Child Survival 18-Guinea

Cost Extension of Cooperative Agreement No. FAO-A-98-000024-00

Community Health Initiative for the Districts of Kouroussa and Mandiana Guinea

1 October 2002 - 30 September 2006

Midterm Evaluation Report

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Glossary of Acronyms and Terms

ACNM	American College of Nurse Midwives
AIDS	Acquired Immune Deficiency Syndrome
AJVDM	Association des Jeunes Volontaires pour le Développement de Mandiana – the Association of Young Volunteers of Mandiana
ANC	Antenatal Care
ARV	Anti-Retroviral
BASICS	Basic Support for Institutionalizing Child Survival (USAID Project)
BCC	Behavior Change Communication
BF	Breastfeeding
CCM	Country Coordinating Mechanism
CDC	The Centers for Disease Control
CLUSA	Cooperative League of the USA
COGES	Health Facility Management Committee
CORE	The Child Survival Collaborations and Resources Group
CRD	Committees Rurales de Developpement
CSHGP	Child Survival and Health Grants Program
CS	Child Survival
CSP	Child Survival Project
CSSA	Child Survival Sustainability Assessment
CSTS	Child Survival Technical Support
CTC	Child-to-Child
DIP	Detailed Implementation Plan
DPS	District Health Office
DRS	MOH Regional Director
EmOC	Emergency Obstetrical Care
ENA	Essential Nutrition Actions
FANTA	Food and Nutrition Technical Assistance
FGD	Focus Group Discussion
FHI	Family Health International
FP	Family Planning
GAAPE	Kouroussa NGO- Groupe d'Appui à l'Auto Promotion Paysanne et à Protection de l'Environnement – the Support Group for the Self Promotion of the Land and the Protection of the Environment
GH	Global Health
HH	Household
HIS	Health Information System
HIV	Human Immuno-Deficiency Virus
HO	Home Office of Save the Children, based in Westport, CT USA
IEC	Information, Education Communication
Imam	Religious Leader
IMCI	Integrated Management of Child Illness
IPT	Intermittent Presumptive Therapy
IR	Intermediate Results

ISCOM	Initiative Santé Communautaire
IUD	Intra-uterine Device
IVACG	International Vitamin A Cooperative Group
JHU	Johns Hopkins University
KPC	Knowledge, Practice, and Coverage Survey
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health
MOST	USAID Micronutrient Project
MSH	Management Sciences for Health
MTE	Midterm Evaluation
MURIGA	Community-funded revolving emergency health loan fund
NGO	Non-Governmental Organization
NIDS	National Immunization Days
OR	Operations Research
PD	Positive Deviance
PD/H	Positive Deviance/Hearth
PHN	Population Health and Nutrition
PRISM	Pour Renforcer les Interventions en Sante Reproductive et MST/SIDA-MSH Regional Health Project
PVO	Private Voluntary Organization
RH	Reproductive Health
SC	Save the Children Federation, Inc. (US)
SC/G	Guinea Field Office of Save the Children
SM	Safe Motherhood
SO	Strategic Objective
SOTA	State of the Art
STI	Sexually Transmitted Infection
TA	Technical Assistance
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VHC	Village Health Committee
WG	Working Group
WRA	Women of Reproductive Age

A. Summary

Save the Children's four-year project, CS-18, *Community Health Initiative for the Districts of Kouroussa and Mandiana Guinea* is a cost-extension funded from 2002-2006. This project builds on six years of child survival and health experience in the region and extends the model into new areas of the Mandiana district and the entire neighboring Kouroussa District. The cost-extension introduces partnerships between Save the Children (SC) and two local non-governmental organizations: 1) *GAAPE* (Groupe d'Appui à l'Auto Promotion Paysanne et à Protection de l'Environnement – the Support Group for the Self Promotion of the Land and the Protection of the Environment) and 2) *AJVDM* (Association des Jeunes Volontaires pour le Développement de Mandiana – the Association of Young Volunteers of Mandiana). Neither organization is a health non-governmental organization (NGO), but their linkage to communities has proven an invaluable asset to rapidly activating the key element of CS-18's success: the Village Health Committees (VHC). An added benefit of this approach includes the organizational capacity benefits to both NGOs and the extension of the Ministry of Health (MOH) capacity building elements started in the original project.

The new partnership approach required SC/Guinea (SC/G) to relinquish their role of direct implementation as in the previous programs, and train NGO animators and MOH health agents to work with communities to develop VHCs, train them, supervise them and act as the Health Information System (HIS) liaison. At the time of the Midterm Evaluation (MTE), all evidence indicates that this is working exceptionally well. The Directorate Prefectoral de Sante (DPS) of Kouroussa district already has evidence of the positive effect the project is having on increasing the number of deliveries in health facilities. VHCs in the new areas are already noticing a reduction in infant measles and neonatal tetanus deaths as well as unplanned pregnancies. NGO partner assessments show increases in all of the capacity elements measured. Grandmothers state that they now recommend healthy, but previously taboo foods be fed to their grandchildren.

The evaluation fieldwork revealed a well functioning child survival (CS) team capable of managing an expanded CS model which conducts their own self-analysis of project progress, strengths, and weaknesses and makes recommendations to reach agreed-upon targets. The CS team planned, organized and carried out most of the evaluation, demonstrating the institutionalization of monitoring and evaluation into their programming. The District and Regional Health authorities enthusiastically endorse the program, stating that they present the methodologies and results in national level MOH stakeholders' meetings. The CS-18 "Mandiana Model" is now cited in RH studies, such as the 2003 PRISM Household Knowledge and Practices survey, as a reason why the Mandiana District has achieved higher coverage of MCH/RH health interventions at lower cost[1] to beneficiaries than other districts in the same region. The Director of Regional Health Services has formally requested SC to jointly seek funding to expand the model to the entire region.

[1] Comparisons of median household expenditures for health care the previous month were 50-75% less in Mandiana than other districts in the study, many in the same region.

The project is well on track to achieve most, if not all, of the project targets. Experience has shown that when implementing programs through partnerships, project startup time is extensive and initial impact on results is slow. Nevertheless, the HIS documents that most indicators are more or less at expected levels.

CS-18 has made major strides in bottom-up Quality Improvement. The establishment and success of the MURIGAs (community-funded, revolving, emergency, health loan funds) has already improved access and accountability between health facilities/providers and their clients. The ability of pregnant women needing emergency obstetrical care (EmOC) to pay for health care has encouraged VHCs to expand the eligibility of funds for other health emergencies, including for child health. A well-informed population is now filing complaints with MOH authorities for the common practice of over-charging for fees in public health facilities. In some cases, this has resulted in the public refund of the excess charges. There are MURIGAS in other parts of Guinea, and through CS-18, the project has refined the methodologies of establishing them, as well as enhanced their record keeping, security and decision making capacities.

SC's staff in Guinea is now proficient in conducting a range of baseline and follow-up assessments. SC is pioneering the use of the Child Survival Sustainability Assessment (CSSA) and the Doer/Non-Doer Analysis of the BEHAVE behavior change and communication framework in the field, and using the results of these studies to enhance program effectiveness. NGO and VHC capacity assessments are comprehensive and replicable. The Doer/Non-Doer Analysis shows promise as a midterm qualitative measurement tool.

Major Conclusions

SC is successfully applying "The Mandiana Model" to scale in the cost-extension, CS-18. The model has strong potential for adaptation in other parts of Guinea, and for other interventions in the same region as the current program. While the model is known to be effective, the costs of specific components are not known. In order to better develop new partnerships, SC will need to know the details of certain program costs.

In order to meet the sustainability objectives of the program, the exit strategy will need to be accelerated.

General Recommendations

As part of the exit strategy, program implementation should be transferred to the partners as soon as possible after the MTE, while at the same time determining the costs associated with different components of the program. The HIS should be adapted and integrated with the MOH and turned over to the DPS.

SC should do internal advocacy to link the CS program with other SC health initiatives.

Recommendations from the External Evaluator to USAID
(These were requested by Susan Youll, Chief, Child Survival and Health Grants Program and represent the Team Leader's personal opinion)

Scaling Up Results

To achieve scale-up of successful programs, USAID/Washington should advocate within the Global Health Bureau and with USAID/Guinea to provide opportunities for PVO programs, such as CS-18 to be included within the Mission portfolio and complement the Mission's Strategic Plan.

USAID/Washington should be more intentional, in general, in strategizing how successful PVO CSPs can be brought to scale by helping them to qualify as partners in USAID assistance programs, whether funded centrally or through the Missions.

USAID/Washington should continue and expand current efforts to disseminate CS program results and successes within USAID and provide assistance to PVOs to link their successful approaches with other USAID funded programs in Population, Health, and Nutrition.

PVO Response to Midterm Evaluations: The majority of recommendations were discussed by the Guinea staff at the end of the evaluation and have been incorporated into the third year district Action Plans (Please see Annex G). These Action Plans were finalized immediately following the completion of the midterm evaluation. Thus, some recommendations in this written report were not discussed with the Guinea staff during the evaluation. These recommendations will require discussion and analysis in the next quarterly meeting between SC staff and partners. While all recommendations will be seriously considered, some may not be implemented due to budgetary constraints. Many recommendations will be implemented at the headquarters level by the CS Specialist.

B. Assessment of the Progress Made Toward Achievement of Program Objectives

1. Technical Approach

a. Project Overview

CS-18 targets two districts with 527 villages, and a total population of 393,060, including 85,402 children under five years old and 106,753 women of reproductive age. The intervention mix includes Immunization (10%), Nutrition and Micronutrients (30%), Maternal and Newborn Care (40%) and HIV/AIDS (20%). Additional funding was received from USAID/Washington's Flex Fund to include family planning (FP) in the community level activities.

The cost-extension seeks to combine the resources of SC and the two partner NGOs (GAAPE and AJVDM) with the district and regional MOH programs to: 1) Increase the use of key health services and improve maternal and child health practices at the household level; and 2) Increase the capacity of local entities to assume responsibility for health activities and adopt innovative CS-18 approaches. The program benefits from SC's strong regional presence which includes decades of child health programming and operations research conducted jointly with the Centers for Disease Control (CDC) and Johns Hopkins University (JHU) in Mali, partnerships with FP and RH bilateral projects in Guinea, and SC's active participation in the CORE Group, especially

the Social and Behavior Change working group of which the CS Specialist based in HO is the co-chair.

The CS-14 final evaluation conducted in August 2002, determined that the project was successful and had a positive impact on national health policy. The report noted strong prospects for sustainability because of the commitments to capacity building by the partners, the leveraging of resources, innovative behavior change communication (BCC) approaches, and steps toward financially sustainable community level health services through emergency revolving funds (the MURIGAs). The CS-14 project was complimented for its synergy and collaboration with other USAID-funded projects and also recognized as having high replication potential beyond Mandiana. The design of the CS-18 program sought to capitalize on the positive findings from the previous projects and extend them into a new district, while at the same time delegating the implementation role to other organizations whose capacity had been previously enhanced.

CS-18 goals include the sustained reduction of under-five and maternal mortality in two health districts; and a sustained improvement in the nutritional status of 0 to 36 month-old children. The overall anticipated results of CS-18 include the increased use of key health services and improved MCH practices at the household level in two districts, and that local entities (MOH, local NGOs, and communities) will be able to assume responsibility for activities and adopt innovative CS-18 approaches.

b. Progress by Intervention Area

Maternal and Newborn Care

Working through NGO animators and Health Agents, the project VHCs mobilize women to seek three antenatal clinic visits with at least one of the visits occurring at the end of the pregnancy. A basic package of services, including tetanus toxoid injection, iron/folate tablets and chloroquine prophylaxis are provided at the antenatal care (ANC) clinics. The MOH has also improved postpartum services. The program conducted extensive formative research to determine how a trained person could access postpartum women during the seven days of the culturally obligatory household confinement. Through extensive consultation with the VHCs, it was determined that traditional birth attendants (TBAs) would be allowed in the homes during this time, which is crucial for newborn survival. TBAs now perform the first postpartum check-up, and the second postpartum check-up is conducted at the health center after the confinement period is over. SC also added Vitamin A supplements to TBA kits, which increased postpartum Vitamin A coverage.

The national TBA training curriculum has been updated and TBAs are provided with UNICEF kits, Vitamin A capsules and registers. Since almost all TBAs are illiterate, the HIS system used in the registers is done in pictographs. This appears to be very effective. TBAs were eager to show the MTE team their records. Postpartum visits, Vitamin A doses, complications and referrals are recorded in the registers.

MURIGAs have been established in each village where a VHC has been started. Communities collect funds for loans to families requiring emergency transportation and fees for obstetrical

services. Communities are very enthusiastic about these, but want to expand coverage for other health emergencies, especially for those involving children.

Project monitoring and DPS data all indicate significant increases in the percentage of women seeking three ANC visits. Even in the new district, Kouroussa, the DPS produced the following data indicating significant increases in the percentage of women attending antenatal clinics:

Women attending at least three antenatal care visits Kouroussa district

Date	Coverage
December 2002	43%
June 2003	45%
December 2003	54%
July 2004	50%*

* Decrease attributed to shortage of maternal cards

Interviews in communities indicate that increased ANC attendance is strongly promoted by the VHCs and women attend as a direct result of this encouragement.

Constraints

Documentation of ANC visits is hindered by the unreliable supply of maternal cards, medicines and supplies. The Kouroussa DPS began photocopying maternal cards using her own funds, when the supply from the central level was low and the ability to document increases in ANC coverage were threatened.

Due to budget limitations, only half of the radio broadcasts planned in the DIP have been done. Although referrals are improving, referrals for obstetrical care from village health agents and TBAs still need improvement. Antenatal visits are hindered by the distance to the health centers, mothers' fatigue, overcharging, limited knowledge about services available in antenatal care, staff shortages, and limited hours of ANC clinics. Postpartum visit coverage is currently limited in Kouroussa, because the TBAs have just recently received training.

Recommendations

Project staff should collaborate with the DPS to widely publicize the health center charges by developing a list of service charges and giving them to the VHCs and the community leaders.

Organize awareness campaigns using the radio. This can be used to congratulate women who have attended three ANC visits.

Encourage the DRS to include postpartum monitoring visits in their programs.

The partners should address sustainable maternal card supplies in their meetings and plans. Project staff can facilitate brainstorming the acquisition of expendable project materials, such as maternal cards, to ensure a supply once project funding is over.

Nutrition

The major nutrition activity centers on growth monitoring at monthly weighing sessions with cooking demonstrations and nutrition talks. Regular participation in the monthly sessions is low (approximately 20% of all children under 3 years of age). This raises some concerns about the ultimate impact of this strategy on nutritional status. The cooking demonstrations are conducted with food from 122 community grain banks that have been created by the VHCs. Interviews with mothers, grandmothers, and VHCs indicate that most correct nutrition BCC messages are being communicated through the various nutrition activities. However the review of the training materials and discussions with project staff suggest that there may be out-dated messages in some of the training curriculums. The revised nutrition curriculum, which will be introduced shortly, is more consistent with current recommendations. In the past, nutrition programs in many parts of Africa have been limited to growth monitoring, without appropriate interpretation and behavior change counseling. These were largely ineffective in decreasing malnutrition. Instruction was limited to counseling on the "food groups" without adapting messages to foods likely to be available and affordable to poor rural families. Discussions and interviews with community members, including grandmothers, reveal that they are reporting appropriate nutrition behavior changes. This indicates that the messages about breastfeeding and feeding appropriate complimentary foods (including foods such as fish, meat, eggs and salt that were previously considered taboo) are getting through to the target audience. Some of the other channels for information include BCC efforts with other community members, especially nutrition talks with grandmothers and HEARTH session participants.

Micronutrients

The project has made major strides in the introduction of Vitamin A supplements during the postpartum period. Monitoring data indicate that 90% of women delivering either in health centers or with trained TBAs, receive two doses within six weeks after delivery. The project is also successful in documenting capsule coverage, until age six, during National Immunization Days (NIDS): something that most national programs have not achieved. The project is one of the first to successfully track and document postpartum Vitamin A in their HIS which has been a major challenge to many PVO CSPs implementing Vitamin A interventions. UNICEF has been an excellent partner in this effort and has provided adequate capsule supplies.

Major efforts in promoting iodized salt were originally hampered by insufficient supplies of testing kits and the poor quality of the salt tested. The DPS in Kouroussa stated that testing kits have recently been obtained and that most of the salt in the markets is now iodized. Government authorities have the right to seize uniodized salt supplies. The project staff will follow-up with the Mandiana district health office and communities to verify the validity of these reports.

Hookworm and other intestinal parasites, in addition to malaria, are major contributors to anemia in the project area. In spite of recommendations to deworm children and pregnant women in the CSHGP technical recommendations for over a decade, and the low cost of these medications, routine deworming is not included in CS-18, or MOH nutrition activities. Deworming children is part of national policy, but not for pregnant women.

Routine chloroquine prophylaxis is promoted in ANC, but increasing levels of chloroquine resistance in Guinea (reported as high as 28% in some areas) have forced a recent national policy change. IPT with Fansidar will be introduced into ANC in the near future. Iron/folate tablets are distributed in ANC and compliance is reported to be good.

Constraints

The lack of baseline anthropometry measurements will make the determination of the population based malnutrition levels and assessment of the project indicators difficult to determine. The measurement method in the DIP lists the MOH Service Statistics as the measurement source for the end of program target of "decreasing by 50% moderate and severe malnutrition (wt/age)". Data from community growth monitoring sessions is known to be biased because of self-selection of the less vulnerable children. In the CS-18 communities, the children who live in the hamlets and migrate back and forth to the informal mining areas, are the most likely to be malnourished and least likely to regularly attend weighing sessions. In addition, limitations on mothers' time due to the agricultural cycle and the need to participate in mining, impact the compliance with recommended attendance. From the CS literature, however, it is known that many of the nutrition BCC activities implemented in the project will have an impact on the nutritional status if target coverages are achieved. The baseline and endline growth monitoring data will compare similar populations, so it will measure impact, although the findings can not be generalized to the entire population. The coverage of proxy indicators of breastfeeding, complementary feeding, measles immunization and feeding during illness will be measured and will more directly capture the impact of the program.

Only 18% (6/33) of the scheduled HEARTH sessions, and 31% of weighing sessions have been completed. Reasons that were given for not attending monthly weighings include; not knowing when they were to be held, the need for mothers to work in the fields or informal gold mines, lack of scales, and the illiteracy of VHCs. Implementation of the PD/Hearth model is occurring in a small number of villages since it has proven to be labor intensive and time consuming. Globally, the impact of the model has only been demonstrated in populations with malnutrition levels equal to, or greater than 30% (mild, moderate and severe combined.) Complete coverage of all villages is neither realistic, nor consistent with the approach, and efforts should be limited to those communities that fit the criteria. Some of the NGO animators did not fully understand all of the components of PD/Hearth. In Kouroussa, NGO animators buy some food for the HEARTH sessions, saying families were too poor to pay for the food and mothers were not committed to completing all 12 days because of competing responsibilities. In another program in Mandiana district, the community was very impressed with the effectiveness of the HEARTH approach. The MTE field team assessed the strengths and areas for improvement in the operational issues of the HEARTH sessions and weighing sessions and made recommendations that will be included in the Action Plan for the remaining two years. These include focusing HEARTH sessions in communities with verified malnutrition above a certain level, and holding the sessions during the months when mothers were unlikely to have as many time conflicts.

Counseling cards that included nutritional messages produced in collaboration with the BASICS Project were of high quality and the pictures appeared to be appropriate for the area. However, the counseling messages were written in French, making the materials only appropriate for health

workers and most likely to be used only in health facilities. The project will have to adapt the materials for illiterate or semiliterate community members. Duplication is likely to be costly, so it is unclear how many of the materials can be reproduced with project funds.

Limitations of salt iodine test kits, and the numbers involved, seem overwhelming: 21,000 tests every four months.

Recommendations:

SC should perform a quality assurance inventory and analysis of all nutrition BCC and IEC activities to make sure the approaches are the most up-to-date. The project should not rely on current MOH nutrition policies for the basis of the nutrition program, as most nutrition policies are out of date. Information from the PD/Hearth investigations can be used as a crosscheck to see if foods and behaviors being promoted in the cooking demonstrations include those that are used by the positive deviants in the communities. This analysis should include cross checking nutrition, ANC and the integrated management of child illness (IMCI) promotions with the latest approaches to effective nutrition interventions. Refresher nutrition training should be offered to staff, health workers and VHCs. This may be difficult, depending on budgetary considerations.

As recommended by the MTE team, the HEARTH model sessions undertaken by each animator should be reduced and focused on communities identified as having malnutrition levels consistent with recommendations (malnutrition > or = 30%). The project should specify that the indicator for decreasing malnutrition is only for those children who participate in the weighing sessions

For the other villages where the primary nutrition strategy is monthly weighing and cooking demonstrations, nutrition BCC messages should be checked and be consistent with essential nutrition actions (ENA) (please see below). If SC wishes to continue this community strategy, managers should focus more attention on assuring follow-up of growth faltering and drop-outs as well as reemphasizing the importance of consistent attendance for the VHC to communicate with the community. If monthly weighing becomes erratic, then the weighing strategy should be reconsidered.

ENA include all of the latest available strategies known to effect nutrition-related morbidity and mortality. SC should procure ENA materials and breastfeeding, complementary feeding and maternal nutrition materials from BASICS, LINKAGES, MOST and FANTA and provide them to the staff. (Many are already available in French.) After this inventory and assessment, SC should determine if additional technical assistance is needed to ensure that the nutrition intervention is consistent with the standards for the program activities. SC should share these materials with the MOH at the local and national levels.

Once the project HIS is integrated with the MOH system, SC should carefully document the successful supplementation of Vitamin A to postpartum women and children over one year old. They should submit this documentation for presentation at the next international IVACG conference, at CORE meetings, on the internet and through other fora for international dissemination.

The project should remain vigilant about promoting the consumption of iodized salt, especially regarding messages about the importance for children and pregnant women. The project staff should make sure that the discussion of the status of salt testing is included in the agenda at meetings with partners.

The project can encourage deworming for children by promoting the purchase of antiparasitic medicines through the community funds (MURIGAS). They can also provide technical materials to the MOH about deworming for pregnant women in order to raise awareness and enhance the policy dialogue about this as a way to address anemia in women of reproductive age (WRA). SC, through their HO representative on the CORE Nutrition Working Group, can advocate for a regional Francophone Africa nutrition conference to update nutritional approaches in PVO Child Survival and RH programs.

Immunization

Increasing immunization levels is one of the interventions where the Mandiana model has proven particularly effective. Community mobilization through the VHCs, accompanied by the capacity building of the health workers and the DPS have enabled the health system to reach the community and provide the beneficiaries with access to the system. Project staff have assisted the MOH in the NIDs. Community focus groups, project HIS data, and DPS assessments all indicate that coverage levels for all antigens have increased. Most importantly, even in the relatively new project areas, communities report dramatic reductions in deaths due to measles and neonatal tetanus as a result of the program. As in many programs, the rapid increase in vaccine coverage, followed by dramatic decreases in child mortality, is a strong motivation for community mobilization in support of other activities.

Constraints

The stock-outs of vaccines and supplies from the central level is a major inhibitor to sustained impact and is largely out of the project, or project partner's control. The local and regional MOH have already advocated for more consistent supplies, to no avail. Ironically, the more successful the project is, the more likely the supply problems are to become worse when demand, but not supply is increased. SC has been unable to effectively advocate at the national level for consistent supplies, which is largely due to the long distance (10 hours by road) between the project's office and Conakry.

The evaluation team identified delayed BCC sessions, awareness about side effects, overcharging at health centers, shortage of cold chain spare parts and irregularity of health outreach as additional factors that hinder sustainable increases in vaccine coverage.

Recommendations

In order to improve the quality of vaccination services at the project level, the team identified the need to strengthen messages about vaccine side-effects, and to decrease drop-outs and reinforce the *stratagie avancee* during joint planning and supervision activities.

Because of the strong reputation of the Mandiana model and the extent of program implementation experience, SC is now in a position to begin to play a larger advocacy role at the national level for reliable vaccine and drug supplies. Without further assistance, the district and regional MOH will be unable to significantly impact national health policy.

This intervention, including the HIS tracking and reporting, should be turned over to the DPS, starting with Mandiana District as soon as possible. This should be accomplished in time for CS-18 to monitor the successful transition and assist with any challenges in assuming full responsibility for implementation. Further details are discussed in the section on Information.

HIV/AIDS

HIV/AIDS was a new intervention introduced through CS-18 by SC in response to rising prevalence levels and indications of high-risk behaviors among community members. Voluntary counseling and testing (VCT) and anti-retrovirals (ARV) services are not yet available in the Kankan region, but may arrive before the program ends. Awareness of the causes and methods of prevention of STI/HIV/AIDS was very low at the beginning of CS-18. The major interventions of CS-18 relative to HIV/AIDS seek to increase levels of awareness and access to some preventive measures (primarily condoms). Peer educators, both male and female, have been added to the VHCs and trained to provide information on the causes and prevention of HIV/AIDS, and to provide condoms at the community level.

The project has undertaken community level discussions of sexual behavior in a conservative Muslim culture. Since all activities are implemented within the context of the VHC, and are provided by male and female peer educators, discussions are culturally acceptable and well received. In spite of concerns that the religious leaders, primarily *imams* would object to condom promotion, interviews and focus discussions have not found this to be the case.

Constraints

The evaluation team found that advocacy with leaders was behind schedule, as were planned video presentations, meetings and debates. Plans to target high-risk groups (miners, military, truck drivers and prostitutes) in the project area have not yet been implemented.

Tracking of HIV/AIDS indicators in the HIS indicate that the coverage of desired behaviors remains quite low, but process indicators show high levels of activity. It is possible that 1) the program hasn't quite reached the extent of the eventual impact or 2) the targets set at the beginning of the program, many of them at 80%, might be too ambitious, or 3) most condoms are purchased through local markets and boutiques.

As in several other intervention areas, the DIP was overly ambitious in terms of how many BCC sessions the project would be able to conduct. Only about 25% of the projected number of sessions addressing HIV/AIDS have been achieved to date. Discussions with SC program managers indicate that now that a larger number of VHCs have been established, the number of sessions should increase. The updated Action Plans are revising the number of BCC sessions, but managers feel that targets should be maintained. (Please see the BCC section.) One of the

indicators measures condom use which is dependent upon supply, in addition to increased awareness, and this target may be harder to change.

Recommendations

The project should target husbands for special discussions on HIV/AIDS and conduct more Doer/Non-Doer analysis with husbands to find out how behaviors in this important area can be changed. Prevention Activities with high-risk groups including miners, truck drivers and prostitutes should be reinforced. SC should put the HIV/AIDS indicators on the agenda for the next partners' meeting for discussion about realistic targets and revisit the strategies for attaining the targets to see if they will be sufficient. SC should consult with other PVOs and community-based HIV/AIDS programs to compare realistic levels for similar programs.

Family Planning

SC secured additional funding from the Flex Fund to expand FP activities at the community level. There are male and FP promoters in the VHCs and they distribute condoms and pills and maintain registers of users. The focus group discussions (FGDs) conducted during fieldwork found that religious and cultural
barriers to FP, even by religious leaders, were fewer than anticipated. SC is cooperating with EngenderHealth to promote the new IUD services that are being introduced at health facilities in the region.

Constraints

As mentioned in some of the other interventions, the implementation of FP BCC sessions is behind schedule, with only 22% completed to date. Details of efforts to speed up these activities as new VHCs are formed, are included in the Action Plan.

Only 55% of the planned advocacy sessions with community leaders have been completed. In response to the MTE fieldwork, more emphasis on managing contraceptive side- effects is needed at the community level.

Recommendations

The quality of FP messages delivered by animators and Village Health Centers should be reenforced during supervisory visits to improve the understanding of certain FP subjects, especially managing contraceptive side effects. Orientation meetings should be organized with the religious leaders at the prefecture, sub-prefecture and district levels in the new project areas.

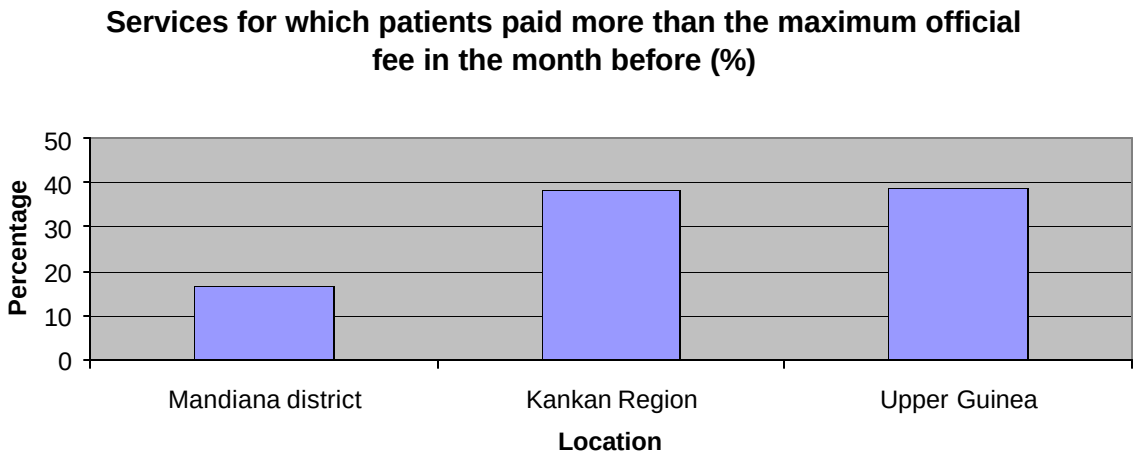
2. Cross-cutting Approaches

a. Community Mobilization

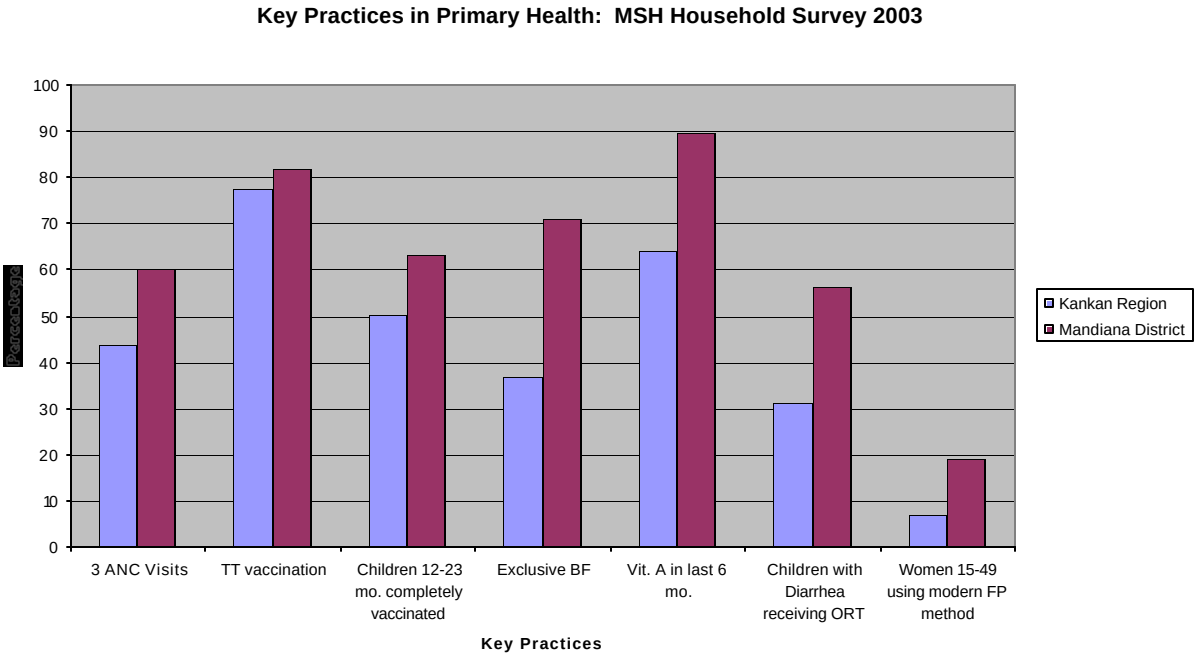
Using the VHC to connect households and communities with the formal health sector via animators and the MOH health outreach strategy (Stratagie Avancee) proved extremely effective

in the original project. Adding the NGO community animators to the cost-extension makes the approach more cost-effective, links health to other development sectors and is more likely to be sustainable, depending on the NGOs' ability to raise funds independently for continued activities.

The effectiveness of " The Mandiana Model" approach to community mobilization has been well documented in previous CSP evaluations, and most recently in a comparison of household Knowledge and Practice indicators conducted by PRISM in 2003[2]. This study captured the effects of CS-14 in Mandiana, but was too early in the life of the cost extension to detect significant change in Kouroussa district. Analysis of the survey results specifically identified SC's work in community mobilization and partnerships as the primary factor accounting for the major difference in indicators between Mandiana and other districts in the region. (please refer to the following graphs)



[2] Keita, Mohamed Lamine, "Knowledge and Practices in Primary Health in the Faranah and Kankan Regions: Results of a household survey. September, 2003.



Of the 213 targeted communities, 175 now have VHCs and MURIGAs in place. In Kouroussa, the new district in the cost-extension, approximately half of the communities (42) have been organized. The Niger River transects the district and there is no bridge. Transport across the river requires a barge, or canoe, and has arisen as a cost and logistics issue which needs to be addressed with the NGO partner. Canoes are less costly, but more dangerous for the animators to use with a motorcycle, while barges are safer, but more costly.

This issue was discussed during the MTE and the financial terms of the subcontract will be revisited. The NGO partner in Kouroussa also identified the type of project motorcycle as problematic. The models supplied are more appropriate for flatter roads than the animators typically encounter, especially in bad weather. Unfortunately the animators will need to use this model of motorcycle, since SC will not be able to buy new motorcycles.

VHCs in CS-18 are comprised of respected members of the community. This approach is more effective than village health committees in earlier CSPs globally. Often in those models, the animation and motivation were done by someone from outside of the community, such as a community health worker, who might have been responsible for a number of communities other than his or her own. Balancing VHCs by gender and with a mix of individuals with different roles in the community, helps support the program at the community and household levels.

Constraints

Barriers to participation are primarily due to families who relocate to peripheral hamlets near the fields. Although part of the village, they can be located up to 20 km away. Children from those households do not tend to participate in weighing sessions, family members don't attend BCC activities, and access to transport for emergencies is more problematic.

Recommendation:

The partners should discuss ways to serve the hard to reach, especially those located in hamlets, and find ways of to reach families who migrate to work in the mines.

b. Communication for Behavior Change

Linked with the community mobilization strategy described above, the BCC strategy uses a variety of techniques and approaches designed to reach various sectors of the community. Literacy in the area is extremely low, for both men and women. Therefore, song, drama, talks and demonstrations are much more effective. Community opinion leaders and household decision-makers, including grandmothers and fathers, help provide support to the mother or caregiver to engage in the desired health behaviors.

As in other successful community-level CSP behavior change strategies, SC is employing multiple channels to communicate the same basic behavior messages and reinforce them. Thus, several sectors of the community receive the same message, but in different ways. On a larger level, periodic radio broadcasts provide valuable information and empower the community by advertising official health center charges for services.

BCC messages through the respected members of the communities are changing behavioral norms in all of the interventions. This was very evident in focus group discussions with different categories of community members, including men and grandmothers. Behavior changes are measured through the customary KPC survey and qualitative assessments. But the project has gone beyond these measures and introduced the Doer/Non-Doer analysis of key behaviors. SC staff were able to design the study, implement it, analyze it, identify the key factors and use that information in the design of the MTE field work tools. This additional triangulation provided more specific understanding of the key behavioral issues in their communities.
When asked if they found the approach helpful, the team responded affirmatively.

SC effectively conducted a Doer/Non-Doer analysis, and used the BEHAVE behavior change framework to analyze BCC factors in four key program behaviors:

In Mandiana:

- Condom use
- Weighing children under 3 years old

In Kouroussa:

- Vaccination of children 0-11 months old
- Prenatal consultation in the last month of pregnancy

Normally, time limitations would not permit an in-depth, Doer/Non-Doer study as part of the MTE fieldwork. However, the team decided several months in advance to put into practice the BEHAVE framework that they had learned earlier in the project at a workshop taught by Eric Swedberg, CS Specialist and CORE SBC Working Group co-chair.

From the Doer/Non-Doer analysis, the SC team was able to independently identify key factors and activities designed to address these factors prior to the beginning of the MTE. Therefore the evaluation started with some key insights to issues that could then be triangulated with the other evaluation tools that the team developed.

This represents one of the first in-depth applications of the BEHAVE BCC model in a Child Survival project. Starting the process well in advance of the MTE date allowed sufficient time for the team to use the framework without the distraction of other evaluation activities. (Please see Annex F for the full copy of the BCC Strategy paper.)

Constraints

Print materials have proven to be more of a challenge than verbal communications. Many French language IEC and BCC materials are not appropriate in the project areas because of poor literacy and only a small number of people speak or read French. At one point, the BASICS II project promised IMCI materials in pictographs, but never sent them to SC. Duplicating multi-color laminated materials in sufficient quantities is always a challenge for CSP budgets, and will be the case in this project.

As mentioned in the technical interventions, it is difficult to ascertain how up-to-date the nutrition messages are in each of the activities. However, in at least one case, a grandmother of a HEARTH participant was trained well enough in the recognition of danger signs of a sick child, that she prevented her daughter from seeking care from a traditional healer when her grandson had respiratory distress. She knew that the grandchild needed to go to the health center and convinced her daughter to take him. She made a specific effort to reach the MTE team when it visited the village to tell how the lessons she learned in the HEARTH session saved her grandson's life.

Recommendation

SC should devote some time to deciding which materials are the most effective in the project community environment before committing to the expenses of large-scale duplication. Materials should be selected as soon as possible to obtain the maximum effect of their use before the end of the program and should be periodically reviewed for technical content.

c. Capacity Building Approach

The project has significantly strengthened the health system, health facility and health worker performance in Mandiana which has impacted the entire area. New Mandiana villages selected for inclusion in the cost-extension had clearly derived some benefit from the original program, even though they were not part of the program at the community level. In some cases, VHCs developed spontaneously by a form of self-apprenticeship where one VHC requested training from another.

At this point, SC's reputation for capacity building has paved the way for easier acceptance by members of the health system for additional activities and programs. Activities at the health

centers and at the hospital which were implemented by the original project, specifically in the areas of EmOC and RH, have enhanced the effectiveness of SC's capacity building efforts.

c.i. Strengthening the PVO Organization

Capacity Building Indicators from the DIP

International Headquarters - Intermediate Results and CS-18 activities

The CS-18 CSP activities directly support three of SC/US IRs:

IR -1: Strengthen and expand SC Field programs through technical assistance (and TA)
- SC currently participates as presenters in CORE meetings and discussions

IR-2: Build SC's recognition as a leader in health through documentation and dissemination
- The HO backstop presented the MURIGA intervention to the JHU "mini-university" and will post a paper describing it on the SC website.

IR-3: Advance the State-of-the-Art through focused, strategic program research.
- Piloting Doer/Non-Doer BEHAVE methodology; community drug boxes operations research (OR); scaling up PD/Hearth

SC/Guinea Capacity Indicators

CS-18, along with a USAID mission basic education grant, were the first SC programs in Guinea. The initial program was managed from the SC/Bamako office. SC now has a small office in Conakry. The major office is still located in the regional city of Kankan. SC/G has benefited from the close association with the SC/Mali office. Staff and partners have had exposure visits to SC Mali. The most recent was the opportunity to observe the community-based drug *caisses* (boxes), a model which will be piloted in the project (CS-18) shortly after the midterm.

The CS projects, especially the cost-extension, have enabled SC to expand operations in Francophone Africa, both geographically but also among sectors. SC recently received a $4 million US Department of Labor grant to address the problems of street youth in Guinea. They have also received previous health funds to assist refugees from Sierra Leone and Liberia in Guinea.

Capacity Indicator	Status
Staff participate in at least one other program evaluation of SC/Sahel office.	Not yet. Saving Newborn Lives evaluation in Mali is a possibility.
SC/G will develop a strategic plan in health.	In progress.
In-depth analysis of monitoring data documented in the quarterly monitoring reports of the District Coordinators.	DPS both say they use project monitoring data in their quarterly reports.
SC/G staff will write the baseline study reports.	This was done. (in French) HO translated into English.
SC will assist in two operations research studies.	Topic of one (CTC) changed to community drug boxes. Another is introducing the Doer/Non-Doer studies.
Senior Guinea staff will have sufficient English skills to present their experience in two conferences/workshops conducted in English.	English training has been given. Presentations at conferences not yet done. Staff express desire for additional English training to meet this expectation, and have not yet done a presentation in English.
Two working papers on SC, CSTS websites.	Eric Swedberg from SC HO presented results of the MURIGA intervention at the 2004 mini-university and the write-up for the SC website will take place after the MTE.

SC CS staff have participated in exposure visits to CS and health programs in Mali and Burkina Faso. They participated in the CORE Francophone "Fresh Air" malaria conference in Bamako in 2003. The project coordinator attended the CSTS-JHU "mini-university" in Baltimore, MD in 2003. The SC Coordinator also participates in the annual global SC Program Learning Group meetings in the U.S.

The SC/G staff demonstrate a high level of skills in planning, management, facilitation, monitoring, evaluation and documentation. They express the desire to be more proficient in English, computer software and epidemiology. Presentation skills are good and the staff frequently use PowerPoint and other computerized planning and presentation equipment and software proficiently.

Involvement in CS-18 increased SC's experience in Maternal Care, providing partnership opportunities with BASICS, FHI, ACNM, MSH and EngenderHealth through the PRISM project.

c.ii. Strengthening the Local Partner Organizations

Ministry of Health - *Regional Level*

Every six months all partners meet, and once a year the partners meet with the national MOH. Two of the annual meetings have already occurred since the beginning of CS-18. OR and

monitoring and evaluation (M&E) protocols are jointly developed. The protocol for community drug kits was recently developed with the DRS. When IMCI was introduced into the area, the project and the DRS jointly received some funds from BASICS for training materials. The roll out was a training of trainers (TOT) at the regional level and the CS-18 project coordinator was included as one of the trainers for district health personnel.

District Level

At the district level, monitoring and supervision plans are jointly developed. On-the-job training is also accomplished through joint report writing, training and regular meetings. CS-18 district offices are located in the DPS building. CS-18 installed a solar electrical system thus benefiting both the project staff and the partner DPS office. CS-18 has provided computer training as well as formal and on-the-job trainings in Quality Assurance for health workers. DPS personnel have been trained and often receive refresher training in program interventions. They have also been sent by the project to Mali for program visits, where they recently visited the community drug box program.

Collaboration between the local MOH and SC is excellent. To support CS-18, the DPS of both Mandiana and Kouroussa provided vehicles for the MTE, while the project paid for the fuel. Several DPS personnel, including the Director of the Kouroussa DPS, participated in the evaluation fieldwork and analysis.

NGO Capacity Building

Since the beginning of the cost-extension, SC has formalized agreements with both NGOs and trained six workers in each NGO. As is the case with many CS PVOs, SC/G discovered that extra time and effort is required to develop partnerships, and then build their capacity. All members of the evaluation team agreed that the results of these efforts are already evident.

The NGOs are the link between the PVO/MOH partnership and the communities. These NGOs have been involved in community mobilization and development in the area, but are not health organizations. The NGO animators organize the VHCs and (along with the health workers) train them in the basic health behavior change communication methods. Their staff come from the local area, speak the local language, and have excellent relationships with the communities.

Capacity assessments of the two partner NGOs were conducted at baseline and during the midterm, using a SC tool, *Assessment of NGO Institutional Level of Development* that looks at key organizational capacity elements such as NGO organization, Mission and Strategic Plan, Monitoring and Evaluation, Programs and Services, Financial Resources, Human Resources, Leadership/Management, Financial Systems, External Relations and Gender. Numeric scores were assigned in each category, making it possible to quantify progress over time. The SC management staff are very adept at using this tool and conducted the assessment and produced the report without outside guidance.

Reassessment at the time of the MTE revealed significant growth in each of the measured capacity levels. This was confirmed during meetings between the NGOs and the MTE team.

Village Health Committees

The VHCs are clearly the backbone of the program. They are the behavior change agents in the communities and are comprised of leaders, TBAs, traditional healers, FP promoters, a village nutritionist and HIV/AIDS peer educators. The NGO animators train the VHC, but it is the VHC who passes the messages, and encourages or enables the woman or guardian, to take action. It is the VHC that manages the MURIGAs and accesses the funds when they are needed. The VHCs also maintain the community-based HIS via a large number of registrations books. They also conduct the monthly weighing sessions, though only certain members, such as the nutritionist, are regularly involved. Because the VHCs are comprised of respected members of the community, their guidance is taken very seriously. When someone doesn't comply with recommended behaviors, the VHC can also apply pressure to change their mind or assist them to get to the health facility.

SC developed a tool to measure change in the functioning of the VHCs and to categorize each VHC as either good, medium or weak according to the following specific categories: creation of awareness, joint decision-making, ability to identify actions, planning community organization and mobilization, contributing funds and the ability to maintain, increase and manage them; evaluation, negotiation, collaboration, measures to increase and multiply their acquired knowledge and conflict management. During the evaluation fieldwork, care was taken to make visits to VHCs in each category.

Since the beginning of CS-18 and its introduction to Kouroussa, the project has formed 42 VHCs, and 42 MURIGAS in those areas. In Mandiana, 60 VHCs received refresher training. In Kouroussa, 54 pairs of HIV/AIDS peer educators were trained, and 54 pairs were trained in Mandiana.

Constraints

Poor literacy levels among both men and women hinder the VHCs from realizing their full potential and are a threat to sustainability for the community-based health information system. This was identified by several sources in the MTE fieldwork and was also brought up during the DIP development processes.

Recommendation

SC should network and advocate with donors, the Government of Guinea, Committees Rurales de Developpement (CRDs), and other development organizations and seek support for adult literacy programs in the CS program communities.

c.iii: **Health Facilities Strengthening**

Since the beginning of the cost-extension, SC has trained health workers in six health centers, three health posts and the regional hospital in Kouroussa in program interventions. Much of the training is conducted on-the-job, during the joint supervisory visits. The project uses a quality

assurance approach and facilitative supervision. In Mandiana, the health center, health post and the hospital staff received refresher training. HIS training was conducted in both districts.

Other organizations, notably the PRISM partnership have been working on Quality of Care in the Kankan health facilities, particularly focusing on RH and EmOC. They have been the source of most Health Facility Assessments and have shared their findings, so that SC did not have to undertake independent assessments.

Communities are linked to health facilities through the health workers who make joint visits to communities with the NGO animator. The NGO animator visits each community 1-3 times a month. The health worker visits about once a month. Communities express satisfaction that the relationship with health center personnel is better and the quality of services has improved.

SC facilitated a dialogue between communities and facilities to help address the overcharging that is rampant in Guinean health facilities. There are a set number of fixed charges for specific services that are supposed to be charged in government facilities. In actuality, clients are charged above that amount. Acknowledging that the fees are set too low, compromises have been agreed upon. Health workers who abuse this compromise and charge too much have been brought up for discipline by the DPS when members of the VHC have lodged formal complaints.

COGES

The COGES were supposed to serve as the vehicle for community input for the health facilities as part of the Bamako Initiative. The DIP planned to do extensive capacity building with them. In reality, they are not comprised of true community representatives and are largely non-functional. For this reason SC decided to focus attention on the parts of the health system where capacity building efforts were likely to be more effective.

Constraints

The major constraint to effective health facility performance is the unreliable drug and vaccine supply. This is largely out of the control of SC and the local MOH partners. The DIP devotes considerable attention to the importance of reliable commodity supplies in effectively administering the program interventions. Even when adequate supplies are shipped from Conakry, 10 hours away by road, the supplies do not all reach the project area. Local transportation is also problematic.

Recommendations

Chronic supply problems plague all health programs in Guinea. If SC is able to secure sufficient funding to develop a health office in Conakry, SC can more effectively advocate with the MOH centrally for better supplies and services that are needed in the Kankan region.

c.iv. Strengthening Health Worker Performance

SC and DPS personnel conduct joint planning and supervision activities on a regular basis. These activities occurred more regularly at the beginning of the project than more recently largely due to DPS availability. By conducting joint supervisory visits with DPS supervisors, both personnel are available to support the health worker, while at the same time the right personnel are available when deficiencies are noted.

SC's facilitative supervision and quality improvement approaches (especially interpersonal counseling skills) have helped the collaboration between the community and the health facilities, especially in increasing access and the ability to pay for quality services related to complicated deliveries. CS-18 developed a supervisor checklist for health workers, for use by the DPS. Training reports document when trainings and refresher trainings are held.

The supervision system is well understood throughout the various levels of the project. The program has developed a variety of supervision tools for different groups (e.g. health workers, animaters, NGO workers, etc). Joint supervision visits are regularly planned and implemented.

Constraints

The joint visits are sometimes postponed when the DPS is not available. Feedback from supervision visits needs to be more widely disseminated.

Recommendations

The team agreed that joint visits should take place at least three times a year, and that the coordination and planning meetings between the DPS and the project in the districts should be strengthened. Joint visits should be written up with a small SC team designated for this purpose, and disseminated to all of the partners.

c.v. Training

The project primarily uses a cascade training approach, starting with SC training either the DPS or NGO personnel, who in turn train either the health center/post workers or the VHC members. This appears to work well, especially since the messages directed at VHCs are well known, consistent and simple. Since the messages are reinforced through many different channels, one single training session is not likely to make or break the success of the approach.

At midterm, the project discovered that the number of BCC sessions that could be conducted was far lower than originally estimated. Currently, only half of the villages in Kouroussa have been phased into the program. Reassessments concluded that indicator targets can still be met with fewer sessions and the target numbers will be reduced in the Action Plan. Most training targets for health center personnel and NGO staff have already been met, as have refresher trainings.

The districts seem to be lucky as they have relatively low overall health worker turnover, so training effectiveness appears to be fairly high. This is very positive especially when compared

to situations some other PVOs face with health staff turnover every two years or less. Mandiana's DPS has been in place for a number years. He is convinced of the program's value and has relied on the project HIS for population figures when writing his reports.

The ultimate assessment of the training strategy effectiveness is the impact on the target population(s). In the case of the key child survival and maternal health indicators, increases in health facility deliveries, breastfeeding and complementary feeding behaviors, condom users, and vaccinated children imply that the training strategy is working well and that all of the supporting factors for the desired behaviors are in place.

d. Sustainability Strategy

The CSTS Child Survival Sustainability Assessment Framework is used to monitor progress in key program areas. Findings in the assessment indicate considerable progress, especially in the sustainable impact of CS-18 on partner capacity.

- Dimension 1 (Health and Health Services) was not reassessed at midterm because a KPC was not conducted.
- Dimension 2, (Local Organization or NGO partners) demonstrated increases from baseline in local organization capacity and viability.
- Dimension 3, (Community and Social Ecology) showed increases in community capacity in both districts. Social Ecological environment was not measured.

(A copy of the CSSA is included in Annex F)

The program is one of the first to implement the framework in the field. Interviews and focus group discussions with partners indicate they feel that most of the capacity elements measured in the program will continue beyond the end of funding. The program is somewhat behind schedule, however, in implementing a specific phase-out plan. This is especially true of integration and turnover of the HIS. This will be a focus area in the Action Plan. (Please see the Information section.)

In addition to the CSSA findings, the team felt that there are considerable factors leading to the sustainability of the program. These include:

- Creation, training and equipping local NGOs to do community based child survival promotion activities.
- The existence of community revolving funds for obstetric and child health emergencies.
- Working through local NGOs, health workers and VHCs.
- Strengthening the capacity of the DPS and NGOs.
- Establishment of a community-based HIS.
- Behavior changes by beneficiaries.
- Communities are taking responsibility for resolving their health problems.
- Mobilizing communities to use modern health services, thereby increasing health facility receipts.

- Reinforcing NGO/DPS/DRS capacity to do operations research.
- Institutionalizing VHCs by gaining legal recognition for them.
- Establishing agreements between VHCs and hospitals in the context of managing referrals for obstetric emergencies.

Constraints

The team still felt that more work needs to be done to support the sustainability of the VHCs, including extending the agreements with hospitals to charges for child health care, developing a VHC association with formal recognition, and closer supervision of how the health workers relate to the VHCs. They also felt that the project activities could be better integrated with the FP activities during the monthly meetings in the communities.

Groundwork for the phase-out strategy is in place, but not as fully developed at midterm as desirable. The HIS is not currently fully integrated with the MOH system and will need to be before the end of the program. This will require the SC M&E staff to devote considerable time to providing the necessary training and software to both districts in order to be able to use the HIS system. The project will have to devote the early part of the second half of the project to joint planning for turning over most of the program functions to the DPS and the NGOs. Low literacy among VHC members limits the extent to which they can continue the CS-18 model independently after the end of the program. Primary education efforts in the area will not have an impact on this for decades, as VHC membership consists largely of more mature adults from the community.

Recommendations

Recommendations for the phase-out are covered elsewhere in the report. The team will devote considerable attention in the Action Plan to addressing this situation.

SC should spearhead the effort to identify opportunities for adult literacy programs in the project area with other development partners such as (such as PACEEQ, FIDA, CLUSA). The issue should be discussed with the CRDs to raise awareness of how low literacy is a development problem that impacts all sectors.

C. Program Management

1. Planning

Partners are involved in joint planning activities every six months. They are also included in special activities, such as the baseline surveys and the evaluations. The workplan from the DIP is basically on schedule. The program's objectives are well understood and embraced by both the field staff and the CS Specialist. They use the program objectives and indicators as the basis for discussion of activities and results. The DIP was translated into French and shared with the partners. Program monitoring data are compiled and analyzed at the routine joint partners meetings. Additional "microplanning" at the VHC level is included in the Action Plan.

2. Staff Training

SC staff training has been significant throughout the project and during the proceeding two projects. Staff turnover is low, so investments in training have provided a good return on the investment. Staff were also given English lessons and software applications training. Very few new employees have joined the staff in recent years. Managers and team members frequently collaborate for decision making.

Staff would like more English language training and instruction in epidemiology. Exposure visits and conferences have been attended by some of the staff, but some of the more junior staff could benefit from additional opportunities.

3. Supervision of Program Staff

Work planning, facilitation, consensus building and sharing responsibilities among the team is impressive. The staff have worked together for many years and, as mentioned, turnover is low. Many decisions are made as a team with leadership shared between the members, depending on the circumstances. Workload and staffing in the office are adequate, but staff often put in extra hours especially during the DIP development and evaluations. The country representative currently splits her time between Guinea and Mali, but takes an active interest in the program.

4. Human Resources and Staff Management

All positions are filled and many staff have been with SC's CS program since the first project, CS-12. The current program manager was promoted to this position when the CS-14 manager left. Many staff come from the local area and, unlike many CS programs, are not anxious to leave for work in the capital city. There are key personnel policies in place and job descriptions. Partner's roles and responsibilities are well defined. For the NGO partners, human resources capacity building is included in the assessment tools and the capacity building plans.

When the Guinean franc was devalued during the project, the Country Representative arranged for staff to receive salary adjustments so that the purchasing power would not diminish.

There is excellent morale and camaraderie among the team members. This positively impacts he team members and contributes to their willingness to work extra hours and under difficult conditions. The team also enjoys excellent professional relationships with personnel in partner organizations as evidenced by PRISM's participation in the midterm evaluation.

SC management and the staff themselves would like to continue working together, and recognize that this will require new programs and additional donor support. There is active interest in pursuing additional program interventions, especially malaria, IMCI, RH, and more comprehensive HIV/AIDS programs. They would also like to investigate working in the area of tuberculosis prevention and treatment. On the other hand, the competencies that staff have developed from managing the child survival project have probably made them more employable in other public health programs. Currently, the program office is seeking additional funding

opportunities. One staff member, the M&E coordinator, is splitting his time between two projects.

5. Financial Management

Financial reports are compiled and analyzed by the Finance Director in the office in Kankan, in the same compound where the SC CS project is housed. Financial reporting to USAID/Washington is done in collaboration with SC's HO in Westport, CT. At the time of the MTE, the "spend down" of USAID project funds stands at approximately 56%.

6. Logistics

The direct material support of the project largely involves the procurement of motorcycles, which was completed earlier in the program. UNICEF birthing kits were supplied during TBA training and were part of the budget. Recurrent drug and vaccine supplies are the responsibility of the government, and as noted earlier, stock-outs of these supplies have negatively impacted health services throughout the region. It is not known if the situation will improve later in the program, since much of the problem has been identified at the central level in Conakry. The staff acknowledge that budgets are tight and say it is because of the number and variety of activities they have undertaken. Does this sentence go here?

Discussions with the Kouroussa NGO, GAAPE, indicate that their subcontract may be inadequate to support the higher transportation costs resulting from crossing the river, as well as the devaluation of the franc. SC staff agreed to reconvene with them after the MTE to renegotiate the terms of the subcontract in light of these problems.

7. Information Management

The quality of the HIS has been well documented in previous evaluations and has been expanded to include the new district. Both process and impact indicators are tracked and reported regularly on Excel spreadsheets. The HIS is well maintained and used by SC staff and the partners, including VHCs, for planning and feedback during routine partner meetings. It also serves as the vital statistics collection for the districts, and makes more accurate estimates of births and deaths (with some estimate of the causes of mortality) available. This will help make possible birth registrations for future school registration. This information also helps the VHCs make health decisions at the local level. The HIS extends from several registers at the community level, collected at health centers and compiled by the project to be shared and analyzed with the partners.

SC conducted special studies including the NGO and CVS capacity assessments at baseline and midterm, the CSTS Child Survival Sustainability Assessment, and the BEHAVE Doer/Non-Doer assessment. Project staff are very adept at developing tools and conducting focus group discussions on topics to inform the BCC strategy and now generate their own study reports.

Constraints

The system is not integrated with the MOH system and this presents a threat to the sustainability of the system after the project ends. SC has provided a database only to the Kouroussa DPS, and has provided computer training to both. The Mandiana DPS has also requested to receive a database and the computer training he has received means that he has the capacity to use it. Currently, data collected by the NGO animators are submitted to the SC M&E staff, and not directly to the DPS.

Recommendations

SC monitoring and evaluation staff should start integrating the project HIS with the MOH data system immediately, even if this requires streamlining or modifying the system. The system should be sufficiently flexible so that it will have applicability should there be a regional program in the future. The Mandiana DPS should be provided with a database and both DPSs should be involved in planning the transition of the system to their management. They should be taught how to use the system to generate reports for the national MOH. By the end of the project, critical CS indicators should be tracked, analyzed and used by the DPS with a clear system for sharing feedback (such as conducting sharing meetings and using pictographic posters at health centers), between the community and the VHC. Reports that are generated should be easy to understand and a system for sharing information widely should be established.

At the community level, the number of registers and the types and amount of data collected should be reexamined for the purpose of collecting only the data that is necessary. Low literacy causes wide variations in the quality of the data collected at the community level. Supervisory visits should also include reinforcing the quality of the registers. For sustainability, SC will need to devise a way for information to flow to, and be managed at, the DPS level in a way that is efficient and easy. In addition, feedback mechanisms should be strengthened at each level.

8. Technical and Administrative Support

The CS Specialist, Eric Swedberg, has made visits to the project at least once a year, sometimes more often, and maintains regular E-mail contact with the office. His visits last an average of two weeks each. This amount of time is as much, or longer than other PVO headquarters managers spend with their projects. He offers both technical and managerial support to the program staff Who have benefited from the continuity of support they have received from him. He has been managing the child survival projects in Mandiana since they began. Mr. Svedberg also functions in a technical capacity and has provided training in child survival interventions as well as in Social and Behavior Change Communication strategies, especially the BEHAVE model. Evidence of the effectiveness of the training was demonstrated when the staff independently conducted Doer/Non-Doer analysis as part of the MTE.

The Guinea Country Representative, Dunni Goodman will be moving to SC/Sahel's regional office in Bamako and will to continue support to the program from there. As part of the MTE, the Evaluation Team Leader, the CS Specialist, the MOH Regional Director (DRS) and the

Country Representative brainstormed how to secure financial support to continue and expand the CS program to a regional level; something the DRS is actively supporting.

SC installed a satellite dish at its Kankan office that, combined with the solar electrical supply and generators, allows for internet, e-mail, regular electricity and air conditioning. Since Kankan has no centralized electrical supply this allows the project to manage the program more professionally than otherwise would be possible. The project has also supplied generators and solar power to the two regional offices located at the DPS buildings (although the Kouroussa solar power system currently needs repair)

Technical assistance is needed in the nutrition intervention to assure that all messages and approaches are consistent with current technical recommendations in the field. This will start with materials that the CS Specialist will procure from BASICS, LINKAGES, MOST and FANTA but may require additional field expertise, especially in assessing implementation of the HEARTH model activities after the recommendations of the MTE are implemented.

If IPT for malaria is implemented in Guinea before the end of the project, project staff and partners will need a technical update. It isn't known if this expertise will be available in Guinea, but it is likely that it will be. (The national IPT policy was changed at the time of the MTE.)

D. Other Issues Identified by the Team

Ready to work in Malaria

SC has developed the foundation for continuing to effect major public health impacts in two districts in the Kankan region, but the full potential has not yet been realized. The enabling environment to address the major killer of children in the area (malaria), while not present earlier during CS-18, is nevertheless developing at the time that CS-18 activities are winding down.

Recommendation:

SC/G should contact the national Roll Back Malaria Program and offer to develop partnerships to work at the district and community level to meet the Abuja targets, possibly through the Country Coordinating Mechanism(CCM) for applications to the Global Fund.

Advocacy within Save the Children

There is a need for continued internal advocacy within SC's global programs (i.e. Saving Newborn Lives, BASICS, HIV/AIDS, etc.) to include SC/G in program activities. Much of the experience gained in implementing child survival, FP and HIV/AIDS programs in Mandiana can provide lessons learned that would be valuable in other programs.

Recommendation:

The SC HO backstop should contact other SC technical specialists and promote SC/G as a location for additional maternal/child, RH and HIV/AIDS programs.

Need for a larger SC health presence in Conakry

The lack of health program presence in Conakry hinders SC/G's ability to network and be involved in health program stakeholders' discussions at the national level. SC is now experienced enough to become a major partner in health programming and play a large role in advocating for better health care services.

Recommendation:

Starting with a stakeholders meeting to present the MTE findings, (and possibly some results from the PRISM study), SC/G should sponsor meetings to present program results at the national level. SC/G should develop a strategy, as part of the SC/G Strategic Plan in Health, to begin participating in more national level policy meetings on health topics and actively seek to develop partnerships for new programs.

E. Conclusions and Recommendations
(Please see the individual sections for operational recommendations)

- The model has strong potential for adaptation to other parts of Guinea; this will require forming a variety of types of partnerships. The positive endorsement of the current district and regional MOH partners can assist developing partnerships in other regions.

- The foundation laid in two districts of Kankan can serve as the template for other community based interventions, particularly malaria, with or without IMCI.

- While the model is known to be effective, the costs, both administrative and in terms of human resources, of each component are not known.

- Effective partnerships take time to develop, but once in place can result in rapid increases in targeting and coverage of project interventions. Program planners should recognize this and understand that the pace of intervention implementation is not steady throughout the life of the project.

- Restrictions on continued CSHGP funding limit the considerable additional impact that could be realized in the areas where SC has implemented the model, which with sufficient funding could probably be scaled up to the regional level. Other donor mechanisms to support CS activities in the country are currently very limited and the future direction of the USAID mission strategic plan is not clear.

Recommendations for Save the Children

- Immediately after the MTE, the Action Plan should start transferring CS activities, including the HIS to the partners with a well-defined exit strategy schedule that is developed jointly with the partners.

- During the next two years, SC, the DPS and DRS, along with the NGO partners, should seek complementary funding to build upon CS-18, especially in malaria, HIV/AIDS and reproductive health. SC should also network within global SC programs. SC (US) should do internal advocacy by sharing results and lessons learned from the program. This will help to attract organizations and donors interested in supporting the expansion of interventions in the current service area, possibly make it a learning center, and/or support a partnership with the Kankan Region to apply the model to other interventions. Some examples of other programs include: Saving Newborn Lives, Title II, FP and HIV/AIDS programs.

  SC should quantify the costs of replicating specific elements of CS-18, in case donors are unable to support the entire package. While doing this, SC should make a determination of the absolute essential components for success.
  SC should be more intentional in seeking support, from within Guinea and internationally to find support for adult literacy programs for the VHC members. Support for adult primary education is extremely difficult to secure. SC could advocate with the USAID/Guinea Mission to raise awareness of the limitations low literacy places on developing civil society at the village level. SC should spearhead the effort to identify opportunities for adult literacy programs in the project area with other development partners such as PACEEQ, FIDA, CLUSA.

Conclusions and Recommendations for USAID (Requested by USAID)

Background

In 1997, in response to feedback from USAID expressing a desire for more applications for the neediest countries, SC submitted a proposal to what is now known as the PVO Child Survival and Health Grants Program for the Mandiana district in Guinea. The USAID mission feedback on the proposal to USAID/Washington at the time stated: "The proposed area is so needy, and the indicators are so poor, that if this CSP were to be even *moderately* successful, it would have *dramatic* impact on mortality." Because the health infrastructure and data availability at the time were so poor, many elements of a quality CS proposal were lacking in the first document submitted. But USAID did something that it rarely does: it *took a chance* and provided funds for SC to take the time to develop a quality program design. Seven years later, fatal child diseases, such as neonatal tetanus and measles that were commonplace then are now rare. Women experiencing obstetrics emergencies have the knowledge and the financial means to access Emergency Obstetric Care and healthy complementary foods that were formerly taboo are now fed to young children.

SC has developed an approach that links communities, health facilities and the national health system that is now known nationally as "The Mandiana Model" and is promoted by the

Government of Guinea as an effective approach to addressing major public health problems. Yet in spite of this success, limitations on CSHGP support mean that without transitioning to another source of funding, SC will have to begin exiting from the area at the end of CS-18.

In order for innovative approaches and operations research that are so promising in proposals to be developed and the lessons learned to be available to go to scale, sufficient time has to be allowed for the operational issues to be worked out in the field. Regrettably, often the techniques and approaches are just showing promise as the time for funding comes near to a close.

Recommendations:

USAID/GH/HIDN should be proactive in advocating internally with USAID Missions to transition funding CS program activities to the country level, provided the PVO continues demonstrating increased results and scale.

USAID/Washington should facilitate a dialogue with the appropriate USAID missions that are undergoing revisions of their Strategic Plans to look for ways to match CSP contributions to Mission strategic objectives (SOs) and intermediate results (IRs). These may go beyond health and extend into programs with Civil Society and Food Security IRs.

USAID/Washington should continue and expand current efforts to disseminate CSP program results and successes within USAID and provide assistance to CS PVOs to link their successful approaches with other USAID funded programs in Population, Health, and Nutrition and possibly Democracy and Governance. For example, follow-on programming to the CHANGE Project could benefit from the direct field application of the BEHAVE framework implemented by SC/G as part of this Midterm evaluation.

USAID/Washington should be more intentional, in general, in strategizing how successful PVO CSPs can be brought to scale by helping them to qualify as partners in USAID assistance programs, whether funded centrally or through the Missions. It is reasonable that individual CSPs should have a limit in funding they can receive from the CSHGP. However, PVOs lack funds to support the budgets required to continue and expand CSP impact after CSHGP funding ends. While conventional wisdom says that funds to support such scale up are available in the Missions, in reality PVOs often do not qualify for many Mission procurements. This is the case even when they have more capacity and experience in certain areas (capacity building, community mobilization, etc) than other development partners. PVOs can be invited to present their capabilities at USAID Regional SOTAs, as well as facilitated to become involved in aligning their programs with Mission Strategic Plans. USAID missions can advocate with Global Fund CCMs for PVOs to be included in their applications.

F. Results Highlight

KNOWLEDGE ABOUT COSTS EMPOWERS HEALTH CARE CONSUMERS

Overcharging for health services is rampant through government health facilities in Guinea. By most estimates, official prices are too low to cover costs of providing health services, and health worker salaries are woefully inadequate. Over the years, health workers have compensated by adding "surcharges" to the official rates. One unfortunate consequence of this practice is to inhibit women from seeking emergency obstetrical care at health facilities, fearing inability to pay the unknown charge. This makes vulnerable women even more vulnerable.

Community based revolving loan programs, MURIGAS, has been developed in the CS-18 project area by SC, and based on a model introduced in several places in Guinea. SC's ISCOM Child Survival project has succeeded in developing effective MURIGAs in collaboration with trained VHCs and the DPS health facilities. Coupled with community education about the danger signs of obstetric complications and reasons to seek emergency care at health facilities, the MURIGA provides the means for a woman to receive care at the time she needs it, and the family the ability to pay the money back over a period of time. Since the money and the knowledge are in the hands of the community, this has empowered them to deal directly with health facilities when families using these funds have historically been treated unfairly.

Working in collaboration with the VHCs, SC collaborated with the DPS health facilities to negotiate prices which were higher than the official rates, but were more reflective of the actual costs of providing services. Then the project publicized the negotiated prices by radio and other means. Knowing the actual prices that they should be charged encouraged families in need of services to use them.

In a few cases, however, women were still charged exorbitant fees for delivery services. But with an organized VHC, who is the ultimate manager of the MURIGA, there was recourse. In one case, a midwife overcharged for a delivery. When the family returned to the village, the VHC was told about it. The VHC took the accusation to the DPS who investigated the charge and found it to be true. The midwife was publicly forced to return the excess funds. Providing communities with this information has contributed to reduced average overall family health expenditures to rates 25-75% lower than comparable districts in the region. [3]

[3] PRISM Household study, 2003.

ANNEXES

Annex A: Baseline Information from the DIP

Major CS-18 strategies include:

- Joint DRS, DPS and SC design, implementation, supervision and evaluation of approaches to maternal and child health in the districts that will inform strategies of other PVOs and the MOH;
- Improve the technical, financial and institutional capacity of two local NGOs;
- Mobilize communities through VHCs to improve essential health services;
- Focused education activities; and
- Improving community and health facility quality of health services.

Five innovative strategies were described in the DIP:

- TBA training using a revised and updated community live-saving skills curriculum;
- BCC interventions to improve postpartum care;
- Introduction of the Positive Deviant (PD) approach for sustainable community based rehabilitation and prevention of malnutrition (the HEARTH model);
- Using a CTC approach to increase immunization coverage; and
- Centres d'Ecoute (listening centers) to provide safe venues for peer education, informal discussion groups and structured socialization.

Baseline studies showed very low levels of children whose births were attended by skilled health personnel (22.9%) and infants 0-5 months old who were exclusively breastfed (38.4%).Children fully vaccinated before their first birthday (35.3%); children who received measles vaccine (37.6%); children who received increased fluids and continued feeding during illness (50.2%) and mothers who could cite at least two known ways of reducing the risk of HIV infection (32.8%), demonstrated the high need and the ambitious efforts required for the project staff to achieve program targets.

SC uses a Results Framework with seven Intermediate Results:

- Increased availability of selected MCH services in the two health districts;
- Improved quality of selected MCH services;
- Increased caretaker knowledge and awareness of selected child survival issues;
- Documented feasibility and results of implementing innovative CS-18 approaches;
- Improved capacity in capacity building of the two local NGOs;
- Demonstrated SC/Sahel capacity in capacity building of two local NGOs and two district health offices; and
- Improved capacity of two local NGOs and communities to effectively address priority health needs of mothers and children under 5.

Changes since the DIP:

Baseline investigations revealed that CTC methodology would probably not be the best BCC approach to reach the target populations because the percentage of target villages with access to schools was very low and the village that had schools tended to be better off, and not be located

in the areas with the lowest coverage. The operations research involving a child-to-child (CTC) approach through the schools was dropped because an insufficient number of villages had schools with the target age group, and those that have those types of schools are not the villages where this approach is likely to have the greatest impact. This OR activity will be replaced by a study of introducing community-based drug boxes following a SC model introduced in Mali and is currently under development. The listening centers, which seemed so promising as areas for interaction with communities, were not under the control of the project and had been closed for unknown reasons at the time of the MTE.

Introduction of the HEARTH model into the area has proven more time consuming than originally thought and the project is modifying the approach to specifically target communities meeting the criteria in the HEARTH manuals. Community level assessments indicate significant changes in the introduction of breastfeeding, exclusive breastfeeding rates, and removing taboos on certain desirable complementary foods.

The plans for COGES Organization Development have been changed to develop a regional association of VHCs. This change was made because the COGES are not really functional. In spite of being the mechanism for the Bamako Initiative in Guinea, the COGES do not contribute to improving the function of the health facilities as they were originally envisioned. This is a similar finding to other parts of Francophone Africa. The VHCs have proven themselves to be a viable and dynamic partner in programming bottom-up health systems improvements. As of the MTE, an organizational meeting had been held and the proposed structure of the VHC association has been discussed with the regional health authorities.

Baseline Information from the DIP-Revised Baseline Indicators (including KPC results from Kouroussa Sectors which were not available at the time of the DIP submission) Oct. 2004 SC Guinea CS-18

Revised Table 6 (from DIP): Selected Indicators of the KPC Studies

Indicators	Mandiana Districts 2002	Mandiana Sectors 2002	Kour-oussa Districts 2002	Kour-oussa Sectors 2003	CS-18 Baseline for 2 Districts
Proportion of children less than 6 months exclusively breast fed	35/90 (38.9%)	39/89 (43.8%)	17/58 (29.3%)	28/90 (37.5%)	119/327 (36.4%)
Proportion of mothers having started to breast feed within one hour after birth	130/300 (43%)	75/293 (26%)	19/289 (6%)	49/300 (29.7%)	273/1182 (23.1%)
Proportion of mothers who add iodized salt to child's meal	54/192 (28, 0 %)	8/119 (6.7%)	13/136 (10%)	33/132 (5%)	108/579 (18.6%)
Proportion of children having their weight on a growth monitoring chart at least once	79/117 (67.5 %)	15/46 (32.6%)	5/39 (12.8%)	2/10 (20%)	101/212 (47.6%)
Proportion of children aged 12 to 23 months completely vaccinated by first birthday	54/77 (70, 1 %)	16/42 (38.11%)	20/136 (15%)	7/41 (17.1%)	97/296 (32.8%)
Proportion of mothers who know at what age a child must be vaccinated against the measles	200/300 (66, 7 %)	58/293 (19.8%)	35/289 (12.1%)	10/300 (3.3%)	303/1182 (35.6%)
Proportion of children suspected of being infected by pneumonia treated with an antibiotic	15/35 (42.8%)	11/63 (17.5%)	12/39 (30.8%)	9/48 (19%)	47/185 (25.4%)
Proportion of children with diarrhea given ORS	35/83 (42.2%)	19/75 (42.2%)	9/89 (1%)	19/100 (19%)	82/347 (23.6%)
Proportion of breast fed children who had more breast feeding than usual during their last diarrhea episode	16/79 (20.3%)	8/75 (10.7%)	7/86 (8.1%)	4/93 (4.3%)	35/333 (10.5%)
Proportion of children not exclusively breast fed whose mother gave them liquid other than the maternal milk more than usual when they had diarrhea	11/83 (13.3 %)	2/75 (2.7%)	5/85 (5.9%)	8/99 (8%)	26/342 (7.6%)
Proportion of children 6 to 9 months given additional food (meat, fish)	30/45 (67%)	24/62 (39%)	7/71 (10%)	11/64 (17%)	72/242 (29.8%)
Proportion of suspected cases of malaria treated with chloroquine	92/159 (57.8 %)	72/160 (45%)	53/76 (69.7%)	29/41 (71%)	246/426 (56.4%)

Indicators	Mandiana Districts 2002	Mandiana Sectors 2002	Kour-oussa Districts 2002	Kour-oussa Sectors 2003	CS-18 Baseline for 2 Districts
Proportion of suspected cases treated with chloroquine, correct posology	69/92 (75 %)	31/72 (43%)	15/76 (19.7%)	12/41 (29%)	127/281 (45.2%)
Proportion of mothers who recognize mosquito nets as a method to avoid malaria	193/291 (66.3 %)	60/293 (20.5%)	31/289 (10.7%)	19/300 (6.3%)	303/1173 (25.8%)
Mothers having received at least two doses of TT	154/177 (87%)	91/124 (73.4%)	80/109 (73.4%)	76/134 (56.7%)	401/544 (73.7%)
Proportion of mothers having at least two antenatal visits during the last pregnancy	259/300 (86.3 %)	169/293 (57.7%)	192/289 (66.4%)	187/300 (62.3%)	807/1182 (68.3%)
Proportion of women of reproductive age who know at least 2 of the 5 signs of danger	134/300 (44.7 %)	95/293 (32.4%)	73/289 (25.3%)	72/300 (24%)	374/1182 (31.6%)
Proportion of women who do not wish a baby within next two years who use modern contraception method	99/200 (49.5 %)	47/196 (24%)	18/186 (9.7%)	8/177 (89%)	172/759 (22.7%)
Proportion of mothers using a condom with irregular partner	34/44 (72.7%)	20/37 (54.1%)	8/17 (47.1%)	1/3 (33.3%)	63/101 (62.3%)
Proportion of mothers having had the STI during the last 12 months and sought care at a health center	15/23 (65.2%)	7/15 (46.7%)	22/54 40.7%	29/68 (42.6%)	73/160 (45.6%)
Proportion of mothers naming at least two ways of prevention against HIV	143/298 (48%)	77/288 (26.7%)	62/275 (22.5%)	58/300 (19%)	340/1161 (29.3%)

Note: The results of the four KPC studies are not weighted by population because the population sizes of the districts and sectors are very similar.

Annex B: Evaluation Team Members and their Titles

N°	Name	Title	Area
1	Fatoumata Diakié	RH Advisor	Kouroussa
2	Facely Kourouma	Coordinator District	Kouroussa
3	Alhassane Ahmadou Diallo	Statistician	Kankan
4	Saran Camara	Animator GAAPE	Kouroussa
5	Amadou Kindia Diallo	Opérateur GAAPE	Kouroussa
6	Ansoumane Dioumessy	Supervisor GAAPE	Kouroussa
7	Camara Sabouyan	Animator GAAPE	Kouroussa
8	Laye Camara	Animator GAAPE	Kouroussa
9	Fodé Mara	Animator GAAPE	Kouroussa
10	Sayon Keita	Animator GAAPE	Kouroussa
11	Magassouba Diamadi	Animator GAAPE	Kouroussa
12	Tibou Dioubaté	Animator GAAPE	Kouroussa
13	Dr Mory Touré	NGO Advisor	Kouroussa
14	Eric Swedberg	CS Specialist	SC Wesport
15	Dr Mamadou Oury Diallo	M&E Coordinator SC	Kankan
16	Damou Rahim Keita	Health Program Coord.	Kankan
17	Bakary Bérété	CTP/Education	Kérouané
18	Jean Capps	Consultante SC	SC Wesport
19	Amiata Kaba	Coord. BCC/PRISM	Kankan
20	Famany Traoré	Animator GAAPE	Kouroussa

N°	Name	Title	Lieux
1	Dr Mamadou Oury Diallo	M&E Coord. SC	Kankan
2	Damou Rahim Keita	Coord. Health Programs SC	Kankan
3	Adama Doumbouya	NGO Advisor	Mandiana
4	Adama Diop	RH Advisor	Mandiana
5	Alhassane Ahmadou Diallo	Statistician M&E SC	Kankan
6	Dr Mory Touré	NGO Advisor	Kouroussa
7	Fatoumata Diakié	RH Advisor	Kouroussa
8	Facely Kourouma	District Coordinator	Kouroussa
9	Dr Abdoulaye Oumar Diallo	District Coordinator	Mandiana
10	Adama Camara	AJVDM Supervisor	Mandiana
11	Bakary Bérété	CTP/Education	Kérouané
12	Amiata Kaba	Coord. BCC/PRISM	Kankan
13	Famany Traoré	Animator GAAPE	Kouroussa

Annex C: Evaluation Methodology

The participatory evaluation methodology was expanded to encourage the CS-18 team to demonstrate their own capacity to organize and conduct an evaluation, including analysis, conclusions and recommendations. The external team leader acted as a resource person and advisor. In addition, three additional elements were added: 1) using the BEHAVE Doer/Non-Doer BCC methodology to look at specific target behaviors; 2) an in-depth discussion of the implementation challenges related to introducing the PD/Hearth Model for the first time and, 3) at the request of Susan Youll of USAID/GH/CSHGP, making recommendations to USAID about how CS programs can achieve and demonstrate results at scale. Representatives from the local MOH, both district and regional, the two NGOs, and the USAID/Guinea funded PRISM project, along with SC's Headquarters Representative and the External Team Leader comprised the team. It was significant that both districts contributed significant amounts of staff time to participate in the evaluation fieldwork. Additional inputs were received from the SC Country Representative and Peace Corps Volunteers. Representatives from the USAID/Guinea mission were invited, but were unable to attend due to schedule conflicts.

Field visits included key informant interviews with local MOH officials, health facility personnel, and group discussions with the two partner NGOs. Community level focus group discussions were held with all key community groups and included:

- VHC members (as a group);
- TBAs;
- Mothers;
- Fathers;
- Grandmothers;
- Community Leaders;
- Peer educators; and
- FP providers.

Extensive information was available from the comprehensive project HIS. Data were shared and analyzed with members of the team. The PRISM project 2003 Household Knowledge and Practices study was used for comparison of the value of the SC CS approach relative to other approaches and comparisons were made to other districts where the CSP was not implemented.

Annex D: List of Persons Interviewed and Contacted

Name	Title	Function	Location
Dr. CONDE, Aissata	Doctor	District Health Director	Kouroussa
KOUROUMA, Amara	Health Worker	Primary Health Care	Kouroussa
Dr. KEITA, Oumar	Doctor	Dist. Hosp. Chief of Maternity	Kouroussa
DIALLO, Abdoul	Health Worker	Primary Health Care	Kouroussa
MAMY Ce Augustin	ATS	Statistician	Kouroussa
Dr. KEITA, Ibrahima Kalil	Doctor	General Medicine	Kouroussa
KEITA, Damou Rahim	Biologist	Coordinator of Health Programs	Kankan
DIALO, Alhassane Ahmadou	Forestry Engineer	Statistician, SC	Kankan
KABA, Amiata	Sociologist	PRISM Regional Coordinator	Kankan
BERETE, Bakary	Sociologist	SC (Education)	Kankan
KEITA, Sayon	Forestry Eng.	GAAPE Animator	Kouroussa
DIOUMESSY, Ansoumane	Forestry Eng.	GAAPE Supervisor	Kouroussa
TRAORE, Famany	Forestry Eng.	GAAPE Animator	Kouroussa
CAMARA, Sarann	Biologist	GAAPE Animator	Kouroussa
CAMARA, Sabouyan	ATS	GAAPE Animator	Kouroussa
CAMARA, Laye Kouroussa	Sociologist	GAAPE Animator	Kouroussa
Dr. TOURE MORY	Doctor	NGO Director GAAPE	Kouroussa
DIAKTE, Fatoumata	ATS	Reprod. Health Coordinator	Kouroussa
KOUROUMA, Facely	Historian	District Coordinator	Kouroussa
DIALLO, Abdoulaye	Doctor	District Health Services Coord.	Mandiana
BARRY, Alpha Oumar	Doctor	Dir. Regional Health Services	Kankan
SAKOVOGUI, Gaston		District Health Services	Mandiana
MAGASSOUBA, Ansoumane		District Health Services	Mandiana
YANSANE, Mamadouba		District Health Services	Mandiana
CONDE, N'faily			
AJVDM Staff Members (group)	Animators	AJVDM	Mandiana
CAMARA, Adama	NGO Supervisor	AJVDM Supervisor	Mandiana

Annex E: Diskette or CD with electronic copy of the report in MS Word

Please see attached.

Annex F: Special Reports

? **Doer/Non-Doer Analysis**

? **Midterm Evaluation of Child Survival Sustainability Assessment Dimensions – CS18 Guinea**

Annex F. Results of Doer/Non-Doer Analysis

Save the Children. USA

BP: 328, tél./Fax: (224) 71 07 25

Kankan / Guinea

Elaboration of Behavior Change Strategies

RESULTS OF DOER/NON-DOER STUDIES

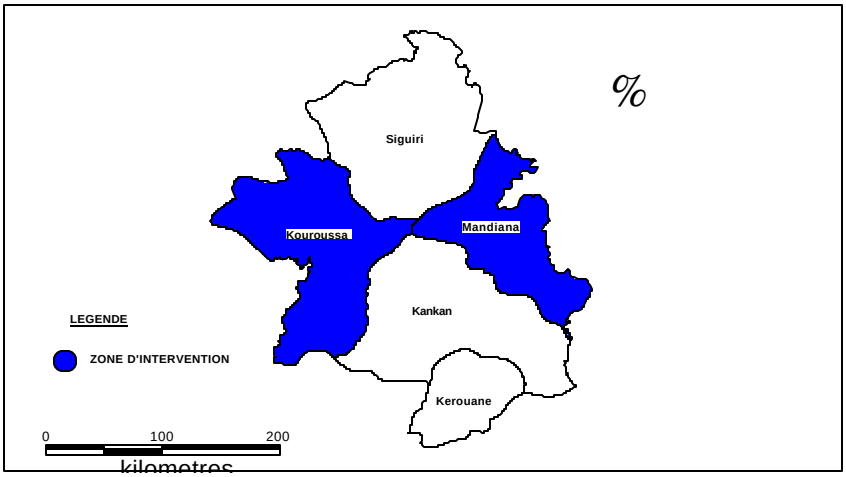
Nutrition

Maternal and Newborn Health

Vaccination

Family Planning

STDs and HIV/AIDS



Prepared by:

Dr DIALLO M Oury, M&E Coord
Mr KEITA D Rahim, Health Coord
Mr DIALLO Alhassane A, Statistician
Dr DIALLO A. Oumar, Mand. Coord
Mr KOUROUMA Facely, Kssa Coord
Dr. TOURE Mory . NGO Advisor
Mme DOUMBOUYA Adama .NGO Advisor
Mme DIOP Adama .RH Advisor
Mme DIAKITE Fatoumata RH Advisor

September 2004

Table of Contents

INTRODUCTION

An evaluation is an opportunity to clarify ideas on changes needed for project interventions and activities. It allows for the identification of obstructing factors and the development of strategies which are better adapted according to the project context. A carefully crafted behavior change strategy is essential to permitting program beneficiaries to understand, appreciate, and apply new behaviors promoted by a health program. The Doer/Non-Doer tool is useful to improve behavior change strategies by identifying behavior determinants that can be addressed by project activities.

Since October 2002, the Community Health Initiative for the Districts of Kouroussa and Mandiana CS-18 Project has worked to reduce child and maternal morbidity and mortality rates. The project intervention areas are:

- Maternal and newborn health;
- Vaccination;
- Nutrition;
- Family Planning; and
- HIV/AIDS/STDs.

Prior to the midterm evaluation, as part of the operational research plan of the project a qualitative study was conducted between June 12 – 15th by the project team, on the following four behaviors:

- Condom use;
- Growth monitoring of children < 3 years old;
- Vaccination of children under 12 months old; and
- Prenatal consultation during the last month of pregnancy.

1. Goal

To reinforce the behavior change strategies and activities in CS-18 communities.

2. General Objective

To increase the participation of the communities in CS activities in the districts of Kouroussa and of Mandiana, by identifying the behavioral determinants of the behaviors studied.

3. Specific Objectives

1. Identify the advantages, disadvantages, facilitating factors, and obstacles which support and discourage groups for the behaviors studied.

2. Improve the ability of the project and NGO partner teams to analyze behavior change strategies.

3. Reach a consensus among the project actors on the priorities for behavior change in terms of priority groups, key factors, activities, and indicators.

4. Improve the communication strategies through the identification of communication channels and key messages.

4. Expected Results

At the end of the workshop the participants will:

- Understand the usefulness of the tool
- Identify determinants of key behaviors
- Create BEHAVE frameworks
- Be able to formulate strategies for the transmission of key messages
- Elaborate the key messages for behavior change
- Master the tools and strategies for analyzing the behaviors of target groups and revising BCC strategies according to community promotion needs.

5. Work Norms and Agenda

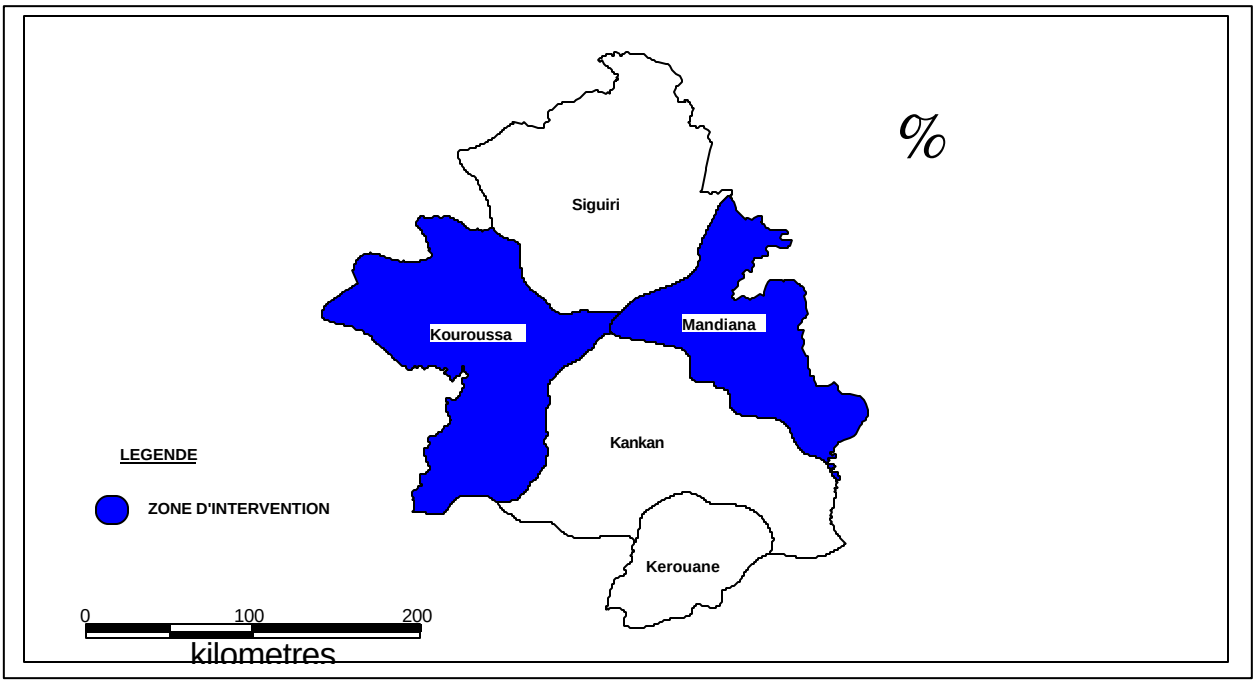
What?	Who ?	When ?	Time
1. Introductions and welcome of participants	Damou	23Sept 04	8h30 mn
2. Presentation of workshop objectives	Dr Oury	23Sept 04	8h34mn
3. Participants Expectations	Alhassane	23Sept 04	8h45
4. Establishing working norms	Damou	23Sept 04	8h53mn
5. Reporting the study results of the Listening Centers	Alhassane	23Sept 04	9h00mn
6. Questions/Responses	M&E Team	23Sept 04	9h16mn
7. Presentation of Doer/Non-Doer study results	Dr Oury	23Sept 04	9h47mn
8. Presentation of tools	Alhassane	23Sept 04	10h5mn
9. Pause	Damou	23Sept 04	10h21mn
10. Division and assignments for small group work	Damou	23Sept 04	10h36
11. Group Work	Team Leaders	23Sept 04	10h50mn
Lunch		23 Sept 04	13h00mn
12. Group Work	Team Leaders	23Sept 04	14h01mn
13. Reporting from Groups	Team Leaders	23Sept 04	16h30mn
14. Evaluation and closing of the Day	M&E Team	23Sept 04	17h 05mn
15. General Information	Damou	24Sept 04	8h30
16. Exchange of documents between the groups	M&E Team	24Sept 04	8h45mn
17. Group Work	Team Leaders	24Sept 04	9h00mn
Pause			10h45mn
18. Group Work Continued	Team Leaders	24Sept 04	11h00mn
19. Lunch	M&E Team	24Sept 04	13h00
20. Presentation of Group Work and Discussion	Team Leaders	24Sept 04	14h01mn
21. Adoption of Draft Document	Group	24Sept 04	16h00
22. Closing of Workshop	Guinea Rep.		17h00
23. Revision and production of draft report	M&E Team	25/09/04	
24. Presentation of report to the staff	Dr Oury	27/09/04	

CHAPTER I: STUDY ZONE

The study took place in the two districts of Kouroussa and Mandiana in the administrative region of Kankan. The total population of the two districts is 393,060 with a land area of 28,850 Km^2. The two districts have similar economic activities.

1. Mandiana :
   - Area: 12,000 Km^2
   - Population: 211,370
   - Density: 17 persons/ Km^2
   - Distance from Conakry : 775 Km
   - Distance from Kankan: 80 Km
   - Economic Activities: agriculture, animal husbandry, and mining
   - Sanitary Information:
     - *Hospital: 1*
     - *Health Centers: 12*
     - *Health Posts: 25*

2. Kouroussa
   - Area: 16.850 Km^2
   - Population: 181,823
   - Density: 11 persons/Km^2
   - Distance from Conakry: 580 Km
   - Distance from Kankan: 83 Km
   - Economic Activities: agriculture, animal husbandry, fishing, and mining
   - Sanitary Information:
     - *Hospital: 1*
     - *Health Centers: 12 of which 8 are functional*
     - *Health Posts: 11*



CHAPTER II. METHODOLOGY

A qualitative study was conducted to obtain information on the main factors of key behaviors of the CS-18 interventions targeting community members in the two districts.

1. The choice of behaviors studied

On the basis of the project's statistics from the first quarter of the second year, four behaviors were selected in this study. These behaviors appeared to be more difficult to change. The four behaviors were studied as follows:

- In Mandiana:
  - Condom use
  - Weighing of children less than 3 years old
- In Kouroussa:
  - Vaccination of children 0-11 months old
  - Prenatal consultations of women during their the last trimester of their pregnancy

2. The characteristics of the sample

The study sample included men and women 15 to 45 years old, in the two sites. The communes visited in Mandiana included the urban commune and in Kouroussa the communes of Babila and Kiniéro. A total number of 50 people were interviewed for each behavior as follows:

- 25 Doers
- 25 Non-doers

The study used a retrospective methodology in which individuals were interviewed based on questionnaires which examined the following variables:

- Advantages;
- Disadvantages;
- Facilitating factors;
- Obstacles;
- Supporters; and
- Discouragers.

3. Training for the Study

This step had two parts:

3.1- The Training Phase

This phase consisted of training the CS-18 team as interviewers, based on the study questionnaires and the pretest of the questionnaires. The purpose of the pretest was to:

- Verify the adequacy and clarity of the questions for the interviewers as well as the interviewees.

- Become familiar with the tool.
- Verify the usefulness of the instructions prepared for each question.
- Prepare the coding of the responses

The training also included the following six elements:

1. The five principles of BEHAVE;
2. The four strategic decisions of the BEHAVE framework;
3. The qualities of the good description of a behavior;
4. The five ways to describe a group;
5. Determinants of behavior (internal and external); and
6. The strategic choices of activities.

3.2- The data collection phase

The data collection took place from June 12–15, 2004 for the four behaviors in the two districts. The NGO animators (GAAPE, AJVDM) collected the data in the communities. The CS-18 Advisors in each district verified the quality of the questionnaires before delivering them to the M&E unit for analysis.

4. Doer/Non-Doer tool analysis

The Doer/Non-Doer tool is *«quick and dirty»* and was easily analyzed. It took only three days to investigate 4 behaviors. The seven steps were:

- Define the behavior to promote;
- Define the doers and non-doers;
- Adapt the six questions;

1. First question to identify the doers and non-doers

2. What are the advantages or the positive things which happen if…
3. What are the disadvantages or the negative things which happen if…

4. What helps you to…
5. What prevents you from…

6. Who encourages or support you to…
7. Who discourages or opposes you to …

- Collect responses in order to create a coding guide;
    - Question a few people (with the instrument) who are as similar as possible to the target groups.
    - Group their responses in categories; create a table.
    - Group the responses by categories.

- Implement the study (at least 20 doers and 20 non-doers);
- Study the answers; and
- Investigate the differences.

Chapter III. RESULTS (the key factors are highlighted)

RESULTS OF THE VACCINATION ANALYSIS

Questions	Answers	Doers		Non-doers	
		Freq	%	Freq	%
According to you what are the advantages of vaccination?	***Advantages***	N=20		N=20	
	Protection against tuberculosis	4	20	2	10
	Protection against polio	1	5	1	5
	Protection against diptheria	0	0	0	0
	Protection against tetanus	5	25	4	20
	Protection against pertusis	1	5	1	5
	Protection against measles	13	65	4	20
	Protection against other diseases	3	15	10	50
	Protection against yellow fever	9	45	1	5
	Protection against fever	4	20	3	15
	Protection against malaria	2	10	2	10
	Protection against diarrhea	2	10	2	10
	Do not know	0	0	3	15
According to you what are the disadvantages of vaccination?	***Disadvantages***				
	Fever	7	35	7	35
	Pain at the injection site	3	15	3	15
	Irritability	0	0	2	10
	Inflammation	7	35	3	15
	Crying	3	15	2	10
	Nothing	4	20	3	15
	Do not know	4	20	7	35
According to you what are the facilitating factors for vaccination?	***Facilitating Factors***				
	Availability	7	35	1	5
	Accessibility	12	60	8	40
	Affordable Cost	5	25	4	20
	Mobile Vaccination Sessions	1	5	2	10
	Education Sessions	3	15	2	10
	Knowledge of the vaccination schedule	2	10	1	5
	Appointments	2	10	0	0
	Do not know	1	5	4	20
	Difficulties/obstacles				
	Vaccine stockouts	0	0	1	5
	Vaccine equipment stockouts	0	0	0	0

According to you what are the obstacles for vaccination?	Cost	3	15	1	5
	Inaccessibility of health facilities	4	20	1	5
	Insufficient Mobile Vaccination Sessions	0	0	1	5
	Insufficient health workers	0	0	1	5
	Over charging for vaccination	0	0	0	0
	Remoteness of health facilities	0	0	3	15
	Misunderstanding of the vaccine schedule	0	0	1	5
	Lack of information	1	5	8	40
	Refuse	2	10	2	10
	Nothing	5	25	2	10
	Do not know	2	10	2	10
According to you who are the persons who approve of vaccination?	***Supporters/people in agreement***				
	Health Workers	13	65	7	35
	Friends	1	5	1	5
	Parents	4	20	2	10
	Religious Leaders	0	0	0	0
	Community Health Workers	5	25	4	20
	Mobile Vendors	0	0	0	0
	Students	0	0	0	0
	VHCs	1	5	4	20
	Peer Educators	0	0	0	0
	Certain Children's mothers	5	25	1	5
	Everyone	2	10	0	0
	Do not know	2	10	6	30
According to you who are the persons who disapprove of vaccination?	**Discouragers/persons who disapprove**				
	Health Workers	0	0	0	0
	Community Health Workers	0	0	0	0
	Parents	1	5	0	0
	Friends	0	0	2	10
	Religious Leaders	0	0	0	0
	Mobile Vendors	0	0	0	0
	Students	0	0	0	0
	VHCs	0	0	0	0
	Peer Educators	0	0	0	0
	Certain Children's mothers	5	25	0	0
	No one	5	25	1	5
	Do not know	7	35	14	70

RESULTS OF THIRD ANC VISIT DURING 9TH MONTH OF PREGNANCY

Questions	*Advantages*	Doers		Non-doers	
		Freq N=20	%	Freq N=20	%
According to you what are the advantages of a third ANC visit in 9th month of pregnancy?	Protection against malaria	2	10	5	25
	Protection against neonatal tetanus	1	5	2	10
	Protection against other diseases	2	10	4	10
	Prevention of anemia	2	10	5	25
	Prevention of eventual problems	7	35	5	25
	Knowing the position of the baby	6	30	7	35
	Facilitate the birth	3	15	2	10
	Identify/treat illness	4	20	5	25
	Do not know	2	10	3	15
According to you what are the disadvantages of a third ANC visit in 9th month of pregnancy?	***Disadvantages***				
	Eclamsia	1	5	0	0
	Lower back pain	1	5	0	0
	Edema	1	5	0	0
	Fatigue	0	0	1	5
	None	7	35	5	25
	Do not know	12	60	13	65
According to you what are the facilitating factors of a third ANC visit in 9th month of pregnancy	***Facilitating Factors***				
	Accessibility	2	10	3	15
	Affordable Cost	5	25	2	10
	Mobile Clinics	1	5	0	0
	Proximity to health facilities	0	0	0	0
	Good knowledge of gestation age	0	0	0	0
	Information/education	5	25	1	5
	Knowledge of danger signs during the pregnancy/birth	4	20	2	10
	Appointments	4	20	1	5
	Availability of medicine	3	15	8	40
	Courage	2	10	4	20
	Do not know	1	5	4	20
According to you what are the barriers of a third	**Barriers/obstacles**				
	Remoteness of health structures	1	5	1	5
	Misunderstanding of gestational age	0	0	1	5

barriers of a third ANC visit in 9th month of pregnancy?	Inaccessibility of health structures	0	0	0	0
	Insufficient mobile clinics	0	0	0	0
	Insufficient health workers	1	5	0	0
	Overcharging/charging for ANC visit	1	5	3	15
	Stock-outs of medicine/vaccine	2	10	2	10
	No appointment given	1	5	1	5
	Lack of knowledge of danger signs during the pregnancy/birth	3	15	0	0
	Fatigue	2	10	1	5
	Welcome	0	0	2	10
	Do not know	8	40	3	15
According to you who are the persons who approve of a third ANC visit in 9th month of pregnancy?	**Supporters/persons who agree**				
	Health workers	10	50	13	65
	Friends	3	15	4	20
	Parents	4	20	8	40
	Religious leaders	0	0	0	0
	Community agents	0	0	0	0
	Mobile vendors	0	0	1	5
	Students	0	0	0	0
	VHC	6	30	4	20
	Peer educators	0	0	3	15
	Husbands	8	40	5	25
	Myself	7	35	3	15
According to you who are the persons who disapprove of a third ANC visit in 9th month of pregnancy?	**Discouragers /persons who disapprove**				
	Health workers	0	0	0	0
	Community agents	0	0	0	0
	Parents	0	0	0	0
	Friends	0	0	0	0
	Religious leaders	0	0	0	0
	Mobile vendors	0	0	0	0
	Students	0	0	0	0
	VHC	0	0	0	0
	Peer educators	0	0	0	0
	Do not know	6	30	7	35
	No one	14	70	13	65

RESULTS OF ANALYSIS OF CONDOM USE BEHAVIOR

Questions	Responses	N= 25		N= 21	
			%		
According to you what are the advantages of using a condom?	**Advantages**				
	Protection against les IST	23	92%	15	71%
	Protection against HIV/AIDS	23	92%	16	76%
	Protection against undesired pregnancies	20	80%	5	24%
	Fertility	1	4%	0	0%
	Spacing births	4	16%	5	24%
	Maintain health	0	0%	1	5%
According to you what are the disadvantages of using a condom?	*Disadvantages*				
	Decreases sexual pleasure	14	56%	7	33%
	Reduces the erection	4	16%	2	10%
	Contaminates	8	32%	2	10%
	The condom tears easily	4	16%		%
	Do not know	0	0%	2	10%
	Reduces sexual feeling	0	0%	1	5%
	Transmits diseases	0	0%	1	5%
	Inconvenient	0	0%	5	24%
According to you what are the things that make it easy to use a condom?	*Facilitating Factors*				
	Availability	12	48%	1	5%
	Accessibility	12	48%	3	14%
	Affordable Cost	19	76%	3	14%
	Reversible Method	5	20%	1	5%
	Easy to use	4	16%	0	0%
	Sure method	6	24%	1	5%
	Information	9	36%	1	5%
	Insufficient trust	8	32%	11	52%
	Do not know	0	0%	6	86%
According to you what are the obstacles to using a condom?	**Obstacles**				
	Against religion	11	44%	2	10%
	Cost	2	8%	0	0%
	Inaccessibility	1	4%	0	0%
	Fidelity	10	40%	6	29%
	Trust	17	68%	8	38%
	No factor	3	12%	3	14%
	Young girls/boys	1	4%	0	0%
	Unbelief	1	4%	0	0%
	Do not know	2	8%	2	10%
	Reduction of sexual pleasure	1	4%	2	10%
	Desire a child	1	4%	0	0%
	Parents wish	1	4%	0	0%

	Support/Agree				%
	Partners	5	20%	1	5%
	Health Workers	18	72%	11	52%
	Friends	5	20%	0	0%
	Parents	2	8%	0	0%
	Religious leaders	0	0%	0	0%
According to you who are the persons who support or approve of you using a condom?	Community Agents	6	24%	0	0%
	Mobile Vendors	1	4%	1	5%
	Students	9	36%	4	19%
	Transporters/truck drivers	1	4%	1	5%
	Men in uniform	3	12%	1	5%
	Miners	2	8%	0	0%
	Prostitutes	10	40%	9	43%
	Adolescents	4	16%	1	5%
	VHC	8	32%	1	5%
	Peer educators	12	48%	2	10%
	Intellectuals	2	8%	1	5%
	Project Workers	3	12%	3	14%
	People sure of condoms	2	8%	0	0%
	Informed persons	4	16%	0	0%

Question	Answers	N= 25		N= 21	
According to you who are the persons who do not support or approve of you using a condom?	*Discouragers*				
	Partners	1	4%	0	0%
	Health workers	0	0%	0	0%
	Friends	0	0%	1	5%
	Parents	9	36%	5	24%
	Religious leaders	4	16%	16	76%
	Mobile vendors	1	4%	0	0%
	Students	0	0%	0	0%
	Transporters/truck drivers	4	16%	0	0%
	Men in uniform	5	20%	0	0%
	Miners	6	24%	0	0%
	Prostitutes	2	8%	0	0%
	Adolescents	2	8%	0	0%
	VHC	0	0%	0	0%
	Peer educators	0	0%	0	0%
	Intellectuals	0	0%	0	0%
	Project workers	0	0%	0	0%
	Uninformed persons	4	16%	0	0%
	Farmers	2	8%	1	5%
	Don’t like condom	2	8%	1	5%
	People wanting pleasure	1	4%	0	0%
	Workers	1	4%	0	0%
	Student	1	4%	0	0%
	Superstitious persons	1	4%	0	0%
	Teachers	0	0%	1	5%

RESULTS OF ANALYSIS OF WEIGHING CHILDREN

Questions	Responses	N=24 Doers		N=25 Non-doers	
	ADVANTAGES	effect	%	effect	%
According to you what are the advantages of weighing your child?	Knowledge of nutritional status	**12**	**50**	**2**	**8**
	Knowing the child's growth	**15**	**63**	**6**	**24**
	Knowing the child's health	**21**	**88**	**12**	**48**
	Knowing the change in the child's weight	**1**	**4,2**	**0**	**0**
	Do not know	**0**	**0**	**6**	**24**
According to you what are the disadvantages of weighing your child?	**DISADVANTAGES**				
	Other responsibilities	**0**	**0**	**6**	**24**
	Misunderstanding	**5**	**21**	**1**	**4**
	Do not know	**7**	**29**	**9**	**36**
	Inconvenient	**9**	**38**	**5**	**20**
	Lack of time	**0**	**0**	**1**	**4**
	Long waits	**0**	**0**	**1**	**4**
	Child being in a large group	**0**	**0**	**1**	**4**
According to you what are the factors which encourage weighing your child?	**FACILITATING FACTORS**				
	Availability of the scales	**11**	**46**	**6**	**24**
	Accessibility	**7**	**29**	**1**	**4**
	Affordable Cost	**7**	**29**	**6**	**24**
	Simplicity	**6**	**25**	**1**	**4**
	Well informed	**5**	**21**	**1**	**4**
	Availability of agents trained to weigh	**19**	**79**	**8**	**32**
	Free service	**2**	**8,4**	**0**	**0**
	Availability of mothers	**1**	**4,2**	**0**	**0**
	Knowledge of the importance of weighing	**1**	**4,2**	**0**	**0**
	Health workers	**0**	**0**	**0**	**1**
	Do not know	**0**	**0**	**9**	**36**
According to you what are the factors which discourage weighing your child?	**OBSTACLES**				
	Religion	**0**	**0**	**6**	**24**
	Cost	**1**	**4,2**	**1**	**4**
	Inaccessibility	**1**	**4,2**	**6**	**24**
	Insufficient equipment	**1**	**4,2**	**1**	**4**
	Insufficient workers	**1**	**4,2**	**1**	**4**
	Insufficient information	**6**	**25**	**8**	**32**
	Work	**12**	**50**	**0**	**0**

	Lack of time of trained persons	**4**	**17**	**0**	**0**
	Laziness/neglect	**2**	**8,3**	**0**	**0**
	Illness of mother	**1**	**4,2**	**0**	**1**
	Do not know	**2**	**8,3**	**9**	**36**
	Nothing	**2**	**8,4**	**0**	**0**
	Refuse	**1**	**4,2**	**0**	**0**
	Lack of money	**0**	**0**	**1**	**4**
According to you who are the people who support weighing your child?	Supporters				
	VHC	**8**	**33,3**	**5**	**20**
	Health workers	**16**	**68**	**17**	**68**
	Friends	**2**	**8,3**	**1**	**4**
	Parents	**6**	**25**	**1**	**4**
	Religious leaders	**0**	**0**	**0**	**0**
	Community Agents	**4**	**17**	**1**	**4**
	Mobile Vendors	**0**	**0**	**0**	**0**
	Students	**2**	**8,3**	**5**	**20**
	Peer Educators	**4**	**17**	**0**	**0**
	Intellectuals	**1**	**4,2**	**3**	**12**
	Mothers of children	**5**	**21**	**3**	**12**
	Everyone	**1**	**4,2**	**1**	**4**
	Do not know	**0**	**0**	**2**	**8**
According to you who are the people who do not support weighing your child?	Discouragers				
	VHC	**0**	**0**	**0**	**0**
	Health workers	**0**	**0**	**0**	**0**
	Friends	**0**	**0**	**0**	**0**
	Parents	**0**	**0**	**4**	**16**
	Religious leaders	**0**	**0**	**1**	**4**
	Community workers	**1**	**4,2**	**1**	**4**
	Mobile workers	**0**	**0**	**4**	**16**
	Students	**0**	**0**	**0**	**0**
	Peer educators	**0**	**0**	**0**	**0**
	Intellectuals	**6**	**25**	**0**	**0**
	Mothers of children	**0**	**0**	**0**	**0**
	Everyone	**0**	**0**	**0**	**0**
	Do not know	**6**	**26**	**7**	**28**
	Uninformed persons	**10**	**42**	**6**	**24**

5. The strategy development for CS-18

The participants formed teams for each intervention area of the program: Nutrition, MNC, vaccination and STD/HIV/AIDS. Each team had between two to three members representing the district health offices of each district.

CONDOM USE (STD/HIV/AIDS) Damou Rahim Keita Facely Kourouma	**GROWTH MONITORING/NUTRITION** Dr Abdoulaye Oumar DIALLO Adama Doumbouya Alhassane A. DIALLO
ANTENATAL CARE DURING 9TH MO. Fatoumata Diakite Dr . Mamadou Oury DIALLO	**VACCINATION OF CHILDREN 0-11MO** Dr. Mory TOURE Adama DIOP

1. Choice of a key behavior for each intervention

a) review of the key behaviors for each intervention area;
b) analysis of the results of the formative research;
c) prioritize one behavior and describe it well.

2. Describe the priority groups and supporting groups for each key behavior

a) discuss what is the largest non-doer groups who could adopt the behavior;
b) describe the priority group using the five ways of describing the group (including their level or stage of adopting the behavior);
c) cite two supporting groups who could influence the behavior of the priority group.

3. Identify the most important key factors which maximize the benefits and minimize the obstacles related to the behavior in the priority group.

a) review the big wishes/benefits and obstacles of the group according to the formative research;
b) describe a minimum of 3 key factors which influence the three determinants;
c) review the list to see if there is an essential factor which has been missed and add it.

4. Describe the types and content of the strategic activities to influence the key factors

a) review the activities already in place which directly contribute to one or more of the factors;
b) select the types of activities best placed to address the key factors;
c) elaborate the content of the messages to deliver through each activity; and
d) note the current activities which need to be stopped.

5. Preparation to share the work with the other groups

a) produce a completed behave framework and copy it for the participants;
b) identify the implications for changing the strategy for the programs intervention;
c) note the aspects which the group wishes more feedback from others;
d) select a reporter and note taker.

6. Exchange of BEHAVE frameworks

The groups exchanged their work through a group review in two cycles.

First Pairs: STD/HIV/AIDS with Nutrition
MNC with Vaccination
Second Pairs: MNC with Nutrition
Vaccination with STD/HIV/AIDS

The two pairs discussed their frameworks for one hour and solicited suggestions and comments.

The final version of the frameworks are presented at the end of this report. The groups identified the need to further refine the activities and message content.

7. Changes/Program Implications

1. Continue to stress importance of vaccination, prenatal consultations, weighing and condom use.
2. Reinforce the mobile clinics and active case finding.
3. Reinforce the use of rural radio messages for the interventions.
4. More emphasis should be put on promoting dialogue between spouses in all areas.
5. Clarify the roles and responsibilities of community agents and health workers.
6. Key messages need further precision in nutrition (weighing), MNC, vaccination and STD/HIV/AIDS.
7. Record children less than 3 years old in the registers.
8. Diffuse the health service charges in the communities.
9. Implicate political and administrative authorities in community mobilization.
10. Reinforce the promotion of FP services (condom) in the project zones.
11. Reinforce the post-training follow-up.
12. Increase the collaboration and synergies between the various community structures.

BEHAVE frameworks for Mandiana and Kouroussa

Intervention: Vaccination

GROUPS	BEHAVIOR	KEY FACTORS	ACTIVITIES
Demographics			
Mothers of children 0-11 months old	To completely vaccinate their children before their first birthday	➢ Availability of services ➢ Geographic accessibility ➢ Affordable Cost ➢ Information, education, and communication	➢ Organize BCC sessions on the importance of vaccination ➢ Reinforce mobile clinics and active research ➢ Organize rural radio broadcasts on the importance of vaccination ➢ Disseminate the price of vaccination in the communities ➢ Training follow-up for health workers (managing the cold chain and vaccination techniques etc.) ➢ Create more synergy between community structures (VHC and parents committees)
Activities			
Agriculture, mining, small commerce			
Desires			
To have a child protected against the immunizable diseases.			
Obstacles			
➢ Distance from health centers ➢ Inaccessibility ➢ Overcharging ➢ Lack of information			
Adoption			
Test/action			
Supporting Groups			
Health workers VHC Parents Mothers			

Intervention: Maternal and Newborn Care

GROUPS **Demographics**	**BEHAVIOR**	**KEY FACTORS**	**ACTIVITIES**
Women of reproductive age 15 to 49 years old	To make at least three ANC visits with the last visit during the 9th month of pregnancy	➢ Availability of medicine ➢ Knowledge of importance of antenatal care visits ➢ Affordable cost ➢ IEC	➢ Organize BCC sessions on the importance of components of ANC ➢ Reinforce mobile clinics and active research ➢ Organize rural radio broadcasts on the importance of ANC ➢ Disseminate the price of ANC in the communities
Activities			
Agriculture, mining, small commerce			
Desires			
The good health of the mother and child			
Obstacles			
➢ Stock outs of medicine/vaccines ➢ Charging/overcharging ➢ Lack of knowledge of danger signs ➢ Welcoming attitudes			
Adoption			
Test/action			
Supporting Groups			
Health workers VHC Parents Husbands			

Intervention: STD/HIV/AIDS

GROUPS	BEHAVIOR	KEY FACTORS	ACTIVITIES
Demographics			
Sexually active persons between 15 to 49 years old	Systematic use of condoms during sex with non-regular partners	➢ Lack of trust ➢ Availability of services ➢ Geographic accessibility ➢ Affordable Cost ➢ Information, education, and communication	➢ Sale of condoms at all levels ➢ Training and refreshers for community agents ➢ Organize BCC sessions on importance of importance of using condoms ➢ Organize rural radio broadcasts on STD/HIV/AIDS
Activities			
Agriculture, mining, small commerce Unprotected sex			
Desires			
To protect themselves against STD/HIV/AIDS			
Obstacles			
Prohibited by Islam Fidelity Trust			
Adoption			
Essai/Action			
Supporting Groups			
Health workers VHC Students Prostitutes			

Intervention: Nutrition

GROUPS **Demographics**	BEHAVIOR	KEY FACTORS	ACTIVITIES
Mothers of children 0-35 months old	Monthly weighing of children 0 to 35 months old	➢ Free growth monitoring services ➢ Simplicity of weighing ➢ Availability of trained workers	➢ Organize BCC sessions on importance of growth monitoring ➢ Organizing monthly weighing sessions ➢ Systematically registering all children 0 to 35 months old
Activities			
Agriculture, mining, small commerce			
Desires			
To have children with good nutritional status			
Obstacles			
➢ Occupation of mothers ➢ Lack of time of the trained persons ➢ Insufficient IEC			
Adoption			
Trial/action			
Supporting Groups			
Health workers VHC Mothers Parents			

Annex F. Updated Sustainability Framework/Midterm Evaluation Report on Progress in Achieving Sustainability (Oct. 2004)

A. Framework for the CS-18 Guinea Sustainability approach

- Sustained U5 mortality reduction (Goal)
- Sustained nutritional status improvement (0-36 mo)
- Nutrition (15%)/Micronutrients (10%) /Vit.A (15%) ; MNC (40%); Immunization (10%); HIV/AIDS (20%)

- Increased use of key services (R)
- Increased availability of services (IR-1)
- Increased quality of services (IR-2)
- Documented feasibility & results of innovations (IR-4)

Health outcomes and services' approach

D

Local organizational capacity		Community capacity & environment
♦ MOH and NGOs able to assume responsibility for activities with Community (R – O2 –IR4) ♦ Improved competence of TBA & HC staff - IR2 - ♦ Improved capacity of 2 DPS to support community health services and activities (IR-5) ♦ Improved capacity of 2 local NGOs to address priority health needs (IR-7a) - i IR6 -	♦ Indicator IR6	♦ Increased MCH practices at the HH level (R) ♦ Community able to assume responsibility for activities with MOH and NGOs (R – O2) ♦ Increased caretaker knowledge of CS (IR-3) ♦ Improved capacity of community to address health needs (IR-7b) IR6 -

IR-6: Improved capacity of SC/Sahel in capacity building (through IR-5 and IR-7): indic. IR5

Mapping CSA Index Scores – SC Guinea DIP Illustration

B. Description of Dimension Measurement at Baseline and Midterm

The CSSA framework for CS-18 Guinea as described in the DIP includes address sustainability on three dimensions. Each of these dimensions was measured at baseline. Two of the three dimensions of the CSSA framework were assessed during the midterm evaluation in September 2004. These recent midterm assessments are compared to the baseline results below.

Table 1: dimensions of evaluation

Dimension	Component
DIMENSION 1 -HEALTH & HEALTH SERVICES	1.1.: Health status
	1.2.: Services approach
DIMENSION 2 –LOCAL ORGANIZATION	2.1.: Local organization capacity
	2.2.: Local organization viability
DIMENSION 3 – COMMUNITY & SOCIAL ECOLOGY	3.1.: Community Capacity
	3.2.: Social Ecological Environment

DIMENSION 1 - HEALTH & HEALTH SERVICES

This dimension was not reassessed at midterm. This is the description of how this dimension was measured at baseline.

Component 1.1.: Health status

CSSA Index score in Component

CS Guinea – baseline CS 18 _____ (7 indicators) 31
Mandiana – baseline CS 14 --------- (9 indicators) 10
Mandiana – baseline CS 18 _____ (10 indicators) 45
Kouroussa – baseline CS 18 ---------- (9 indicators) new zone 16

Component 1.2.: Services approach

The only information available was area-wide, including the two project districts. We used a linear scale to build an index in this dimension, and then used the median score between different elements in this component. Thus we had:

Health Facility Assessment
- essential maternal services 40% score=40
- essential drugs 66% score=66
- immunization status checked 16% score=16
- counseling 25% score=25

TBA assessment
- TBA equipped 33%
- TBA trained 53%

We consider that TBAs need to be trained and equipped to be effective: score = 33
Health Posts staffed
- No figure given – assumption based on text 10% score=10

Assuming these measures/approximations describe the health services component. We take the median score to obtain the component index score. Median (10,16,25,33,40,66) = 29 (component index score)

DIMENSION 2 - LOCAL ORGANIZATION

Component 2.1.: Organizational capacity of NGO
Component 2.2.: Organizational viability of NGO

The capacity assessment of NGOs at baseline had questions about management capacity (component 2.1) and 2 categories on relationships and financial resources used for component 2.2.

Without refining the measures described in the DIP (we use the score given by the number of questions checked in each category). We obtain the following scores for the 2 NGOs

	Capacity	Viability	Overall
GAAPE	35/75; score=47	4/9; score=44	39/83; score=47
AJVDM	24/75; score=32	5/9; score=55	29/83; score=35

At midterm the same assessment tool was used to evaluate the two local NGO partners and obtained the following scores:

	Capacity	Viability	Overall
GAAPE	55/75; score=73	6/9; score=67	61/84; score=73
AJVDM	48/75; score=64	8/9; score=89	56/84; score=67

DIMENSION 3 - COMMUNITY & SOCIAL ECOLOGY

Component 3.1.: Community competence/capacity

At baseline the VHCs in Mandiana district were assessed on 15 criteria (scale of 0-3). For each VHC a % of the maximum score (45/45) as a measure. An index scale was developed to assess VHC capacity.

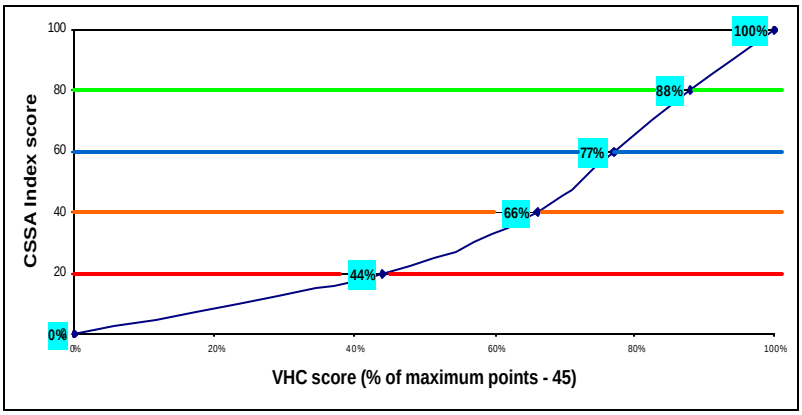


Table: VHC scores

	1. Indicator status band for CSSA	2. VHC Capacity	3. Index score Range for each band
	Strong	88.01% - 100% (=**45**/45)	81-100
	Promising	77.01% - 88% (=**40**/45) *{(10*3)+(5*2)}*	61-80
	Intermediate	66.01% - 77% [=35/45] *{(10*2)+(5*3)}*	41-60
	Emerging	44.01% - 66% [=**30**/45] *15*2*	21-40
	Critical	0% - 44% [=**20**/45] *{(10*1)+(5*2)}*	0-20

The mean Mandiana VHC score, which is 68.89% or 45.3 points on the CSSA index scale was used for baseline. There were no VHCs established in the Kouroussa District at baseline.

The VHCs were assessed at midterm on a simpler 6 criteria each with a possible 3 points. Although this is a less comprehensive assessment, it does give an indication of progress achieved in building VHC capacity since project start. An outstanding VHC would have a score of 18 (100%). The Mandiana VHCs had an average percentage score of 76% and the Kouroussa VHCs had 71%. When converted to the index score this is 56 points for the Kouroussa VHCs and 61.3 points for Mandiana VHCs.

DIMENSION 3 - COMMUNITY & SOCIAL ECOLOGY

Component 3.2.: Social ecological environment

Table i-13: Human Development Index

	1. Indicator status band for CSSA	2. Human Development Index	3. Index score Range for each band
	Strong	0.81 – 0.939	81-100
	Promising	0.67 – 0.80	61-80
	Intermediate	0.54 – 0.66	41-60
	Emerging	0.40 – 0.53	21-40
	Critical	0.258 – 0.39	0-20

0.414 (UNDP)

Women education rate: Non-educated women can benefit from the education of their peers; for this reason the scale was skewed to give a higher score for mid-range literacy rates (e.g. 50% literacy is the top of the "Intermediate" band, instead of the middle, and the “strong” band starts at a literacy rate of 71%).

Table i-14: Women education

	1. Indicator status band for CSSA	2. Regional women literacy rate	3. Index score Range for each band
	Strong	71% - 100%	81-100
	Promising	51% - 70%	61-80
	Intermediate	31% - 50%	41-60
	Emerging	16% - 30%	21-40
	Critical	0% - 15%	0-20

This table was used to get an index in this component.

Name of the Element:	**Women Basic Education**	Name of the Element:	**HDI**
1- **From Table r-14:** Actual measured value of the indicator (in %– i.e. if %CHWs=10%, write 10)	**13 (13% of women with basic education)**	**From Table r-14:** Actual measured value of the indicator:	**0.414 (UNDP)**
[Table i-14]: Take the measured value of the indicator (%) and identify in which status band the indicator will be placed (from critical to strong). Status band:		**[From Table i-13]:** Take the measured value of the indicator and identify in which status band the indicator will be placed (from critical to strong). Status band:	
2- Indicate the base score for the status band (e.g. 80 points for “strong”; 20 for “emerging”): **[Table i-14]**		Indicate the base score for the status band (e.g. 80 points for “strong”; 20 for “emerging”): **[Table i-13]**	
3- Maximum value (%) for indicator in this band (e.g. 30 in the emerging band): **[Table i-14]**		Maximum value for indicator in this band (e.g. 0.53 in the emerging band): **[Table i-13]**	
4- Minimum value (%) for indicator in this band (band minimum = lower band		Minimum value (%) for indicator in this band (band minimum = lower	

maximum e.g. 15 in the emerging band): **[Table i-14]**		band maximum e.g. 039 (**Table i-13**) in the emerging band):	
Now calculate the following:			
5- Actual measured value (line 1) minus Band minimum (line 4) =			
6- Band maximum (line 3) minus Band minimum (line 4) =			
7- Divide line 5 by line 6 =			
8- Multiply the result in line 7 by 20 =			
9- Add the result of line 8 to the base of the band score (line 2) =	***Women literacy rate element index = 17***	***HDI element index = 22***	
Choose the Median score on line 9 for the two element indicators to calculate the social ecological environment component index	***social ecological environment component index = 19***		

This component of the third dimension was not reassessed at midterm.

C. Sustainability Frameworks Graphics of Guinea Sustainability Dimensions

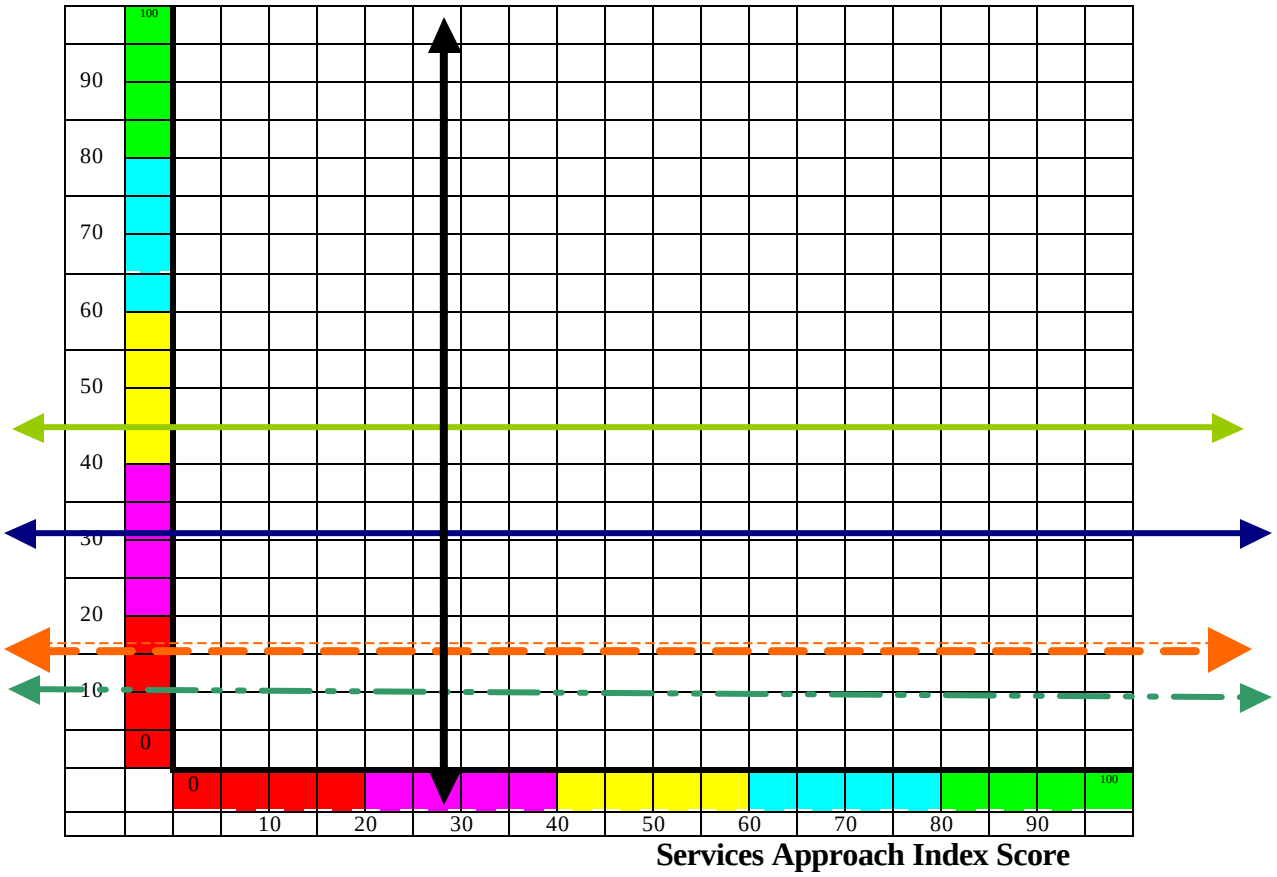
This section displays in graphical form the improvements made in the sustainability dimensions of CS-18.

DIMENSION 1 - HEALTH & HEALTH SERVICES (not reassessed at midterm because a KPC was not conducted)

Component index scores	District Mandiana		District Kouroussa	
	CS 18 Baseline	Midterm	Baseline	Midterm
Component 1.1.: Health status	45	Not measured	15	Not measured
Component 1.2.: Services approach	29	Not measured	29	Not measured but TBAs have been trained and equipped

* based on 7 CATCH indicators

Health Status Index Score



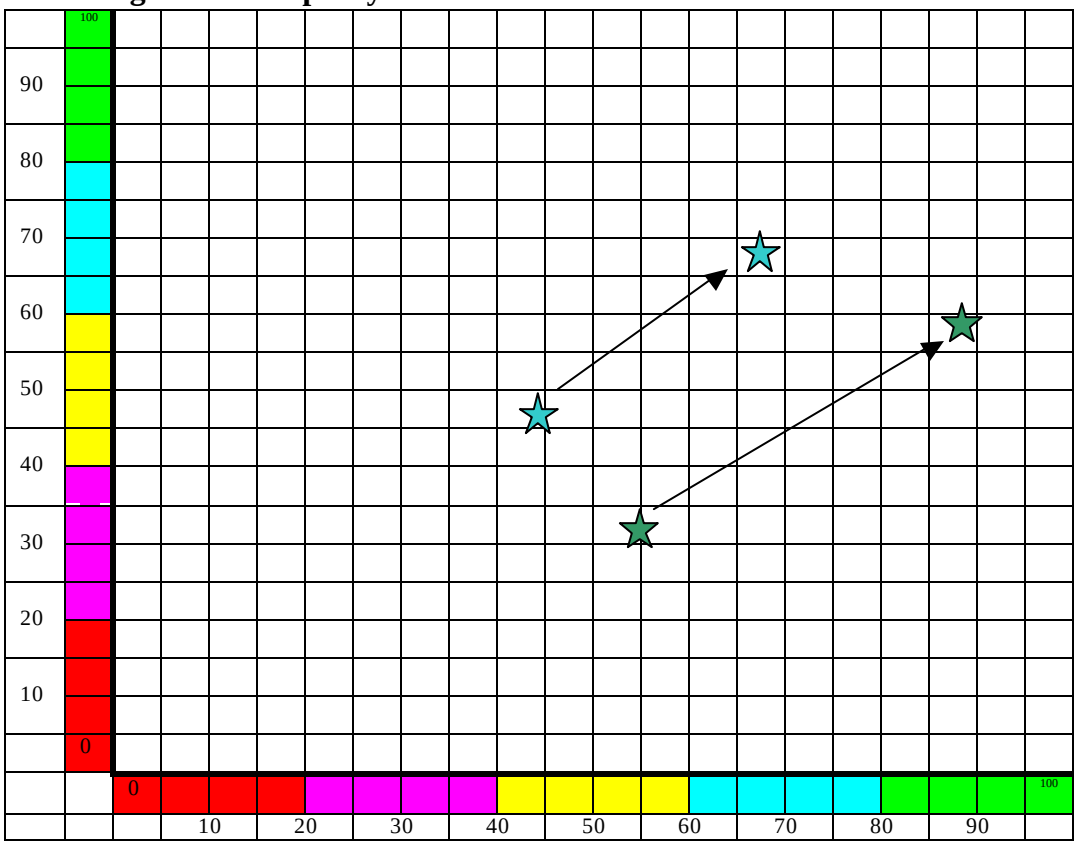
Services Approach Index Score

CS Guinea – baseline CS 18 _____ (7 indicators)
Mandiana – baseline CS 14 --------- (9 indicators)
Mandiana – baseline CS 18 _____ (10 indicators)
Kouroussa – baseline CS 18 ---------- (9 indicators) new zone

DIMENSION 2 - LOCAL ORGANIZATION (local NGO partners)

Component index scores	District Mandiana		District Kouroussa	
	Baseline	Midterm	Baseline	Midterm
Component 2.1: Local organization capacity	32	64	47	73
Component 2.2: Local organization viability	55	89	44	67

Local organization capacity Index Score

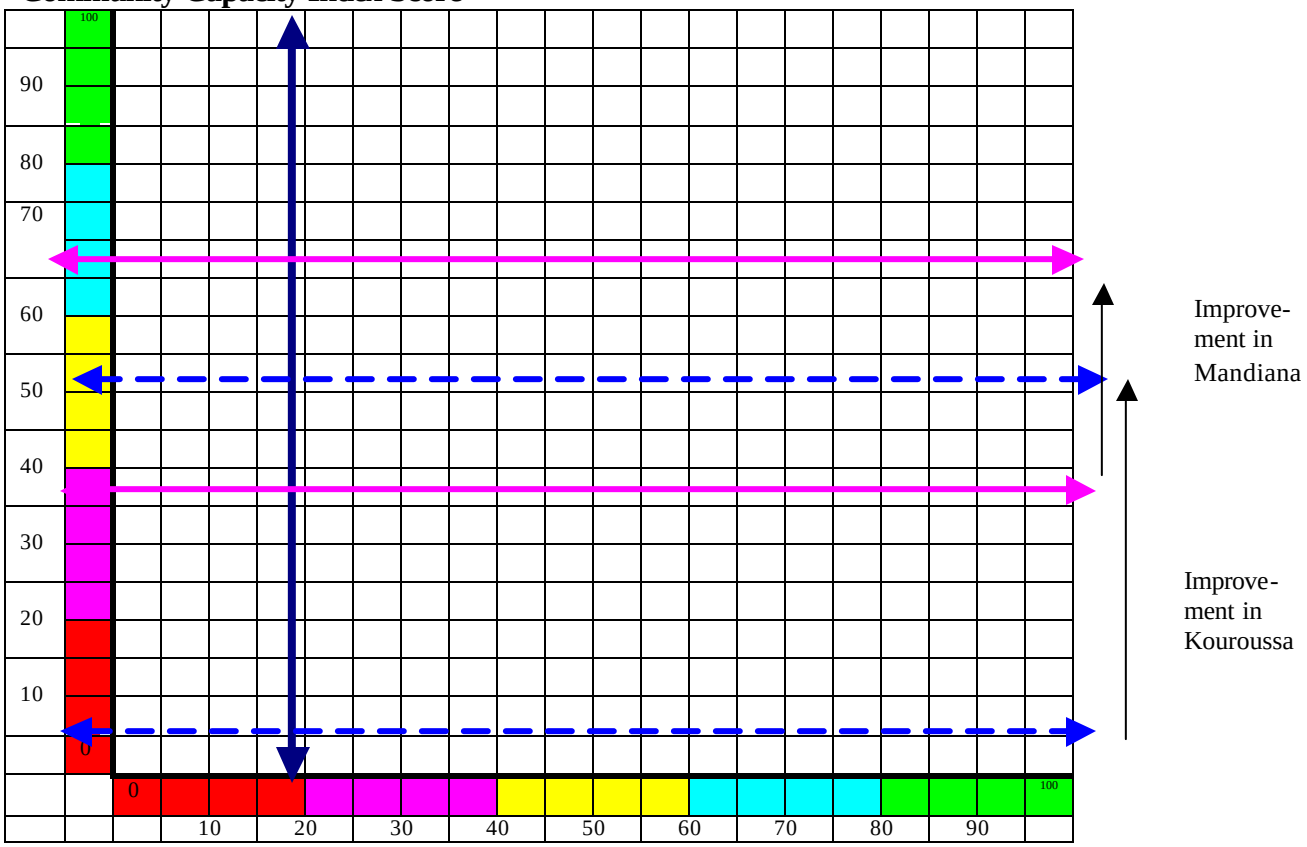


Local organization viability Index Score

DIMENSION 3 - COMMUNITY & SOCIAL ECOLOGY

Component index scores	District Mandiana		District Kouroussa	
	Baseline	Midterm	Baseline	Midterm
Component 3.1.: Community Capacity	45	61.3	0	56
Component 3.2.: Social Ecological Environment	19	Not measured	19	Not measured

Community Capacity Index Score



Mandiana VHC index score

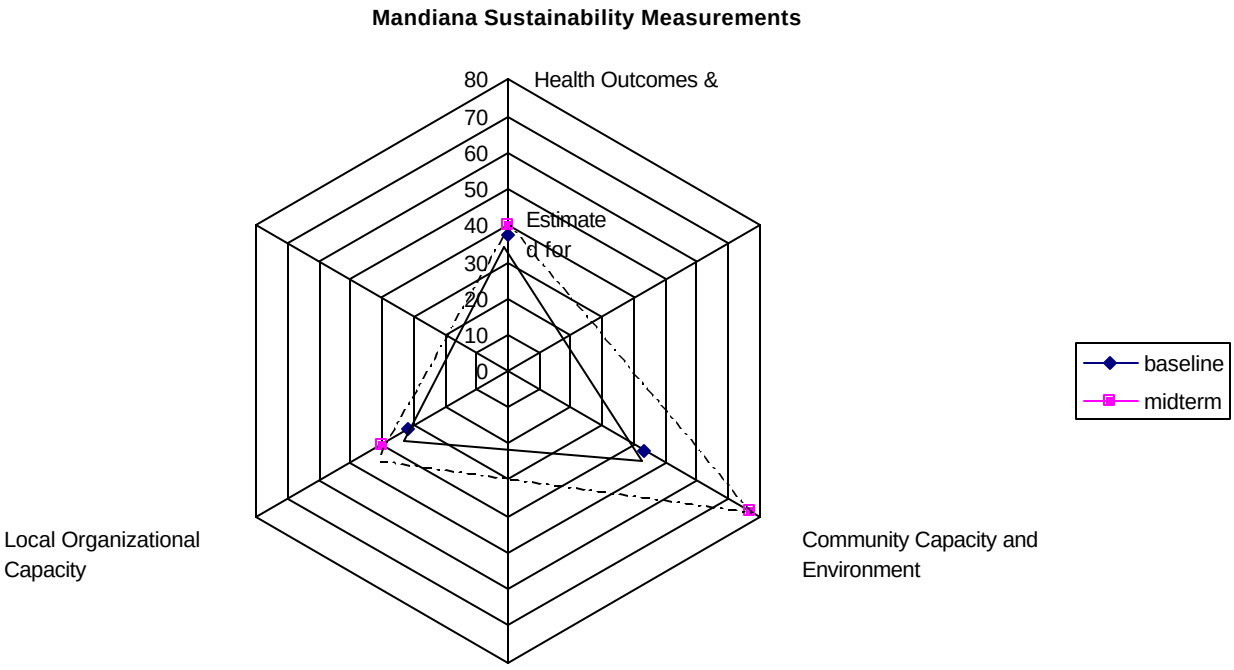
Kouroussa **VHC index score**

Final sustainable health summary figure for each district:

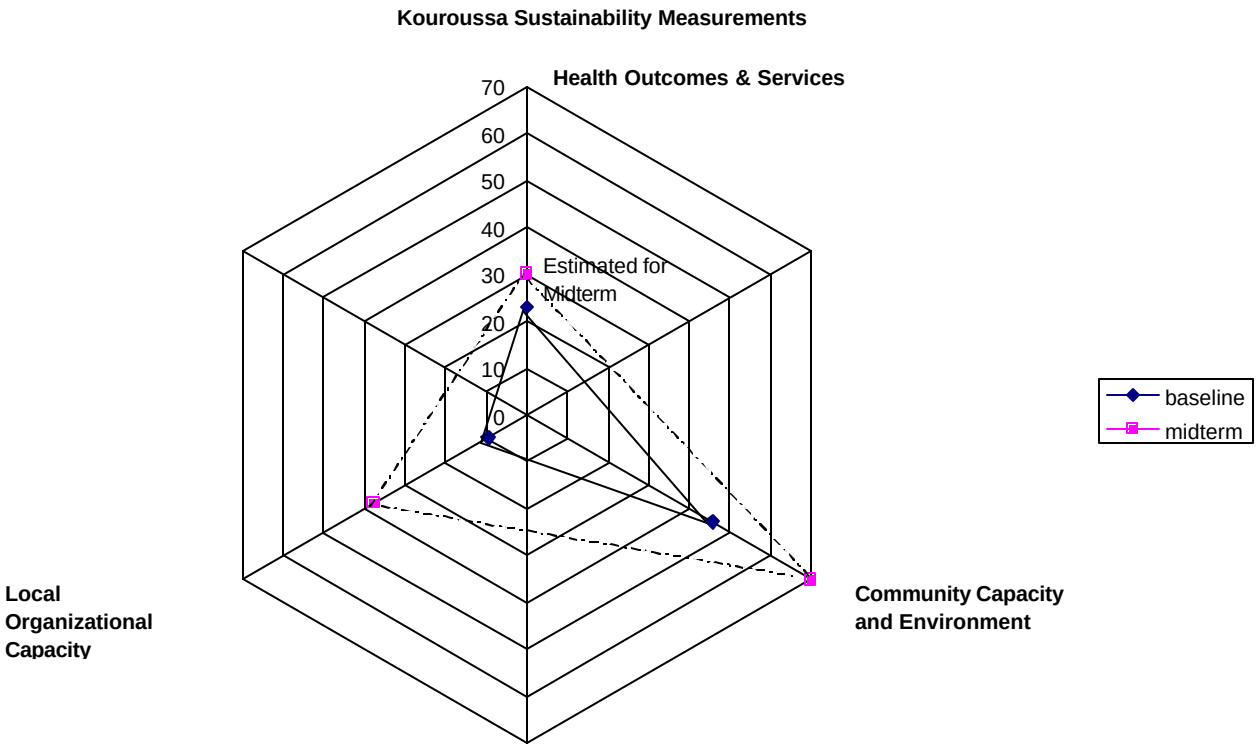
Use Component Index	Aggregation rule	Dimension Index	Mandiana		Kouroussa	
			Baseline	Mid-Term	Baseline	Mid-Term
1.1 1.2	Mean of 1st component and of 2nd component	**DIMENSION 1**	37	Not measured	23	Not measured but TBAs trained & equipped
2.1 2.2	Mean of 1st component and of 2nd component	**DIMENSION 2**	43.5	76.5	45.5	70
3.1 3.2	Mean of 1st component and of 2nd component	**DIMENSION 3**	32	40.1	9.5	37.5

The above values for each district are graphically displayed in radar graphs below.

DISTRICT of Mandiana



DISTRICT of Kouroussa



Annex G: CSGHP Data Form

Child Survival Grants Program Project Summary
Mid-Term Submission: Oct-25-2004

Field Contact Information:

First Name: Dunni Damou

Last Name: Goodman Kieta

Address:

City: Kankan

State/Province:

Zip/Postal Code:

Country Guinea Guinea

Telephone: 224 710725

Fax: 224710726

E-mail: dgood1980@yahoo.com savegnea@sotelgui.net.gn

Project Web Site:

Project Information:

Project Description:	This four-year Child Survival-18 Program, The Community Health Initiative for the Districts of Mandiana and Kouroussa, is a partnership between SC (SC), the two District Health Offices and a local non-governmental organization (NGO). This partnership builds on the extensive programming experience of SC in Guinea. It will address the primary causes of child and maternal mortality in an underserved, poor, and remote area of Guinea. SC and its partners will combine their resources and experience, and apply these towards improving child survival in Guinea by: (1) Increasing the use of key health services and improved MCH practices at the household level; and (2) Increasing the capacity of local entities (the district health offices, the local NGO, community organizations) to assume responsibility for health activities and adopt innovative CS-18 approaches. SC Sahel's extensive experience, capability, and credibility in community mobilization, maternal and child health interventions, and capacity building of partners in Guinea, position this partnership well to play an important role in the most needy regions of this country.
Partners:	District Health Offices and 2 Guinean NGOs
Project Location:	Districts of Kouroussa(expanded area for CS XVIII) and Mandiana(original project site in CS XIV project)

Grant Funding Information:

USAID Funding:(US $)	$1,400,000	**PVO match:(US $)**	$416,675

Target Beneficiaries:

Type	Number
infants (0-11 months):	17,080
12-23 month old children:	17,080
24-59 month old children:	51,242
0-59 month old children:	85,402
Women 15-49:	106,753
Estimated Number of Births:	73,774

Beneficiary Residence:

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

General Strategies Planned:

Private Sector Involvement
Advocacy on Health Policy
Strengthen Decentralized Health System
Information System Technologies

M&E Assessment Strategies:

KPC Survey
Organizational Capacity Assessment with Local Partners
Organizational Capacity Assessment for your own PVO
Participatory Rapid Appraisal
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for midterm or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Mass Media
Interpersonal Communication
Peer Communication
Support Groups

Capacity Building Targets Planned:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
CS Project Team	Local NGO	Traditional Healers	Dist. Health System Health Facility Staff Other National Ministry	Health CBOs CHWs

Interventions:

Immunizations 10 **%**
** CHW Training
** HF Training
*** Polio

*** Classic 6 Vaccines
*** Vitamin A
*** Surveillance
*** Mobilization
Nutrition 15 **%**
** IMCI Integration
** CHW Training
** HF Training
*** ENA
*** Comp. Feed. from 6 mos.
*** Hearth
*** Cont. BF up to 24 mos.
*** Growth Monitoring
*** Maternal Nutrition
Vitamin A 5 **%**
** IMCI Integration
** CHW Training
*** Supplementation
*** Post Partum
Micronutrients 10 **%**
** CHW Training
*** Iodized Salt
*** Iron Folate in Pregnancy
Maternal & Newborn Care 40 **%**
** IMCI Integration
** CHW Training
** HF Training
*** Emerg. Obstet. Care
*** Neonatal Tetanus
*** Recog. of Danger signs
*** Newborn Care
*** Post partum Care
*** Delay 1st preg Child Spacing
*** Integr. with Iron & Folate
*** Normal Delivery Care
*** Birth Plans

*** STI Treat. with Antenat. Visit
*** Control of post-partum bleeding
*** Emergency Transport
HIV/AIDS 20 **%**
** CHW Training
*** Behavior Change Strategy
*** Access/Use of Condoms
*** STI Treat. with Antenat. Visit
*** ABC

Indicator	Numerator	Denominator	Estimated Percentage	Confidence line
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	0	0	0.0	0.0
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	0	0	0.0	0.0
Percentage of children age 0-23 months whose births were attended by skilled health personnel	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	0	0	0.0	0.0
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	0	0	0.0	0.0
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	0	0	0.0	0.0
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	0	0	0.0	0.0
Percentage of children age 12-23 months who received a measles vaccine	0	0	0.0	0.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two	0	0	0.0	0.0

signs of childhood illness that indicate the need for treatment				
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	0	0.0	0.0

Comments

TB Indicator			
Indicator	**Numerator**	**Denominator**	**Estimated Percentage**
% of new smear positive cases who were successfully treated	0	0	0.0

HEALTH PROGRAM
CS - 18
KOUROUSSA

Annex H. Action Plans

COMMUNITY HEALTH INITIATIVE PROJECT: ANNUAL PROGRAM PLAN
Fiscal Year : October 2004 - September 2005

OBJECTIVES	Target Population	ACTIVITIES	PERIOD T1	T2	T3	T4	RESULTS expected	achieved	Indicators	Responsible Party	Method of verification
I. Vaccination											
1- 90 % of infants receive one dose of BCG before the age of one year	children 0-11 mo. old	Fixed Site Vaccination	X	X	X	X	12HC		# of children vaccinated	HW/HC Manager	
		Retrain VHC in EPI especially on management of side effects	X	X	X	X	42 VHC		# of VHC retrained	NGO district team	Animator Reports
		Retrain NGOs in EPI especially on management of side effects	X				6 Anim.		# of NGO workers retrained	NGO District Team and HW	Training report
2- 80 % of infants receive DTP3 before the age of one year		Outreach visits micro-plan	X		X		24 MP		# of MP	Anim./EPI Agent	HC OV notebook/Anim. report
		Execute outreach visits	X	X	X	X	576 OV		# of OV executed	EPI Agent/Anim./VHC	HC OV notebook/Anim. report
3- 80 % of infants receive measles before the age of one year	children 0-11 mo. old	BCC Sessions focusing on (1) importance of vaccinations and the vaccine schedule; and (2) side effects and their management	X	X	X	X	1464-VHC 330-Anim.		# of BCC sessions	EPI Agent/Anim./VHC	notebook act.VHC Activity Reports
		WRA to reach	X	X	X	X	24634		# of women	EPI Agent/Anim./VHC	VHC notebooks, rapp act
4- 80 % of children receive all necessary vaccinations before the age of one year 5- Reduce the dropout level from 27% to 15%	children 0-11 mo. old husbands mothers of infants 0-11 months old	Active case finding	X	X	X	X	144		# of cases	EPI Agent/Anim./VHC	registre d'activ.VHC/rapp.Ani/
		Retrain HW in EPI Train VHC	X	X X	X X	X	12 HC/10 HP 38 VHC		# of HW retrained # of VHC trained	District Advisors HW/NGO	Activity Reports Modules + Reports
6- Increase the use of advanced strategies to 85%	Health workers	Outreach visits micro-plan	X		X		24		# of microplans in SA		HC
		Execute outreach visits	X	X	X	X	12 HC		# of OV exec.	EPI Agent/Anim./VHC	HC OV notebook/Anim. report
		Active case finding	X	X	X	X	144		# of cases		registre d'activ/VHC
II-Maternal and Newborn Care											
1- 80% of mothers with infants aged 0-23 months receive two doses of TT during pregnancy, before their ninth months	pregnant women	Retrain HW	X	X	X	X	22		# of HW retrained	DPS/Save Coord.	Reports
		Retrain NGO personnel	X				6		# of personnel retrained	SC District Team/DPS	Activity Report
		Provide HC with TT vaccine medicines	X	X	X	X	12 HC		# of HC provided with TT & medicines	DRS/DPS/Save	Stock record HC/DPS order

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
2- 80% of mothers with children aged 0-23 months receive 3 prenatal consultations during their pregnancies, one of which is during the 9th month	pregnant women	BCC Sessions favoring women of childbearing age	X	X	X	X	1464 330		# BCC sessions	VHC/Anim/District Team	Reports
			X	X	X	X	24634		# of women	VHC/An/District Team	VHC registers, Report
		Organize outreach visits	X	X	X	X	576 OV		# of OV	VHC/HW/Anim./Advisors	HC OV notebook/VHC Report Report Anim.
		Organize active case finding sessions	X	X	X	X	144 sessions		# of sessions	VHC/HW/Anim/Save	Reports
		Organize mini-campaigns		X		X	2 mini campaigns		# of mini-campaigns	Save/DPS	Report
		Advocacy on the availabily of health cards	X	X	X	X	# of visits		# of visits	Save	Report
3- 80% of pregnant women use iron folate supplementation during their pregnancy	pregnant women	Implicate local/rural radio stations to broadcast messages		X	X	X	1 broadcast 3 rebroadcasts		# of broadcasts	SC Health Coord.	notebook of VHC activities Technical record cassettes
4- 80% of pregnant women use la chloroquine prophylaxis (or IPT when introduced) during their pregnancy	pregnant women	Prenatal visits	X	X	X	X	12 HC		# of ANC	HW/Advisor	ANC card
5- 80% of pregnant women are attended by a trained health worker while gving birth.	Pregnant women	Retrain TBA	X	X	X	X	45		# of TBA	NGO/HW/Save Advisor	Reports
		Train TBA		X	X		38 AV		# of TBA	Save/DPS	Report
		Train HW		X			13 HW		# of HW	Save/DPS	Report
	husbands	Integration of post-natal consultations during vaccination activities (outreach visits) Post-natal visits	X	X	X	X	12 HC		# of ANC2	HW/Advisor DPS	Review notebook
6- 60% of mothers with infants aged 0-23 months receive at least two postnatal visits by a trained healthworker, one of which occurs in the first week after giving birth.	mothers of infants 0-23 months old	post natal visit	X	X	X	X	80		# of TBA postnatal visits	TBA	VHC registers
		Diminish costs by establishing a system of price regulation forms	X	X	X	X	80 forms		# of forms	Save/DPS NGO	Forms

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
7- 60% of mothers with infants aged 0-23 months can identify at least two signs of danger during pregnancy and post-partum.	WRA	Organize BCC sessions	X	X	X	X	1464 330		# BCC sesions	VHC/NGO/HW/Advisor	VHC notebooks/rap An
		WRA to reach	X	X	X	X	24634		# of women	Ani/VHC	Reports,notebook VHC
8- 80% of mothers with infants aged 0-23 months who experience difficulties during pregnancy are refered to a health center or hospital	leaders	Reinforce MURIGA funds	X	X	X	X	80		# of MURIGA reinforced	VHC/NGO/DPS / Save	notebook de gestion
	WRA	Create MURIGA			X	X	38		# of MURIGA	NGO/DPS /Save Save	Reports
	community	Train local treasurers in MURIGA management			X	X	42 tresurers		# of tresurers trained	NGO/DPS Save	Report de formation
		Organize village workshops		X			1 workshop		# of workshoHP	NGO/DPS /Save Save	Reports
III - HIV/AIDS/STD											
1- 80 % of husbands use condoms with extramarital sexual partners	husbands	Retrain peer educators	X	X	X	X	160		# of peer educators retrained	Anim/NGO/DPS	Reports
		Train peer educators		X	X		106		# of PE trained	NGO/DPS Save	Training report
		BCC Sessions	X	X	X	X	1464 330		# of BCC sessions	agent BCC NGO Animator	Report BCC Report d activites
2- 80 % of mothers can name at least two methods to prevent HIV/AIDS	mothers	Provide health structures/	X	X	X	X	12 HC		# of HC stocked	Save/DRS/DPS	Report Save/DPS/
3- 4 Leaders per village are trained in the prevention of HIV/AIDS	Leaders	HW with medicine and contraceptives.									DRS
4. 80% of child bearing age know that condoms can be used to prevent the infection of HIV/AIDS	WRA	Community education sessions									
		Condom sales	X	X	X	X	17568		# of condoms sold	Agents BCC	Report BCC
		Discussions with village leaders	x	x	x	x	320		# of leaders	Anim./VHC	Reports/Reg.VHC
5- 80% of adolescents know that condoms can be used to prevent the infection of	Adolescents	BCC Sessions	X	X	X	X	120		# of sessions	Anim	Reports
6- Reduce STD infection among mothers from 20 à 10%		Debates	X	X	X	X	4		# of debates	An/AC/BCC/HW/Save	Reports
		Video projection	X	X	X	X	6		# of video projections	An/AC/BCC/HW/Save	Activity Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
7. Increase the number of people with STDs who seek medical attention from 56 a 90%.	Prostitutes	Organize orientation sessions with village leaders		X		X	6		# of orientation sesions	Save/HW An/AC/BCC/HW	Activity Reports
		Identify zones frequented by prostitutes,miners, truck/taxi drivers, and military personnel		X			5		# of zones identified	Advisor/Anim.	Reports
		Organize BCC sessions with prostitutes.		X	X	X	9		# of BCC sessions	Save/anim.	Reports
	Miners	Organize BCC sessions with miners.		X	X	X	9		# of BCC sessions	Save/anim.	Reports
	Truck/taxi drivers	Organize BCC sessions with truck/taxi drivers		X	X	X	9		# of BCC sessions	Save/anim.	Reports
	Military	Organize BCC sessions with military personnel							# of BCC sessions	Save/anim.	Reports
			X	X	X	X	1464-VHC 330 Animators		# of BCC sessions	VHC Ani/Save	Reports VHC Registers
		WRA reached	X	X	X	X	24634		# of women	Ani/VHC	VHC Registers
		Conduct a 'doer/nondoer' survey for husbands regarding their condom use with extramarital sexual partners.		X			1		# of surveys completed	Save/DPS NGO	Study Report
		Husbands reached	X	X	X	X	12317		# of husbands	VHC/Anim	VHC Registers Activity Reports
		Adolescents reached	X	X	X	X	14977		# of adolescents	Ani/VHC	VHC Registers Activity Reports
IV- NUTRITION											
1. 40% of mothers breastfeed their newborns in the first hour after birth		Retrain Animators especially on complementary feedings and maternal nutrition during BF	X				6 NGO		# of animators retrained	Save	Reports
2- 60% of mothers breastfeed, and give	mothers	Train HW		X			13		# of HW trained	Save	Reports
their infants exclusively breast milk, for the first 6 months after birth	leaders grand-mothers	Organize BCC Sessions especially on complementary feedings and maternal nutrition during BF	X	X	X	X	1464 330-Moder.		# of sessions	Anim VHC	Activity Reports notebook VHC
(from41-60%)		BCC Sessions	X	X	X	X	24634		# of women	Ani/VHC/	Activity Reports notebook VHC
	husbands	Organize EBF week				X	1		# of EBF weeks	NGO/Save/DPS	Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
3- 80% of infants receive complimentary foods between 6-9 months of age.	infants aged 0-35 months	Create and reinforce cereal banks	X	X	X	X	80		# of cereal banks restocked	Anim/VHC	Report
4- Diminish moderate and severe malnutrition from 30% to 15%		Organize nutritional demonstrations	X	X	X	X	960 demonstrations		# of demonsrations	Nut./VHC/Anim./Advisor	VHC notebooks/Reports
		Organize hearths - 1 per moderator per year with levels of malnutrition < or = 30%	X	X			6		# of FARN	Nut./VHC/Anim.	Animator Reports
		Orgainize information days with public cryers to plan for the monthly weighing days	X	X	X	X	720				
		Monthly baby weighings for infants aged 0 - 35 months	X	X	X	X	720		# of monthly weighings	Nut/VHC./animateur/Sav	notebook d'act. VHC VHC Activity Reports
		# of children to be weighed	X	X	X	X	14780 infants		# of infants weighed	VHC/HW Ani	VHC registers
5- 95% of children aged 6 to 59 months receive one dose of vitamine A every six months	WRA	DistributeVit A to children aged 6-59 months	X		X		23,402		# of infants 0-69 months	Save/DRS/DPS NGO/VHC	District Report Vit.A.
6- 60% of postpartum women will receive 2 doses of Vit A within 6 weeks of delivery	mothers of children aged 6-59 months	Organize BCC sessions regarding the importance of eating foods rich in Vit A	X	X	X	X	1464-VHC 330 Animators		# of BCC sessions	NGO/VHC/HW/ Save	Animator Reports VHC Activity Reports
		Mothers with children aged 6-59 months reached	X	X	X	X	7489		# of mothers		Animator Reports VHC Activity Reports
		Provide HC/HP/TBA and hospitals with Vit A capsules	X	X	X	X	12HC/ 10 HP 80 AV		# of HC/HP/AV provided with Vit.A.	Unicef/HKI/DRS DPS/Save.	Vitamin A distribution Report
		Negociate with the school health administration to provide mebendazole to pre-school aged children		X	X		1 negociat		# of negociations	Coord programm	Report

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
7- 70% of households use iodized salt in family meals	WRA	Organize BCC sessions discussing the importance of iodized salt	X	X	X	X	1464 330		# of BCC sessions	VHC/NGO	NGO report VHC Activity Reports
		WRA reached					24634		# of WRA		Animator Reports/VHC registers
		Organize monitoring sessions of the salt which is sold and consumed.	X	X	X	X	3200 lots of salt to be tested		# of salt lots tested	VHC/NGO	Iodized salt test form
	Heads of households	Retrain VHC about the importance of iodized salt	X	X	X	X	80 VHC		# VHC retrained	NGO/DPS/Save	NGO report/DPS report Save
		Retrain moderators about the importance of iodized salt	X				6 Animators		# of NGO personnel retrained	DPS/Save	Reports
		Train healthworkers and VHC about the importance of iodized salt.		X	X		13 HW 38 VHC		# of HW and VHC trained	DPS/Save NGO	
V- FAMILY PLANNING											
1- 50% of mothers with children under 2 years old who do not wish to have another child in the next two years use modern contraceptive methods (37% baseline)	WRA	Retrain NGO personnel on management of side effects	X				6 NGO		# of NGO personnel retrained	District Teams	Training reports
		Train HW on CBD		X			13 HW		# HW trained		
	Husbands Leaders	On site training especially on management of side effects	X	X	X	X	22 HW 168 AC		# of HW and AC trained	Save/DPS	Reports
		Train CBD agents		X	X		76		# of CBDA trained	DRS/Save	Reports
		Organize monthly meetings between CBDA and HW	X	X	X	X	144		# of monthly meetings held	HW/NGO	HC
		Establish a reserve stock	X				1		# of stock	District Teams	Delivery report
		Organize BCC sessions	X	X	X	X	1464 330		# of BCC sessions	VHC/NGO	Report NGO/VHC registers
		WRA to reach	X	X	X	X	24634		# of WRA	Ani/VHC	Report NGO/VHC registers
		Discussions with traditional and religious leaders, and local officials	X	X			320 leaders		# of leaders	NGO/Save	NGO/Save reports
		Provide CBDA/HC with contraceptives and management tools	X	X	X	X	12 HC 160 AC		# of provisions	DPS/HC	DPS/Save reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD T1	T2	T3	T4	RESULTS expected	achieved	Indicators	Responsible Party	Method of verification
VI- SUSTAINABILITY											
1- 80% of villages have CBD agents who supply contraceptives.		Continuous supervision of CBDA VHC	X	X	X	X	80 VHC 160 CBDA		# of VHC retrained # of CBDA retrained	HW	Reports
		Create VHC	X				80 VHC		# of VHC created		Save/DPS/NGO
2- 80% of villages have a system of renewable funds for the wellbeing of pregnant women and children from 0-5 years old	WRA,unions VHC,Leaders Community	Train treasurers in management techniques		X	X	X	80 VHC		# of tresurers trained in management skills	NGO/Save	Reports
3- 80% of women are capable of planning, monitoring, and evaluating health-related activities in their villages.	VHC,Leaders	Retraining in monitoring and	X	X	X	X	80 VHC		# of VHC retrained	NGO/Save	Reports/module
		evaluation		X	X	X	6 NGO		# of NGO personnel trained	Coordinators	Reports/module
		PRA training			X		3 Save		# of people trained	Health Coord.	Reports
		Negotiate literacy trainings			X	X	1 negoc.		# of neg.	Coord.district NGO Advisor	Reports
		Joint data collections									
		Establish VHC micro-plans	X				42 micro plans		# of micro plan established		Module
4- 80% of villages have a plan for health development	VHC,Leaders	Reinforce VHC/NGO/DPS competencies	X	X	X	X	80 VHC 1 DPS 1 NGO		# of VHC, DPS et NGO reinforced		Training reports Training module
		Institutionalize VHC		X	X		80 VHC		# of VHC institutionalized		Agreements, SRI
		Establish Plans			X	X	80 PVDS		# of PVDS	Anim./superviseur Advisor.NGO	Reports
5 - Reinforce the capacity of NGOs and the DPS		Training in negotiation techniques		X			3 Save personnel 6 NGO personnel		# of Save personnel # of NGO personnel	Save	Reports Module
		Install the HIS database	X	X			1		# of DPS staff trained	M&E Coord.	Coord. Report

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
VII-SUPERVISION & MONITORING AND EVALUATION											
	VHC	Monthly support visits	X	X	X	X	11		# of monthly visits	Advisors	Reports
	NGO	Bimonthly suppport visits	X	X	X	X	6		# of bim. visits	Coord.program.	Reports
1 - 100% of personnel and structures	NGO/SC	Quarterly supervision visits	X	X	X	X	4		# of trimest. Supervisions	Coord.district	Reports
implicated in CS-18 are visited and	HW	Joint supervision Joint report writing	X	X	X	X	4		# of joint super.	CD/DPS/CP	Reports
technically supported		Statistical data collection	X	X	X		12		# of reports	Animators	Statatistical forms
		Monitoring		X		X	2		# of monitorings		
		Report production	X	X	X	X	4		# of reports	M&E Coord.	Statistical Reports
		Monitoring NGO improvement plan				X	1		# of plans	NGO Advisors	Report Plan
		Create pictoral report forms	X				5		# forms	SAVE	revised data form
		Test pictoral report forms	X	X	X	X	5		# VHCs tested	SC/Animators/VHC	revised data form
		Workshop to review the VHC HIS system	X				1		# notebooks eliminated	M&E Coord.	M&E Coord. Report
		Monthly coordination meetings	X	X	X	x	12		# of meetings	DPS/District Teams	Meeting reports

Abbreviations: HC = Health Center, VHC = Village Health Committee, WRA = women of reproductive age, OV = outreach visits, HP = health post
TT = tetanus toxoid, DPS = District Health Office, DRS = Regional Health Office, HW = health worker, BCC = behavior change communication
CBD = community-based distribution, CBDA = CBD Agent

SAVE THE CHILDREN/USA/GUINEA
HEALTH PROGRAM
CS - 18
MANDIANA DISTRICT

COMMUNITY HEALTH INITIATIVE PROJECT: ANNUAL PROGRAM PLAN
Fiscal Year : October 2004 - September 2005

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
I- IMMUNISATION											
		Fixed site vaccination	X	X	X	X	12HC		# of vaccinated infants	Save/DPS/NGO	HC
1- 90 % of children receive one dose of BCG before their first birthday		Retrain VHC in EPI especially on management of side effects	X				133 VHC		# of retrained VHC	NGO/District Team	Animator Report/Save
		Retrain NGOs in EPI especially on management of side effects	X				3 Animators		# of retrained NGO members	District Team/AS	Report Activity
2- 80 % of children receive DTC before their first birthday		Outreach Micro-plans	X		X		24 MP		# of OV micro-plans	Animator/EPI Agent	HC OV notebook/Animator report
		Execution of Outreach Visits	X	X	X	X	576 OV		# of OV executed	EPI Agent/Anim/VHC	HC OV notebook/Animator report
3- 80 % of children receive Rouvax before their first birthday	infants 0-11 months old	BCC Sessions focusing on (1) importance of vaccinations and the vaccine schedule; and (2) side effects and their management	X	X	X	X	3192 ses.		# of BCC sessions implemented	HW/Anim./VHC	VHC activity notebook
			X	X	X	X	144		# of Active Case finding sessions	EPI Agent/Anim/VHC	VHC activity notebook/Animator report
4- 80 % of children receive all their vaccines before their first birthday	husbands	HW Retraining in EPI	X	X	X	X	12 HC/17HP		# of retrained HW	Advisors	Report Activity
	mothers of infants	Women's Participation in BCC Sessions	X	X	X	X	50797		# of female participants in BCC sessions	Animators	Report Activity
5- Reduce the level of abandonment from 27% to 15%		Men's Participation in BCC Sessions	X	X	X	X	25399		# of male participants in BCC sessions	Animators	Report Activity
6- Increase the level of advanced strategies to 85%	health workers	Outreach Micro-plans	X		X		24 MP		# of OV micro-plans	EPI Agent/Anim/VHC	HC
		Execution of Outreach Visits	X	X	X	X	12 HC		# of OV executed	EPI Agent/Anim/VHC	HC OV notebook/Animator report
		Case finding sessions	X	X	X	X	144		# of sessions	EPI Agent/Anim/VHC	VHC activity notebook

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
II-MOTHER AND INFANT HEALTH											
1- 80% of mothers with infants aged 0-23 months receive two doses of Vit.A during pregnancy before the 9th month	pregnant women	HW Retraining	X	X	X	X	29 HW		# of HW retrained	DPS//Save	Reports
		NGO Retraining		X			6 NGO Animators		# of Animators retrained	District Team/DPS	Report Activity
		Provide HC with VAT/medicines	X	X	X	X	12 HC		# of HC provided with Vit. A	DRS/DPS/Save	Stock book
2- 80% of mothers with infants aged 0-23 months receive 3 prenatal consultations, one of which is during the 9th month of pregnancy.	pregnant women	BCC Sessions	X	X	X	X	3192 sessions		# of BCC sessions	VHC/HW/Anim/Save	Reports
		Organize active case finding	X	X	X	X	144 AC		# of sessions	VHC/HW/Anim/Save	Reports
3- 80% of pregnant women take iron folate supplementation during pregnancy	pregnant women	Implicate local radio stations to diffuse the messege		X	X	X	3		# of radio broadcasts	Health Coord.	Technical Report
4- 80% of pregnant women take chloroquine or IPT during pregnancy	pregnant women	Prenatal visits	X	X	X	X	12 HC		# of ANC	HW/Advisor	ANC cards
		Implicate local radio stations to diffuse the messege		X			1		# of radio broadcasts	Save/NGO/VHC/DPS	Technical Report
		Women's participation in BCC sessions	X	X	X	X	50797 WRA		# of female participants in BCC	\	Reports
		Men's participation in BCC sessions	X	X	X	X	25399 husbands		# of male participants in BCC	Animators	Reports
		Participation of pregnant women in BCC sessions	X	X	X	X	9143 WRA		# of pregnant women participants in BCC	Animators	Reports
	pregnant	AV Retrainings	X	X	X	X	133		# of TBA retrained	NGO/HW/Save	Reports
5- 80% or pregnant women are attended by a trained health worker when giving birth	husbands	Integrate post-natal consultations with vaccination activities (advanced strategy)	X	X	X	X					notebooks
6- 60% of mothers with infants aged 0-23 months receive at least two post-natal visits by a trained health worker, with one visit in the first week after giving birth	mothers of infants 0- 23 months	Post-natal visits	X	X	X	X	133 TBA		# of post-natal visits by TBA	TBA	ANC cards/Animator report
7- 60% of mothers with children aged 0-23 months can identify at least 2 danger signs during pregnancy and post-partum	WRA	Organize BCC sessions	X	X	X	X	3192 Sessions		# of BCC sessions	VHC/NGO/AS/cons. SR	VHC notebooks/Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
8- 80% of mothers with children aged 0-23 months who have complications during their pregnancies are refered to a health center or hospital	WRA,community leaders	Renforce MURIGA	X	X	X	X	133 VHC		# of MURIGAs reinforced	VHC/NGO/DPS /Save	Management Notebook
		Evaluation of MURIGA accounting committees	X	X	X	X	133 comit.		# of committees evaluated	NGO/DPS /Save	Reports
		S/P Committee retraining	X	X	X	X	12 Com.		# of committees	NGO/DPS /Save	Reports
III - HIV/AIDS/STD											
1- 80 % of husbands use condoms with extramarital sexual partners	husbands	Peer Educator Retraining	X	X	X	X	120		# of peer educators retrained	Anim/supe.NGO/Consei.	Reports
		Mandiana II VHC theatre production	X	X	X	X	4		# of productions	Animator/VHC	Reports
		BCC Sessions	X	X	X	X	6384 Sessions		# of BCC Sessions	CBDA	Report SBC
2- 80 % of mothers know at least two methods to prevent HIV/AIDS	mothers	Provide health centers/AC with contraceptives and medicine	X	X	X	X	12 HC		# of HC stocked.	Save/DRS/DPS	Report Save/DPS/
3- 4 Leaders per village are trained in HIV/AIDS prevention	Leaders	Discussions with village Leaders	X	X	X	X	177		# of discussions	Animators	Reports
4- 80 % of women of child bearing age know that condoms can be used to prevent the transmission of HIV	WRA	Condom sales	X	X	X	X	38304		# of condoms sold	CBDA	Report SBC
5- 80 % of adolescents ages15-24 know that condoms can be used to prevent the transmission of HIV	Adolescents	Discussions with youth groups	X	X	X	X	60		# of discussions	Animator/HW/CBDA	Reports
6- Reduce STD infection in mothers from 20% to 10%		Debate	X				1		# of debated held	Animator/HW/CBDA	Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
7- Increase the number of STD-infected mothers seeking medical attention from 56% to 90 %>		Video Projection	X			X	2		# of projections	Animator/HW/CBDA	Activity Report
		Round table discussions		X			1		# of round table discussions	Animator/HW/CBDA	Activity Report
		Identify zones frequented by prostitutes, miners, and truck/taxi drivers		X			1		# of zones identified	Advisor/Animator	Reports
		Organize BCC sesions with prostitutes		X	X	X	9		# of BCC Sessions	Save/anim.	Reports
		Organizer BCC sessions with miners		X	X	X	9		# of BCC Sessions	Save/anim.	Reports
		Organize BCC sesions with truck/taxi drivers		X	X	X	9		# of BCC Sessions	Save/anim.	Reports
		Organize BCC sessions with military personnel	X	X	X	X	4		# of BCC Sessions	Save/Anim.	Reports
		Conduct a survey of 'do/not do' with husbands		X			1		Survey conducted	Save/DPS/ONG	Report
		Women's participation in BCC sessions	X	X	X	X	50 799 WRA		# of female participants	Advisor/Animator	Reports
		Men's participation in BCC sessions	X	X	X	X	25 399 husbands		# of male participants	Advisor/Animator	Reports
		Adolescent's participation in BCC sessons	X	X	X	X	30,884		# of adolescent participants	Advisor/Animator	Reports
IV- NUTRITION											
1- 40% of mothers breastfeed their babies during the first hour after giving birth		Retrain Animators especially on complementary feedings and maternal nutrition during BF	X				6 NGO		# of Animators retrained	Save	Reports
2- 60% of mothers give only breast milk to their babies during the first six months after giving birth	mothers, village leaders	HW retraining		X			31 HW		# of HW retrained	Save	Reports
	grandmothers, husbands	Organize BCC Sessions especially on complementary feedings and maternal nutrition during BF	X		X	X	3192 Sessions		# of BCC Sessions	ONG/Save/DPS	VHC notebook
3- 80% of infants receiving complementary foods between 6-9 months		Organize Exclusive BF week				X	1		# organized	ONG/Save/DPS	Reports
		Restock cereal banks	X	X	X	X	133 banks		# of cereal banks restocked	ONG/Save/AS	Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
4- Decrease moderate and severe malnutrition from 30% to 15%	infants aged 0-35 months	Organize nutritional demonstrations	X	X	X	X	1596 demonstra-tions		# of demonstrations	Nut./VHC/Anim./Consei.	VHC notebook
		Organize hearths		X	X	X	3		# of hearths	Nut./VHC/Mod.	Animator report
		Orgainize information days with public cryers to plan for the monthly weighing days	X	X	X	X	720				
		Monthly weighings for infants aged 0-35 months	X	X	X	X	30 478 weighings		# of weighings	Nut/VHC./moderator/Save	VHC notebook
		Organize baby weighing sessions					1596 Sessions		# of sessions		
5- 95% of children from 6 to 59 months receive one dose of vitamin A every 6 months **6-** 60% of women who have given birth receive two doses of Vitamin A within 6 weeks of delivery	WRA mothers with children aged 6-59 months	Distribute Vit A to all children aged 6-59 months	X		X		48,857		# of children aged 6-59 months having received Vit.A	Save/DRS/DPS/ONG/VHC	Report of Vit.A distribution
		Organize BCC sessions discussing the importance of foods rich in Vit.A	X	X	X	X	3192 Sessions		# of BCC sessions	NGO/VHC/Save	VHC notebook/Animator report
		Provide Vit. A to HC/PS/AV	X	X	X	X	12HC/25 HP/133 TBA		# of HC/HP/TBA stocked with Vit. A	Unicef/HKI/DRS/DPS/Save	Report of Vit.A distribution
7- 70% of households use iodized salt in family meals	WRA	Organize BCC sessions discussing the importance of iodized salt	X	X	X	X	3192 Sessons.		# BCC sessions	VHC/NGO/AS/Save	NGO/DPS/SAVE reports
		Test salt sold in markets and used in households	X	X	X	X	5320 salt lots to be tested		# of salt lots tested	VHC/NGO	test report
	Heads of house holds	Retrain VHC regarding the importance of using iodized salt	X		X		133 VHC		# of VHC/HW retrained	NGO/DPS/Save	NGO/DPS/SAVE reports
		Retrain village moderators regarding the importance of using iodized salt	X		X		3 Mod.		# of moderators retrained	DPS/Save	Reports
		Distribute mébendazole to infants aged 6-35 month		X		X	21335 infants.		# of infants 6-35 months having received mebendazole	VHC/NGO/Save	Report/VHC
		Women's participation in BCC sessions	X	X	X	X	50797 WRA		# of female participants	Advisor/Anim.	Reports
		Men's participation in BCC sessions	X	X	X	X	25399 husbands		# of male particpants	Advisor/Anim.	Reports
		Grandmother's participation in BCC sessons	X	X	X	X	2660 grandmothers		# of grandmothers participating in BCC	Advisor/Anim.	Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
V- FAMILY PLANNING											
1- 50% of mothers with infants younger than 2 years not wishing to have another child in the next two years use modern contraceptive methods (37% baseline)	WRA husbands, village leaders	Retrain NGO personnel on management of side effects	X				6 NGO		# of retrained NGO agents	District Team	Training report
		Train Save personnel	X				1 Save		# of Save personnel trained	District Team	Training report
		On site training especially on management of side effects			X		29 AS		# of HW retrained	Save/DPS	Reports
		Retrain CBDA	X	X	X	X	266 CBDA		# of CBDA retrained	NGO/HW/save	Reports
		Organization of monthly meetings between CBDA and	X	X	X	X	144 meetings		# of meetings actualized	AS/NGO	HC report
		Finalize the evaluation of stock supply		X			1 Eval.		# of evaluations	District Team/DPS	Evaluation report
		Organize BCC sessions and sales of contraceptive products	X	X	X	X	3192 Sessions		# of BCC sessions	VHC/HW/NGO	Reports ONG/ Save
		Organize informative discussions with religious and traditional leaders, and elected officials	X	X	X	X	177 leaders		# of leaders reached	NGO/Save	Rap.ONG/Sav e
		Organize a workshop for the adaptation of management tools	X				1 workshop		Workshop organized	Save	Rap. Atelier
		Women's participation in BCC sessions	X	X	X	X	31 748 WRA		# of female participants	Save/Anim	Reports
		Men's participation in BCC sessions	X	X	X	X	15874 husbands		# of male participants	Save/Anim	Reports
		Provide HC/AC with contraceptives and management tools	X	X	X	X	12 HC 266 AC		# of provisions	DPS/HC	DPS/SAVE reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD T1	T2	T3	T4	RESULTS expected	achieved	Indicators	Responsible Party	Method of verification
VI-MONITORING AND EVALUATION											
	VHC	Monthly visit	X	X	X	X	11		# of visits.	Advisors	Reports
	NGO	Bimonthly supervision	X	X	X	X	6		# of supervisions	Program coordinators	Reports
	NGO/SC	Trimestrial Supervision	X	X	X	X	4		# of supervisions	District coord.	Reports
	HW/NGO	Joint Supervision	X	X	X	X	4		# of supervisions	CD/DPS/CP	Reports
		Statistical data collection	X	X	X	X	12		# of data collections	Animators	Collection forms
		Monitoring	X		X		2		# of monitorings	DPS/NGO/Save	Reports
		Production of reports	X	X	X	X	4		# of reports	M/E	Reports
		Monitoring NGO improvement plan				X	1		# of plans	NGO Advisors	Report Plan
		Create pictoral report forms	X				10		# forms	SAVE	revised data form
		Test pictoral report forms	X	X	X	X	10		# VHCs tested	SC/Animators/VHC	revised data form
		Workshop to review the VHC HIS system	X				1		# notebooks eliminated	M&E Coord.	M&E Coord. Report
		Monthly coordination meetings	X	X	X	x	12		# of meetings	DPS/District Teams	Meeting reports
	DPS	Database installation on DPS premises	X	X			1		# of databases installed	M/E	Reports
VI- SUSTAINABILITY											
1- 80% villages have SBC providors		CBDA/VHC retraining	X	X	X	X	133 VHC 266 AC		# VHC retrained # CBDA retrained	NGO/Save/AS	Reports
2- 80% of villages have a system of renewable funds to aid pregnant women and children aged 0-5 years	WRA, union, VHC, leaders comm.	Management retraining	X	X	X	X	133 VHC		# of VHC retrained	NGO/Save	Reports
		Meeting to review the agreement between VHC and hospital	X				1		Meetings conducted	DPS/NGO/Save	Reports
		Public diffusion of the agreement between VHC and hospital		X			1		# Diffusions	Save/Ani.	
3- 80% of VHC have the capacity to plan, monitor, and evaluate health activities in their villages		Retraining in M/E	X				133 VHC		# of VHC retrained	NGO/Save	Reports/module
	VHC,Leaders	MARP training		X	X		3 NGO/3 Save		# of people trained	Save	Reports/module
		Negotiate literacy training			X	X	1 negoc.		Negotiation realized	Save/Ani.	Reports
4- 80% of villages have a health development plan	VHC,Leaders	Establish Plans			X	X	133 Plans		# of plans	Anim./Conse.NGO	Reports
		Training in negotiation techniques		X			3 Save & 3 NGO staff		# of persons trained	Save	Reports/module

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
5-100% of S/P have a VHC association capable of elaborating and following their PVDS, and of mobilizing funds to be used in health and other areas.	VHC	Creation of VHC associations	X				12 Assoc.		# of associations created	Save/Ani.	Reports
		Elaboration of a village plan for health development		X			1 Plans		# of plans	Save/Ani./VHC/DPS	Reports
		Elaboration of an activities micro-plan	X	X	X	X	1596 micro.		# of micro-plans	Save/Ani/VHC/DPS	Reports
		Training in negotiation techniques			X		12 offices		# of people trained	Save/Ani/VHC/DPS	Reports
		research funds	X	X	X	X	12 searches		# of searches	VHC	Reports
		Institutionnalization of VHC associations			X		12 asoc.		# of VHC's institutionalized	Save/DPS/VHC	Reports
6- 1 DPS has a database donated by Save with which to analyze additional community data		Development or a partnership between the VHC and DPS		X	X	X	1		# of partnerships created	Save/NGO/PDS	Reports
		Conitnual supervision of the VHC by health workers	X	X	X	X	12		# of supervisions	Health workers	Reports
	DPS	Installation of a database on the premises of the DPS	X	X	X	X	1		Database installed	M/E	Reports
7- The NGO AJVDM partners with VHC the DPS to realize health activities in the prefecture.		Training in the research of funds	X	X			1		# of people trained	Health Coord.	Module/Trainin g Report
		Training in M/E		X			1		# of people trained	M/E	Module/Trainin g Report
		Creation of an evaluation of performance	X	X	X	X	4		# of evaluations	district team	NGO/Save
		Reinforcement of the partnership between VHC and DPS	X	X	X	X	1			Save/DPS	
EXIT PLAN											
	VHC	Creation of VHC association	X				12 Ass.		# of associations created	Save/Ani.	Reports
		Trimestrial community meetings between NGO/Save/VHC/AS	X	X	X	X	4		# of meetings	Save/DPS/VHC/Ani,	Reports
		Joint data collection by the DPS/NGO/Save	X	X	X	X	4		# of data collections	DPS/NGO/Save	Reports
		VHC Micro plan	X	X	X	X	1596		# of micro-plans	Save/VHC/Ani/DPS	Reports
		Elaboration of a village plan for health development		X			12 Plans		# of development plans	Save/Ani./VHC/DPS	Reports

OBJECTIVES	Target Population	ACTIVITIES	PERIOD				RESULTS		Indicators	Responsible Party	Method of verification
			T1	T2	T3	T4	expected	achieved			
8- Reinforcement of NGO competencies	NGO	Training in the research of funds	X	X			1 training		# of NGO workers trained	Health Coord.	Module/Report de formation
		M/E Retraining	X	X	X	X	133 VHC		# of people trained.	District Team	Report d'activtés
		Monitoring of plan to improve NGO performance	X	X	X	X	4		# of evaluations	District Team	NGO/Save
		Organization of meetings	X	X	X	X	12		# of meetings	Save/DPS	Reports
9- Development of a partnership between VHC and DPS	DPS	Organization of joint data collections		X	X	X	3		# of collections	Save/NGO/PDS	Reports
		Continual supervision of VHC by health workers	X	X	X	X	12		# of supervisions	Health workers	Reports
		Database installation on DPS premises	X	X	X	X	1			M/E	Reports
OPERATIONAL RESEARCH											
1- Strengthen capacity in OR		Organization of 'do/not do' survey detailing husband's condom usage		X			1		# of surveys	M/E	Reports
		Creation of a village pharmecutical chest	X				1		# of chests	Save/DPS/NGO	Reports

Abbreviations: HC = Health Center, VHC = Village Health Committee, WRA = women of reproductive age, OV = outreach visits, HP = health post
TT = tetanus toxoid, DPS = District Health Office, DRS = Regional Health Office, HW = health worker, BCC = behavior change communication
CBD = community-based distribution, CBDA = CBD Agent