	MADI	THIOYENE	452	506.24	41535	
76	MADI	THISSE K.MADOGO	290	324.8	41860	
77	NDRA	AINOUMANE	14	15.68	41876	
78	NDRA	BOWE	791	885.92	42762	16
79	NDRA	DJISSA SADIO	125	140	42902	
80	NDRA	DJISSA ALIOU	344	385.28	43287	
81	NDRA	HANENE	91	101.92	43389	
82	NDRA	K. ABDOU MATA	113	126.56	43515	
83	NDRA	K. CHEIKH KANDJ	115	128.8	43644	
84	NDRA	K. FAFA BOURY	327	366.24	44010	
85	NDRA	K. LAYINE SAKHO	517	579.04	44589	
86	NDRA	K. MALICK DIARE	296	331.52	44921	
87	NDRA	K. MAMOUR ANTA	337	377.44	45298	17
88	NDRA	K. MATAR SOUNA	184	206.08	45504	
89	NDRA	K. MOMATH ANTA	648	725.76	46230	
90	NDRA	K. SERIGNE NDAR	183	204.96	46435	
91	NDRA	K.BIRANE GUEYE	142	159.04	46594	
92	NDRA	K.BIRANE NDOUPY	965	1080.8	47675	

93	NDRA	K.EL HADJI SAMB	181	202.72	47878	
94	NDRA	KERE WALO	103	115.36	47993	18
95	NDRA	KEUR BAKA AWA	170	190.4	48184	
96	NDRA	KEUR BOH FALL	72	80.64	48264	
97	NDRA	KEUR DAME	285	319.2	48583	
98	NDRA	KEUR GAYE	251	281.12	48864	
99	NDRA	KEUR KATIM	107	119.84	48984	
100	NDRA	KEUR MACIRE	157	175.84	49160	
101	NDRA	KEUR MASSAKHO	180	201.6	49362	
102	NDRA	KEUR THIerno	240	268.8	49631	
103	NDRA	KOTONETE	728	815.36	50446	
104	NDRA	MBAKERY	193	216.16	50662	
105	NDRA	MEDINA DIANE	178	199.36	50861	19
106	NDRA	MEDINA MBANDJI	286	320.32	51182	
107	NDRA	MEDINA SALAM	146	163.52	51345	
108	NDRA	MISSIRAH THISSE	260	291.2	51636	
109	NDRA	NDAWENE	96	107.52	51744	
110	NDRA	NDIAYE COUNDA	169	189.28	51933	
111	NDRA	NDIENGUENE MODY	387	433.44	52367	
112	NDRA	NDIOBENE	199	222.88	52590	
113	NDRA	NDIOFFORY	265	296.8	52886	
114	NDRA	NDRAME ESCALE	1230	1377.6	54264	20
115	NDRA	NGUEYENE NDARY	57	63.84	54328	
116	NDRA	TALLENE GOBO	44	49.28	54377	
117	NDRA	TALLENE GUEDE	249	278.88	54656	
118	NDRA	THIAMENE KMASSO	216	241.92	54898	
119	NDRA	THIAMENE M.BINT	289	323.68	55222	
120	NDRA	THIAMENE MAKa	226	253.12	55475	
121	NDRA	THIARENE DJISSA	415	464.8	55940	
122	NDRA	THIOYENE MATAR	108	120.96	56060	
123	NDRA	TOUBA II	404	452.48	56513	21
124	WACK	AMADY GUENAR	478	535.36	57048	
125	WACK	ASSANE DIASSE	228	255.36	57304	
126	WACK	BABOU MBOMBE	409	458.08	57762	
127	WACK	CHEIKHOU NDIAYE	190	212.8	57975	
129	WACK	DAGA BANY	376	421.12	58396	
130	WACK	FASS NGUAYENE	61	68.32	58464	
131	WACK	FETTO	315	352.8	58817	
132	WACK	GALAYE BARRY	69	77.28	58894	
133	WACK	GUEYENE DJIM	152	170.24	59064	22
134	WACK	GUINEE	226	253.12	59317	
135	WACK	K. AL MBATH	86	96.32	59414	
136	WACK	K. AMADY NDIIBE	90	100.8	59515	
137	WACK	K. DEMBA SIRA	184	206.08	59721	
138	WACK	K. MODOU NENE	290	324.8	60045	
139	WACK	K. SEYDOU HANE	220	246.4	60292	
140	WACK	K.DIAGA DIALLE	139	155.68	60448	
141	WACK	K.MADY YACINE	747	836.64	61284	
142	WACK	K.MAMADOU MAMA	170	190.4	61475	

143	WACK	K.MAMOUR COUMBA	510	571.2	62046	23
144	WACK	K.OMAR OUMY	264	295.68	62341	
145	WACK	K.SAMBA AMATH	289	323.68	62665	
146	WACK	KEUR BOURAMA	127	142.24	62807	
147	WACK	KEUR DINGUERE	105	117.6	62925	
148	WACK	KEUR LAMINE	130	145.6	63071	
149	WACK	KEUR MALAINE SA	155	173.6	63244	
150	WACK	KEUR MAME TAPHA	120	134.4	63379	
151	WACK	KEUR MATAR	470	526.4	63905	
152	WACK	KEUR MATEKHE	136	152.32	64057	
153	WACK	KEUR NDIAGAPEUL	85	95.2	64152	
154	WACK	KEUR NDONGO	338	378.56	64531	24
155	WACK	KEUR NGOR	250	280	64811	
156	WACK	KEUR SAMBA KA	400	448	65259	
157	WACK	KEUR SAROKHY	390	436.8	65696	
158	WACK	KEUR SEYDOU BA	217	243.04	65939	
159	WACK	KEUR YORO KHODI	1747	1956.64	67896	25
160	WACK	KOUTANGO	190	212.8	68108	
161	WACK	MANDERA	446	499.52	68608	
162	WACK	MBADIENE	371	415.52	69023	
163	WACK	MBAYENE	599	670.88	69694	
164	WACK	MEDINA MASS	184	206.08	69900	
165	WACK	MEDINA THIAMENE	532	595.84	70496	26
166	WACK	MERELA YORO	224	250.88	70747	
167	WACK	NDIAGO I	661	740.32	71487	
168	WACK	NDIAYENE GORKO	269	301.28	71789	
169	WACK	NDIBA	350	392	72181	
170	WACK	NGOMENE	170	190.4	72371	
171	WACK	NGUER BABOU	510	571.2	72942	27
172	WACK	NIDJIE	89	99.68	73042	
173	WACK	PANE SADER	564	631.68	73674	
174	WACK	PASSY BABOU	372	416.64	74090	
175	WACK	SABOYA	1202	1346.24	75436	
176	WACK	SAMAKO MBAMBARA	302	338.24	75775	28
177	WACK	SAMAKOU TOUCOUL	384	430.08	76205	
178	WACK	SAMBOUMBA	354	396.48	76601	
179	WACK	SANGOULAYENDIAG	150	168	76769	
180	WACK	SANTHIE MERELA	147	164.64	76934	
181	WACK	SANTHIE SAMADY	66	73.92	77008	
182	WACK	SOUKOUTA	904	1012.48	78020	
183	WACK	THIAMENE DOGO	388	434.56	78455	29
184	WACK	THIARENEALASSAN	678	759.36	79214	
185	WACK	THIWALLO	370	414.4	79629	
186	WACK	TOUBA I	160	179.2	79808	
187	WACK	TOUBA II	85	95.2	79903	
188	WACK	TOURE	80	89.6	79993	
189	WACK	WACK MBATIO	327	366.24	80359	
190	WACK	WACK NGOUNA	2057	2303.84	82663	30
			73806	82662.72		

Pas = $82663/30=2755$

Nombre au hazard = 1078 (01078878179)

ZONE DE LOUGA

NUMDO	CR	VIL	POP	PO002	CUMUL	GRAPPES
1	leon	AINOU MEDINA	30	34	34	
2	leon	BAITY GUEYE	400	448	482	
3	leon	BATLAMINE	358	401	883	
4	leon	BOUNDOUWOULA 1	217	243	1126	1
5	leon	BOUNDOUWOULA 2	43	48	1174	
6	leon	CHERIF	36	40	1214	
7	leon	DABAYE NDIAYE	36	40	1255	
8	leon	DAL DIAME	121	136	1390	
9	leon	DAO I	50	56	1446	
10	leon	DAO II	150	168	1614	
11	leon	DAROU NDIAYE	80	90	1704	
12	leon	DIAMAGUENE WOL.	33	37	1741	
13	leon	DIOKOUL WADE	82	92	1833	
14	leon	GABANE PEULH	185	207	2040	
15	leon	GABANE	205	230	2270	
16	leon	GABAR 1	241	270	2539	
17	leon	GABAR 2	148	166	2705	
18	leon	GALDAMEL	227	254	2959	2
19	leon	GOTY TOYE I	45	50	3010	
20	leon	GOTY TOYE II	110	123	3133	
21	leon	K. AMADY MOUNA	144	161	3294	
22	leon	K. GOUMBA FAYE	174	195	3489	
23	leon	K. MALICK FALL	173	194	3683	
24	leon	KEUR KOURA	503	563	4246	
25	leon	KEUR MANDIOL	116	130	4376	
26	leon	KEUR NDARY	78	87	4464	
27	leon	KEUR PATHE	4	4	4468	
28	leon	KOGNE KOGNE 1	85	95	4563	
29	leon	KOGNE KOGNE 2	50	56	4619	
30	leon	LAMBADJ NDIAYE	119	133	4753	3
31	leon	LAMBADJ PEUL	70	78	4831	
32	leon	LEONA	700	784	5615	
33	leon	LONGHOR	350	392	6007	
34	leon	MADEYANA	229	256	6263	
35	leon	MAKA M. MADICKE	97	109	6372	
36	leon	MAKA NDIAYE	70	78	6450	4
37	leon	MAKA TARE	144	161	6612	
38	leon	MARAYE SECK	140	157	6769	
39	leon	MARNANE	78	87	6856	
40	leon	MBANBE	56	63	6919	
41	leon	MB. MB. MAPATHE	593	664	7583	
42	leon	MBAYE M. MAYORA	72	81	7663	
43	leon	MEDINA WASSUMA.	100	112	7775	
44	leon	MEDINA THIOLOM.	380	426	8201	5

45	leon	MERINA DAKHAR	137	153	8354	
46	leon	MERINA N. PEULH	50	56	8410	
47	leon	MERINA SANTHIE	37	41	8452	
48	leon	MERINA SIMONG	89	100	8552	
49	leon	MOUREL	308	345	8897	
50	leon	NDADE	178	199	9096	
51	leon	NDALDAGO	149	167	9263	
52	leon	NDEMBA 1	105	118	9380	
53	leon	NDEMBA 2	125	140	9520	
54	leon	NDIAGNE FALL	140	157	9677	
55	leon	NDIALAKHAR SAMB	75	84	9761	
56	leon	NDIALE PEUL	80	90	9851	
57	leon	NDIALEGNE	139	156	10006	6
58	leon	NDIAMB FALL	559	626	10633	
59	leon	NDIAYENE PEULH1	142	159	10792	
60	leon	NDIAYENE PEULH2	212	237	11029	
61	leon	NDIAYE. SANTHIE	34	38	11067	
62	leon	NDIAYENE WOLOF	49	55	11122	
63	leon	NDIOBENE M. MAD	150	168	11290	
64	leon	NDOUNE	300	336	11626	
65	leon	NGUEURENG P. I	30	34	11660	
66	leon	NGUEURENG P. II	32	36	11695	
67	leon	NGUEURENG WOLOF	26	29	11725	
68	leon	NGONDAME	64	72	11796	7
69	leon	NGOUFAT I	250	280	12076	
70	leon	NGOUFATE II	221	248	12324	
71	leon	NIANDOUL	214	240	12563	
72	leon	NIAYEM	260	291	12855	
73	leon	NORAINY	34	38	12893	
74	leon	OUASSEMASSAL	194	217	13110	
75	leon	POTOU I	750	840	13950	8
76	leon	POTOU II	185	207	14157	
77	leon	RAYETTE MAYO	50	56	14213	
78	leon	SAGUE	25	28	14241	
79	leon	SAGUE D. YAGUE	420	470	14712	
80	leon	SAGUE SATHIELE	590	661	15372	9
81	leon	SAGUE SAYORO	62	69	15442	
82	leon	SALIMPEUL	70	78	15520	
83	leon	SALIM SARR	104	116	15637	
84	leon	SAM NDIAYE	89	100	15736	
85	leon	SAM SECK	157	176	15912	
86	leon	SAM SAM	9	10	15922	
87	leon	SANTHIOU DABAYE	65	73	15995	
88	leon	SANTHIOU DIADJI	321	360	16355	
89	leon	SANTHIOU DIAOBE	36	40	16395	
90	leon	SERRE PEULH	180	202	16597	
91	leon	SERRE WOLOF	55	62	16658	
92	leon	TAIBA PEUL 1	105	118	16776	
93	leon	TAIBA PEUL 2	69	77	16853	

94	leon	TARE	642	719	17572	10
95	leon	THIARE NDIAYE	330	370	17942	
96	leon	THIARE PEULH I	52	58	18000	
97	leon	THIAR PEULH II	42	47	18047	
98	leon	THIARE SENE	91	102	18149	
99	leon	THIARENE	120	134	18283	
100	leon	THIELEMANE	42	47	18330	
101	leon	THIOWOR	1456	1631	19961	11
102	leon	TOBY DIOP	50	56	20017	
103	leon	WAKHALE DIAME	124	139	20156	
104	leon	WEKHE	89	100	20256	
105	leon	YAGOUL BOYO	114	128	20383	
106	ngue	AFE NIANG	160	179	20562	
107	ngue	BAITY RIP	316	354	20916	12
108	ngue	BANGATH	360	403	21320	
109	ngue	BAY NACK LO	107	120	21439	
110	ngue	BAY NACK PEULH 1	36	40	21480	
111	ngue	BAYE NACK PEUL2	30	34	21513	
112	ngue	DABAYE PEULH 1	60	67	21581	
113	ngue	DABAYE PEULH 2	50	56	21637	
114	ngue	DABAYE SARR	370	414	22051	
115	ngue	DAROU NIANG	162	181	22232	
116	ngue	DIADJI BOU MACK	575	644	22876	13
117	ngue	DIADJI NGAYTA	19	21	22898	
118	ngue	DIAMA	75	84	22982	
119	ngue	DIAPAL PEULH	35	39	23021	
120	ngue	DIAPAL SARR	41	46	23067	
121	ngue	FASS GAYE	16	18	23085	
122	ngue	GANAR	49	55	23140	
123	ngue	GOUYAR SARR	1128	1263	24403	14
124	ngue	KEBE SAME PEULH	90	101	24504	
125	ngue	KEUR BARA WADE	55	62	24565	
126	ngue	KEUR MAFALL	300	336	24901	
127	ngue	KEUR SAMBOU I	672	753	25654	
128	ngue	KEUR SAMBOU II	700	784	26438	15
129	ngue	KHAMBALA FALL	286	320	26758	
130	ngue	KHAMBALA TOP	161	180	26939	
131	ngue	KHANADJI	141	158	27097	
132	ngue	KHELCOM PEULH	80	90	27186	
133	ngue	KHELCOM SARR	20	22	27209	
134	ngue	MBANDE DIOP	143	160	27369	
135	ngue	MBAYE MBA. FARI	102	114	27483	
136	ngue	MBAYE MBAYE SALIOU	36	40	27523	
137	ngue	MBAYENE	83	93	27616	
138	ngue	MBOUBENE MBATAR	111	124	27741	16
139	ngue	MERINA BA	71	80	27820	
140	ngue	MERINA DIOP	17	19	27839	
141	ngue	MERINA BA	71	80	27919	
142	ngue	NDAME LO	42	47	27966	

143	ngue	NDAME PEULH	60	67	28033	
144	ngue	NDER MBALO	157	176	28209	
145	ngue	NDER NIANG	52	58	28267	
146	ngue	NDIANDIA NIANG	135	151	28418	
147	ngue	NDIEYE NIANG	301	337	28755	
148	ngue	NDIOCK SALL	200	224	28979	
149	ngue	NGUEUNE SARR	664	744	29723	17
150	ngue	PALENE FALL	478	535	30258	
151	ngue	RIMBAKH	270	302	30561	
152	ngue	SANTH. DIOBENE	104	116	30677	
153	ngue	SINE PEULH	77	86	30763	
154	ngue	SINE WADE	220	246	31010	
155	ngue	THIARENE SARR	424	475	31485	18
156	ngue	THIECKENE	133	149	31634	
157	ngue	YAROUWAYE	320	358	31992	
158	ngue	YERMANDE DIENG	398	446	32438	
159	saka	AFE SOW	29	32	32470	
160	saka	AHLOULAYE GAYE	220	246	32717	
161	saka	AMBIDIEBE	80	90	32806	
162	saka	BADEME WOLOF	15	17	32823	
163	saka	BAIRATE MBAYE	22	25	32848	
164	saka	BAYRAT PEULH	70	78	32926	
165	saka	BAKHDAR MBENGUE	150	168	33094	19
166	saka	BARALE	750	840	33934	
167	saka	BARRY NIANG	104	116	34051	
168	saka	BARY PEUL	100	112	34163	
169	saka	BEGAYE SAMB	128	143	34306	
170	saka	BEGAYE ARDO	91	102	34408	
171	saka	BOGAL	100	112	34520	
172	saka	BOYA SECK I	64	72	34592	
173	saka	BOYA SECK II	51	57	34649	
174	saka	DAROU SALAM	69	77	34726	20
175	saka	DEBY DIAW	250	280	35006	
176	saka	DEBY PEUL	37	41	35047	
177	saka	DIAKHA LOUME	104	116	35164	
178	saka	FASS BAKHDAR	31	35	35199	
179	saka	GADE NAR	73	82	35280	
180	saka	GOUYE SAPP	136	152	35433	
181	saka	KADIAR DIOP	32	36	35469	
182	saka	KADIAR PEUL	400	448	35917	
183	saka	KALA DIENG	114	128	36044	
184	saka	KALA PEUL	50	56	36100	
185	saka	KALA SANTHIE	114	128	36228	
186	saka	KALA SARR	104	116	36344	
187	saka	K. ALIOU THIEDO	15	17	36361	
188	saka	K. BALLA NIASSE	150	168	36529	21
189	saka	K. BAME NDIAYE	100	112	36641	
190	saka	K. CODE	60	67	36708	
191	saka	K. IBRA NIANG	210	235	36944	

192	saka	K. MAANTA	117	131	37075	
193	saka	K.Ma ND. BACARY	120	134	37209	
194	saka	K.MBAYE KANE	400	448	37657	
195	saka	K.MBAYE KANE PEUL	58	65	37722	
196	saka	K.MEISSA MBOUP	174	195	37917	
197	saka	KEUR MODOU FALL	172	193	38110	
198	saka	KEUR MODY L.BA	63	71	38180	
199	saka	KEUR MOR DIOP	22	25	38205	
200	saka	KEUR PATHE PEUL	120	134	38339	22
201	saka	KEUR PATHE SANTHE	180	202	38541	
202	saka	KEUR SAM PENDEL	130	146	38686	
203	saka	KIP 35	15	17	38703	
204	saka	L'ISLAM I	78	87	38790	
205	saka	L'ISLAM II	32	36	38826	
206	saka	MAKA FALL	340	381	39207	
207	saka	MAKA GUEYE	89	100	39307	
208	saka	MAKA LEYE	99	111	39418	
209	saka	MAKA YAMB YADE	40	45	39462	
210	saka	MARAYE PEULH	40	45	39507	
211	saka	MARAYE WOLOF	36	40	39548	
212	saka	MASSAR DIOP I	61	68	39616	
213	saka	MASSAR DIOP 2	63	71	39686	
214	saka	MASSAR I	61	68	39755	
215	saka	MBAND PEULH	105	118	39872	
216	saka	MBAYE M. DIAGNE	70	78	39951	
217	saka	MBAYE MB. PEULH	60	67	40018	23
218	saka	MBEKHEUL PEULH	103	115	40133	
219	saka	MBRAMA RATE	177	198	40332	
220	saka	MBOUBENE MBAKHDAR	27	30	40362	
221	saka	MERINA PALLENE FALL	88	99	40460	
222	saka	MOURA	15	17	40477	
223	saka	N'DABE TALL	130	146	40623	
224	saka	NDADJ SARR	724	811	41434	
225	saka	NDANGAR NDIAYE	300	336	41770	24
226	saka	NDANGOUR FALL	142	159	41929	
227	saka	N'DIAWASS	200	224	42153	
228	saka	NDINDE I	101	113	42266	
229	saka	NDINDE II	99	111	42377	
230	saka	NDIAGUENE PEUL	180	202	42578	
231	saka	NDIAGUENE PEUL	181	203	42781	
232	saka	NDIAYENE POTOU	50	56	42837	
233	saka	NDIEYE PEUL	35	39	42876	
234	saka	NDIEYE SATOURE	245	274	43151	
235	saka	NDIOBENE DIAMADJ	90	101	43251	
236	saka	NDIOBENE MBATAR	158	177	43428	
237	saka	NDIOMBOSSE DIOP	60	67	43496	
238	saka	NDOUFFENE	100	112	43608	25
239	saka	NDIOURENE	20	22	43630	
240	saka	NGAAINDE (k.Djiby sow)	180	202	43832	

241	saka	NGAYE BALLA	146	164	43995	
242	saka	NGAYENE SARR	100	112	44107	
243	saka	NGOMENE	70	78	44186	
244	saka	NGONAKE	112	125	44311	
245	saka	NGUICK FALL	840	941	45252	
246	saka	NIANGUENE	133	149	45401	26
247	saka	PENEIDJI	150	168	45569	
248	saka	RIMBAX SYLLA	302	338	45907	
249	saka	ROYE DIEYE	337	377	46284	
250	saka	ROYE PEULH	15	17	46301	
251	saka	SAKAL	1420	1590	47892	27
252	saka	SANTHIOU MERINA	380	426	48317	
253	saka	SINOUE BAR	121	136	48453	
254	saka	TABANE PEULH	30	34	48486	
255	saka	TAIBA NDIAYE	800	896	49382	28
256	saka	TEUDBITY NDIQB.	100	112	49494	
257	saka	THIALA KEBE	170	190	49685	
258	saka	THIAMBENE SAMBE	210	235	49920	
259	saka	THIAMBENE TILL	170	190	50110	
260	saka	THIAR ALL	75	84	50194	
261	saka	THIAR DIOP	120	134	50329	
262	saka	THIAR NDIAYE	113	127	50455	
263	saka	THIARE PEULH	110	123	50578	
264	saka	THIARENE SYLLA	80	90	50668	29
265	saka	THIEKENE	140	157	50825	
266	saka	THIELE PEULH	35	39	50864	
267	saka	THIELE WOLOF	250	280	51144	
268	saka	TOGAL NDIAYE	97	109	51253	
269	saka	TOGAL PEUL	183	205	51458	
270	saka	WADANE WOLOF	100	112	51570	
271	saka	WARENE PEULH	40	45	51614	
272	saka	WARENE WOLOF	300	336	51950	
273	saka	YADOULAYE	286	320	52271	
274	saka	YAKHI NIAY (WINDOU)	302	338	52609	30
275	saka	YAMANE SECK	70	78	52687	
276	saka	YARI DAKHAR	300	336	53023	

NOMBRE AU HAZARD 11048
PAS DE SONDAGE= 1767

ANNEXE 4 : QUESTIONNAIRE

Plan Sénégal
Au service de l'enfance
BP 320
LOUGA

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9674280
9674461
FAX : 9671 667
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QUESTIONNAIRE ENQUETE KPC Districts Sanitaires de Louga et Nioro (Kaolack)

District Sanitaire :
Département:.....
Arrondissement:.....
Communauté Rurale :.....
Village :.....
N° Grappe :
Quartier :.....
Date de l'enquête : __ __/__ __/ __ __
Nom de l'enquêteur :
Nom du superviseur :.....

*Salutations, expliquer le but de votre visite. Demander les documents existants concernant l'enfant et sa mère
(carnet de santé, fiche de vaccination, bulletin de naissance, carte d'identité de la mère, jugement supplétif....)*

I - IDENTIFICATION

- 1 - Nom de la mère :**
Date de naissance de la mère (*Demander si possible un document*): jour/mois/année ____ / ____ / ____
Age de la mère en années : (*à calculer à partir de la date de naissance*)..... ____
- 2 - Nom de l'enfant :**
Date de naissance de l'enfant (*Demander si possible un document*): jour/mois/année ____ / ____ / ____
Age de l'enfant en mois : (*à calculer à partir de la date de naissance*)..... ____
- 3 - Espace inter génésique entre les enfants âgés de 0 – 59 mois :**
Donner l'âge en mois (*si possible après avoir consulté un document des enfants de la tranche d'âge concernée à savoir 0 – 59 mois*) des éventuels frères et sœurs de (**Nom de l'enfant**) et qui sont âgés de moins de 60 mois *EN ALLANT DU MOINS AGE AU PLUS AGE*
- 1 - 2^{ème} enfant (qui vient immédiatement AVANT(**Nom de l'enfant**) : âge de l'enfant en mois.....mois
2 - 3^{ème} enfant : **âge de l'enfant en mois**mois
3 - 4^{ème} enfant : **âge de l'enfant en mois**mois

4 - 5^{ème} enfant : âge de l'enfant en moismois

II- INSTRUCTION ET OCCUPATION DE LA MERE

4- *Ndax meun nga jang ?* Savez vous lire ?

(Plusieurs réponses sont possibles, noter toutes les réponses)

1. Français.....[]
2. Arabe (Wolofal).....[]
3. Langues Nationales.....[]
4. Autres langues (à préciser)[]
5. Ne sait pas lire.....[]

5- *Ndax ame nga yengu yengu yuy jur koom-koom ?* Avez-vous une activité génératrice de revenu ?

(Plusieurs réponses sont possibles, noter toutes les réponses)

1. Aucune.....[]
2. Travail artisanal.....[]
3. Agriculture de rente.....[]
4. Petit commerce à domicile.....[]
5. Commerce au Marché.....[]
6. Autres (à préciser).....[]

III- SUIVI DE LA GROSSESSE ET DE L'ACCOUCHEMENT

6- *Ndax ame nga karne wer-gi yaram walla yenneen kayit yu ko firndéel* Avez-vous un carnet de santé ou autre document de santé? ?

1. Oui..... [] *(Demander à voir le document et remplir les questions de 7 à 11)*
2. Non..... [] *(Passer à la question 12)*

7- *Regardez et notez le nombre de consultations prénatales inscrites sur le document.*

1. Aucune..... []
2. Une visite..... []
3. Deux visites []
4. Trois. visites et plus..... []

8- *Regardez et notez le nombre de consultations postnatales inscrites sur le document.*

1. Aucune..... []
2. Une visite..... []
3. Deux. visites []
4. Trois. visites et plus..... []

9- *Regardez et notez s'il y a des prescriptions de comprimés de fer sur le document.*

1. Oui..... []
2. Non..... []

9 bis- *Regardez et notez s'il y a des prescriptions de comprimés de Vitamine A sur le document.*

1. Oui..... []
2. Non..... []

10- *Regardez et notez s'il y a des prescriptions de chloroquine sur le document.*

1. Oui..... []
2. Non..... []

11- *Regardez et notez le nombre de vaccinations antitétaniques inscrites sur le document*

1. Aucune[]
2. Une.....[]

3. Deux ou plus.....[]

12- *Jigeen ju emb, niata yoon la wara dem gnu seet ko (wisitu) ?*

Selon vous, combien de fois une femme enceinte doit-elle aller en consultations prénatales ?

Ne pas lire les réponses ci- dessous

1. Moins de trois fois..... []
2. Trois fois et plus..... []
3. Ne sait pas []

13- *Bo eumbé yan niam nga warul léke?*

Selon vous, quels aliments vous ne mangez pas si vous êtes enceinte ?

(Plusieurs réponses sont possibles, noter toutes les réponses) - Ne pas lire les réponses ci-dessous

1. Protéines (œuf, viande, poisson).....[]
2. Fruits []
3. Légumes..... []
4. Céréales.....[]
5. Aucun interdit alimentaire.....[]
6. Autres (à préciser).....[]
7. Ne sait pas[]

14- *Ku la dimbali ci daggumlutt bi ngay mucc ci (turu xale bi) ?*

Qui vous a assisté (coupé le cordon) pour l'accouchement de (nom de l'enfant) ?

1. Médecin / Infirmier / Sage-femme... ..[]
2. Matrone.....[]
3. Accoucheuse Traditionnelle[]
4. Parents, Amies, Voisins.....[]
5. Aucune Personne.....[]

15 – *Yann gallankor (melo) nga xam you mana indi ay jafe-jafe ci jigeeen bu ëmb ?*

Quels sont les facteurs de risques liés à la grossesse ? Ne pas lire les réponses

1. femme en grossesse âgée de moins de 18 ans[]
2. femme en grosses âgée de plus de 40 ans[]
3. femme en grossesse **mesurant moins d'un mètre cinquante (1,50m).**[]
4. femme qui boîte et qui tombe en grossesse[]
5. femme en grossesse pour la 4è fois ou plus[]
6. femme en grossesse et qui a déjà avorté[]
7. femme en grossesse et qui a déjà eu un mort-né[]
8. femme en grossesse et qui est anémiée (très pâle)[]

9. femme enceinte diabétique[]
10. femme en grossesse et qui est hyper tendue[]
11. femme dont le volume abdominal dépasse l'âge de la grossesse[]
12. femme en grossesse et qui présente des oedèmes (jambes gonflées)[]
13. femme en grossesse et qui présente de l'albumine dans les urines (urines troubles)[]
14. femme en grossesse et qui ne perçoit pas les mouvements fœtaux (enfant ne bouge pas)[]
15. femme en grossesse qui n'a pas effectué les consultations prénatales (ou ne les a pas terminées)[]
16. femme en grossesse et qui a le corps chaud[]
17. femme en grossesse et qui perd du sang[]
18. un accouchement qui a duré 24 heures ou plus[]
19. grossesses rapprochées : intervalle inférieur à 2 ans[]
20. ancienne opérée au cours d'un accouchement[]

IV- ALIMENTATION DE L'ENFANT

16- *Fi gnu tollu, ndax yaa ngi naampal (turu xale bi) ak sa ween ?*

Donnez-vous actuellement le sein à (nom de l'enfant) ?

1. Oui..... [] *Si oui passer à la question 18*
2. Non..... []

17- *Da woon ngay naampal (turu xale bi) ak sa ween ?*

Avez-vous donné auparavant le sein à (nom de l'enfant) ?

1. Oui..... [] *Passer à la question 18*
2. Non..... [] *(Passer à la Question 19)*

18- *Nu diir bi tollu ci diggaante juddug (turu xale bi) ak fimu ndieuké nampe ?* Combien de temps s'est il écoulé entre la naissance de (nom de l'enfant) et sa mise au sein ?

1. Dans la première heure après sa naissance..... []
2. Entre une à huit heures après sa naissance..... []
3. Au delà de huit heures après sa naissance..... []
4. Ne se rappelle pas..... []

19- *Cette question comporte plusieurs items allant de « a à l » ; les lire:*

a. *Dinga jox (turu xale bi) ndox walla yeneen yu ni mel ?*

Donnez-vous a (nom de l'enfant) de l'eau ou autre liquides ?

1. Oui..... []
2. Non..... []

b. Dinga jox (туру хале би) beneen meew bu dul sa bos ?

Donnez-vous à (nom de l'enfant) un autre lait que le lait maternel?

1. Oui..... []

2. Non..... []

c. Dinga jox (туру хале би) ruuye, sombi walla fondé ?

Donnez-vous à (nom de l'enfant) de la bouillie?

1. Oui..... []

2. Non..... []

d. Dinga jox (туру хале би) ay megnneefu kaw ?

Donnez-vous à (nom de l'enfant) des fruits?

1. Oui..... []

2. Non..... []

e. Dinga jox (туру хале би) karoot, mango walla pappayo ?

Donnez-vous à (nom de l'enfant) de la carotte, des mangues ou des papayes?

1. Oui..... []

2. Non..... []

f. Dinga jox (туру хале би) ay gnam yu demé ni mbum (nabadaay, ndure, thiakhat), supomme, bissap, walla xobu gnambi ak lu ni mel ?

Donnez-vous à (nom de l'enfant) des aliments à base de feuilles vertes ?

1. Oui..... []

2. Non..... []

g. Dinga jox (туру хале би) ndawal, maanaam yapp, djeun, kethiakh walla guedj ?

Donnez-vous à (nom de l'enfant) de la viande ou du poisson ?

1. Oui..... []

2. Non..... []

h. Dinga jox (туру хале би) bereef, niébbé mbaa guerte ?

Donnez-vous à (nom de l'enfant) du « beref », du niébe ou des arachides ?

1. Oui..... []

2. Non..... []

i. Dinga jox (туру хале би) ay nen mba soow ?

Donnez-vous à (nom de l'enfant) des œufs ou du lait caillé ?

1. Oui..... []

2. Non..... []

j. Dinga yokk lém walla suukar ci niami (туру хале би) ?

Ajoutez-vous du miel ou du sucre aux aliments de (nom de l'enfant) ?

1. Oui..... []

2. Non..... []

k. Dinga yokk diw maanaam diwunior, diwutiir, dax ak niomseen ci niami (туру хале би) ?

Ajoutez-vous du beurre ou autre graisse aux aliments de (nom de l'enfant)?

1. Oui..... []

2. Non..... []

l. Ndax xorom iodé nguay xoromé niami (туру хале би) ?

Ajoutez-vous du sel iodé aux aliments de (nom de l'enfant)?

1. Oui.....[]
2. Non.....[]
3. Ne connaît pas.....[]

m. *Ndax xalébi moss na dieul toxh vitamine A ba mou amé djirom ben wer ak legui ?*

A t-on administré de la vitamine A à l'enfant depuis qu'il a atteint l'âge de 6 mois ? (expliquer que la vitamine A est contenue dans des capsules utilisées lors des Journées Nationales de Micro nutriments (JNM) pour la différencier de la polio orale des Journées Nationales de Vaccination (JNV))

1. **Oui (lors des JNM ou dans une structure sanitaire, points de prestations de services).....[]**
2. **Non.....[]**

20- *Ci sa xalaat, busa doom amé niaata weer nga ko wara jox yeneen niam yudul sa ween ?*

Selon vous, à quel âge une mère doit-elle introduire d'autres aliments que le lait maternel?

1. Avant 4 mois..... []
2. Entre 4 et 6 mois..... []
3. A 6 mois ou plus..... []
4. Ne sait pas..... []

V- DIARRHEE

21- *(Turu xale bi) ndax amoonna biir buy daw, ci biir niaari ayi bés yu mujj yi ?*

(Nom de l'enfant) a-t-il eu la diarrhée dans les quinze jours précédant l'enquête?

1. Oui..... [] *(Passer à la question 22)*
2. Non..... [] *(Passer à la question 27)*
3. Ne sait pas..... [] *(Passer à la question 27)*

22- *Bi biiru (turu xale bi) di daw, ndax daan nga ko jox ween wi :*

Pendant la diarrhée de (nom de l'enfant) l'avez vous allaité au sein :

SI OUI

(Lire les différents choix à la maman)

1. Plus que d'habitude ***Lu eppe li daan ame***[]
2. Comme d'habitude ***Naka ni mu daan amé***.....[]
3. Moins que d'habitude.... ***Lu yéés ni mu daan amé***.....[]

SI NON

(Lire les différents choix à la maman)

4. Vous avez arrêté de l'allaiter ***Da nga bayyi woon nampal bi***.....[]
5. Votre enfant était déjà sevré ***Daffa fekkoon mu fer***.....[]

23- Bi biiru (turu xale bi) di daw, daa woon nga ko jox ndox ak lu mel ni xeetu ndox yuduul sa ween :

Pendant la diarrhée de (nom de l'enfant), lui avez-vous donné des liquides autres que le lait maternel :

SI OUI

(Lire les différents choix à la maman)

1. Plus que d'habitude.. **Lu eppe li daan**

ame.....[]

2. Comme d'habitude..... **Naka ni mu daan amé**.....[]

3. Moins que d'habitude.... **Lu yéés ni mu daan amé**.....[]

SI NON

(Lire les différents choix à la maman)

4. Vous avez arrêté de lui donner des liquides autres que le lait maternel. **Da nga bayyi woon di ko jox ndox ak lu mel ni xeetu ndox yuduul sa ween**.....[]

5. Vous l'avez allaité exclusivement au sein.... **Da nga ko nampal ween rek**..[]

24- Bi biiru (turu xale bi) di daw, daa woon nga ko jox ruuy walla yeneeni niam ?

Pendant la diarrhée de (nom de l'enfant), lui avez-vous donné des bouillies ou autres aliments

SI OUI

(Lire les différents choix à la maman)

1. Plus que d'habitude.. **Lu eppe li daan ame**...

.....[]

2. Comme d'habitude..... **Naka ni mu daan amé**.

.....[]

3. Moins que d'habitude.... **Lu yéés ni mu daan amé**.....[]

SI NON

(Lire les différents choix à la maman)

4. Vous avez arrêté de lui donner des bouillies ou autres aliments **Da nga bayyi woon di ko jox ruuy walla yeneeni niam**.....[]

5. Vous l'avez allaité exclusivement au sein . **Da nga ko nampal ak sa ween rek**.....[]

25- Bi biiru (turu xale bi) di daw, naka nga ko faje ?

Pendant la diarrhée de (nom de l'enfant), quels traitements lui avez-vous donnés ?

(Plusieurs réponses sont possibles, mais ne pas lire les réponses à la maman)

1. Aucun traitement..... []

2. Sachet de

RVO.....[]

3. Solution domestique eau- sel-

sucré.....[]

4. « Liquides maison » : Infusions, Tisanes ou “Jus de Bouye”
.....[]
5. Médicaments anti-diarrhéiques,
antibiotiques.....[]
6. Autres (à préciser)
.....[]

26- *Fo yobbu woon (turu xale bi) mu faju, walla ko laajoon xalaatam bi biiram di daw ?*

Pendant la diarrhée de (nom de l'enfant) où vous vous êtes adressée pour demander des conseils ou traitements ? (Plusieurs réponses sont possibles - Ne pas lire les réponses à la maman)

1. A l'hôpital[]
2. Centre ou poste de santé.....[]
3. Pharmacie.....[]
4. Agent de santé communautaire/Matrone[]
5. Thérapeute traditionnel.....[]
6. Parents et amis.....[]
7. Autres (à préciser)[]
8. N'a pas demandé de conseil ou traitement.... []

27- *Yann maandarga (tecctal) gno meena takh nga yoobu (turu xale bi) gnu seet ko ci bérabu wér-gi-yaram bu biraam di daw ?*

Quels signes vous amènent à demander un avis ou à consulter quand (nom de l'enfant) a la diarrhée ?

(Plusieurs réponses sont possibles - Ne pas lire les réponses)

1. Ne sait pas..... []
2. Vomissements..... []
3. Fièvre..... []
4. Signes de déshydratation (sécheresse de la bouche,
yeux enfoncés, pli cutané déshydratation urines rares, soif). []
5. Prolongement de la diarrhée au delà de 3 jours. []
6. Sang dans les selles.....[]
7. Perte d'appétit.....[]
8. Asthénie.(Très grande fatigue)[]
9. Autres signes (à préciser) []

28- *Naka lañuy défaré ndiar biñuy djokh xalé bu biram di daw ?*

Comment prépare t-on la solution salée sucrée domestique?

(les réponses données traduiront les connaissances de la mère qui permettront de cocher un des items ci-dessous)

1. connaît.....[]
2. Ne sait pas.....[]

VI- VACCINATION ET SURVEILLANCE PONDERALE

29- *Ndax (turu xale bi) amna keyitu niak walla karné wér-gi yaram ?*

Est-ce que (nom de l'enfant) possède une fiche de vaccination ou un carnet de santé ?

1. Oui [] (*Regardez le document et passez à l' item 30*)
2. Non..... [] (*Passer à la question 32*)
3. Carnet ou fiche égaré.....[] (*Passez à la question 32*)

30- Regardez et notez les vaccinations inscrites sur le carnet de l'enfant: jour/mois/année

BCG ...(cicatrice)..... _ _ _ / _ _ _ / _ _ _
 DTC1..... _ _ _ / _ _ _ / _ _ _
 DTC2..... _ _ _ / _ _ _ / _ _ _
 DTC3..... _ _ _ / _ _ _ / _ _ _
 Polio1. _ _ _ / _ _ _ / _ _ _
 Polio2..... _ _ _ / _ _ _ / _ _ _
 Polio3..... _ _ _ / _ _ _ / _ _ _
 Rougeole..... _ _ _ / _ _ _ / _ _ _
 Fièvre jaune..... _ _ _ / _ _ _ / _ _ _

31- Regardez et notez combien de fois l'enfant a été pesé au cours des trois mois précédant l'enquête :

1. Aucune fois..... []
2. Une (1) fois..... []
3. Deux (2) fois..... []
4. Trois (3) fois et plus..... []

VII- INFECTIONS RESPIRATOIRES AIGÜES

32- Ndax (turu xale bi) amoon nay jafe-jafe ci wallug nooyi walla seuxeut ci biir niaari ayi bés yi mujj yi ?

Est-ce que (nom de l'enfant) a présenté des difficultés respiratoires ou une toux au cours de ces deux dernières semaines?

1. Oui..... [] (Passer à la question 33)
2. Non..... [] (Passer à la question 35)

33- Yobbu woon nga (turu xale bi) gnu seet ko bi mu améey jafe-jafe ci wallug nooyi walla seuxeut ?

Avez-vous amené (nom de l'enfant) en consultation lorsqu'il a présenté ces difficultés respiratoires?

1. Oui..... [] (Passer à la question 34)
2. Non..... [] (Passer à la question 35)

34- Fo yobbu woon (turu xale bi) mu faju, walla ko laajoon xalaatam ci bimu améey jafe-jafe ci wallug nooyi walla seuxeut ?

Où avez-vous amené (nom de l'enfant) pour traitement, ou bien à qui avez vous demandé conseil lorsqu'il a présenté ces difficultés respiratoires? Plusieurs réponses sont possibles. Ne pas lire les réponses.

1. Hôpital..... []
2. Centre ou poste de santé..... []
3. Clinique ou médecin privé..... []
4. Agent de santé communautaire/Matrone..... []
5. Thérapeute traditionnel..... []
6. Pharmacie..... []
7. Parents ou amis..... []
8. Autres (à préciser) []

35- Yann maandarga (tecctal) gno meena takh nga yoobu (turu xale bi) gnu seet ko ci bérabu wër-gi-yaram bu améey jafe-jafe ci wallug nooyi walla seuxeut ?

Quels sont les signes d'infection respiratoire chez (nom de l'enfant) qui pourraient vous amener à consulter une structure de santé?

(Plusieurs réponses sont possibles) Ne pas lire les réponses

1. Ne sait pas.....[]
2. Accélération du rythme respiratoire.....[]
3. difficultés respiratoire.....[]
4. Tirage.....[]
5. Perte d'appétit.....[]
6. Fièvre.....[]
7. Toux.....[]
8. Autres (à préciser)[]

VIII- PALUDISME

36- *Ndax yarammu (turuxale bi) tangoon na ci niaari ayi bés yu mujj yi ?*

(Nom de l'enfant) a-t-il présenté une fièvre au cours de ces deux dernières semaines?

1. Oui.....[] *(Passer à la question 37)*
2. Non.....[] *(Passer a la question 38)*
3. Ne sait pas.....[] *(Passer a la question 38)*

37- *Loo déf ci biir bésbi bi yarammu (turuxale bi) tangee ?*

Qu'avez vous fait dans les 24 heures lorsque (nom de l'enfant) a eu de la fièvre?

1. N'a rien fait.....[]
2. Amené chez le Guérisseur traditionnel.....[]
3. Donné de la Chloroquine (Nivaquine)[]
4. Amené au centre de santé[]
5. Ne se rappelle pas.....[]
6. ASC.(case de santé)[]
7. Autre (à préciser).....[]

38- *Cisa xalaat, naka lagnu meena moytoo sibbiru ci keur ?*

Selon vous, comment éviter le paludisme dans votre ménage? (Plusieurs réponses sont possibles. Ne pas les lire)

1. Utilisation de moustiquaires simples.....[]
2. Utilisation de moustiquaires imprégnées.....[]
3. Utilisation d insecticides.....[]
4. Assainir les alentours de la maison.....[]
5. Ne sait pas[]
6. Chlroroquine (Nivaquine).....[]
7. Autres (à préciser)[]

39- *Ndax ame nga payong (sanké, mustikeer) ?*

Possédez-vous une moustiquaire ?

1. Oui.....[] *si possible voir la moustiquaire, et si c'est vu cocher le n° 2*
2. Moustiquaire vue[] *(passez à la question 41)*
- 3.Non.....[] *(passez à la question 45)*

40- *Ndax sa payong (sanké, mustikeer) xooj(suub) nañ ko ?*

La moustiquaire est-elle imprégnée ?

1. Oui.....[] (passer à la question 42)
2. Non.....[] (passez à la question 45)

41- *Kaĩ nga am sa payong(sanké, mustikeer) bu ñu xooj (suub)bi?*

Quand avez- vous votre moustiquaire imprégnée?

1. Moins de six mois.....[]
2. Plus de six mois.....[]

42- *Kaĩ nga gueudia xooj (suub) sa payong (sanké, mustikeer)*

A quand remonte la dernière imprégnation? (lire les réponses à la maman)

1. Moins de six mois.....[]
2. Plus de six mois.....[]
3. Ne sait pas[]

43- *Kan moo fanane biigue ci biir sa payong (sanké, mustikeer) bu ñu xooj (suub)bi ?*

Qui a dormi la nuit dernière sous la moustiquaire imprégnée? (Plusieurs réponses sont possibles)

- 1- enfant enquêté.....[]
- 2- frère/sœur de l'enfant enquêté.....[]
- 3- mère.....[]
- 4- père.....[]
- 5- Autres.....[]

44- *yan mandarga cibbiru ñoy takh nga yobbu xalé mu seti doctor ?*

Quels sont les signes de référence du paludisme chez l'enfant selon vous ? (ne pas lire les réponses, mais cocher celles qui ont été citées)

1. si la fièvre persiste après trois jours de traitement à la chloroquine.....[]
2. si l'enfant vomit.....[]
3. si l'enfant a une forte fièvre.....[]
4. si l'enfant a des crises convulsives..... []
5. si l'enfant refuse de manger.....[]
6. autres (préciser).....[]

IX - HYGIENE ET ASSAINISSEMENT

45- *Kaĩ ngay wara raxass say loxo ak sabou ?*

Quand devriez-vous vous laver les mains avec du savon ? Ne pas lire les réponses

- 1- avant de préparer les repas des enfants[]
- 2 -avant de donner à manger aux enfants[]
- 3- à la sortie des toilettes.....[]
- 4 – après avoir fait la toilette des enfants[]

46 -*Ndax am ngèn « latrine »(soutouroul kay) fi ci keur gui ?*

disposez-vous d'une latrine dans la concession ?

1. oui.....[]
2. non.....[]

X –IST/ SIDA

47 – Mass nga deeg feebary SIDAA ?

avez-vous entendu parler du SIDA ?

1. oui.....[] passer à la question 49
2. non.....[] passez à la question 51

48 – Naka la doomi jàngoro SIDAA di duggée ci nit ?

comment se transmet le SIDA ?

(ne pas lire les réponses)

1. sang []
2. rapports sexuels []
3. placenta..... []
4. lait maternel..... []
5. autres..... []
6. ne sait pas []

49 – Naka la Nuy moytoo SIDAA ?

comment se protège – t- on contre le SIDA

(Ne pas lire les réponses)

1. préservatif (capote) []
2. abstinence []
3. fidélité []
4. autres (préciser) []

50 - Yann maandarga (tectal) lagnu meeno xame feebary sëy ci jigéen ?

Quels sont les signes d'une infection génitale chez la femme ?

(Ne pas lire les réponses)

1. Beaucoup de pertes []
2. Plaie..... []
3. Prurit intense (grattage) []
4. Autres (à préciser) []

XI –PF

51- Ndax xam nga pexey soriyantool njur ?

connaissez-vous des méthodes d'espacement des naissances

(Ne pas lire les réponses)

1. Pilule..... []
2. Dispositif intra utérin (appareil) []
3. Préservatif (capote) []
4. Dépo injectable (piqûre) []
5. Norplan (chirurgie) []
6. Autres (à préciser) []

FIN DU QUESTIONNAIRE

***Ñoo ngi leen di geureum hubaax ci ligneen nangu toontu
sunuy laaj. Jaa ngeen jeuf.***

Nous vous remercions d'avoir accepté de nous recevoir et de répondre á nos questions.

ANNEXE 5 : LISTE DES PARTICIPANTS AU PROCESSUS DU KPC

1 – PARTICIPANTS A LA REUNION PREPARATOIRE

1. Gnilane Ndiaye SYLLA, GC
2. Dr Thidiane NDOYE, CNS
3. Diaguily KOITA, RNFSE
4. Dr Etienne DIOH, CPSE/AID
5. Ousmane Raymond SEYE, PUM Kaolack
6. Maodou NDIAYE, PU Kaolack
7. Touty CISSE, ADOC
8. Amadou GAYE, SS Kaolack
9. Aïssatou FALL, ASIG Kaolack
10. Gnagna GUEYE, ASIG Louga
11. Guineth FALL, SS Louga

2 – PARTICIPANTS A LA FORMATION DES SUPERVISEURS

1. Dr Thidiane NDOYE, CNS
2. Diaguily KOITA, RNFSE
3. Dr Etienne DIOH, CPSE/AID
4. Ousmane Raymond SEYE, PUM Kaolack
5. Touty CISSE, ADOC

6. Amadou GAYE, SS Kaolack
7. Aïssatou FALL, ASIG Kaolack
8. Guineth FALL, SS Louga
9. Seyni THIAM, Resp. rég. Brigade Hygiène Kaolack
10. Mamadou SENE, Resp. district Brigade Hygiène Nioro
11. Dr Masserigne NDIAYE, MCR Louga
12. Mme Nafi Ndiaye AIDARA, Sup.district Louga SR
13. Moussa SARR, CPSE Dfid/Lottery

3 – PARTICIPANTS A LA FORMATION DES ENQUETEURS

Kaolack

1. Dr Etienne DIOH, CPSE/AID
2. Amadou GAYE, SS Kaolack
3. Touty CISSE, ADOC
4. Aïssatou FALL, ASIG Kaolack
5. Seyni THIAM, Resp. rég. Brigade Hygiène Kaolack
6. Mamadou SENE, Resp. district Brigade Hygiène Nioro

Louga

1. Diaguily KOITA, RNFSE
2. Guineth FALL, SS Louga
3. Gnagna GUEYE, ASIG Louga
4. Dr Masserigne NDIAYE, MCR Louga
5. Mme Nafi Ndiaye AIDARA, Sup.district Louga SR

4 – PARTICIPANTS AU SUIVI DE LA COLLECTE DES DONNES SUR LE TERRAIN

Kaolack

1. Dr Etienne DIOH, CPSE/AID
2. Amadou GAYE, SS Kaolack
3. Touty CISSE, ADOC Kaolack
4. Aïssatou FALL, ASIG Kaolack
5. Mamadou SENE, Resp. district Brigade Hygiène Nioro
6. Dr Philomène THIAM, Pédiatre (invitée)

Louga

1. Diaguily KOITA, RNFSE

2. Guineth FALL, SS Louga
3. Gnagna GUEYE, ASIG Louga
4. Mme Nafi Ndiaye AIDARA, Sup.district Louga SR

5 – PARTICIPANTS A LA SAISIE DES DONNEES

1. Dr Etienne DIOH, CPSE/AID
2. Diaguily KOITA, RNFSE
3. Aïssatou FALL, ASIG Kaolack
4. Gnagna GUEYE, ASIG Louga
5. Magatte LAKH, opératrice de saisie
6. Awa NDIAYE, opératrice de saisie
7. Dior DIOP, opératrice de saisie
8. Marème GUEYE, opératrice de saisie

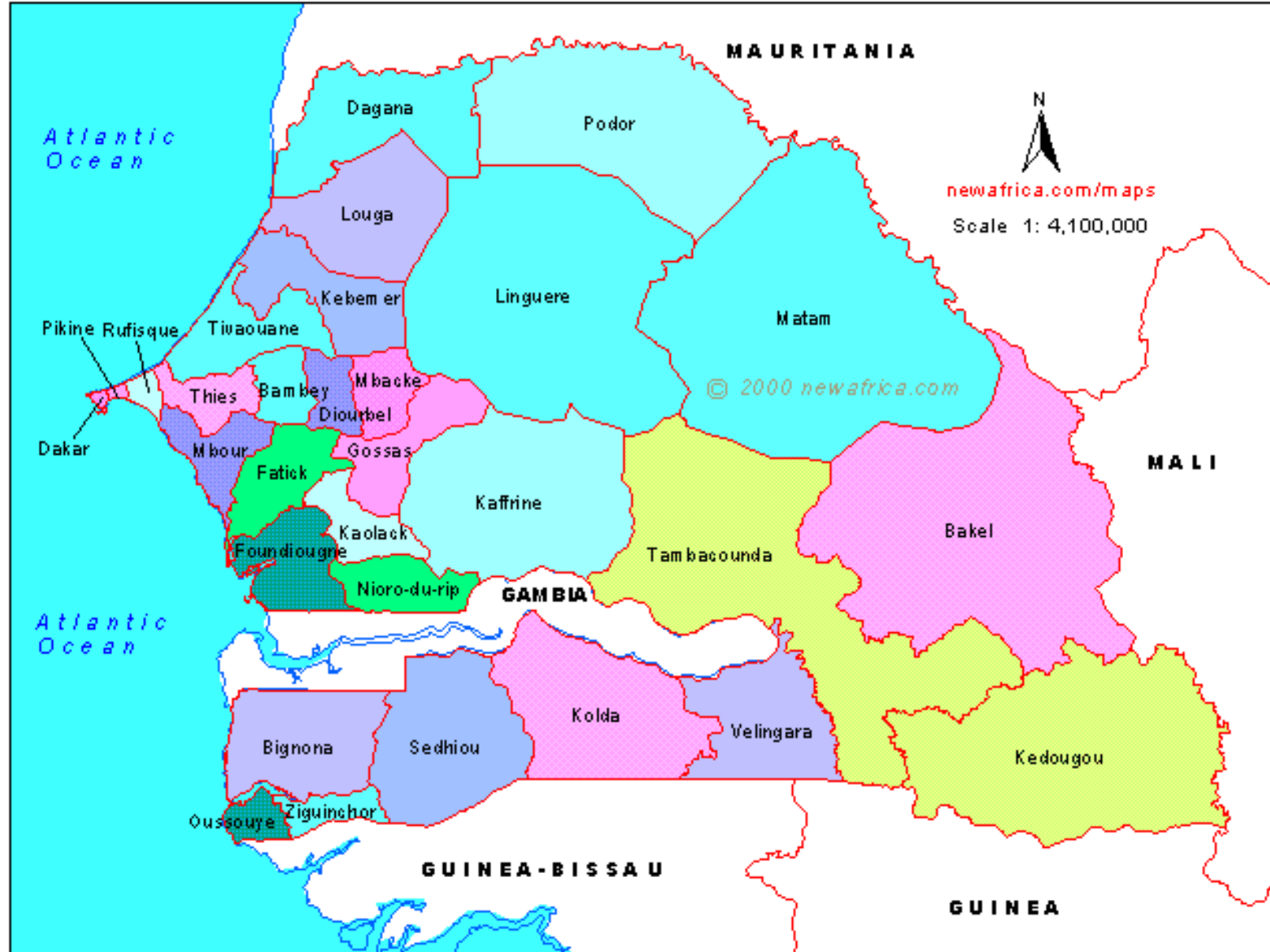
6 – PARTICIPANTS A L’ATELIER D’ANALYSE DES DONNEES

1. Dr Thidiane NDOYE, CNS
2. Diaguily KOITA, RNFSE
3. Dr Etienne DIOH, CPSE/AID
4. Ousmane Raymond SEYE, PUM Kaolack
5. Touty CISSE, ADOC Kaolack
6. Amadou GAYE, SS Kaolack
7. Seyni THIAM, Resp. rég. Brigade Hygiène Kaolack
8. Mme Sokhna Ndiaye DIALLO, PUM Louga
9. Guineth FALL, SS Louga
10. Abdoukhadre NDIAYE, Resp. rég. adjoint Brigade Hygiène Louga
11. Mme Nafi Ndiaye AIDARA, Sup.district Louga SR
12. Moussa SARR, CPSE DfID/Lottery
13. Jean BASSENE, DEF’A
14. Dr Philomène THIAM, Pédiatre (invitée)

ANNEX 7

MAPS

SENEGAL ADMINISTRATIVE MAP



Senegal



Original Program Area



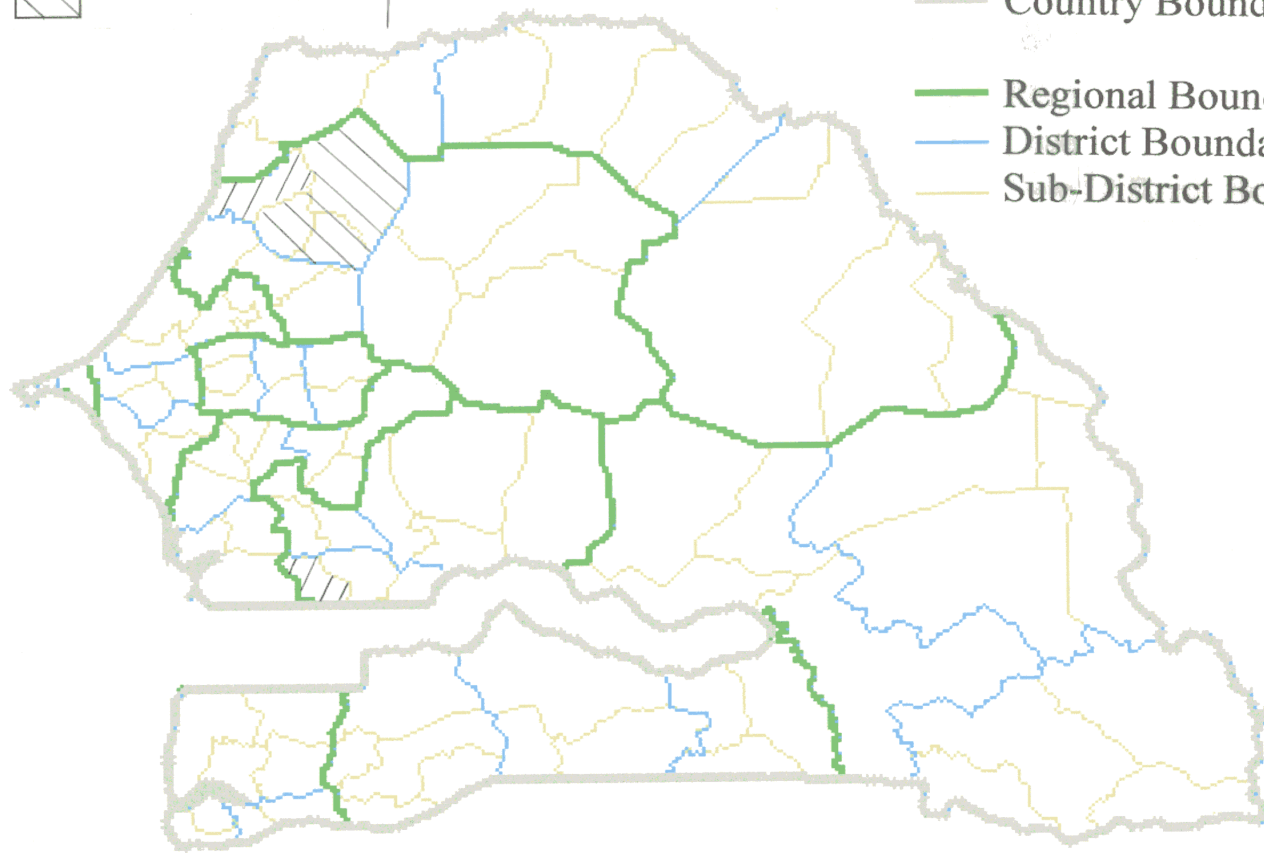
Expansion Area

Country Boundary

Regional Boundary

District Boundary

Sub-District Boundary



USGS/EROS