PLAN INTERNATIONAL USA, Inc.
d/b/a Childreach

USAID Child Survival Grant
FAO-A-00-00035-00
September 30, 2002 - September 29, 2004

MID-TERM EVALUATION
CHILD SURVIVAL XVI PROJECT CAMEROON
OCTOBER 2002

Prepared by:
FRANTZ SIMEON MD/MPH, Consultant
October 2002

TABLE OF CONTENTS

III. ATTACHEMENTS

LIST OF ACRONYMS

AAPPEC	Association for the Self – Promotion of the East Province Population
ACHRP	Association of Community Health Resource Persons
BCC	Behavior Change Communication
CAPP	Center for supply of drugs and health materials
CBO	Community Based Organizations
CHW	Community Health Worker
COGE	Health Area Management Committee
COSA	Health Area Committee members
CS	Child Survival
CS XVI	Child Survival XVI
DHC	District Health Committee
DHMT	District Health Management Teams
DIP	Detailed Implementation Plan
EPI	Expanded Program of Immunization
FESADE	Women's Health Development in Sub Saharan Africa
HIS	Health Information System
ICC	Nurse in charge of Health Centers
IEC	Information, Education, and Communication
IHC	International Health Centers
ITN	Insecticide Treated Net
KPC	Knowledge, Practice, and Coverage Survey
MOH	Ministry of Health
MTE	Mid-Term Evaluation
NGO	Non Governmental Organization
NID	National Immunization Day
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PVO	Private Voluntary Organization
SSS	Salt and sugar solution
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
U5	Under five years
USAID	United States Agency for International Development
VHC	Village Health Committee
WCBA	Women of Child Bearing Age

II. SCOPE OF WORK

The midterm evaluation team was presented with these objectives:

a. Review program performance by objective. Evaluate whether the project design effectively relates to the objectives and indicators. Provide recommendations for changes in program strategies and activities.

b. Compare Planned activities with actual results, analyzing any constraints that may have limited the achievement of goals to date, and factors that have contributed to successful project implementation. Take into consideration logistical constraints, time commitments, and resource availability in measuring both intended and unintended effects on the target population.

c. Offer recommendations for changes to be made in program management and operations.

d. Review all project indicators for appropriateness to the project and for feasibility of accurately demonstrating change. Review the effectiveness of the Health Information System (HIS) in monitoring impact and change to use information in ongoing project management. Provide recommendations for changes in information collection and use, including modifications to indicators and targets.

e. Examine the strengths and areas of improvement in relationship between all stakeholders in program implementation.

f. Assess progress and achievements in relation to stated objectives from the Detailed Implementation Plan (DIP);

g. Follow United States Agency for International Development (USAID) midterm guidelines.

h. Assess the appropriateness of the objectives and strategies being used by the project in relation to the reality in the field.

i. Make recommendations with regards to Planning for follow on funding: consider the sustainability approach.

j. Make recommendations strategies emphasizing capacity building.

In addition to the questions stated in the USAID guidelines for midterm evaluations, (from 1 to 10 below) the consultant will address the following issues:

1) How is the Child Survival Project influencing other projects in Plan Cameroon?

2) How is the Child Survival Project integrated into Plan Cameroon's structure?

3) For immunization, how is the health information system contributing to immunization coverage?

4) For malaria do communities understand the importance of the Insecticide Treated Net (ITN) programs? Do they have ideas about how to sustain the program?

5) For IMCI, how has Plan influenced the National IMCI program?

6) For Capacity Building, how have the concepts of shared vision, mental models, personal mastery, team learning and system thinking been applied?

7) Is there gender balance in the Village Health Committees (VHC) and the Dispensary Health Committees (DHC)?

8) How is the Health Information System (HIS) used for decision making by Village Health Committees, Dispensary Health Committees and the Ministry of Health (MOH)?

9) How have the first phase communities changed since the beginning of the project? Are there specific characteristics that signal that these committees moved from full intervention to partial involvement and on to the sustainability stage?

10) Other concerns expressed during the Planning meeting and agreed upon by the team evaluation.

A. EXECUTIVE SUMMARY

Plan International Cameroon is implementing a four-year Child Survival project in the poorest region of Cameroon located in the Western part of the heavily forested Eastern Province, which borders Democratic Republic of Congo. The project will cover three Health Districts: Bertoua, Doume, and Nguelemendouka and will benefit a population of 211,264 inhabitants of 267 villages located in 27 Health Areas.

Plan has been working in this Province since 1996 and has established strong ties with the community particularly with the Bantus, one of two tribes that inhabit the area.

At the beginning of the project the health problems of this province were among the worst in Cameroon: only 24.7% of the children under one were completely immunized, as compared with a national rate of 36%; 56% were stunted and 21% were underweight; infant mortality rate was 77/1000; under 5 mortality rate was 151/1000; and maternal mortality rate was 430/100,000 live births.

Cultural factors presented serious obstacles to care seeking behavior. Local residents had little trust in modern medical practices and personnel. Health services utilization rates were low due to inadequate quality of care.

Pregnancy complications and malaria were the leading causes of maternal death. The reported causes of childhood morbidity were malaria, pneumonia and diarrhea.

Target populations: 38,009 (Children under 5), 8,447 (infants, 0 – 11 months) and 48,568 (Women of Child Bearing Age).

The overall goal of the Project is to improve the health status of Children Under 5 years (U5) and Women of Child Bearing Age (WCBA). Strategies are: fostering existing community-based health organizations, supporting and building the capacities of MOH personnel and partner Non Governmental Organizations (NGOs), sensitizing and educating mothers and other influential community members. Main activities are: immunization, malaria case management, acute respiratory infection management, diarrhea case management, exclusive breastfeeding, capacity building. Key actors are: Plan International Cameroon, MOH, Association for the Self – Promotion of the East Province Population (AAPPEC), and Confessional Care Providers.

Since the project has already completed two years of implementation. A mid-term evaluation took place from September 15 to October 3, 2002. It was conducted as a highly participative effort by a 34 persons team. The team met for 3 days in Bertoua to discuss objectives of the evaluation, prepare and field test data collection instruments. It spent 5 days in the field gathering information through 27 focus groups, 8 interviews with key informants, 8 health centers observations and LQAS in 16 Health Areas. It then spent 4 days compiling data, analyzing findings, developing lessons learned, and preparing recommendations. A debriefing seminar was held on the 3rd of October at Manza Hotel in Bertoua for feedback to interested parties.

The findings of this mid-term evaluation were qualitative in nature but the LQAS and documentation review gave some indications about the level of quantitative achievements.

Focus groups discussions indicated that most beneficiaries have been exposed to Information, Education, and Communication (IEC) strategy. They understood most of the

subjects but, except for participation in rally posts, they have shown minor behavior changes. The level of awareness is high. However, knowing has not always been changed into doing differently. Trust in the health system is coming back very slowly. Some beliefs still persist. Some traditional healing habits have not changed. All groups appreciated what they have already received and expressed higher expectations than the project can afford to satisfy.

The LQAS showed good progress in immunization coverage as compared with the beginning of the project. But it also showed that most of the health areas are not performing at the expected level. In Bertoua, 50% of the health areas performed at the expected level for complete immunization of children, 12 – 23 months, and pregnant women, and performed at 33% for effectiveness of HIS. In Doume, none of the areas performed well for immunization of children, 12 – 23 months, and pregnant women. However 50% are doing well as far as the effectiveness of HIS. In N'ka 25% passed for complete immunization of children, 12 – 23 months, and pregnant women, and none for effective HIS. The LQAS discriminated among health areas on track and those under performing, allowing project staff to go on a case-by-case approach and to design tailor made technical assistance.

Interviews with key informants, in depth discussions with key actors, and review of documentation revealed that many aspects of strategies implementation have been done successfully. These insights helped the team to shape a global picture of the project and at the same time dissect into fine details. These precious pieces of information unveiled the fact that the capacity building approach has brought some marvelous results and has changed the way health services are being offered to communities in the area of the project. It also broadens the scope of work of the local partner and Community Based Organizations (CBOs). For the first time in its long history AAPPEC, whose activities were limited only to Baka population, has expanded its interventions area to embrace Bantou communities. Trained members of CBO are now very active in promotion and sale of ITNs and IEC. Cost recovery system is done through fee for services in the health centers, and selling of ITNs to the general population. The beneficiary community expressed its willingness to continue new acquired behaviors but none of its members talked about the financial aspects or alternative sources of funding.

Analysis of the data from the Mid-Term Evaluation (MTE) indicates that the main activities and strategies of Cameroon's Child Survival (CS) XVI project have been implemented. Much progress has been made towards achievement of project objectives: knowledge level of beneficiaries and service providers has improved; a more effective cold chain is backing up rally posts with positive effect on immunization coverage; quality of health services has improved; supervision and monitoring are now a reality; trust in modern medical practices and health personnel has increased. Some areas, however, need further attention. The IEC strategy has not yet produced all expected behavior changes, the partnership is still vulnerable despite some very positive steps, training activities have not reached their full scope, financial sustainability strategy is not clearly defined.

Main recommendations include: empowerment of Village Health Committees (VHC) members, strengthening of health centers management, reinforcement of institutional capacity building, reinforcement of training, redesign of supervision, social marketing of ITN, social mobilization, redefinition of partnership, improvement of the HIS, refinement

of Behavior Change Communication (BCC) strategy, advocacy for gender equity, and implementation of a viable sustainability strategy.

Evaluation results have already been discussed with Plan staff. This report was written, based on conclusions and recommendations made by the entire mid-term evaluation team. The author is Dr Frantz Simeon, an independent consultant hired by Plan.

A INTRODUCTION

Plan International Cameroon has already completed two of its four - years Child Survival project, which it is implementing in the western part of the heavily forested Eastern Province of Cameroon, chosen because of its poor health indicators and inadequate access to health services.

As stated in the DIP, a mid-term evaluation took place from September 15, to October 3 2002. The data from the midterm evaluation indicates that Plan has already implemented its main activities and strategies. Some very positive results have been achieved. But some areas need further attention.

This section will follow the format of the USAID/BHR/PVC PVO Child Survival Guidelines for Midterm Evaluation. It will describe briefly the project and its objectives, the methods used to conduct the evaluation, and then will present findings following the sequence in the midterm evaluation guidelines provided by Plan International. It will highlight the main accomplishments, the progress made towards achievement of project objectives, the main constraints, and problems. It will shed lights on other issues identified by the team, will emphasize areas in need of further attention. It will finally present lessons learned and recommendations.

B. PROGRESS TOWARD ACHIEVEMENT OF PROJECT OBJECTIVES

1. Technical Approach

Overview of Project Objectives, Overall Strategy and Technical interventions

a. Overview

The Child Survival Project of Plan Cameroon is implemented in three districts: Bertoua, Doume, and Nguelemendouka.

It is located in the western part of the heavily forested Eastern Province: the poorest part of Cameroon.

The project will benefit a population of 211,264 inhabitants of 267 villages located in 27 Health Areas. The project is targeting approximately 95,024 beneficiaries with 38,009 children under five, 8,447 infants 0 to 11 months and 48,568 women of reproductive age (15 to 49). Inhabitants of the project area belong to either the Bantu or Pygmy tribes.

The overall goal of the Project is to improve health status of children under 5 (U5) and women of childbearing age (WCBA).

The project is implemented through a partnership between PLAN, MOH, and AAPPEC using the following three-pronged strategies:

- Fostering existing community-based health organizations and health workers to offer more services of better quality in a sustainable manner
- Support and build the capacities of MOH personnel and partner NGOs to improve quality of health services in the project intervention area

- Sensitize and educate mothers and other influential community members through a multiple level outreach activities for increased quality service demand and health protective behavior adoption.

Main activities are:

- Immunization
- Malaria case management
- Acute respiratory infection management
- Diarrhea case management
- Exclusive breastfeeding
- Capacity building

b. Methods used to conduct this evaluation

The methods used to conduct this evaluation are:

1. Focus groups
2. Interviews
3. LQAS
4. Observations
5. Documentation review

The evaluation was conducted as a highly participative effort by a 34 persons team. A total of 47 villages were visited. Focus groups were conducted with 380 persons: 324 beneficiaries, 36 MOH staff members, and 20 PLAN staff members. Interviews were carried out with 8 key informants: 4 from the MOH, 1 from AAPPEC, 1 from Confessional Care Providers, 2 from PLAN Cameroon. Throughout the evaluation process, in-depth discussions were held with the Health Coordinator, the Project Coordinator, the Monitoring and Evaluation Coordinator, two representatives of MOH, the Consultant of Women's Health Development in Sub Saharan Africa (FESADE).

A lot quality assurance sampling (LQAS) was conducted in 16 health areas and involved 301 children, 12-23 months, and 301 mothers from 15-49 years.

c. Progress by intervention area

The following table is a summary of activities related to specific interventions proposed in the DIP. It shows the percentage of achievement of these planned activities by October 2002.

Progress made towards benchmark or intermediate results

Activity	Responsible	Planned	Achieved	% Achievement October 02
1 PREPARATORY ACTIVITIES	**Plan Cam.**			
Hire Project staff	Plan Cam	10	10	100%
Hire 6 Community Health	CS Team	6	6	100%

promoters				
Baseline Surveys: KPC, IHFA,	CS Team	3	3	100%
Procurement of vehicles	Plan Cam	2	2	100 %
Procure refrigerators	Plan Cam	4	4	100 %
Procure solar energy sets	Plan Cam	4	0	0 %
Procurement of motorcycles	Plan Cam	8	16	200 %
Procure baby weighing scales	Plan Cam	267	178	67%
Procurement of ITN	Plan Cam	6251	12,250	196 %
Need assessment of existing women's groups	FESADE		17	100 %
Focus Group Discussions	CS Team		09	100 %
Start Up Workshop	Plan Cam, Plan US	1	1	100 %
DIP Preparation	CS Team, Plan US	1	1	100%
Presentation of KPC, IHFA and FGDs Results	CS Team	45	48	107 %
Population census	CS Team, FiCo, AAPPEC	267 Villages	74	28%
Assessment of community resource persons	CS Team			67%
Mini-start up workshop at the provincial level-Bertoua	MOH/CS Team	1	1	100%
Mobilization of community collaboration through phasing in process	AAPPEC/ CS Team	267 villages	200	75%
Develop HIS system	CS Team/ MOH	1	1	100%
Need Assessment of outreach activities per health facility	CS Team	26	26	100%
II TRAINING				
Orientation of Project Staff	Plan Cam	1	1	100%
Training of KPC/IHFA/ surveyors	CS Team/Plan US	1	1	100%
EPI-INFO Training	Consultant	1	1	100%
Focus Group Discussion Training	CS Team	1	1	100%
Preparation of training modules/FESADE	CS Team	7	7	100 %
Identify existing IEC materials and adapting them	CS Team			80 %
TOT health personnel	CS Team		3	
TBAs Training	MOH/CS Team		154	70 %
Health committee members	MOH/CS Team		242	50 %
Women's group leaders' training	FESADE AAPPEC	120	20	17 %

	CS Team			
Net dipping for PHT	CAPP			100 %
Management training	MOH			0 %
Distribution of IEC materials	CS Team	8	7	89%
Adapt IMCI for communities	CS Team	1	1	100 %
Refresher course for health personnel	MOH/CS Team			0%
Computer training for CS team	CS team			0%
III. MEETINGS				
Contact meetings with partners	CS PC	2	2	100 %
Site visits	NHA	8	8	100 %
Coordination committee	CS PC/MOH	8	5	63%
DIP Review in Washington DC	PC/NHA/ Plan US	1	1	100%
Exchange Visits	CS Team/ Plan	1	0	0 %
Planning and evaluation meeting	CS PC/ MOH	12		
Steering Committee	CS Team/ MOH	4	1	25%

IV SUPERVISION				
Develop supervision system	CS Team/ MOH		1	Checklist for IMCI
Individual monthly report	CS Team	20	20	100%
Individual monthly work Plan	CS Team	20	20	100 %
Develop monthly report forms	CS Team	1	1	100 %
Joint quarterly supervision at provincial level	MOH/CS Team	3	0	0%
Joint monthly supervision at health district level	CS PC/ MOH	9	19	211%
Joint monthly visits at the community level	CS Team/MOH/AAPPEC	2	2	100% ongoing
Individual Work Plan	CS Team/ MOH/ AAPPEC	12	9	75 %
V: IMPLEMENTATION				
Phase I (Chosen health areas)	CS Team/ MOH	9	9	100%
Reinforce immunization activities	CS Team/ MOH	3	Ongoing	
Diarrhea	CS Team/ MOH/ AAPPEC		Ongoing	
Malaria	CS Team/ MOH/ AAPPEC	11	Ongoing	
Malnutrition	CS Team/ MOH/ AAPPEC	11	Ongoing	
Ongoing immunization activities	CS Team/ MOH/ AAPPEC	12	Ongoing	
Entry Phase II	CS Team/ MOH/ AAPPEC	9	9	100%
Distribution of impregnated ITN	CS Team/ MOH/ AAPPEC	12,250	1400	22 %
Community information system functioning	CS Team/ MOH/ AAPPEC	267	100	37 %
Health education sessions	CS Team/ MOH/ AAPPEC		Ongoing	75 %
VI: EVALUATION				
Monthly report		20	20	87%
Quarterly report	CS Team	7	7	100%
Annual report	CS team	1	1	100%
Monthly review meetings at the	MOH/CS		8	

community level	Team/ AAPPEC			
Mid-Term Evaluation	CS Team/ Consultant	1	1	100%

This table shows that almost 70% of Planned activities were realized at a satisfactory level but some need special attention: training and supervision need further improvement; mobilization is not conducted over the total area covered by the project; steering committee is only 25 % executed; community information system is not functioning well; none of the three joint quarterly supervision activities at the provincial level has been realized.

LQAS results

A LQAS has been conducted during the mid-term evaluation. The LQAS is a pass or fail method which helps determine if a unit is performing at a specific level. The purpose of this survey was to monitor progress in immunization of WCBA, to verify the effectiveness of the registration system for children, 12-23 months, the immunization status of these children, and to control the quality of the community HIS.

Data was collected on 301 WCBA and 301 children, 12 –23 months, with immunization cards. The hypotheses were: the file of children completely vaccinated and women who received at least 2 doses of tetanus toxoid during their last pregnancy are acceptable for immunization and the file of children whose information in the family card matches the institutions records are acceptable for community HIS.

The goal set was 85% with minimum level of 60%. The sample size corresponding to that goal is 19. The acceptable size is 13. This means that 13 out of 19 randomly selected children or women should be acceptable for a health area to be considered performing at the expected level that guarantees that by the end of the project immunization coverage will be met and HIS will be reinforced. Health areas with less than 13 acceptable are performing below 60% and need some kind of technical back up.

Vaccination trends in health areas/districts according to LQAS surveys

Health District	Health Area	12-23months completely vaccinated	Name in COSA Register	TT vaccine for mothers
Bertoua	Bazzama	10/19	13/19	7/19
	Mandjou	13/19	15/19	14/19
	Mokolo IV	12/19	None	7/19
	Ndouan	13/19	None	8/19
	EPC Radio	15/19	None	18/19
	Belabo	6/19	None	17/19
Doume	Dimako	5/19	None	7/19
	Goumbegeron	7/19	9/19	10/19
	Doume	7/19	11/19	8/19
	Nkoum	9/19	19/19	8/19
	Motcheboum	11/19	18/19	6/19

	Seguelendom	10/19	17/19	11/19
Nguelemen-Douka	Azomekout	13/19	10/19	14/19
	Bika	7/19	12/19	None
	Ngoap	3/19	5/19	5/19
	Nguelemen-Douka	9/15	12/15	2/15

BERTOUA

In the district of Bertoua, three (Mandjou Ndouan, EPC Radio) out of six health areas (50%) passed for complete immunization of children, 12 – 23 months. The remaining three failed. In only two (Bazzama, Mandjou) out of six health areas, the names of the children investigated in the households were found in the register of the Health Area Committee members (COSA). Three (Mandjou, EPC Radio, Belabo) out of six health areas passed for Tetanus Toxoid 2 **(**TT2) immunization for pregnant women. Mandjou is the only one, which passed for all 3 criteria. EPC Radio passed for 2 criteria. Mokolo IV failed for all three criteria.

DOUME

In Doume all health areas failed for immunization of children, 12 – 23 months. However, three out of six passed for matching of names in the household and names in the register of COSA. None passed for TT2 immunization of pregnant women. In this District immunization coverage needs a real booster.

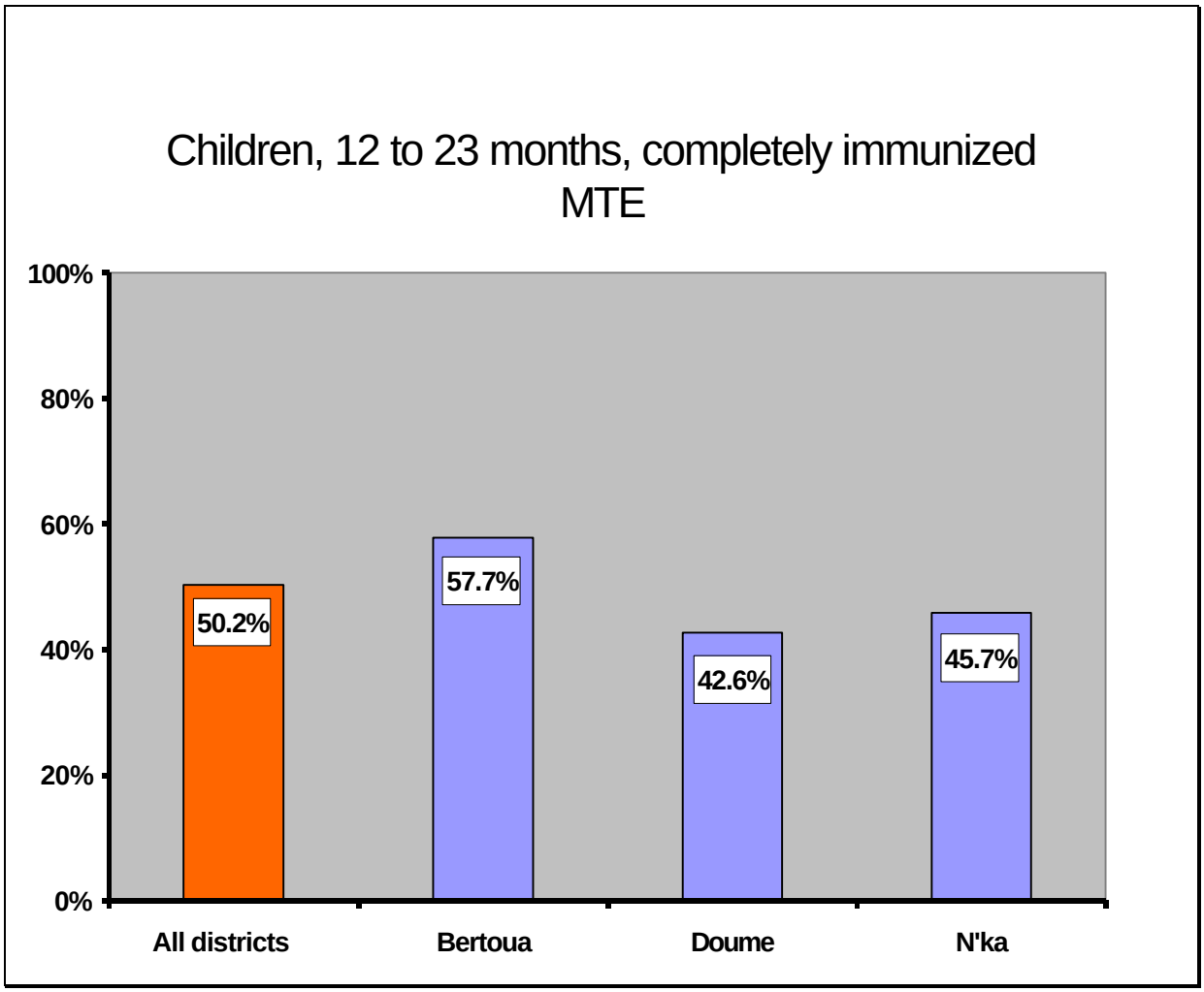
NGUELEMENDOUKA

Only one (Azomekout) out of four health areas of N'ka 25% passed for immunization of children, 12 – 23 months, and pregnant women. None passed for matching of information between household cards and COSA register.

Comparing the three districts, Bertoua is the best in immunization coverage but the weakest in community HIS.

These results show that there is a lot to be done to meet stated objectives for immunization coverage and to improve the HIS during the remaining two years of the project. All districts need technical assistance that will be tailor made by specific health areas.

Table 1

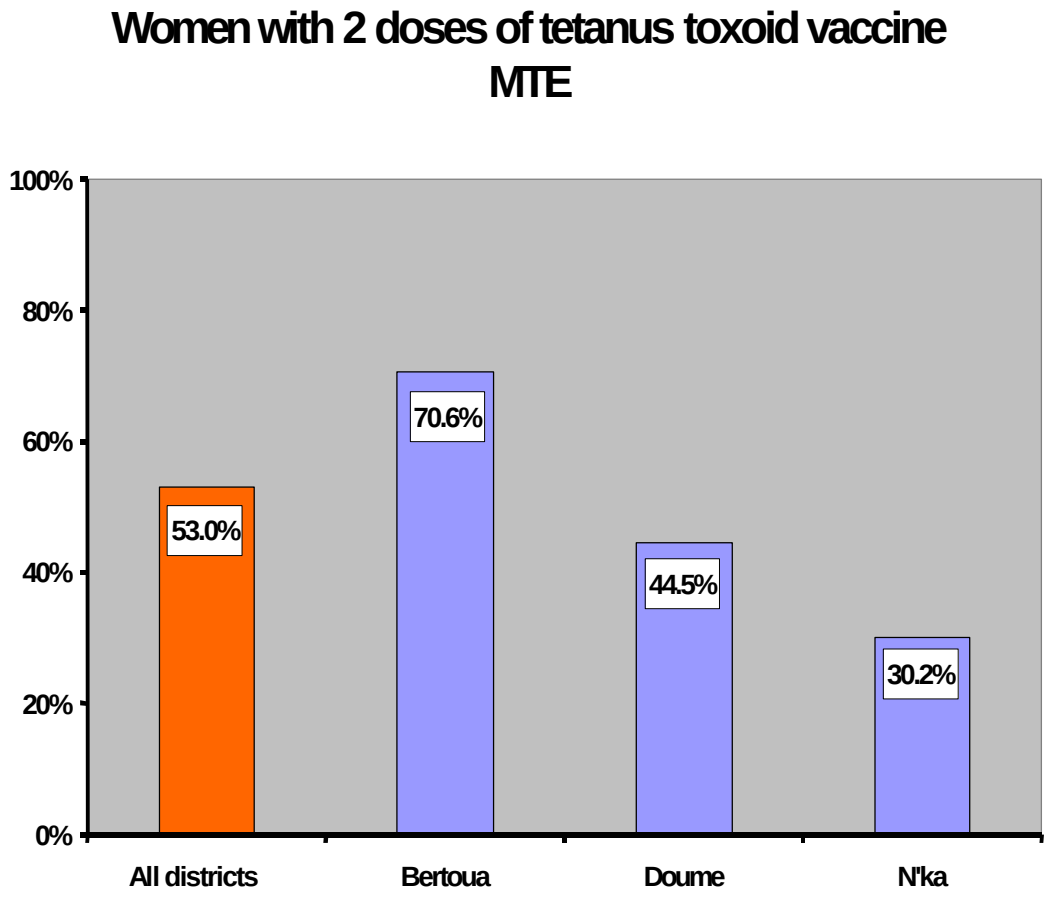


Specific objectives of the CS project for immunization are, by 2004; increase vaccine completion by age 12 from 24.7% to 60%; for pregnant women from 47% to 70%.

Over all districts coverage for complete immunization of children 12 –23 months is 50.2%. This percentage is almost 2 times more than the 24.7% at the beginning of the project and almost 1½ of the 36% national coverage. Great progress has been made during the first two years of the project.

If the actual rate is maintained the project will certainly go beyond the stated objective of 60% for children completely immunized by 12 months of age. The progress is not evenly distributed in all 3 districts but all are making great efforts toward achievement of project objectives. Bertoua with 57.7% has a better performance than N'ka at 45.7% and Doume at 42.6%.

Table 2



The actual immunization coverage of 53% for pregnant women show a great progress towards achieving the objective of 70% coverage for this target group by the end of the project.

Bertoua with 70.6% has already reached the coverage expected for this target group at the end of project. It is in advance as compared to the others. Doume with 44.5% has a better score than N'Ka 30.2%. This is an indication that much progress needs to be made in Doume and N'ka with emphasis on the latter. However, it is to be mentioned that N'ka has just been organized as a District and is only fully operational since the last twelve months.

Table 3

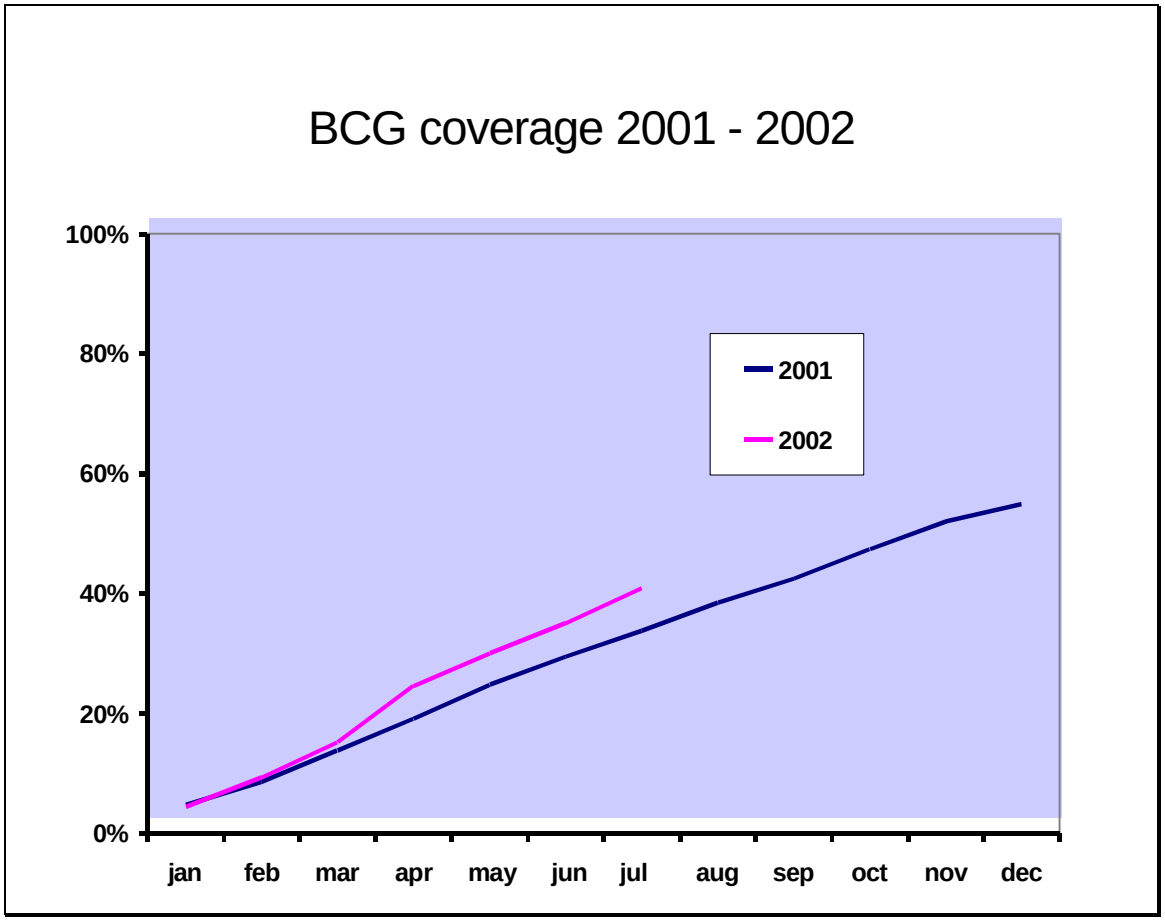


Table 3 shows a net improvement in BCG total coverage from 2001 to 2002. From late February up to July the 2002 curve is rising above the 2001 curve. This is in line with the improvement observed in complete immunization of children, 12 – 23 months.

Table 4

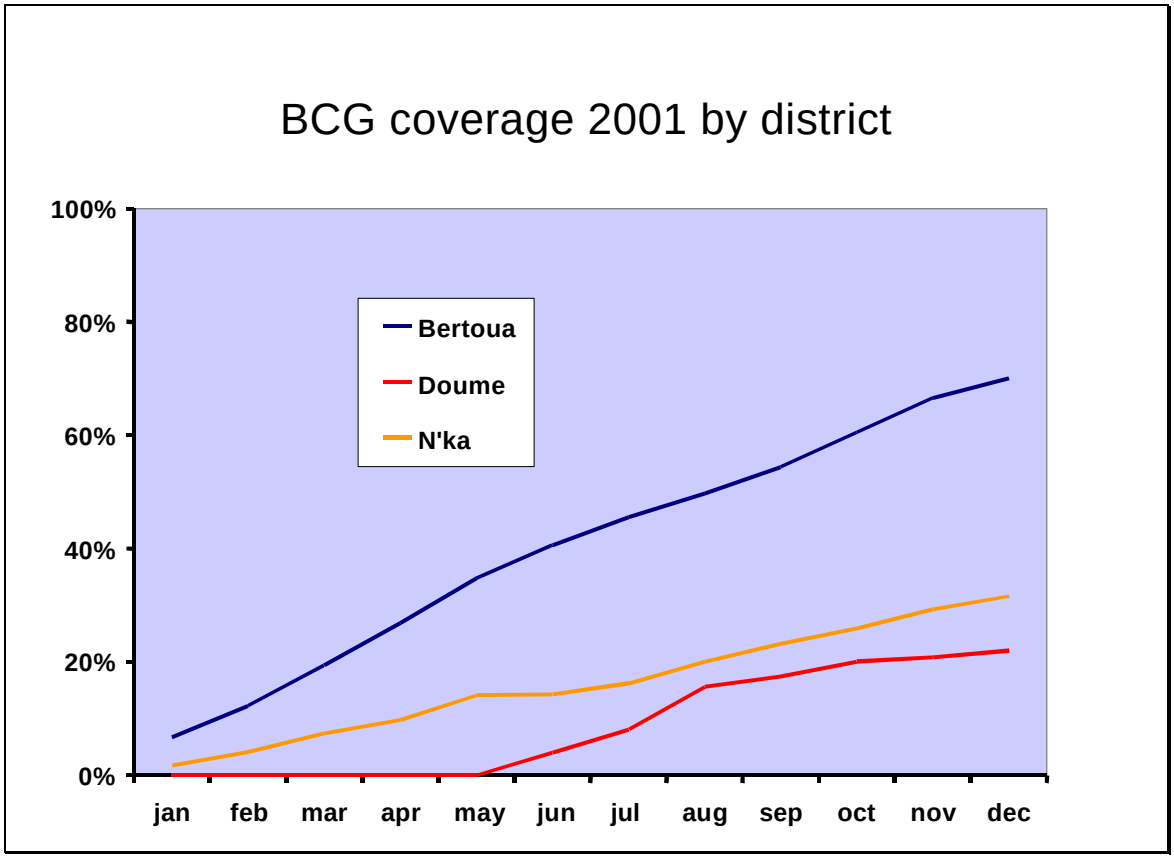
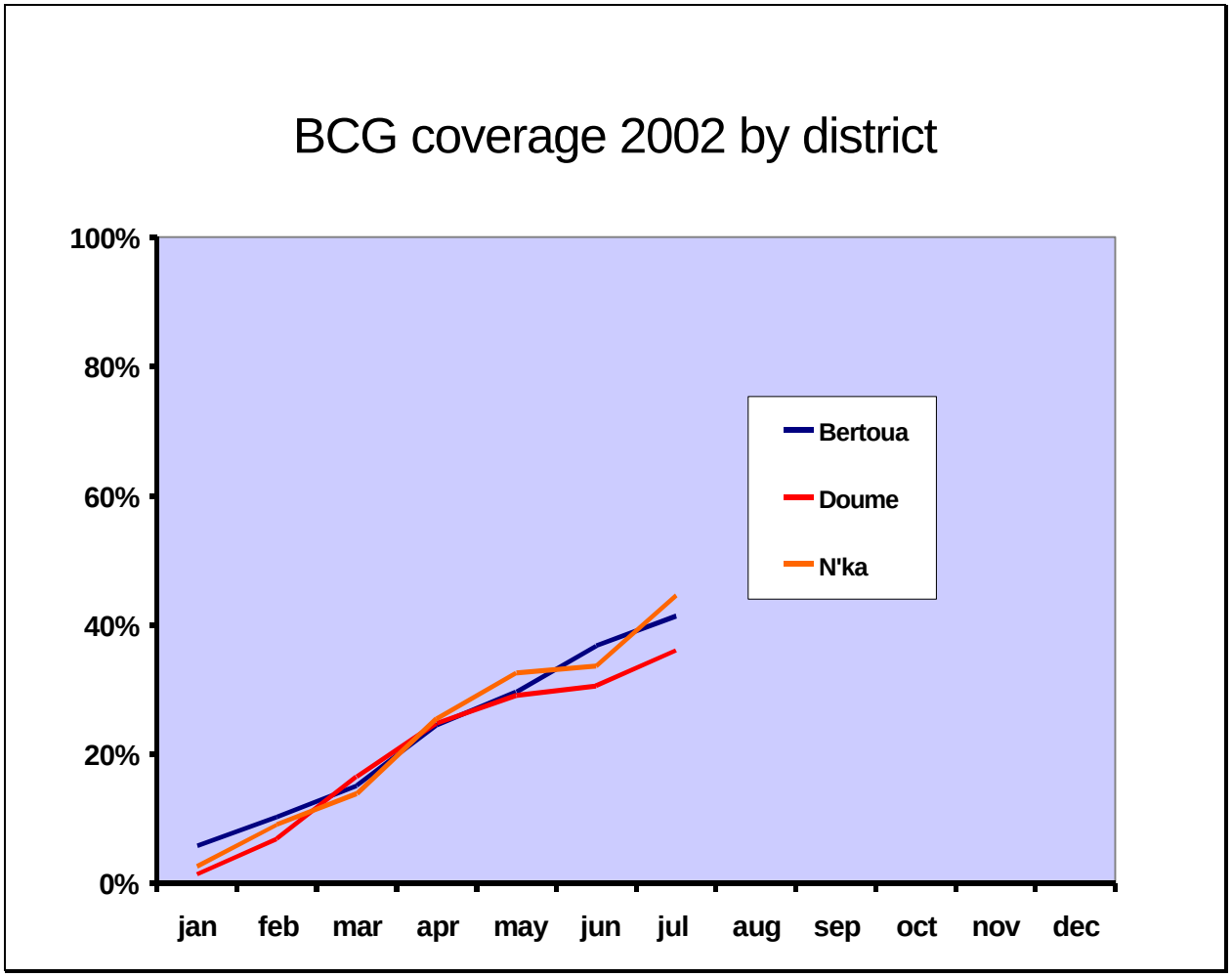


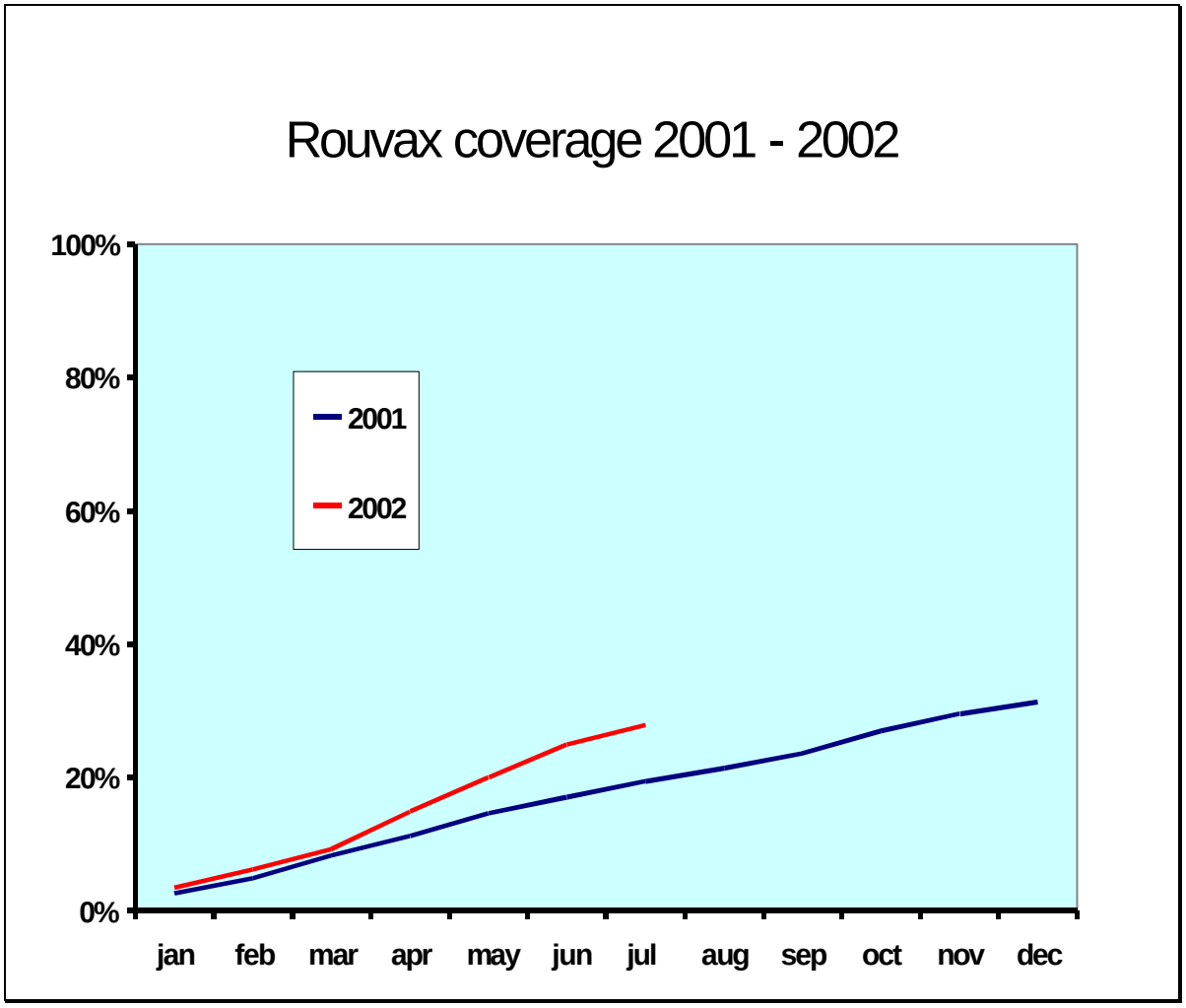
Table 5 shows the big gap, which existed among districts in 2001 for BCG coverage Bertoua was the one with the best coverage followed by N'ka. Doume, which started to give results by the month of May, was last.

Table 5



By the year 2002, almost all districts were performing at the same level from January to almost August. Bertoua seems to be the one evolving straight. The two others show some fluctuations, some ups and downs while the general trend is towards an increase in coverage. At some points Doume (March) and N'ka (April, May, July) toppled Bertoua. The one making the most progress is N'Ka, which is the best performer of all by the month of July.

Table 6



The Rouvax total coverage of 2001 is better than that of 2002. Starting from end of March, the difference between those two years is clearly in favor of 2002.

Table 7

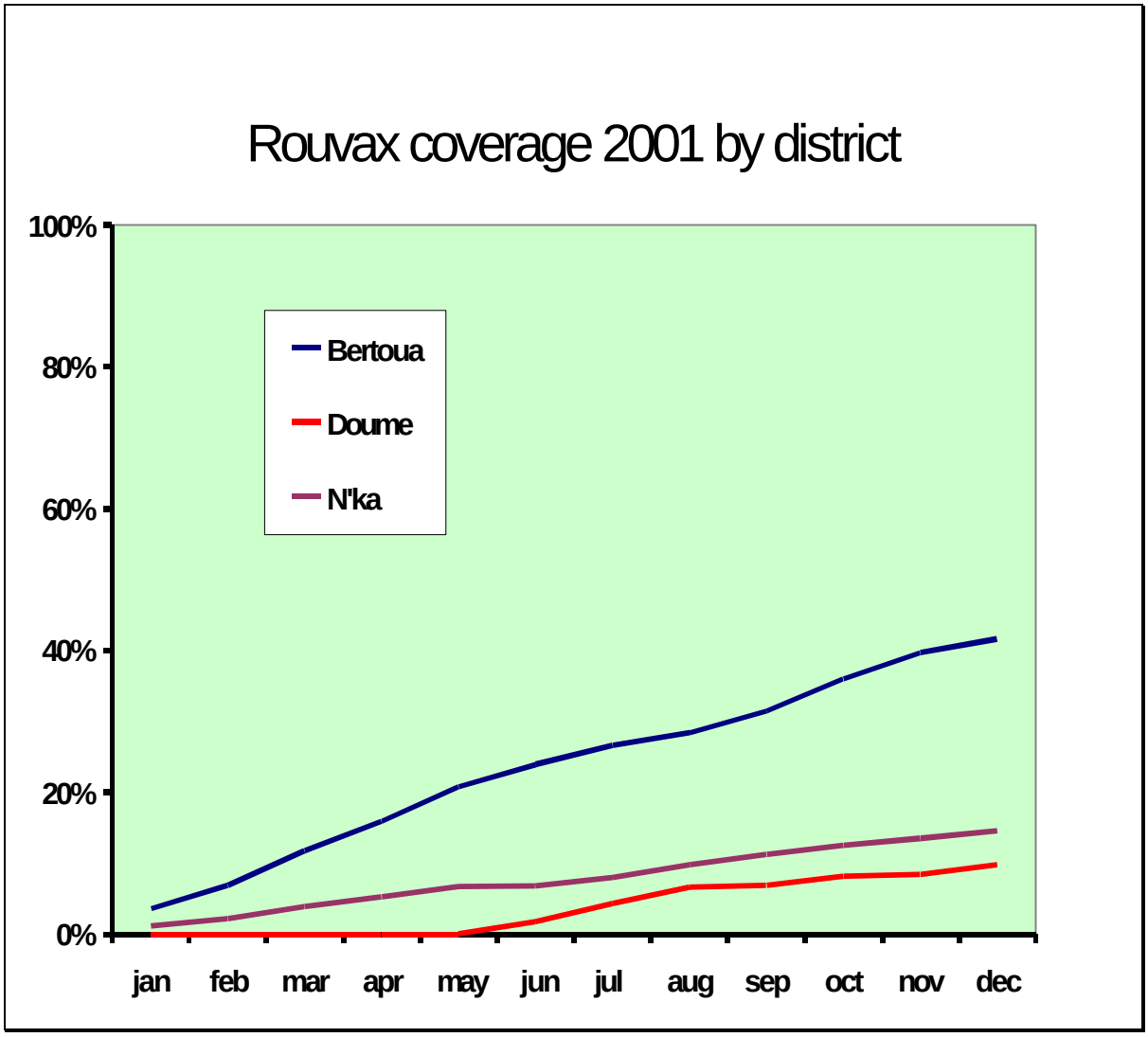


Table 7 is almost the same as table 4 with Doume starting to produce results by May, Nk'a evolving mid level and Bertoua being the best.

Table 8

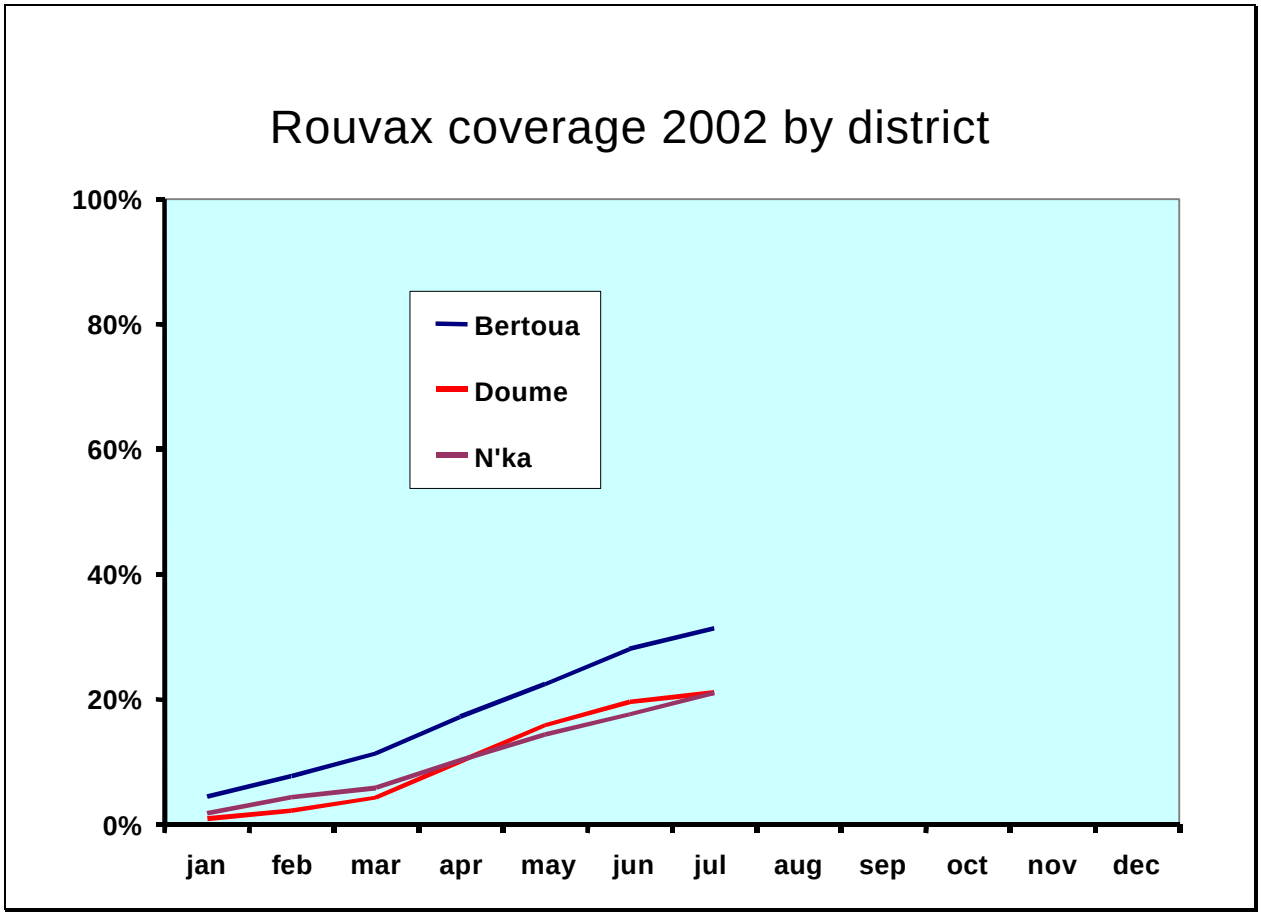
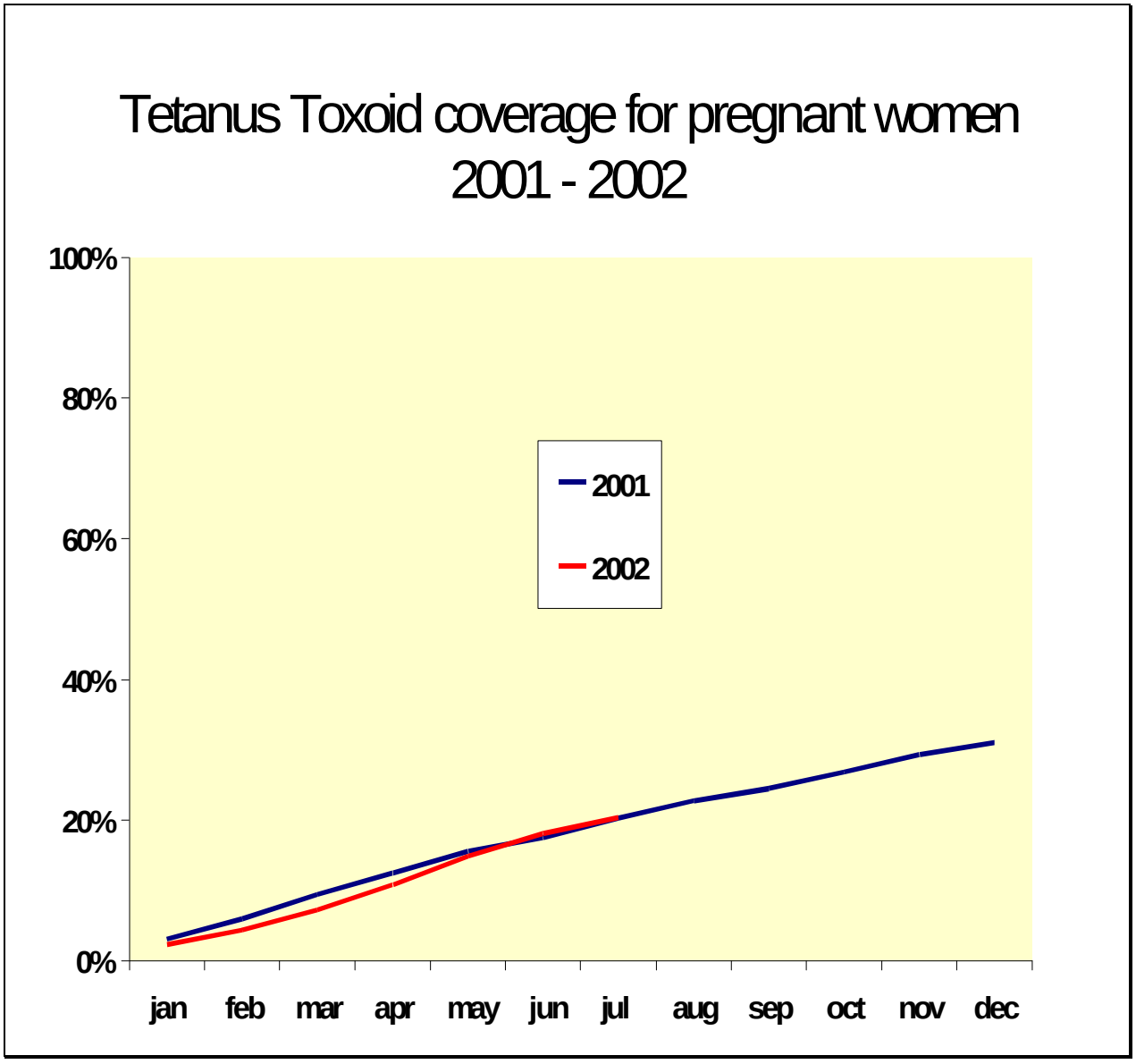


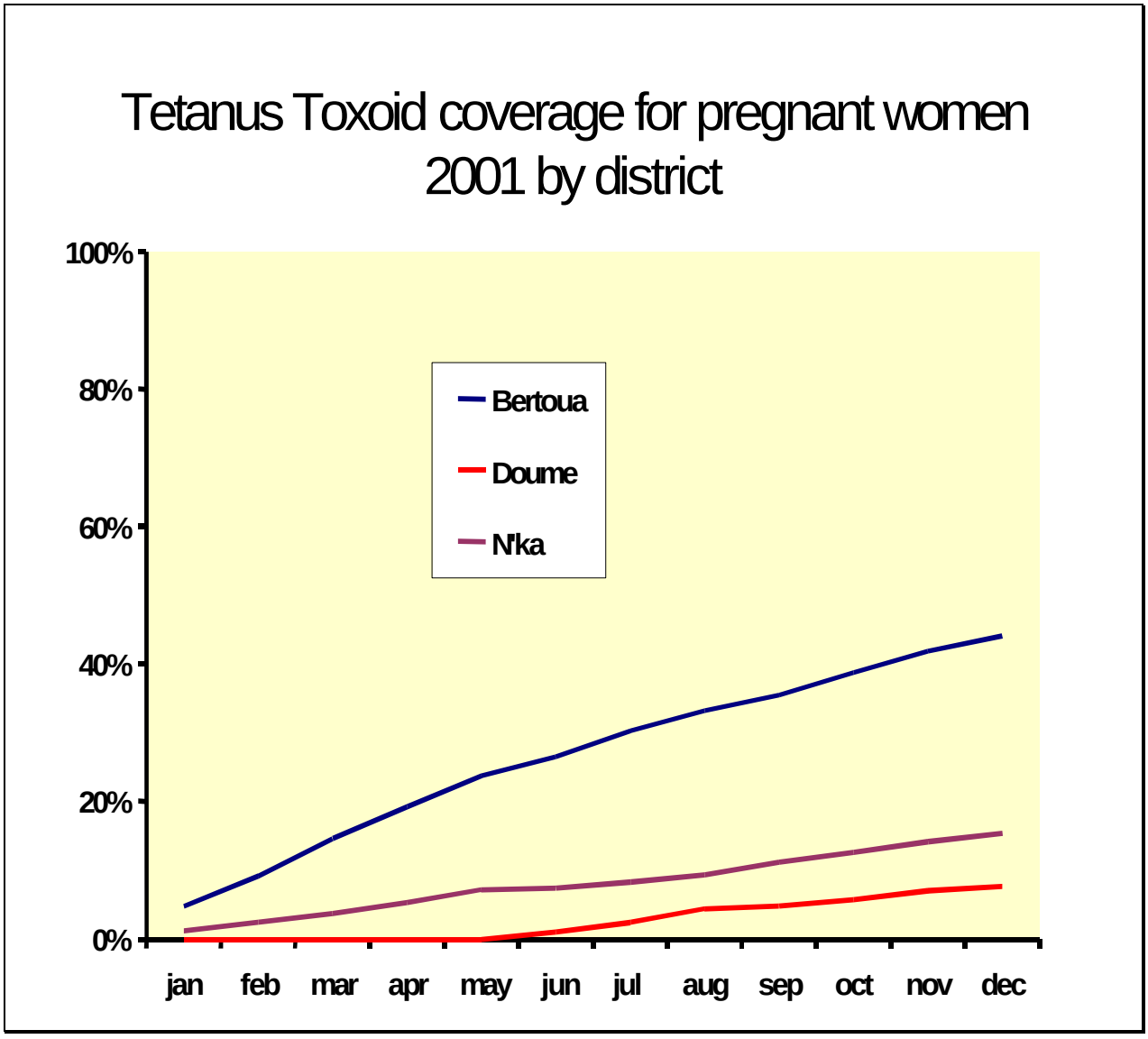
Table 8 shows the continual lead of Bertoua for Rouvax coverage but great improvement of Doume and N'ka, which seems to evolve at the same pace since the beginning of the year. From January to mid March all districts were very slow in progress but by mid March this year all of them seem to have found a renewed enthusiasm.

Table 9



Tetanus toxoid coverage seems to have been better in 2001 as compared with 2002 from January to mid May. It is only from the second half of May to July that this coverage reached the level of last year.

Table 10



Comparison of the three districts for 2001 reveals that Bertoua is on top, followed by N'ka, and Doume coming last with a good start only in May.

Table 11

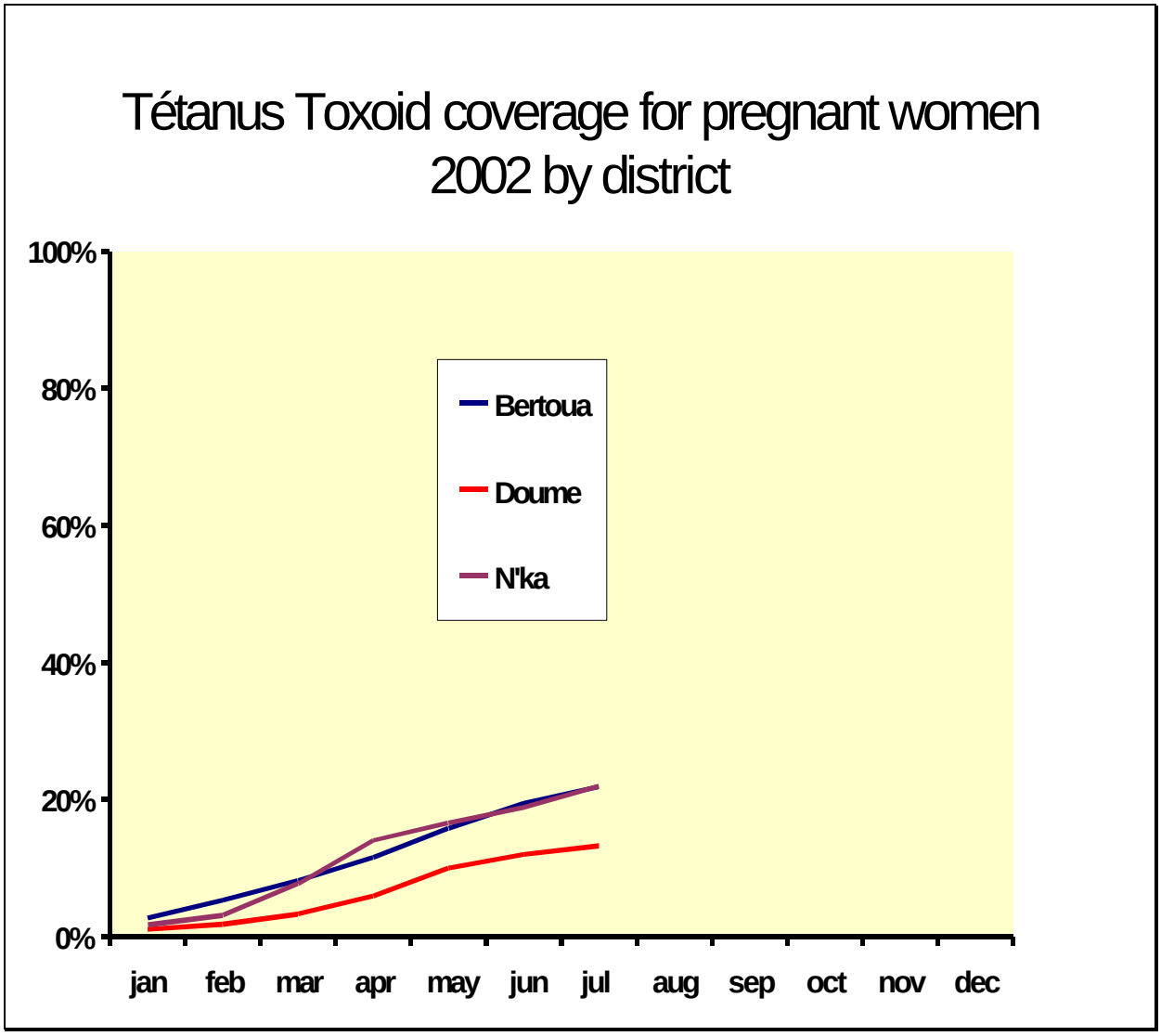


Table 11 again shows a very aggressive N'ka starting mid level at the beginning of the year, toppling Bertoua at some point (April) and at last evolving at the same pace than Bertoua. Doume even though making great progress is performing way below the two others.

The general conclusion is that immunization coverage for children, 0 – 11 months, and pregnant women is in progress and it can be anticipated that the project will reach the stated objectives for this intervention and could even go beyond, if the same level of effort is maintained in the three districts. Emphasis, however, should be put into pregnant women's immunization in Doume and N'ka.

Effectiveness of the Child Survival interventions

Immunization

Almost all participants of focus group discussions know that immunization protects children against some diseases and pregnant women against tetanus.

Mothers of Children, 0 – 23 months, do not know the number of contacts necessary for a child to be completely immunized. There is confusion about timing of BCG vaccine.

This may be due to the fact that a nurse would not open a vial of vaccines just for one child and would wait until the children needing this type of immunization reach a certain number. For this reason nurses sometimes ask mothers who bring their child for BCG vaccine to come back in a week or so thus creating this uncertainty in the mind of the community about the real timing of BCG vaccine.

CBO members (men and women) know different vaccines by names. Few of them know the number of contacts for complete immunization of a child. Some think that BCG can be administered from one week up to six months after birth.

The number of contacts for pregnant women and WCBA is not well known by mothers and CBO members.

The MOH is sending out two messages in this matter: one for WCBA who should receive five doses for complete immunization, one for pregnant women who should receive two doses during their pregnancy. These messages reach the same target group and create a great deal of confusion so much so that the ones who say two doses are right and the others who answer five doses are not wrong.

Traditional Birth Attendant (TBAs) do not know very much about immunization, except that it is important for mothers and children. However, they advise pregnant women to get immunized and they encourage them to immunize their children.

Trained COSA (men and women) were able to cite all types of vaccines a child should receive and they specified which one protects against which preventable disease. Almost all of them know that tetanus toxoid vaccine protects the mother and his child against tetanus. They were also able to explain the number of contacts for complete immunization of children and mothers.

Diarrhea

Participants in the focus group were able to define diarrhea. They could enumerate different causes.

Very few **mothers of children, 0 –23 months,** knew about Oral Rehydration Salt (ORS) and how to prepare it. Those who were aware of its existence knew that ORS replaces water that a child loses through diarrhea. Others confused the preparation of ORS with that of Salt/Sugar Solution (SSS). But nobody seems to use it because it is not really available in the field. Oral rehydration therapy is done with home made solution and traditional herbs and medicine. Most of the mothers affirmed that a child with diarrhea should continue with breastfeeding and should receive more food. A minority said that they would stop diarrhea with some drugs.

CBO members link diarrhea with lack of hygiene (dirty water, dirty hands, food not well kept, feeding bottle, worms). They treat diarrhea with leaves and Salt/Sugar Solution even though they know what ORS is and how to prepare and administer it. They can even explain that Oral Rehydration Therapy (ORT) is replacement of the water lost during diarrhea. They affirm that breastfeeding should be continued and the child should receive more food and more liquid. CBO members in the Baka community are very conservative. They use only one type of treatment (leaves).

Almost all trained Health Area Committee members (COSA) do know what course of action to take when a child has diarrhea. The majority has mastered the preparation and the administration of SRO, while a minority still does not know how to administer it. They all know the duration of conservation. But as other groups, due to non-availability of the product, they do not use it much. Instead they use homemade solutions. Some of them advise mothers to go to the health center if diarrhea persists despite rehydration therapy. They do not master the notion of continuous breastfeeding during diarrhea and think treatment should include use of charcoal, leaves, and bread. In this matter CBO members are much more knowledgeable than COSA.

Malnutrition

All participants in the focus group describe malnutrition with the sign of severe malnutrition.

Mothers of children, 0 – 23 months, mentioned that malnutrition is due to a deficiency of balanced diet in the body of the children or lack of balanced diet in the body of the mother. Some said it is due to premature stopping of breastfeeding before 24 months.

They understood the importance of breastfeeding in prevention of malnutrition of children, 0 – 6 months, and the virtue of balanced diet in the treatment of malnutrition of older children. Since they defined malnutrition

with signs of severe malnutrition, some mothers believe that any child with malnutrition should be brought to the hospital.

CBO members said that the causes of malnutrition are: improper weaning practice, illiteracy and uncaring attitude, lack of nutritive elements in the food and taboos (foods not to be consumed). Some mentioned poverty, familial conflict that brought a child to his/her grandmother who is unable to take good care of the child.

Treatment, according to them, should include exclusive breastfeeding for children, 0 – 6 months, balanced diet that provides energy, protects and ensures growth for older children. They know what is good weaning practice. They link prenatal care and good nutrition of the mother during pregnancy to prevention of child's malnutrition.

COSA said the cause of malnutrition is an imbalanced diet, use of artificial (powder) milk and worms.

Treatment include, according to COSA, balanced diet, vitamins, indigenous treatment and hospitalization. Prevention is achieved through exclusive breastfeeding, deworming, training of the mothers in good nutritional practice.

Using local names of food, COSA were able to explain various balanced dishes. Other groups were unable to give examples of balanced dishes. Some, confusing malnutrition with diarrhea, say prevention can be done through hygiene.

A great number of COSA were able to explain the growth chart as opposed to very few members of the other groups.

Breastfeeding

Mothers, CBO members, COSA, agreed that the colostrum is mandatory for children's good health. They agreed that a child should be breastfed less than one hour after birth.

Duration of exclusive breastfeeding varies from one group to the other. According to different groups, it goes from 2 to 6 months.

COSA agree that it should be 6 months. But they do not understand the weaning process. Weaning for them is stopping breastfeeding completely.

TBA knew the importance of colostrum for baby's good health. They advise mothers to breastfeed their child exclusively for the first 6 months of life. They encourage mothers to start breastfeeding less than one hour after birth. Half of them master the good weaning practice and serve as counselors for the mothers

As for **Mothers** there seems to be a big gap between knowledge and practice. Many of them, mostly young mothers, agreed that they do not

practice what they know about breastfeeding arguing that exclusive breastfeeding weakens mothers and prevents them from having nice breasts.

Malaria

Mothers, CBO members, TBAs, COSA do not know the cause of malaria. Very few say that it is caused by plasmodium. Some erroneous beliefs still persist: malaria according to some participants is caused by rain, dirt, flies bites, consumption of some kinds of food, and walking bare foot or nude.

While their knowledge about the cause is incorrect, all groups were able to cite the signs of the disease: intermittent fever, headache, vomiting, loss of appetite and shivering.

Treatment varies with different groups:

Mothers of children, 0 – 23, months, affirm that a child having malaria should be brought promptly to the hospital. Before reaching the hospital, he should be covered with a wet towel and should receive aspirin, acetaminophen or a combination of one chloroquine and one acetaminophen regardless of the age and the weight of the child.

COSA tend to treat malaria with traditional drugs. If it fails then they consider going to the hospital.

For CBO members treatment adheres to three different modes: 1) take some medication at home (paracetamol, nivaquine, quinimax), 2) treat with some leaves and 3) in case of failure, go to the hospital.

Prevention according to all groups can be done through sanitation and use of ITN.

Insecticide treated nets (ITN)

The Communities are aware of ITN as preventive measure against mosquito bites. COSA and CBO members know that it kills mosquitoes on contact. Some CBOs are promoting and selling ITN. Despite its availability, the majority of the population is not using it. They blame the high price, poverty, and lack of knowledge, lack of ownership of a bed, insufficient stock as the leading causes of low-utilization. Some are waiting, as they say, free ITN that will be given to Plan sponsored children.

Pneumonia

Acute respiratory infection is known as pneumonia in many communities and as bronchitis in others as revealed by focus group discussions.

Almost all COSA and few members of other groups were able to identify three signs of the disease: shortness of breath, cough and fever. Some could

identify two signs: shortness of breath and fever. Others only recognized shortness of breath.

All groups understood that they should seek medical attention when a child has pneumonia or bronchitis.

Interviews with key informants and in-depth discussions with key actors.

Interviews with key informants, in-depth discussions with key actors, and review of documentation revealed that many aspects of strategies implementation have been done successfully. These insights/views helped the evaluation team shape a global picture of the project and at the same time dissect the fine details.

According to these key informants:

- The capacity building approach has brought some marvelous results and has changed the way health services are being offered to communities in the area of the project. It also broadens the scope of work of the local partner and CBOs. For the first time in its long history AAPPEC, whose activities were limited only to Baka population, has expanded its intervention areas to embrace Bantou communities.

- COSA are the backbone of the advanced strategy for children immunization and growth monitoring, a key for the success of many health interventions. They are the ones in direct contact with the base of the pyramid: mothers and general population. Since there are two of them per village, they can play a key role in health education, organization of rally posts, social mobilization and improvement of information system. Messages they are conveying should be well internalized by them. They need to be technically assisted not only in receiving information but also in transmitting knowledge to others. In this regard they need special attention and continuous training.

- Health Area Management Committee (COGE), which is an emanation of Health Area Committee members (COSA), should play well their role of co – management of the health centers with the Nurse in charge of Health Centers (ICC). In this matter the Confessional partners can help. Management of their health centers seems to be well organized. If COGE members receive special management training they will understand that conflict is not the issue at stake. They would be more flexible and more willing to take steps to correct the continuous robbery that is depleting the stock of the community pharmacies. If this shortage of drugs continues, it will have a negative impact on the whole CS project and will prevent full confidence in the health system.

- It would be interesting if each village could have at least one CBO. Since most of their members are grandmothers they can easily influence the behaviors of young mothers and help them adopt health protective ones.

- Sale of ITN should not be considered as a cost recovery operation. The most important thing is to increase use of ITN and decrease malaria prevalence. The cost recovery will be through decrease in the overall cost of treatment when there will be less cases of malaria.

Observations

Observations showed that in general many aspects of health care are neglected like cleanliness of the health centers, back up of health personnel, information organization, effort to get community participation, and effort to provide good quality of health care.

Change in the technical approaches outlined in the DIP and rationale

The major change in the DIP application from the proposal, which is also reflected in the project budget and work Plan, is the addition of six community health promoters to the staff. In the proposal, it was anticipated that two project supervisors would be sufficient to oversee project activities in the three districts. However, upon closer examination during the DIP Planning process, it was determined that additional staff would be necessary. This addition is particularly appropriate since the project has decided to extend its activities to all the villages in the three districts. Due to some technical difficulties a Consultancy Agreement and not a Partnership Agreement was signed with FESADE

2. Cross-cutting approaches

a. Community Mobilization

At the beginning of the project, its staff held orientation meetings with the community members. These meetings were useful for communicating the objectives of the project and for gaining information from the communities regarding their priorities and for discovering useful strategies for implementing the project.

The project also learned that the strengthening of the health facilities and the training of the VHC members and their involvement in the Planning and implementation of health activities would be productive for the running and sustainability of the MOH supported services

The project staff participated in the National Immunization Day Campaigns. They provided money, personnel and logistics. They also supported Vitamin A distribution.

From focus group discussions conducted by the evaluation team and from review of project monitoring information, it appears that the community is responding well to these community mobilization efforts. Participation of mothers at the immunization and prenatal visits is increasing dramatically, as noted frequently by MOH staff and health personnel in partner institutions. It seems that simply having strengthened the services by training health facility personnel and VHC

members and providing logistics, supplies and equipment for services has already generated an increase in service level.

b. Communication for Behavior Change

The major strategies used by the project for promoting behavior change include sensitizing mothers attending monthly rally posts. VHC members and MOH staff using their new knowledge and the appropriate IEC materials provided by the project hold these IEC sessions. Other aspects as radio messages and theaters have not been developed yet.

These sessions made some dramatic changes in the way the community approaches now health services and reacts to sickness.

The effects of behavior change are being measured by the level of use of services and adoption of new behaviors. The number of people seeking services has dramatically increased.

c. Capacity Building Approach

1. Strengthening the PVO Organization

Plan is an original member of the PVO/NGO Networks for Health Consortium and the CORE Group and a member of the capacity-building task force of the Child Survival Technical Support Group in Washington DC. An assessment conducted in the spring of 1999 demonstrated that it has a strong institutional commitment to continuous quality in health programs. “Both the country and headquarters assessment teams identified CS/RH/FP/HIV as an institution-wide program priority receiving increasing attention and resources.” Plan was found to be open to new ideas that it uses for decision - making and for sharing with constituents around the world. The assessment showed also that Plan had weaknesses in technical skill performance and operational research. Based on these findings Plan promoted, for CS programs, quality as the key performance evaluation criterion at all levels. The number of highly efficient technical staff has been increased. Operational research has been considered a priority. In fact, an operational research regarding ITN use and promotion has been implemented at the field level.

Plan Cameroon, backed by the headquarter staff, has demonstrated for the past two years a great adaptability and mastery of CS approaches. Its staff at the country and regional offices is highly dedicated and highly qualified. Staff members have used their diagnostic, and analytical skills to assess the needs of health care facilities and partner organizations. Plan has reinforced these structures with human, financial and material resources. It has enhanced its partners’ skills through training. Plan’s vast experience in strategic and operational planning, in monitoring and evaluation served as back up for the implementation of CS activities. The staff managed to overcome difficulties created by a very difficult environment. Integration of health with other program interventions has already had a very positive impact. Families now understand that health is an integrated part of development. As this Child Survival project has been chosen by the MOH of Cameroon as the first pilot site for implementation of IMCI, Plan is playing a leadership role in this field. It is working very closely with the National IMCI Committee in charge of adapting the WHO/UNICEF diagnosis algorithm to the Cameroon situation.

2. Strengthening Local Partner Organizations

In an effort to strengthen the capacity of its local partner, the project trained AAPPEC personnel and provided logistical support to this organization. A total of seven motorcycles enable now AAPPEC staff to be more efficient in the field. Through a cooperative agreement financial support was also provided.

As a result of this strengthening effort AAPPEC, for the first time in its long 28 years history, decided to expand its scope of work to embrace Bantou communities. Up to this point its interventions were only limited to the Baka population.

Community – based partners (COSA/COGE, CBOs) received training and technical assistance as well. CBOs benefited also some form of financial assistance through the ITNs donation. CBO members are now very active in the promotion of ITNs and IEC activities.

The challenge awaiting the project in the strengthening process is the increasing number of CBOs and their different level of organizational development. The urban groups are better-structured, more mature, have more members and a wider range of activities. Some are just starting, others have not reached maturity, all are in need of nurturing. There is also a high turnover of the COSA/COGE. To keep pace with these rapid developments, the staff of the project risk being very solicited in the future.

3. Health Facilities Strengthening

Health facilities have been equipped with new materials. Broken materials have been repaired. New rally posts have been added. Financial resources have been provided to facilitate health interventions. New staff members and logistic were available. Help has been provided for supervision and monitoring.

4. Strengthening Health Worker Performance

Through training and logistical support the project strengthened health worker performance. This approach enabled the health worker to teach protective health behaviors to the community. Logistical support helped him increase the number of rally posts and bring services closer to the general population and specially to the target groups.

5. Training

The training strategy was to reinforce knowledge of all project staff members, all VHC members, TBAs, CBO members. Training was done in cascade through training of trainers. The trainers in turn duplicated the training sessions. This strategy was good but was not fast enough. Even though much of the work has already been done some training sessions have not yet been realized, and some target groups have not been fully covered.

d. Sustainability Strategy

Reinforcement of the local partner and the MOH is the main strategy used by the project to ensure sustainability. Cost recovery system is done through the COGE, which help in management of health centers. ITN are given to CBOs, which in turn should sell them and replenish their stock to be able to satisfy demand of that product. This approach can help the ITN program for malaria prevention become financially self-sustaining.

The beneficiary community expressed its willingness to continue the new acquired behaviors. But none of its members talked about the financial aspects or alternative sources of funding. They were anxious about the possibility that the project might run out of cash saying it is too early to think about the end of the project and wishing only that another organization could take over if PLAN is no longer able to do what it is doing now.

C. MANAGEMENT

1. Planning

Planning is done at different level of the partnership at institutional and community level. Meetings are held every month for planning and every week for follow up. It is done on a regular basis at the top-level through monthly coordination meetings. But this process is not well established. Some staff members show signs of frustration because they believe that these meetings are called only for show off and that everything is already set and cannot be modified at all. They say that some interventions in the field are realized without coordination causing duplication and waste of resources.

2. Staff Training

Training needs have been assessed. Personnel have been trained at institutional and community level in all aspects of child survival interventions, management, monitoring and supervision. Much needs to be done in these areas some planned training has not yet taken place.

3. Supervision of Program Staff

Financial and logistic supports are provided to the MOH for supervision. Supervision system has been developed at 50%. Joint quarterly supervision at provincial level Planned has not yet been realized. Joint monthly supervision at health district level has been realized beyond expectations at 211%.

4. Human Resources and Staff Management

All aspects of human resources management are done by PLAN office in Yaounde. Posts are advertised; selections are made through a selection committee. Contracts are signed with employees based on criteria used by PLAN for many years in different countries. Employees receive all fringe benefits permitted by law.

5. Financial Management

Community level

At community level management is concerned with the health centers. This part is not under the control of Plan. The COGE ensure co-management with the MOH staff. The ICC plays a role of technical advisor. In some cases they share costs of interventions with the MOH. Some of the Committees are working well while others indicate shortage of drugs and financial losses due to theft.

Institutional level

At the institutional level, some standard provisions based on secure and internationally accepted accounting procedures used by Plan's for many years, guide financial transactions. Expenses are incurred based on planned activities;

qualified managers and internal auditors do follow up. Financial external audits are realized on an annual basis.

6. Logistics

The project has two 4WD vehicles and 16 motorcycles. Motorcycles were provided to the MOH personnel and AAPPEC staff. Plan very often uses the two 4WD vehicles to help the MOH with interventions and supervision.

7. Information Management

Collection and use of information is done well at Plan headquarter in Bertoua. TBAs, COSA and Health Centers collect information. The system displayed some weaknesses during the MTE, the LQAS revealed some discrepancies between households information and COSA information. The system needs to be refined. The Monitoring and Evaluation Coordinator gets information mainly through PLAN and AAPPEC field staff. He prepares a synthetic report copy, which is sent to the MOH and to the partners.

The results are used regularly for decision making by MOH and other partners. But information circulation among partners needs improvement. Some partners complained about receiving information too late to take appropriate action.

8. Technical and Administrative Support

The project receives technical and administrative support from Plan office of Yaounde, and from the back stoppers in Washington. The support consists mainly in the preparation of the proposal and the Detailed Implementation Plan, training, and financial and administrative management.

D. OTHER ISSUES IDENTIFIED BY THE TEAM

Influence of the CS project on other Plan Cameroon projects

The CS has a great influence on the way other Plan projects are perceived by other partners and the general population. Despite its vulnerability the partnership approach had already taught some lessons that can benefit other Plan's project in Cameroon.

Partnership

Strengths of the partnership

Staff members identify strengths of the partnership as: the enthusiasm, the determination, the will to succeed, the willingness of its members to achieve project's objectives; the collaboration, the mutual understanding, the credibility of the partners in the field, the experience of Plan in Cameroon, the experience of AAPPEC with the Baka community, the combination of actions in the field, the challenge created by the newness of the project, the receptivity of the community to the new approaches, the back up of the MOH.

Weaknesses of the partnership

The partnership, despite these positive steps, is facing some problems. It is not embodied in solid ground. Many partners are complaining about others. Trust is not a common denominator. Some tend to believe that others have hidden agendas. Others complain about an overlap in intervention areas. The general spirit prevailing in the partnership is that of competition more than complementing each other and taking united action. Partners tend to use each other as an opportunity and not as an ally. The community is not considered a full partner with full rights and duties.

ITN promotion

This program just started through CBOs as an operational research. However, some predictable problems that call for immediate solution seem to be facing the promotion of ITN. Groups, which received this product, are selling them between 5,000.00 to 7,000.00 francs. They are talking about replenishing their stock buying new ITN from the Center for supply of drugs and health materials (CAPP) for 10,000.00 francs. This approach if maintained, may jeopardize the ITN program.

Influence of the CS project on national immunization coverage

The CS project provided cold chain for vaccines, repaired those that were broken. It provided motorcycles to health agents enabling them to bring rally posts to the mothers near their households. It supported logistically and financially mini-immunization campaign organized by the MOH and help with HIS. The increase in the immunization coverage of the three districts that, at the start of the project, were among the areas of less coverage is a real boost for the national immunization coverage.

Influence of the CS project on national IMCI

The CS project of Plan Cameroon is serving as the first experiment of the country in IMCI. As such, it thrived to establish the required conditions. The initial step was the HFA study, which was shared with the MOH. Following steps included: strengthening of health facilities, participation of health staff in IMCI training, preparation of educational materials, advocacy for holistic aspect of children's health care. The service providers are encouraged to check children's health cards as part of all health consultations for the child. The project is also trying to get the active involvement of the community in health care and disease prevention of children. This IMCI approach, implemented in a holistic manner, is organized around 4 priorities: immunization, diarrhea control, nutrition and malaria. Plan shares, on a regular basis, lessons learned during the pilot phase with the National IMCI Committee.

Gender aspect in VHC

VHC have very few women. When they are admitted into VHC, they do not play a key role. They stay at clerical positions. This is due to the cultural beliefs in a male-dominated society. The awareness of this gender imbalance in decision-making positions is already a step towards a solution. This situation will not

change overnight. A step-by-step approach with progressive women's empowerment and men's education could bring results overtime.

E. LESSONS LEARNED

Communication for behavior change

- Knowing is not doing. It takes time for knowledge to be transformed in behavior. Some young mothers of children, 0 – 23 months, know all information about breastfeeding practices but most of them agree that they do not breastfeed their child the way they are taught to. Many affirm starting to give food to their children as early as 2 months after birth;
- Young mothers who have been to school are more reluctant to participate in IEC sessions than those who have not attended school because of preconceived notions that they are already aware of all the required information.

Community involvement

- Some people believe that volunteering will lead to a paid job, whatever explanation maybe given at the beginning of their involvement
- Lack of community spirit is a real handicap to the implementation of interventions that benefit everybody
- Poverty does not always mean lack of resources. It is very often a state of mind
- Community expectations sometimes go beyond project capabilities
- Distance and geographical dispersion of community members in a community health project are challenges that can be overcome with discipline and organizational skills
- Groups of people more knowledgeable and more solid financially when they are involved in social activities can stimulate many others to follow them. Urban CBOs are such examples in the project.

Visibility

- Working with local authorities can have a great impact on the visibility of NGO's. The CS project is bringing such visibility to Plan.

Partnership

- Co–management of COGE in some health centers is more a potential for conflict than good management since those community members lack the necessary training to play their role
- Credibility of a partner already well known, as AAPPEC, can help in the implementation of interventions
- Partners should communicate and should have a shared vision
- Communication, mutual understanding, shared vision, concessions, are important factors for reinforcement of partnership.

Advocacy

- With involvement of local authorities interventions will be more effective;
- Gender inequity is a way of life for most men in the project area. Men are reluctant to accept their wife's involvement in women associations because they fear women's empowerment;
- Men must be involved in CS interventions. Their involvement will reinforce the intervention's effectiveness.

Social mobilization

- When the CBO are convinced of the pertinence of IEC messages, they are more willing to support interventions
- Non-involvement of media in the social mobilization up to now is a missed opportunity to reach more people of the target groups
- Some gatekeeper should be put into place when community members are trained in community health interventions. Otherwise they tend to go beyond the scope of their attributions. (Some COSA play roles that are not theirs. They deliver pregnant women and act as if they were doctors).

D. CONCLUSION AND RECOMMENDATIONS

CONCLUSION

The data from the mid-term evaluation indicate that the CS XVI project of East Cameroon is on track despite some start up difficulties. It is now making progress towards meeting its objectives by the end of the grant. The knowledge level of beneficiaries and service providers is generally good and communities appreciate the knowledge they have gained and the increased access to health services. A more effective cold chain is backing up immunization interventions. More women now participate in rally posts with their children. There is a higher coverage rate for immunization. People now are more interested in the health and well being of their children. Supervision and monitoring has become a reality. The capacity building approach brought some very positive effects. CBO groups have learned more about how to organize themselves.

Some areas, however, need further attention. The media aspect of the BCC strategy is not yet fully developed, the partnership is still vulnerable despite some very positive steps, activities related to training are not fully implemented, financial sustainability strategy is not clearly defined.

RECOMMENDATIONS

Recommendations regarding empowerment of VHC members

- **Plan** should complete the training of all the COSA and organize refresher courses as needed to enable them to play their role as the backbone of the advanced strategy for immunization
  MOH assisted by Plan staff should schedule special meetings for groups of them on a regular basis to discuss strategy, constraints and problem solving

Recommendations regarding strengthening of health centers' management

Plan, through its management, should help design a system with different levels and different mechanism of control, which can serve as gatekeeper to ensure that health centers management is done well and that there is less shortage of essential drugs. The COGE need to be trained in the use of the new system.
MOH, through the Provincial Delegation and Medical Health Districts staff, should be able to enforce application of the system and, using Plan logistic support, should supervise on a regular basis its maintenance and help make appropriate adaptation and correction whenever necessary. MOH staff will need appropriate training and Plan should be prepared to offer it.

Recommendations regarding reinforcement of institutional capacity building

- **Plan** should reinforce the strategy of institutional capacity building. Through this strategy the management of community pharmacies should be reengineered using the official document that exists regarding their organization, the MOH staff should receive continued reinforcement enabling them to offer better CS services, FESADE should receive help to establish an

office in Bertoua which would put that organization in a good position to continue its support to the project's community even with other sources of funding.

Recommendations regarding training

- **Plan** should use its expertise and expertise of FESADE to provide appropriate training and technical assistance to COSA, COGE, CBO groups. **MOH and FESADE** should follow up on quality and correctness of information transmitted to the general population. Adequate control instruments must be designed to check the way education sessions are realized in terms of interaction, content, feedback, etc.

Recommendations regarding supervision

- Supervision: A supervision system should be designed and applied. If, as MOH staff stated, it already exists it could be refurbished and/or adapted if necessary. The essential part of it should be its application. Aspects of care like cleanliness of the health centers, back up of health personnel, information organization, effort to get community participation, and effort to provide good quality of health care should be strengthened through regular supervision.
  Plan can participate in the improvement and/or adaptation of supervision system. It can support the MOH with regular planning and execution of supervision schedule.
  MOH and Association for the Self – Promotion of the East Province Population (AAPPEC) each in its capacity can play a master role in support of MOH staff and community volunteers.

Recommendations regarding CBO

- **Plan** should: help duplicate the existing number of CBOs taking into consideration that each village needs at least one; use the expertise of FESADE to train them and assist them in organizational development; assess their needs for other non-health support and involve other sections of Plan to assist them in those aspects; encourage them to embrace all aspects of development and to consider human beings in a holistic way; and conduct a study on level of financial help provided to CBOs by sale of ITN.

Recommendations regarding TBAs.

- **Plan with the help of MOH** should: collect, if not yet done, the average of deliveries realized by each TBA to have an idea of their work load; verify use of their equipment and materials; consider systematic replenishment of their boxes, if possible; provide boxes to all trained TBA's; ask the COSA and the village hierarchy to help the TBAs to get paid for their services

Recommendations regarding Social Marketing

- **Plan and other partners** should increase availability and accessibility of ITN to the entire population. They should discuss with MOH and share with them the same idea of a malaria free zone. They should seek together subsidization for ITN. An aggressive social marketing strategy should be adopted for the next two years to guarantee success of the ITN program.

Recommendations regarding partnership

- **All partners** should try to redefine together the meaning of partnership. They should understand that the process of working together is not an easy task. The partnership should be considered a three-way relationship between Plan, other organizations and the population.
- **Plan** should break the bureaucracy, multiply informal meetings among partners and look for information about projects where partnership works. If possible realize some exchange visits to see and experience good partnership in action and try to understand what make it possible.

Recommendation regarding HIS

- Collection and use of data should be reinforced. The COSA should make regular home visits and establish a complete list of children, 0 –11 months. They should share the information with the ICC. This way they would help maintain the rosters up to date. If this is done the denominator for calculating immunization coverage will be updated too. And this will add more viability to the data and improve decision-making based on them.

Recommendation regarding BCC

- **Plan** should develop further the media aspect of the BCC
- Use FESADE expertise to do so; organize folks and theater representation in the villages
- Improve interpersonal communication, peer education, counseling; reinforce competence of COSA in communication techniques
- Use every possible contact with the population to promote health protective behaviors
- Reinforce immunization messages
- Create and encourage support groups for exclusive breastfeeding for the first 6 months of life and offer incentives to mothers who achieve the goal and use them as role models
- Support use of more liquid, more breastfeeding and more food during diarrhea
- Organize the messages about pneumonia around acute respiratory infection using the signs of PCIME
- Use cautiously the willingness of some CBOs to be involved in theater play.

Recommendations regarding gender equity

- Advocate for integration of more women in community groups mainly COSA/COGE to realize a gender balance
- Reinforce women's empowerment activities
- Work with men to facilitate gender equity.

Recommendations regarding human resources

- At the end of the project absorb if possible the personnel or help them to find jobs in other institutions

Recommendations regarding follow up

- Since the personnel has already mastered the LQAS during the MTE process, this method should be added as a follow up tool.

Recommendation regarding viability

- To ensure sustainability, the project should try to develop local capacity
- Identify leaders who can play key functions and community organizations, which can continue the work with efficiency
- Transfer knowledge and some managerial functions to the community. (Community leaders could play an important role in identifying those human resources. They should be prepared to assume this type of responsibility).

Annex A
Baseline information from the DIP

A. Baseline information from the DIP

Grant Funding Information:

USAID Funding:(US $)	$1,000,000	**PVO match:(US $)**	$ 366,778

Target Beneficiaries:

Type	Number
Infants (0-11 months):	8,447
0-59 month old children:	37,909
Women 15-49:	48,568
Estimated Number of Births:	42,233

Beneficiary Residence:

Urban/Peri-Urban %	Rural %
10%	90%

2.F.1. Program Goals and Objectives

The goal of this project is the sustained reduction in infant and child mortality by fostering a partnership between communities and health facilities to address the major causes of morbidity and mortality in children less than 5 years of age. The following tables provide specific project objectives.

Malaria Goal: To reduce malaria associated mortality and morbidity in children and pregnant women through improved malaria case management, malaria treatment and antenatal chemoprophylaxis as well as the promotion of the use of bednets and their re-treatment among the project population.

Objectives	Indicators	Measurement Method	Major Activities
Increase from 6% to 20% the # of households that have an ITN	% of mothers who state that they own an ITN	KPC	♦ Development and implementation of IEC ♦ Organization of mothers' groups ♦ Establishing ITN distribution and re-treatment program
Increase from .4% to 20% the # of children, 0-23 months, and their mothers who sleep under an ITN	% of mothers who stated that they and their child, who is 0-23 months, slept under an ITN the night before the survey.	KPC	♦ Development and implementation of IEC ♦ Organization of mothers' groups ♦ Establishing ITN distribution and re-treatment program
Increase from 28%	% of mothers of	KPC	♦ Development and

to 50% the # of mothers of children 0-23 months who received iron/folic acid supplementation during the last pregnancy	children 0-23 months who received iron/folic acid supplementation during the last pregnancy as recorded on the maternal health card		implementation of IEC ♦ Training of TBAs on importance of Iron/folic supplementation
# of women's groups trained on home management of malaria	# of women's groups trained on home management of malaria	Project monitoring system	♦ Organization of mothers' groups ♦ Training of mothers' groups
# of health facility staff trained in MCM	# of health facility staff trained in MCM	Project monitoring system	♦ Health facility staff training

Malnutrition goal: To reduce malnutrition associated morbidity and mortality through monthly growth monitoring and follow-up, household feeding programs, nutrition education, breastfeeding promotion and vitamin A supplementation.

Objectives	**Indicators**	**Measurement Method**	**Major Activities**
Increase from 11% to 40% the # of children, 0-23 months, who attended a growth monitoring session during the last 4 months and whose weight was plotted on the road to health growth monitoring card	% of children, 0-23 months, who attended a growth monitoring session during the last 4 months and whose weight was plotted on the growth monitoring graph of the child health card (denominator all children 0-23 months)	KPC	♦ Organization and training of mothers' groups ♦ MOH outreach activities. ♦ Development of community HIS ♦ Community mobilization to make use of outreach activities ♦ IMCI training and supervision of health facility staff
Decrease from 19.1% to 10% the # of moderate and severely malnourished children	% of children 0-23 months who had weight/age below 2 standard deviations	KPC	♦ Organization and training of mothers' groups in nutrition demonstration based on hearth findings ♦ MOH outreach activities ♦ Community mobilization to make use of outreach activities

			♦ IMCI training and supervision of health facility staff
Increase from 0% to 40% # of mothers of children (0-23 months) with mild to moderate malnourished children who participate in community based rehabilitation program	% of children, 0-23 months, with mild to moderate malnutrition identified in growth monitoring sessions who participate in community based rehabilitation program	Project monitoring system	♦ Organization and training of mothers' groups ♦ MOH outreach activities ♦ Community mobilization to make use of outreach activities
Increase from 3% to 50% the # of children seen at health facilities who had nutrition status plotted on the road to health chart of the child health card.	% of cases of children, under 5, seen at health facilities who had nutrition status plotted on the road to health chart of the child health card.	HFA (Observation)	♦ IMCI training of health facility staff
Increase from 29% to 35% the # of mothers of children (0-6 months) of age who exclusively breastfed the child	% of mothers of children (0-6 months) of age who exclusively breastfed the child	KPC	♦ Development and implementation of IEC
Increase from 66% to 80% the # of mothers of children (6-9 months) who are giving the child complementary food	% of mothers of children (6-9 months) who are giving the child complementary food	KPC	♦ Development and implementation of IEC

Diarrhea Goal: To reduce diarrhea associated mortality and morbidity through prompt and appropriate case management of (a) all episodes at home with fluid and dietary management and (b) recognition of danger signs with appropriate referral.

Objectives	Indicators	Measurement Method	Major Activities
Increase from 42.3% to 70% the number of children who received more fluids than usual during the last diarrhea episode	% of mothers of children (0-23 months) who gave more fluids than usual during the last episode of diarrhea	KPC	♦ Developing and implementing IEC for diarrhea management in the home. ♦ IMCI training and supervision of health facility staff (emphasis on counseling on home care of child after visit to the health center)
Increase from 78.4% to 88.4% the # of children who were breastfed the same or more during the last diarrhea episode	% of mothers of children (0-23 months) of age who breastfed the same or more during the child's last diarrhea episode	KPC	♦ Developing and implementing IEC for diarrhea management in the home. ♦ IMCI training and supervision of health facility staff
Increase to 75% the # of mothers of children (0-23 months) who can name at least 2 danger signs for referral of diarrhea cases	Proportion of mothers of children (0-23 months) who can name at least 2 danger signs for referral of diarrhea cases	KPC	♦ Developing and implementing IEC for diarrhea management in the home. ♦ IMCI training and supervision of health facility staff
Increase from 51% to 70% the # of children who were given the same or more food during the last diarrhea episode	% of mothers of children (0-23 months) of age who gave the child the same or more food during the last diarrhea episode	KPC	♦ Developing and implementing IEC for diarrhea management in the home. ♦ IMCI training and supervision of health facility staff
Increase from 23% to 70% the # of children with simple diarrhea, seen in health facilities, that was correctly treated	The % of cases of simple diarrhea treated correctly (ORS, not antibiotic) by health facility staff.	HFA (Observation)	♦ IMCI training and supervision of health facility staff.

Immunization goal: To increase immunization coverage in the program area for all infants by the end of their first year of life, and provide tetanus toxoid (second dose) immunization for pregnant women.

Objectives	Indicators	Measurement Method	Major Activities
Increase from 24.7% to 60% the # children (12-23 months) who were fully immunized before their first birthday	Proportion of children (12-23 months) who received BCG, DPT3, Polio3 and Measles before their first birthday. Verified from child health cards.	KPC	♦ MOH outreach activities. ♦ Development of community register. ♦ Community mobilization to make use of outreach activities ♦ IMCI training and supervision of health facility staff (emphasis on checking immunization status)
Reduce the DPT dropout rate from 37.5% to 15%	% of children who received DPT1 who also received DPT2 and DPT3 [(DPT1-DPT3/DPT1)]	KPC	♦ MOH outreach activities. ♦ Development of community register. ♦ Community mobilization to make use of outreach activities ♦ IMCI training and supervision of health facility staff
Increase from 60.7% to 80% the # of children, 12-23 months, vaccinated with measles	% of children (12-23 months) of age who were vaccinated with measles as registered on the child health card	KPC	♦ MOH outreach activities. ♦ Development of community register. ♦ Community mobilization to make use of outreach activities ♦ IMCI training and supervision of health facility staff
Increase from 47% to 70% the # of mothers of children (0-23 months) who had TT2 during their last pregnancy	% of mothers of children (0-23 months) who had TT2 during their last pregnancy	KPC	♦ MOH outreach activities. ♦ Development of community register. ♦ Community mobilization to make use of outreach activities ♦ TBA training about importance of TT vaccination
Increase from 9.4% to 40% the # of children who received Vitamin A supplementation	% of children (6-23 months) who have Vitamin A supplementation registered on a child health card	KPC	♦ MOH outreach activities. ♦ Development of community register. ♦ Community mobilization to make use of outreach activities

during the last 6 months (This objective will be valid if the MOH implements regular Vit. A supplementation in the East)			activities ♦ IMCI training and supervision of health facility staff ♦ Development and implementation of IEC
Increase from 30% to 80% the # of children seen in health facilities that had immunization status checked	Of cases seen at the health facility, the % who had their immunization status checked on the child health card	HFA (Observation)	♦ IMCI training and supervision of health facility staff

IMCI goal: To improve the quality of care of children both in health facilities and at home by ensuring (1) that health facility personnel and caretakers follow a holistic approach to treatment of illnesses, (2) that caretakers understand proper home care for illnesses and (3) that there is good communication between health facility personnel and caretakers.

Objectives	Indicators	Measurement Method	Major Activities
Increase from 58.5% to 80% the # of mothers who know at least 2 danger signs that children need to be seen at a health facility	% of mothers who know at least 2 danger signs	KPC	♦ Development and implementation IEC strategy for community IMCI
Increase from 11% to 50% the number of children, 0-23 months, seen at health facilities that were assessed for all danger signs.	% of cases of children 0-23 months who were seen at health facilities who were assessed for all danger signs.	HFA (Observation)	♦ IMCI training and supervision at the health facility level
Increase from 36% to 70% the # of caretakers who were correctly counseled about their sick child	% of cases seen at health facilities where the health facility staff completed correctly all the counseling tasks	HFA	♦ IMCI training and supervision at the health facility level
Increase from 45% to 70% the # of caretakers who	% of cases seen at health facilities where caretakers	HFA (exit interview with caretaker)	♦ IMCI training and supervision at the health facility level

were given oral medications, who know how to correctly administer the treatment	who were prescribed oral medications for their sick child, knew how to correctly administer treatment		

Capacity Building and Sustainability: To strengthen both the MOH and community health organizations so that they can work together to improve the health situation of children and families.

Objectives	Indicators	Measurement Method	Major Activities
MOH:			
Improved personal mastery and change of mental models of facility staff through acquiring IMCI skills.	1. % of cases of children (0-23 months) who were seen at health facilities and were assessed for all danger signs. 2. % of cases seen at health facilities where the health facility staff completed correctly all the counseling tasks 3. % of cases seen at health facilities where caretakers who were prescribed oral medications for their sick child, knew how to correctly administer treatment	- HFA - Interviews FGD	♦ IMCI training ♦ Supervision of IHC staff by DHT
Improved team learning and systems thinking through adjustments made to the supervisory system, in order to emphasize supportive supervision and joint problem solving through regular meetings between health facility staff and community representatives.	1. New supervisory instruments are developed that include a section for joint problem solving. 2. Description of problems solved together during supervisory visits. 3. Description of problems solved jointly between health facility staff and communities through discussions at health area committee meetings. 4. % of IHCs who receive regular supervisory visits by DHT. 5. % of VHCs and community resource	- Project monitoring system - Interviews FGD	♦ Development of participatory supervisory system and instruments. ♦ Regular supervisory visits of DHT to IHC. ♦ Regular supervisory visits of IHC to VHCs and Community Resource persons.

	persons who receive regular supervisory visits from IHC.		♦ Quarterly health area committee meetings.
Communities:			
Health area committees (COSA) develop clear visions about changes in the health situation that they want to see for each health area and about the role of the COGE. ACHRP develop clear visions about their role in improving health in communities.	1. % of COSA that have a written vision statement. 2. % of ACHRP that can articulate a vision statement.	- Project monitoring system - Interviews FGD	♦ Field staff (PLAN and partners) work with COSA and ACHRP using participatory methods.
Health area committees develop abilities for systems thinking through making action plans, which improve the health situation in each health area. ACHRP develop system thinking abilities directed toward improving health at the local level.	1. % of health area committees with action plans. 2. %of ACHRP with action plans.	- Project monitoring system - Interviews FGD	♦ Field staff (Plan and partners) work with COSA and ACHRP using participatory methods.
Health area committees change mental models for handling health issues through combined work of the different villages in each health area.	% of health areas with joint village Plans for addressing health issues.	- Project monitoring system - Interviews FGD	♦ Field staff (PLAN and partners) work with COSA and ACHRP using participatory methods.
Health area committee members and community health resource persons improve personal mastery of managing the community health	1. COGE trained in financial record keeping. 2. % of COGE who have participated in management training. 3. % of COSA who have participated in training in the health topics of this project	- Project monitoring system - Interviews FGD	♦ COGE members trained in financial record keeping. ♦ COSA members

system.	(Immunization, Diarrhea, Malaria, Nutrition, IMCI)		trained in management. ♦ COSA members trained in health topics (Immunization, Diarrhea, Malaria, Nutrition, IMCI)
Health area committees work with both communities and health facilities in order to improve the health situation of children and families in the health area.	1. % of COGE with financial records up to date. 2. % of COSA that hold regular meetings with health facility staff. 3. % of COSA with action Plans.	- Project monitoring system - Interviews FGD	♦ COGE establish financial systems and maintain them. ♦ Field staff performs supportive supervision of COSA. ♦ Field staff work with COSA as they develop action Plans.
Association of Community Health Resource Persons (ACHRP) works with individual communities in order to improve health situation for community members.	1. % of ACHRPs that hold regular meetings. 2. % of ACHRPs that have action Plans.	- Project monitoring system - Interviews FGD	♦ Communities mobilized for outreach services. ♦ Communities mobilized for through BCC ♦ Community health resource persons follow up families with special needs. ♦ Community

			resource persons maintain and use community HIS.
Health facilities and Community Health Resource persons are linked in efforts to improve community health	% of ACHRPs who receive regular supervisory visits from health facility staff.	- Project monitoring system - Interviews FGD	♦ Health center staff visits Planned activities of ACHRPs.

Program location

The CS XVI project is located in three Health Districts of the western part of Cameroon's heavily forested Eastern Province. The province is Cameroon's poorest and borders the Democratic Republic of Congo. The project will benefit inhabitants of 267 villages (a total population of 211,264) located in 27 Health Areas of Bertoua, Doume and Nguelemendouka health districts. (NG or Nguelemendouka was recently split off from Doume by the MOH).

Plan has been working in this large, sparsely populated province since 1996 and has established strong ties with the community particularly with the Bantus, one of two tribes that inhabit the area. Plan Cameroon is partnering with AAPPEC, an NGO with 28 years experience working with the Pygmies, in addressing the health needs of this marginalized population. The health problems of this province are among the worst in Cameroon with only 14% of the children under one being completely immunized, as compared with a national rate of 36%. Malnutrition is also a serious problem with 56% of the children being stunted and 21% underweight.

Target groups

The project is targeting approximately 95,024 beneficiaries with 38,009 children under five, 8,447 infants (0 to 11 months) and 48,568 women of reproductive age (15 to 49). Inhabitants of the project area belong to either the Bantu or Pygmy tribes. In addition to their own language, the Bantus speak French. The Bantus, comprised the Bayas and Makas, outnumber the Pygmies (Bakas) and tend to dominate this vulnerable group. The Pygmies are nomadic matriarchal forest dwellers that are settling into temporary encampments, some of which are integrated with the Bantus.

Health Infrastructure

The project will be dedicating its efforts to strengthening the MOH health care delivery system. Regarding existing health infrastructure, there is a provincial hospital located in the Bertoua health district, which receives second level referrals for the whole Eastern Province. The Province is divided into 12 health districts (these are not always equivalent to Administrative districts), and only 9 health districts have a district hospital. Health districts are further divided into health areas, which are then served by Integrated Health Centers (IHC). A nurse or a doctor usually staffs these IHCs. The smaller health units may be staffed by a nurse assistant or a nurse's aide. Some health areas still do

not have IHCs. Pharmacies with MOH essential drugs are located at the IHCs, and are sustained by community revolving funds, which function at a minimum level at most health centers.

There are 7 private health centers in the project area. Compared to the public health centers, they are adequately staffed and provide quality services. However, there are only a limited number of these private centers (1 per 34,000 inhabitants).

Health Care Facilities in Project Area

	Bertoua	Doume	Nguelemndouka
Population	**131,647**	**47,620**	**31,997**
Provincial Hospital	**1**	**0**	**0**
District Hospital	**0**	**1**	**0**
Health Areas	**17**	**6**	**4**
CMA*	**2**	**0**	**1**
Public Health Center	**10**	**6**	**4**
Semi-private health Center	**2**	**0**	**0**
Private health Center	**4**	**2**	**1**
Total # of Health Centers	**18**	**8**	**6**

*(CMA = Integrated Health Center with a medical doctor)

Program Design

The program approach complements and strengthens the existing government health care system by training health personnel, strengthening facilities and logistical systems and strengthening community health activities and committees. Plan will work in partnership with the MOH, AAPPEC, FESADE, the Catholic Mission and the Protestant Mission to carry out the Planned interventions. In addition, WHO, UNICEF and the Organization for the Fight against Epidemics in Central Africa (OCEAC) have agreed to provide technical assistance to the project.

PLAN Cameroon's Child Survival Project will implement two complementary strategies to reach the project's objectives: 1) Creation of a community based health system which is linked to and supports the MOH services through strengthening the skills of providers, community resource persons, and community members, and 2) Design and implementation of the Integrated Management of Childhood Illness (IMCI) approach at the facility level with emphasis on community participation, and four interventions priorities: malaria control; improved immunization coverage; diarrhea case management; and reduction of malnutrition..

To build trust and encourage community partnership, the project will 1) develop and maintain close contact with the communities, 2) involve the communities in project implementation and 3) provide non-financial incentives for community volunteers.

Partnership

Relationship with Other Health Related Activities and Partners

MOH, PLAN: All program strategies will follow MOH policies or where they do not exist (such as treatment of malnutrition) will assist in their development. PLAN Cameroon has

been working with the MOH in the targeted districts of the Eastern Province since 1996. In 1997 PLAN assisted the MOH in the implementation and evaluation of the National Polio Eradication campaign. The following year, PLAN conducted a baseline survey to assess the nutritional status and vaccination coverage of children under five and used the results to collaboratively design health activities with the MOH. PLAN has supported MOH community health services by training HACRs and promoting water and sanitation projects. As noted above, PLAN will be heavily involved in training of MOH facility and community staff and in facility strengthening. PLAN has agreed to continue and expand its water and sanitation activities in the project area in order to complement the CS interventions. PLAN will also be promoting home gardens in the project area as a complement to the project's nutrition interventions. PLAN is working with the Ministry of Agriculture and supplies garden tools and initial seed stocks to the communities. The agricultural extension workers provide training and education.

Catholic and Presbyterian Missions: The Catholic mission currently manages health services in six of the project's health areas and the Protestant mission manages two. These services are managed in accordance with MOH policies and procedures and the facilities are staffed with MOH personnel as well as Catholic Mission staff. According to the project's survey information, these are the only regions where the full range of MOH services are regularly provided. They also conduct outreach to all affiliated communities in these health unit areas. In addition, the Catholic Mission supports an IEC resource organization, AMA, which has developed many training and IEC materials in collaboration with the MOH, as well as other organizations. PLAN is currently using some of these IEC materials to convey health messages to the communities through HACRs who have been trained in other PLAN health programs. The Presbyterian Mission manages the health services in two areas but they do not provide outreach services. PLAN will work with the Catholic and Protestant missions by sharing resources and involving them in the development of project materials and protocols.

AAPPEC: AAPPEC (Association for the Self-Promotion of the East Province Population), a Dutch-funded NGO, has made impressive strides to improve the health and socio-economic status of the Pygmy tribe since it's founding in 1972 by the archbishop of Bertoua. With its mission of promoting self-development and peaceful cohabitation and equality of all the people of the Eastern Province, AAPPEC implements community-based projects in five program areas: promotion of basic education, promotion of preventive health practices, gender awareness, promotion of agriculture and agro-forestry, and promotion of peace and justice. AAPPEC has good community level relationships because of its field-based approach to development. Out of 200 personnel, 196 are working in the project area. AAPPEC staff speaks and writes in the local languages and dialects so they are able to translate materials and develop educational materials for non-literate populations, such as the Baka (Pygmies). This is especially important for community health workers such as TBAs. In collaboration with UNICEF, AAPPEC has implemented water and sanitation projects, TBA training and ORT promotion. They also work with some of the MOH staff in the project area to ensure that the Baka community receives adequate outreach services. AAPPEC's partnership with the project is important as they will assist in the development of CS materials for training and education of non-literate community workers and members. They will also conduct the CS training and education activities in the Baka communities (together with the project staff), since they already work in these communities and speak the language.

FESADE (Women's Health Development in Sub-Saharan Africa): FESADE is a local NGO created in 1993 that is based in the capital of Cameroon (Yaounde). Its expertise is in the areas of health promotion, social mobilization and creation of income generation activities. They are currently working in five of Cameroon's ten provinces and are interested in expanding to the Eastern Province. The organization's goal is to improve women and children's health and promote credit programs through women's groups. FESADE has worked in partnership with many agencies including GTZ, WHO, John Hopkins University, and the Canadian International Development agency. PLAN is partnering with FESADE in order to take advantage of their experience in capacity building of community-based organizations, since that is one of the project's key activities. In turn, FESADE will gain child survival programming experience from PLAN.

PLAN has chosen to collaborate with the partners above because of their unique experience in the project area or in areas of expertise relevant to project objectives. During proposal preparation, several meetings were held with the selected partner organizations in which they discussed organizational needs and complementary areas of expertise. Prior to the DIP, PLAN's International Child Survival Coordinator organized a start –up workshop in which all project partners participated and outlined their expertise and what they could offer the project. The project is currently following up with each of the partners and formalizing agreements with each concerning roles and responsibilities.

Health information system and mechanism for program monitoring

2.F.2. Program Monitoring and Evaluation Plan

2.F.2.1. Organizational Approach to Monitoring and Evaluation

PLAN is committed to collecting and analyzing data for decision making in all of its program Domains and for Country Strategic Planning. PLAN has developed an organizational system for collection of this information. This system is called CPME. This system collects both quantitative and qualitative information from each of the Domains as well as general information about socio-economic conditions and child rights. Information from this system was used in order to prepare the proposal for this Cameroon Child Survival project.

For individual projects, PLAN promotes the development of monitoring and evaluation systems that are tailored to the individual project's needs.

2.F.2.2. Monitoring and Evaluation Plan for the Program

The aim of this monitoring and evaluation system is to promote local ownership of the project and its activities by communities, the MOH and partner NGOs. Through this system PLAN and the local partners will be able to track progress, analyze problems and make decisions. This project places importance on the process of developing this system with partners and communities so that they will be empowered to analyze their own activities and Plan future work. The following description of this M&E system will be adapted through work with communities, MOH and partner organizations. This way they will obtain the information that they need to make decisions about project activities.

The M&E Plan will consist of the following systems, which are all linked together:

- Community health information system
- Project monitoring system
- MOH health information system
- Supervision system
- Evaluation system

The project will develop a community health information system, which will allow community members to track key health events and activities. This system will include the following information:

1. Vaccination status of each child (0-23 months)
2. Participation of growth monitoring sessions of each child (0-23 months)
3. Growth monitoring session and nutritional demonstrations by mothers' groups
4. Malnourished children
5. Referral of sick children to heath centers
6. Births
7. Deaths (children 0-59 and maternal)
8. Pregnant women
9. Household with ITNs
10. ITN re-treatment campaigns
11. Key childhood diseases
12. Outreach visits from the health center

PLAN and partner organizations will work with communities in order to develop formats for community information. This process will emphasize working with the community to determine what health information is most important for them. The community will keep track of this information. This information will be kept by the community for its own use and also selectively passed on to the MOH. Information about health status of individual children in a village will be kept on a roster. Additional forms will be developed for other information and for tracking health activities in the community. Community health resource people who are representatives on the health area committee will manage the system. The roster and formats will take into consideration the literacy level of the community health resource people, many of whom have basic literacy skills. Plan Cameroon has developed similar systems in other communities.

This community health information system will provide information so that community health resource persons can track children with special problems. For example families with children who need vaccination can be visited and informed about outreach activities. Community resource people can follow-up with malnourished children. This system will provide the village health committee representatives to the area health committee with data to back them up when they ask for services. For example, if the community realizes that many children have low immunization status, the community could request a special outreach visit to that community.

A village alert system will accompany the community information system. This alert system can let the community know about up-coming events such as outreach visits or NIDs. It can also be used to alert the community to health issues, for example that many children need to be immunized. In this case, the community can be mobilized to encourage those children to attend vaccination sessions.

The project monitoring system will be designed to gather information for decision making by personnel at different levels who are involved with the project. This system is connected to the project Planning system. Project supervisors will make monthly work Plans based on the overall project Plan developed as part of the DIP. They will help assistant field supervisors and community health promoters develop daily work Plans for activities in the community. Assistant field supervisors and community health promoters will report on activities accomplished once a month and will extract monthly data from community HIS systems. The assistant supervisor will compile data and will write a monthly report that will be passed on to the project coordinator and to partner organizations (MOH, AAPPEC, FESADE). The project coordinator will analyze the information from these monthly reports and write a quarterly report that will be passed on to the country health advisor, the program support manager in the country office, the country director, the program area coordinator, technical backstoppers in Plan's DC office and project staff.

At each step of this process, those who compile data will have opportunities to use the data to make decisions. The community will use the data for communicating needs to the health facilities. Field educators and field supervisors will use the information collected to refine actions. The project coordinator will work with field staff during monthly meetings to adjust project Plans. The program area coordinator will work with the project coordinator to improve coordination between Child Survival project activities and other PLAN activities. The country office will work with the project coordinator to refine overall technical and management strategies. Technical backstoppers in headquarters will work with both the country office and the project coordinator in ensuring overall quality of project implementation.

Monthly reports will be designed to take into consideration information needs of partner organizations as well as Plan's own needs for project monitoring. The supervisor in charge of monitoring and evaluation will work with the MOH, AAPPEC and FESADE in order to determine what information they need from the project. One monthly report from the field supervisors will contain information for partners to be able to track project progress.

The quarterly report written by the project coordinator is an important analytical tool for analyzing project progress and problems and for communicating with the country office and technical backstoppers. The report consists of both narrative and quantitative information. The report consists of an introduction, narrative description of key activities, description of problems and solutions and a table that contains quantitative information about number of activities performed compared to activities Planned. After writing this report project coordinators will better understand project difficulties and successes in order to work with staff to solve the problems. Both the country office and technical backstoppers will be able to assist with problem solving after reading these reports.

The role of the supervisor in charge of monitoring and evaluation is key in developing this system at all levels so that each level understands what information they need and what decisions they can make with this information. The supervisor in charge of monitoring and evaluation will oversee the quality of the information collected. He will continue to strengthen the monitoring and evaluation system during the life of the project. His involvement will be most active at the beginning of the project and gradually change, but will gradually be reduced as groups become more efficient at using information.

The MOH system includes monthly reporting forms from health facilities, outreach registers, health facility registers and child health cards. The monthly report includes: information on curative activities in the health facility; disease specific cases seen; mandatory reporting of diseases; preventive activities both in the health facility and during outreach sessions, referrals and counter-referrals; management activities; supplies; management committee meetings and supervisory visits. These monthly reports are sent to the district level where they are compiled and sent to the provincial level where they are compiled again and sent to the national level. In the facility, there are registers for immunization and for curative and preventive services. During outreach sessions, they record information in an outreach register book. Information about individual children is recorded on child health cards that include growth-monitoring graphs. The mother keeps these cards. Pregnant women also have a maternal health card, which they keep with them. This card is only used during pregnancy and is usually thrown away after the child is born.

The supervision system will be designed to ensure project effectiveness and to enhance the current MOH system, which is linked to community representation to health area management committees. This is a supportive supervision system based on dialog observation and information analysis. From within the project field supervisors supervise assistant field supervisors and community health promoters. Field coordinators supervise field supervisors. The project coordinator supervises field coordinators. The national health coordinator supervises the project coordinator. Monthly meetings will be held to analyze monthly reports and discuss any issues that arise.

For the MOH system, health area facilities are supervised by both the district medical office and health area management committees. The district medical office is responsible for technical and managerial supervision. The health area committee is responsible for managing the community pharmacy, which is located at the health facility. With the introduction of IMCI, there will be need to develop checklists for supervision of health worker performance once they have completed IMCI training. The project will work with the MOH to develop these tools. The project will work with the health area management committees so that they will play a greater role in supervising heath facility management. In order to ensure a link between community health resource persons and the health facilities, health facility staff will supervise work performed by community health resource persons through periodic meetings and during outreach visits.

The project evaluation system involves baseline studies conducted at the beginning of the project. These same studies will be repeated at the end of the project in order to determine progress in meeting objectives. The studies are the Knowledge, Practice, and Coverage Survey (KPC), HFA and Focus group discussions (see section 1.E. Summary of Baseline and Other Assessments for further description of these studies). The project will contract outside evaluators to perform mid-term and final evaluations as specified by USAID guidelines.

The project will consider using LQAS to evaluate progress periodically during project implementation, based on the experiences of other Plan projects that have already used LQAS methodology.

Through this monitoring and evaluation system, people at different levels and from different organizations will come together to use the information and make decisions. These levels include, women's groups, village health committees, health area committees, health facilities, project staff, coordinating committees of partner organizations at the provincial level and the steering committee at the national level.

Women's groups and village health committees will meet once a month to discuss health problems based on the community registers. Community resource people who are members of the health area committees will hold monthly meetings to discuss problems detected through the community HIS. Community health resource people will share information and decisions with health facility staff at monthly meetings. During these meetings, joint decisions can be made that address problems discussed. Health facility staff will combine information from the MOH system with information from the community HIS in order to Plan their own activities such as programming outreach visits and estimating supplies needed for the next quarter.

Project staff will meet once a month to discuss information collected from the community HIS, the project monitoring system and the MOH system and make decisions about project activities. The project coordinating committee will meet every three months. This committee will meet at the provincial level in Bertoua. The committee is composed of PLAN Cameroon (Program area manager, national health coordinator and project coordinator), Ministry of Health (Provincial Delegate, District Medical officers from Bertoua and Doume/Nguelemendouka) and representatives from FESADE, AAPPEC, the Catholic Mission and the Presbyterian Mission. The Steering committee is the national coordinating committee for the project and will meet every six months in Yaounde. This committee is composed of representatives from PLAN Cameroon (Country Director, Program Support Manager), Ministry of Health, FESADE and the Catholic Mission). This steering committee plays an important role in guaranteeing overall institutional support for the activities carried by partners in the project area.

2.F.2.3. Current Community Information System

Currently, the MOH collects information on services provided during outreach activities on an outreach register book. This information is for reporting and Planning by the MOH. AAPPEC has been working with Baka communities for 28 years and has its own system for tracking community activities. Other formal systems of community information have not been developed in the project area.

2.F.2.4. Monitoring Tools

The following monitoring tools will be developed by the project:

- Community HIS: Child health roster; community register
- Project Monitoring System: Monthly Planning forms, Daily Planning forms, Monthly field report forms, Quarterly reports.
- Supervisory tools: Check lists for monitoring health worker performance at the health facility level after IMCI training

The project will use existing monthly report forms and registers from health facilities, child health cards and maternal health cards.

2.F.2.5. Data Collection

The community resource person will collect information for the community HIS. This resource person will pass information as needed to the health facility. Health facility staff also will extract information from the community HIS, during outreach visits. Assistant field supervisors and community health promoters will extract information from the community HIS and incorporate this into monthly reports. They will record information about their activities and pass this on to field supervisors who will compile the information and combine it with information about their own activities.

For Baseline and Final evaluations, project staff will collect the information. For the KPC local people will be hired temporarily to conduct interviews.

2.F.2.6. Supervision of Data Collection

The monitoring and evaluation supervisor will be responsible for supervision and quality control of information collected.

2.F.2.7. Data Analysis and Sharing with Stakeholders

Data analysis will be performed as described through meetings at various levels as described above in section *2.F.2.2. Monitoring and Evaluation Plan for the Program*. These meetings involve all the stakeholders in analysis and decision-making.

2.F.2.8. Data Management System

The system will be managed by the monitoring and evaluation supervisor who will gradually turn over this function to health committee resource people and to the MOH.

2.F.2.9. Monitoring of Health Worker Performance

Health facility staff will be monitored through the MOH system. The district medical office supervises health worker performance at health area centers. With the introduction of IMCI at the health facility level, new supervisory checklist will have to be developed. The project will work with the MOH to develop these checklists in order to monitor change in skills and behavior after IMCI training.

2.F.2.10. Strengthening Monitoring and Evaluation Skills of Staff and Partners

The monitoring and evaluation supervisor will strengthen the monitoring and evaluation skills of staff and partners through a participatory approach to developing the monitoring and evaluation system as described above. Already staff has been trained in baseline studies (KPC, HFA and focus group discussions). They used this training to perform these studies in preparation for the development of the DIP.

Annex B
Team members and their titles

Team members and titles

LISTE DES PARTICIPANTS

No	Noms et Prénoms	Titre	Provenance
01	Dr FRANTZ Simeon	Consultant	USA
02	Dr MOAMPEA MBIO Marie Claire	No 1 General Inspector /MOH	Yaounde
03	Dr MPIOUANG LOMBO Levie	DPSP/EST	Bertoua
04	Dr ALY Toupouri	SPSC/DPSPE	Bertoua
05	Dr METANGMO Pierre M	Plan, USA	USA
06	Mr PREM SHUKLA	CD, Plan Cameroon	Yaounde
07	Dr TALLAH Esther	Health Coordinator Plan Cameroon	Yaounde
08		Plan, Cameroon	Yaounde
09	Dr	Plan, Togo	Lome
10	KATABO Pierre	PAM Plan :EST	Bertoua
11	Dr MFORNYAM Chrystopher	CS Coordinator Plan, Cameroon	Bertoua
12	NGUELE Jerôme	AAPPEC Coordinator	Bertoua
13	NGO NGUE Delphine	FESADE	Yaoundé
14	MEZO Yollande	Plan, Cameroon	Bertoua
15	ZENGOUENG Gaston Paulin	COGEDI President	Doume
16	KOMBOT Rigobert	COSADI President	Nguelemendouka
17	MANGA W Emmanuel	COSADI President	Bertoua
18	TAH Sadrack	APCT	Bertoua
19	MVONGO Mbana Flauribert	APCME	Bertoua
20	AFANA FANNY	HS/Bertoua	Bertoua
21	NDJI Patrice	HIS/Bertoua	Bertoua
22	ANGOA MIMBANG	HS Doume/N'ka	Doumé
23	TCHUIISSEU KOMENI Viviane	HIS/Doume/N'ka	Doumé
24	NANGA Ernestine	HP/AAPPEC	Doumaintang
25	MPIANG MPIANG Jacques	HP/AAPPEC	Mboma
26	AFANEMBENG Roger	HP/AAPPEC	Dimako
27	NDIBO Nathalie	HP/AAPPEC	Bertoua
28	KADJOUME Alice	HP/AAPPEC	Diang
29	ELONGO ZANGA Michel	AAPPEC supervisor	Bertoua
30	MGBA Joseph	HP/AAPPEC	Bombi
31	TAKU James	Accounting/Plan	Bertoua
32	MEGOAMBE Bienvenu	Driver/Plan	Bertoua
33	ABOSSI	Driver/Plan	Bertoua
34	OTTOU Anselme	Driver/MOH	Yaoundé

Annex C
Assessment methodology

Assessment Methodology

Five methods were used to collect information:

- Focus group discussions;
- Interviews;
- LQAS;
- Observation;
- Documentation review.

The entire mid term evaluation, except for the finalization of the report, was conducted as a highly participative effort during the period of September 15, to October 3, 2002. The participative approach was adopted to enhance the skills of stakeholders in monitoring and evaluation, to give them a sense of ownership of the evaluation process, and to increase the chance that the evaluation results and lessons learned be used in the remaining life of the project.

Work Schedule

A 34 persons team composed of members from the different stakeholders: MOH, AAPPEC, FESADE, Confessional care providers met for three days in Bertoua to discuss objectives of the evaluation, prepare and field test data collection instruments. The team spent 5 days in the field to gather information. It spent 4 days compiling and interpreting data, analyzing findings, and preparing lessons learned and recommendations. A debriefing seminar was held in 3rd of October at Manza Hotel in Bertoua for feedback.

Data Collection instruments

A series of 4 questionnaires and 4 discussion guides were used to collect information for this evaluation

Discussion guide for COSA/COGE
Discussion guide for mothers of children (0 – 23 months)
Discussion guide for Traditional Birth Attendants
Discussion guide for Community Based Organization
Questionnaire for Health center staff
Questionnaire for local partner
Questionnaire for Plan project staff
Questionnaire for Plan Program Unit staff

Data Collection

A total of 47 villages were visited. Focus groups were conducted with 380 persons: 324 beneficiaries, 36 MOH staff members, and 20 Plan staff members. Interviews were carried out with 8 key informants: 4 of the MOH, 1 of AAPPEC, 1 of Confessional care providers, 2 of Plan Cameroon. Throughout the evaluation process, continuous discussions were held with the Health Coordinator, the Project Coordinator, the Monitoring and Evaluation Coordinator, two representatives of MOH, the Consultant of FESADE.

A lot quality assurance sampling (LQAS) was conducted in 16 health areas and involved 301 children (12-23 months) and 301 mothers from 15-49 years.

Annex D
List of persons interviewed and contacted

List of persons interviewed and contacted

No	Noms et Prénoms	Titre	Provenance
01	Dr MOAMPEA MBIO Marie Claire	No 1 General Inspector, MOH	Yaounde
02	Dr MPIOUANG LOMBO Levie	DPSP, EST	Bertoua
03	Dr ALY Toupouri	SPSC, DPSPE	Bertoua
04	Dr METANGMO Pierre M	Plan, USA	USA
05	Mr PREM SHUKLA	CD, Plan Cameroon	Yaounde
06	Dr TALLAH Esther	Health Coordinator Plan Cameroon	Yaounde
07	Dr DECOSAS Josef	WARO Regional Health Advisor	Ghana
08	Dr GNAHOUI – DAVID Bernard	Plan, Benin	Cotonou
09	Dr MFORNYAM Christopher	CS, PC Plan Cameroon	Bertoua
10	Dr. KOLLO Basile	DCH	Yaounde
11	NGUELE Jerome	AAPPEC Coordinator	Bertoua
12	Dr. TEDJOUA Etienne	DMO Bertoua H/D	Bertoua
13	Dr DOAW Jean Blaise Mekanda	DMO Doume H/D	Doume
14	Dr. NGOUAJIO Patrice	DMO Nguelemendouka H/D	Nguelemendouka
15	GAWIN Eva	Catholic Diocesan Health Coordinator	Bertoua
16	NGO NGUE Delphine	FESADE	Yaounde