Africare

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TAMBACOUNDA HEALTHY START PROGRAM
Health Districts of Tambacounda and Koumpentoum
in Senegal
(2003-2008)

MID-TERM EVALUATION REPORT

In collaboration with

The Ministry of Health and Prevention
The Health Districts of Tambacounda and Koumpentoum
USAID's Tambacounda Healthy Start Program (THSP)
Africare Senegal

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ACRONYMS

ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CBO	Community Based Organization
CHW	Community Health Worker
DMO	District Medical Officer
HPNOIC	Health Post Nurse Officer in Charge
CS	Child Survival
CW	Community Worker
DIP	Detailed Implementation Plan
EB	Exclusive Breastfeeding
EPI	Expanded Program of Immunization
GMP	Growth Monitoring and Promotion
GOS	Government of Senegal
HE	Health Education
HP	Health Post
JICA	Japanese Agency for International Cooperation
IEC	Information, education, and communication
KAP	Knowledge, Attitudes, and Practices
KPC	Knowledge, Practice and Coverage
LAM	Lactational Amenorrhea Method
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOH	Ministry of Health and Social Affairs
NGO	Nongovernmental organization
NID	National Immunization Days
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
URO/CREN	Oral Rehydration Unit/Center for Nutritional Educational and Rehabilitation
PNC	Prenatal Consultation
PVO	Private and Voluntary Organization
TBA	Traditional Birth Attendant
USAID	United States Agency for International Development
WG	Women's Promotion Groups
WRA	Women of Reproductive Age

A- SUMMARY

The Tambacounda Healthy Start Program (THSP) is a five year maternal and child health program implemented by Africare in the Tambacounda Region of Southeastern Senegal. The program has the goal of reducing maternal and child morbidity and mortality among pregnant women and children under one year of age. The program's five objectives are to:

1) Increase the access to, demand for, and use of quality maternal and child health services, including emergency care;
2) Improve case management of malaria for pregnant women and children under five at the community and health post levels;
3) Improve nutrition of pregnant women and newborns, including promoting vitamin A supplementation and the practice of exclusive breastfeeding;
4) Improve diarrhea recognition and management at community and household levels; and
5) Improve the capacity of local partners to plan, implement, monitor, and evaluate child survival interventions at the community and district levels, with an emphasis on capacity in maternal and newborn health, malaria, nutrition, and breastfeeding.

To date the main accomplishments of the THSP are substantial increases in the number of women attending antenatal clinic and those being assisted by a trained person during delivery. The program's sustained campaign to promote prenatal care to women has also led to the increase in the number of women who are accessing intermittent preventive treatment (IPT) against malaria. In collaboration with partner districts and UNICEF, the program has also increased access to vitamin A supplementation in children and post partum women. Since the program's inception, regular IEC activities have also led to increased use of iodized salt and an increase in the number of caretakers who recognize diarrhea danger signs that need prompt treatment. The percentage of mothers who understand the need to wash their hands at specified times to prevent diarrhea transmission has also doubled from baseline.

Overall, the THSP has progressed towards the attainment of all its objectives and in a few instances may have already exceeded some targets. Given the program's late start and the many challenges facing the program team these results are commendable. However, much remains to be done. The program will need to address those indicators that seem to be in decline compared to the baseline, such as the prevalence of underweight children (which increased slightly from 20% at baseline to 23.5%). The program managers have asked to validate certain results of the mid-term KPC that indicate large increases over the baseline KPC. Given the THSP's focus on health promotion this may be more an indication of a high level of sensitization in the population, rather than an actual change in behavior. The respective indicators will be discussed in the appropriate technical sections.

The main constraints affecting program implementation are a lack of sufficient financial and human resources to cover the vast program area of the Tambacounda region. Villages tend to be small and dispersed and the roads are some of the worst in Senegal. While the program's capacity building has significantly improved access to, demand for, and utilization of community health services, it has also prompted an increase in referrals to district health posts and regional health centers for emergency services and more complex care. This increase in referrals is of some concern to district and regional health service providers; they

are worried about their ability to meet a rising demand given the public health system's lack of human, logistical, and infrastructural resources in the Tambacounda region.

The program has made some progress in grounding its sustainability plan. It has established Village Committees that are designed to continue child survival activities once the program ends. To date, the program has created 209 Maternal Care Groups and has trained 235 Community Health Workers (CHWs) in health promotion and facilitation. A functional cost-recovery scheme allows the CHWs to earn a small stipend from each medicine or insecticide treated bednet (ITN) that they sell. In addition, the program is poised to launch its micro-credit component, which should further contribute to sustainability.

Thus far, the program has limited its monitoring activities to collecting process data and has not yet established a system to collect impact data to regularly measure behavior change. The establishment of such a system will allow the program to validate the mid-term KPC results, and provide a framework for decision-making, allowing program managers to make more efficient use of limited resources. Below is a selected list of conclusions and recommendations from the evaluation.

Conclusion #1: The program's levels of human resources in the original program design are inadequate to account for the realities of the program area (vast territory, geographically dispersed villages, semi-nomadic populations, and poor road infrastructure). Since its inception, the THSP has been understaffed (operating during the first two years with only three supervisors for the entire zone). Recommendation: Scale down the planned total number of program villages and the number of targeted beneficiaries to strengthen program implementation. Improve workload distribution by hiring more supervisors for the remainder of program implementation.

Conclusion #2: Certain line items in the program are under-budgeted for the scope of program activities. Recommendation: Realign the budget and locate additional funding to strengthen program activities with additional human resources and equipment.

Conclusion #3: To date, the program has only collected data for monitoring purposes and has not evaluated progress towards achieving program objectives on a regular basis. Recommendation: Hire a Monitoring and Evaluation Specialist to carry out these activities.

Conclusion #4: The Maternal and Child Health intervention appears to be the strongest component, achieving and even exceeding some of its targets. While the number of births assisted by trained personnel has risen from 45% to 65%, there is still a signal lack of trained birth attendants in the intervention zone (for the 137 program villages in Tambacounda district, there are only 24 TBAs, nearly half of whom are in the urban setting of Tambacounda commune. Recommendation: Help identify those CHWs who meet the minimum requirements for becoming TBAs and work with the communities and the health districts to facilitate the training of these candidates. Provide refresher training in reproductive health including prevention of infection.

Conclusion #5: While the Child Survival component (nutrition, diarrheal, and malaria prevention and management) is making progress towards its objectives, it needs additional strengthening. Recommendation: Reinforce complementary feeding, nutrition management of the sick child and diarrheal management with ORS. Collaborate with the *Bureau Régional de L'Alimentation et de la Nutrition* (BRAN) on technical aspects of the nutrition component.

Conclusion #6: The Health District facilities have difficulty meeting the increased demand for services resulting from THSP referrals and increased health seeking practices. This is due to lack of adequate medical equipment, facilities, and trained human resources.

Recommendation: Seek outside collaborating agencies who will help equip health facilities in obstetric emergency equipment and train district staff

Grantee's response to the MTE recommendations:

Recommendation: Scale down the planned total number of program villages and the number of targeted beneficiaries to strengthen program implementation. Improve workload distribution by hiring more supervisors for the remainder of program implementation.

Response: In May 2006, the program hired six additional experienced supervisors, which brings the total number of program supervisors to nine. The program also received a matching grant from Pfizer which pays for the salaries of several of these supervisors. The actual number of program villages is presently 155 central villages and 174 satellite villages. This represents 82% of the end of program target of 400 villages. However, the program managers anticipate that some of the villages that were recruited in the first years of the program will no longer require the same intensive level of supervision in the second half of the program, thus allowing the supervisors to extend their coverage while improving workload distribution. The program team will review the salary line item of the THSP budget to determine whether of not it will be financially feasible to hire additional supervisors. They will also explore the possibility of further matching grants for the same purpose.

Recommendation: Realign the budget and locate additional funding to strengthen program activities with additional human resources and equipment.

Response: Because of the late start of program activities, Africare did not spend the budgeted program amount in year 1 of the program. Savings were especially significant in the "local salaries" line item. This allowed Africare to recruit additional supervisors in year 3. However, a realignment of budget line items is necessary (the logistical and general subsistence line items are almost exhausted, for instance). Africare will seek a modification of agreement (MAARD) to do so. Africare was also be able to attract matching grants from the Japanese International Cooperation Agency (JICA) for a community health component in the Maka zone, from the World Bank for a nutrition component in Tambacounda commune, and from Pfizer for an Acute Respiratory Infection (ARI) activity that covers the entire program area. Nevertheless, additional funding will be necessary in years 4 and 5 to make ends meet. Although Africare has already met its matching grant requirements for the entire program, the Dakar program team is presently exploring several potential leads for additional matching grants.

Recommendation: Hire a Monitoring and Evaluation Specialist to carry out these activities.

Response: We agree that this is an area of need. We will be hiring an M&E specialist by December 2006.

Recommendation: Help identify those CHWs who meet the minimum requirements for becoming TBAs and work with the communities and the health districts to facilitate the training of these candidates. Provide refresher training in reproductive health including the prevention of infection.

Response: We agree with these recommendations. See action plan below.

Recommendation: Reinforce complementary feeding, nutrition management of the sick child and diarrheal management with ORS. Collaborate with the *Bureau Régional de L'Alimentation et de la Nutrition* (BRAN) on technical aspects of the nutrition component.

Response: We will explore possibilities of collaborating with BRAN. Since October 2006, the program has been backstopped in Washington by an experienced nutritionist who will provide technical assistance on child health.

Recommendation: Seek outside collaborating agencies that will help equip health facilities in obstetric emergency equipment and train district staff.

Response: The Japanese International Cooperation Agency (JICA) has started a large technical assistance project aimed at improving the quality of services at the health posts and health centers of the Tambacounda region. While there is a certain amount of de facto collaboration between the THSP program and the Japanese project on the ground, we have asked USAID Senegal to broker a more formal partnership between Africare and JICA. USAID recognizes that a successful collaboration between the two programs would likely result in an increased positive impact for the beneficiaries, and has agreed to mediate the partnership.

Action Plan (see Annex I).

Changes from program description and DIP:

Change in level of effort for main interventions: There have recently been several changes in national policy as it relates to the first line treatment of malaria (from chloroquine to dual therapy with amodiaquine and SP to ACT). At the time the DIP was written, the MOH was not authorizing community-based distribution (CBD) of anti-malarials. The new MOH policy is that trained Auxiliary Health Agents (AHAs) can distribute ACT through the health huts. The selection of those AHAs to train rests on the same criteria as for CBD of cotrimoxazole for acute respiratory infections (ARIs): one of the requirements is that the AHA must have at least a primary school education and be able to read and write in French. At present, the MOH has begun training the AHAs in first-line treatment with ACT.

As mentioned in the DIP, the level of effort for the malaria intervention was reduced to 20% from 30% and a diarrhea intervention was added at a 10% level of effort. The basis for adding the diarrheal intervention resulted from the 2004 baseline KPC survey results which revealed diarrhea as the number one childhood illness reported (with a 45% prevalence).

Budgetary changes: Since the submission of the original program budget, Africare has been compelled to deal with a drastic decrease in the exchange rate. At the time the proposal was written, one US dollar was worth 700 CFA. Since the beginning of the program, the US dollar has hovered at a rate between 500 and 550 CFA. Rather than request an increase in the budget, Africare has realigned cost centers (decreasing some line items while increasing others) to meet the increased costs while remaining within the overall limit of available funds and has obtained a number of matching grants to facilitate program implementation. A revised budget and budget narrative was submitted with the DIP.

Maternal Care Groups: The proposal stipulated that 600 Maternal Care Groups of 10 members each would be established. Due to human resources constraints, THSP decided to create larger Maternal Care Groups ranging in membership from 18 to 30. Hence, the total number of Maternal Care Groups at program end may be reduced as a result of this change.

B- ASSESSMENT OF PROGRESS MADE TOWARD ACHIEVEMENT OF PROGRAM OBJECTIVES

1. Technical Approach

a. General overview

The Tambacounda Healthy Start Program (THSP) located in the department of Tambacounda, aims at reducing maternal and child morbidity and mortality through four interventions: 1. Maternal and newborn care (LOE: 50%), 2. nutrition/exclusive breastfeeding (LOE: 20%), 3. malaria prevention and control (LOE: 20%), and 4. diarrheal prevention and management (LOE: 10%). The THSP's goal is to decrease the morbidity and mortality rates of pregnant women and children under one year of age in the Tambacounda Region by improving community based health care services, increasing community access to health information, and strengthening community linkages with the health care system. The THSP's five objectives are to:

1. Increase the access to, demand for, and use of quality maternal and child health services, including emergency care;
2. Improve case management of malaria for pregnant women and children under five at the community and health post levels;
3. Improve nutrition of pregnant women and newborns, including promoting vitamin A supplementation and the practice of exclusive breastfeeding;
4. Improve diarrhea recognition and management at community and household levels;
5. Improve the capacity of local partners to plan, implement, monitor, and evaluate child survival interventions at the community and district levels, with an emphasis on capacity in maternal and newborn health, malaria, nutrition, and breastfeeding.

Key strategies to attain these objectives include:

1. Building capacity at the health posts and community levels by training 70 health personnel and 200 Traditional Birth Attendants (TBAs);
2. Assisting communities to establish functioning referral and transport systems in collaboration with the MOH and community health committees;
3. Educating and mobilizing communities by training 400 CHWs drawn from among the members of local women's groups;
4. Organizing pregnant women, care givers, and grandmothers into maternal care groups;
5. Designing and carrying out a social marketing campaign to increase access to and use of ITNs, ORS, safe birthing/hygiene kits, and iron pills.

b. Progress report by intervention area

Maternal and Child Health

Activities

Maternal health activities include the creation of Maternal Care Groups, reproductive health education and discussions, family planning, identification and pairing of pregnant women with a mentor for reproductive health and child growth monitoring, birth plan development, micro-credit for pregnancy-related expenses, pre-and postnatal care promotion, pregnancy

danger sign recognition and reduction in the delays to seek care, deliveries by a skilled attendant, home visits, and referral of obstetrical emergencies.

Progress towards intermediate objectives

According to the initial KPC and to mid-term focus group responses, before the program started, women sought prenatal care infrequently and irregularly. They were often sick and did not know pregnancy danger signs. They treated themselves with traditional medicines of plants and roots such as goyé and kinkéliba, and would seek assistance from traditional healers. They only went to the health post as a last resort after having tried various remedies. When women did seek antenatal care, those consultations often took place late in the pregnancy. Many women would hide their pregnancies from their husbands. Many were also reluctant to be examined by male nurses. Most women gave birth at home. Post-natal consultations were rare. Women rarely used modern contraceptives. Villagers often had to travel considerable distances to obtain medicines and vitamins such as iron.

Participants from all focus groups indicated that they have adopted many behavior changes in reproductive health since the THSP program came into their lives. Women, men, village leaders, and CHWs all report that women seek prenatal care more regularly and recognize pregnancy danger signs more readily. Through the program facilitated discussions on family planning that are held in the Maternal Care Groups, women have gained a better understanding of family planning. They are less likely to conceal their pregnancies. According to the community leaders' focus groups, pregnant women now take the initiative to seek antenatal care and manage their pregnancies by communicating with nurses and trained TBAs. Most give birth at the health post now, since they have learned the risks of home births. The number of women seeking post-natal care has increased and more women use family planning for child spacing.

Male focus group respondents indicated that they do participate in discussions, take part in home visits, and volunteer on community sanitation days. They also provide financial support for reproductive health services, medicines and transportation for their wives. Some of the men had helped establish Maternal Care Groups by making financial contributions. Some men also show support by calling on the husbands of women who seem disinterested in Maternal Care Group activities. Some men indicated that their wives shared with them the information they received in the Care Groups. The majority of focus group men, however, said that they had never directly participated in program activities, since they were not invited to participate.

Knowledge, Practices and Coverage (KPC) survey results seem to corroborate most of the qualitative findings. However, the program managers intend to validate the quantitative results of the mid-term KPC for the following reason: The focus on health promotion may have led to a high level of sensitization among the population. The large increase in positive responses may reflect this sensitization rather than actual changes in behavior. In December 2005, the program conducted a qualitative study that included focus group discussions with maternal care groups. The results of the study indicated that women knew the "right answers" to the initial set of questions. Upon further questioning, they had not yet adopted the appropriate behaviors.

Given that caveat, however, all indicators in this intervention increased above the 2004 baseline. The number of mothers who attended at least three prenatal care visits rose 27 percentage points from the baseline 33%, thus reaching the EOP target of 60 percent. Births

assisted by a qualified person increased by ten percentage points from 45% to 55%, nearly attaining the EOP target of 60 percent. One-third of mothers reported breastfeeding newborns during the first hour after birth, which represents a 13 percentage point increase over the baseline survey. Utilization of at least one method of modern contraception increased from 10% to 21%, surpassing the EOP target of 13 percent. This represents approximately twice the national average of 11%.

Tambacounda Health District data also reveal an increasing trend in selected reproductive health indicators. As of 2004, MOH increased the number of recommended prenatal care visits to a minimum of four. The percentage of women who sought three prenatal care visits in 2003 increased from 26% to 45% in 2005. Those who sought four antenatal care visits increased almost fourfold between 2003 (5%) and 2005 (19%) respectively. As for deliveries, a qualified person assisted approximately one-quarter (26%) pregnant women in 2003 compared to 37% in 2005. Some of these increases can be attributed to intensified Health District prenatal care outreach activities which took place in 2005 with the support of the United Nations Population Fund (UNFPA). Another possible factor is the MOH decree of that same year, stating that all deliveries (both vaginal and by Cesarean section) are free of charge. With respect to the use of modern contraceptives among women of reproductive age, the district does not have reliable data available for comparative purposes.

Effectiveness of RH intervention

The program's strategy to reduce maternal and neonatal mortality is: 1) to increase demand for maternal and newborn care in the community; 2) to increase adoption of key behaviours during pregnancy, birth, and the post partum period; 3) to improve quality of maternal and new born care at community and health level.

The THSP has centered its maternal health technical intervention on UNICEF's four delays framework. To date, the program has been working to address delay #1: delays in problem recognition due to traditional beliefs, low perceived risk, low knowledge of causes of death, danger signs and complications, and ineffective screening; and delay #2: delays in deciding to seek care due to a woman's low status/lack of participation in decision making, lack of birth planning/preparedness, high rates of unattended home births and untrained attendants, and poor quality services.

Overall, referrals and improved utilization of health services have increased. This increase is supported anecdotally, by qualitative interview results, and statistically by health post admission figures. The program interventions that have been particularly effective in affecting positive behavior involve the Maternal Care Groups as: 1) fora for intimate discussions among women on reproductive health topics, 2) the stimulus for birth preparedness plans involving first the pregnant woman and her mentor, then the husband and family, 3) a basis for advocacy, and 4) an enabling environment for IEC/BCC interventions. Here are some of the program highlights:

Maternal Care Groups

The cornerstone to THSP's strategy to reduce maternal and neonatal mortality is the Maternal Care Group. THSP is working with women's groups in participating villages to establish and facilitate groupings of women that allow women to learn about the importance of key health behaviours, birth preparedness, recognizing danger signs during and after pregnancy, to establish systems of referral for emergencies in an intimate setting using existing networks of solidarity among local women.

In each village, the program team meets with the village committee and members of women's groups to explain the concept, structure, and function of the Care Group (CG). Members of women's groups are then asked to group themselves into Care Groups of no more than 25 women per group; each village is limited to a maximum of four CGs to allow the volunteer facilitator enough time to meet with each CG every month.

Each CG has a coordinator, and a treasurer, and a facilitator. The facilitator is either the TBA or CHW (RH volunteer) based in the village, and is always a woman. Activities carried out with CG include:

- Group discussions by the TBA or CHW on key behaviours such as prenatal visits, exclusive breast feeding etc.
- Mentoring of pregnant women within the group by more experienced group members. This mentoring includes joint preparation of a birth preparedness plan and home visits.
- Regular contributions to a fund to help women who need financial assistance for ANC visits, referral, and emergencies. These funds can also be used to purchase drugs for women who can't afford them.

This year the program has established a total of 209 Care Groups in the Tambacounda District, with a membership of 5,225 women of reproductive age. Between October 2005 and September 2006, over a thousand members of the CG were mentored during their pregnancy, of these, 833 were also helped to develop a birth preparedness plan. Care Group members also provided financial support for 583 to members who needed medical care for themselves or for their children. Care Group members made over 2,700 home visits to members who were either pregnant or had recently delivered, and 619 follow visits to women who had been referred to a health facility.

The program has been successful in mobilizing women in the beneficiary communities, and participation in the Care Groups is very high. However, some work still has to be done to empower women to take ownership of their groups. Most women are happy to participate in CG activities, and indeed, there is a great demand by women's groups to form Care Groups. However, organization of the groups' activities is still left to the CHW or TBA, and in general CG coordinators lack the capacity to facilitate the groups. The THSP will thus have to provide some capacity building support to CG members to ensure their sustainability after the EOP. A particular problem has been women's inability to contribute even nominal sums to the basket fund. The imminent start of the micro credit activities is expected to improve CG fund raising capacity.

Health promotion for improved maternal and newborn health outcomes

The THSP's strategy for behaviour change consists of group discussions and home visits carried out by CHWs and TBAs, village level social mobilisations, and radio programs addressing key maternal and newborn health topics. This year THSP volunteers reached over 15,500 women and approximately 1,900 men though discussion groups and home visits. Health education topics included prenatal consultation, assisted delivery, post natal consultation and family planning. THSP also invited district and region staff to discuss maternal health topics on its weekly radio program. The program is aired on the RTS Tambacounda which has regional coverage.

Referral of women to the health post

To promote pre and post natal visits, the early identification of problems during and after pregnancy, and assisted births, the program has trained CHWs and TBAs in the identification of cases for referral. The volunteers are provided with referral forms that they can issue to members of their communities who need further care at the health post. The volunteer fills out the patients' problem in the section marked 'reason for referral' on the form. The program also informed District and Health Post staff about the use of the form, which provides space for health staff to write down the diagnosis and treatment given to the patients. Volunteers can then check the form during follow-up home visits and ensure that the prescribed treatment is being followed. Between October 2005 and September 2006, 1500 women were referred to the health post for reproductive health reasons, the vast majority these referrals, 1091, were for prenatal consultations.

Community Based Services

The program has trained TBAs in the program zone to provide basic reproductive health services. These include pre and post natal consultations for TBAs based in health posts and health huts, as well as the provision of IPT during prenatal visits and vitamin A within 42 days after delivery. The program has also supported refresher training in simple deliveries for all TBAs and has trained them in basic life saving first aid to mothers and newborns. The small number of TBAs active in the intervention villages limits the effectiveness of this activity. In Tambacounda district, the program identified 24 active TBAs in the 75 central villages; eleven of these are based in structures less than 5 kilometres away from the district health center[1]. In the past year, TBAs have conducted a total of 1,040 consultations and assisted in 666 simple deliveries. In Koumpentoum district, where the program has just completed the enrolment of 95 new villages, the program has identified a total of 23 active TBAs.

Changes in approach

There were no changes in this approach

Special outcomes, unexpected successes or constraints

Successes: Given the generally low use of family planning in Senegal and a number of traditional barriers to FP in the program zone, the twofold increase in modern FP use among WRAs enrolled in the program constitutes an unexpected success.

Constraints: Although the program's IEC/BCC strategies contributed to breaking down a number of barriers to FP use, many such barriers remain, particularly among men. Focus group discussions revealed mixed opinions about FP, as well as misinformation, ignorance and fear. Differing Islamic interpretations and understandings of the topic complicate the issue of family planning.

For example, during the focus group sessions, one man said: "In the beginning, everyone said that Islam does not accept family planning, but now, we know it is for the mother's and child's health. So, it is a good thing." A second man countered: "For me, all that is not accepted by Islam, I would not do it and I would not allow my wife to do it either." Another male participant stated that: "There are negatives to modern family planning such as infertility, the risk of giving birth to twins, and miscarriages. There exist traditional contraceptive methods which are more effective and with fewer risks." Yet another pointed

[1] Four health posts are in the Tambacounda municipality which is the regional, departmental, and district capital; the regional hospital and district health centre are both located here.

out that "Some women seek contraception secretly, that means they want it but their husbands are not convinced." Discussions with CHWs revealed that although people in their villages readily discussed FP, they did not think that many people practiced it. Other CHWs claimed that some village and religious leaders in the program intervention zone forbid discussions on family planning. Nevertheless, it seems clear that as women become more informed, they have been empowered to take the initiative for their reproductive health by seeking to obtain FP methods.

In the THSP proposal, Africare had planned to provide refresher training for 200 trained birth attendants (TBAs). This was based on figures provided by the Tambacounda Health District and by Engender Health, an NGO that had trained TBAs in the Tambacounda region in 2001-2002. At program start-up however, the THSP was able to identify only 25 TBAs in activity in the entire program zone. Many of the original TBAs had been absorbed into the health system in other parts of Senegal, or had gotten married and moved away, etc. As a result, most program villages do not have access to a TBA. The THSP program cannot support the initial training of prospective TBAs due to budgetary and time constraints. TBAs undergo a six month practical training by midwives at the district health center. Because the training is supervised by district midwives only a limited number of TBAs (six) can be trained at one time. To make up the deficit of TBAs for Tambacounda district alone, the THSP would need to support eight back-to-back, 6 month training sessions.

To fill the gap created by the lack of TBAs, the THSP program has collaborated with the Health Districts to train 53 female volunteers (some of whom are traditional birth attendants) in reproductive health promotion. These volunteers were given a special title, of "Reproductive Health CHWs." This differentiates them from TBAs, since they are not officially recognized as being trained to assist deliveries.

The 53 RH CHWs completed their training in January 2006, but some only received their didactic materials (*cartes conseils* or "advice" cards) in October 2006. The cards produced by BASICS were in French and Wolof, whereas the main languages in Tambacounda are Mandinka and Fulani. The program was obliged to translate the documents into those languages before reproducing the cards.

In her most recent supervision report, based on a field trip undertaken with the Tambacounda District Reproductive Health Coordinator, the THSP Maternal and Child Health Advisor has recommended that some TBAs based in village health huts be provided with additional equipment for disinfection of the obstetric utensils they received in their delivery kits. This equipment includes pots for boiling, gas stoves, and timers or watches. At present, some of them are using their cooking pots and wood burning fires for disinfecting utensils. The program will work with the concerned Village Committees to resolve this constraint.

Next steps

Maternal Health:
The program should concentrate on developing communications and transportation systems for obstetric emergencies to address the following barriers: delays in reaching the health facility due to geographic distance; lack of resources to pay for services; inadequate communication and transportation systems; and inadequate knowledge of where to seek care and how to get to the facility. The THSP will need to mobilize communities to organize and establish a system to evacuate obstetrical and other emergencies. While mobile phone

ownership in villages has increased exponentially in recent years, and Senegal has an extensive cell phone network, many program areas are still out of reach of the network. Nevertheless, the THSP should sensitize beneficiaries to learn their health post telephone number and their Health Post Officer in Charge contact information to call for the district ambulance in the case of emergencies. While the district ambulance typically evacuates from health post to health centre, according to the former District Primary Health Care Supervisor, the district ambulance does respond to village emergencies and has saved a number of lives. Although under-utilized due to lack of awareness, the emergency transportation system is also insufficient. In Koussanar, the Rural Community has raised funds for an ambulance which is based at the health post, but this is only one of 12 posts in the area.

The THSP, in collaboration with the communities and the Health district, should explore other options to combine with Health District emergency transportation. The option of the horse and buggy has met with criticism due to the fact it is not adapted to the terrain, especially during the rainy season. Moreover, the high degree of care necessary to maintain a horse is a problem. One alternative would be connecting women with at-risk pregnancies to care houses in proximity of health infrastructures. The THSP should facilitate a dialogue between the health districts and beneficiaries to plan and find resources to establish and support such facilities. Women should then be encouraged to move to these facilities as they near their due dates and a communications action plan should be established and launched at onset of labor. This may be arranged through the Maternal Care Groups or the larger women's groups at the community level.

The THSP has improved quality of care through outreach, referral and follow-up. However, the program cannot fully address delay #4, given the program's focus on community services and referral. Delay #4 involves delays in receiving quality treatment at the health facility due to lack of medicine, supplies and equipment to treat complications, cumbersome administrative processes, lack of competent, motivated personnel, lack of adequate supervision and management information systems, lack of outreach and follow-up mechanisms. Although the THSP has strengthened health facilities by building the capacity of selected health district personnel in obstetric emergencies management, the district health care facilities lack the necessary medical equipment to truly reduce maternal mortality. The next step for the THSP should be to seek the collaboration of a partner organization that can supply the regional and district health facilities with the appropriate medical equipment.

Family planning:
The program should train its Reproductive Health CHWs in the lactic amenorrhea method (LAM). Given the confusion surrounding family planning among men, FP discussions and activities need to target and involve men, particularly with respect to their role in contributing to a healthy family. Potential topics include the importance and benefits of delayed marriages and pregnancies (waiting until their fiancées or wives are at least 19), the financial responsibility and consequences of large families, and the man's role in high-risk pregnancies and maternal mortality. The latter includes discussions of the "four toos": pregnancies at too young an age (girls aged <18), too old an age (women aged >35), too many children (>3) and children too close to each other in age (children born less than two to three years apart.)

Nutrition and breastfeeding

Activities
Nutrition and breastfeeding activities include:

- maternal care group and community discussions on exclusive breastfeeding for up to six months,
- promotion of complementary feeding with continued breastfeeding up to at least two years,
- culinary demonstrations and growth monitoring in selected villages,
- iron and vitamin A supplementation for pregnant and post-partum women during prenatal and post-natal consultations and
- referral of obstetrical emergencies and severely malnourished children to the health post.

The MOH targets children under 5 for vitamin A supplementation, deworming and immunizations during its annual Child Survival Days. The THSP collaborates with the MOH, the Health District, and UNICEF on National Immunization Days (NID), National Micronutrient Days (NMD) and Child Survival Days to target children under five for vitamin A supplementation, deworming and immunizations. The THSP supports those initiatives by contributing logistical support (fuel, cars), human resources (for social mobilization, identification of households needing immunizations and re-treatment of bednets), and funds.

Those activities scheduled in the DIP that have not yet taken place are:

- the referral of moderately malnourished children to the 17 *Centres d'Education et de Récupération Nutritionnelle* (CERN) for nutrition rehabilitation,
- support of community efforts to raise poultry for consumption and
- establishment of micro-credit schemes to expand such activities.

The CERNs were established by Africare's PARINS project in the Tambacounda commune, and are managed and financed by the communities they are located in. These communities raise funds locally to finance the feeding sessions. As the program does not yet intervene in Tambacounda commune (this will begin this year) no children have yet been referred. The program is also working with present village committees where growth monitoring takes place to explore the possibility of establishing similar centers.

Progress towards intermediate objectives

The mid-term KPC results show that most THSP indicators in nutrition and micronutrient supplementation improved as compared to the baseline. With respect to maternal nutrition, 60% of mothers received vitamin A supplementation within 42 days post-partum as compared to 11% at baseline. Iodized salt consumption within households increased from 49% to 59 percent. As for child nutrition, 85%[2] of mothers report practicing exclusive breastfeeding for six months compared to 24% at baseline. Vitamin A supplementation of children 6 to 24 months increased from 40% to 72 percent. However, growth monitoring decreased from 37% to 21% and malnutrition (underweight) increased from 20% to 24% in the intervention zone.

As a comparison, Tambacounda health district data indicate that only 12% of postpartum women received vitamin A supplementation within the 42 days after delivery in 2005. Data for the other indicators were not available. Typically, the Health Districts take advantage of UNICEF-financed Child Survival Days to supplement children in vitamin A. Some Officers in Charge (OICs) also take the opportunity to stock their health posts with vitamin A supplements left over from the micronutrient campaigns. However, not all OICs regularly

[2] In Senegal, the MOH accepts as exclusively breastfed, children who have had nothing other than breast milk and the one-time blessed water associated with Muslim beliefs in this part of the world.

restock their health posts in vitamin A. Despite the MOH's 2004 mandate concerning routine vitamin A supplementation, according to the THSP MCH Advisor, postpartum women in the Tambacounda District's Health Center do not receive vitamin A supplementation. The Tambacounda District's Primary Health Care Supervisor believes that this is a financial issue: the health structures prefer to obtain free vitamin A from the UNICEF campaign rather than to purchase vitamin A. The program managers believes it is more a question of bad planning, as UNICEF has informed Africare that it provides the district with Vitamin A for mass campaigns as well as routine administration.

Effectiveness of the intervention

Overall, this intervention seems effective for micronutrient supplementation. The THSP's IEC/BCC and social mobilization strategies (engaging influential personalities such as religious leaders, village chiefs and CHWs) are very effective in rallying communities to national and district campaigns for targeted interventions like deworming, vitamin A supplementation, and immunization during Child Survival Days and other National Immunization and Micronutrient Days. However, overall child nutrition shows a negative trend, with growth monitoring on the decrease and malnutrition on the rise.[3]

In fact, nutrition appears to be the weakest THSP intervention, primarily due to the program's original design. Evaluation team members had the opportunity to visit the village of Koar where the IMCI CHW presented exclusive breastfeeding and complementary feeding to a group of 33 women and children. Although this village has been enrolled in the THSP for more than a year and a half, the CHW was presenting this nutrition theme for the first time (until then the focus had been on RH, malaria and diarrhea). The messages were accurate (exclusive breastfeeding for six months, complementary feeding with food variety and nutrient-rich foods with a focus on vitamin A). One important message the IMCI CHW did not address was the proper positioning for optimal breastfeeding.

A few evaluation team members attended a growth monitoring session and a culinary demonstration in Koussanar. The IMCI CHW held accurate books, weighed and read weights correctly, and gave appropriate, standard nutrition advice. The culinary demonstration utilized World Food Programme (WFP) enriched flour donated to the Case des Tout Petits (the GOS's educational programme for children age two to five). The porridge comprised of WFP enriched ground flours of maize, peanuts, beans seasoned with onions, dried and smoked fish, local vegetables, iodized salt and red pepper, seemed nutritious and was tasty.

As many beneficiaries have historically been used to receiving supplemental food for improved nutrition during growth monitoring sessions from other non-Africare programs, some beneficiaries are unmotivated to attend growth monitoring sessions where no food incentives are distributed. The CHWs report this as a problem for THSP growth monitoring sessions. To further compound the problem, some Health Post OICs do not offer growth monitoring regularly due to their heavy workloads. As a result, most children under five are not growth monitored.

The original proposal design and the DIP focused primarily on micronutrient supplementation and exclusive breastfeeding indicators for improved child survival. While

[3] The baseline and the mid-term KPCs were conducted during the dry and rainy seasons respectively. The increase in malnutrition rates may be seasonal due low availability and access to foods during the rainy season until after the harvest.

the THSP has progressed on these indicators, they are insufficient in making a nutritional impact considering that most malnutrition happens between the ages of 6 and 24 months. The introduction of complementary foods after exclusive breastfeeding has stopped, and increased risk of infection through this vehicle (poor food preparation, hygiene and sanitation, inadequate foods) and increased mobility of the child, all make children in this age group particularly vulnerable. Until the THSP reinforces these areas, overall malnutrition (under-nutrition) rates may either remain stable or continue to rise. The consultant highly recommends that the program extends the intervention age range to at least 24 months, so as not to miss a serious impact opportunity if the age range is not extended and the strategies are not strengthened. The HEARTH approach would be an appropriate strategy to build community capacity to nutritional rehabilitation.

Changes in technical approach
There were no changes in this approach.

Special outcomes, unexpected successes or constraints
Budgetary constraints and a program design that focuses primarily on micronutrient indicators and exclusive breastfeeding seem to limit the nutrition component of child survival. Only 27 villages will implement important activities such as growth monitoring combined with culinary demonstrations. At the midterm, 15 CHWs had been trained in growth monitoring and had received Salter scales.

According to the results of the initial KPC, grandmothers are the main caretakers (35%) of children in the program zone. Given this statistic, and the fact that grandmothers do not automatically participate in the Maternal Care Groups, the project needs to do more to enroll grandmothers. The administration of toxanthal (Islamic holy water that is often non-sterile) remains a practice that may interfere with exclusive breastfeeding. According to the mid-term KPC, 50% of children under two received the holy water. According to the Africare Senegal Health Program Manager, the holy water is typically administered as the first drink the child receives as protection before even breastfeeding. The MOH has been tolerant of this practice and counts children as exclusively breastfed if they receive no other food or drink than breast milk and holy water.

The Health District's ability to offer health care services to severely malnourished children who are referred remains inadequate due to lack of medical equipment and expertise at the health post level. The present procedure is to refer these children to the Health Center in Tambacounda. Some caretakers refuse this referral for lack of resources and/or because of the distances involved. This results in inadequate treatment of these cases at the health post level. The THSP's community efforts to refer, link and increase health care services access and utilization among severely malnourished beneficiaries are thus frustrated by this weak link in the referral system. Again, the use of the HEARTH model is recommended to resolve this constraint.

Follow-up and next steps

Exclusive Breastfeeding
The next steps for this component consist of reinforcing exclusive breastfeeding. Considering there are alternatives to ingesting the non-sterile holy water (such as whispering Coranic verses in the child's ear), the THSP should consider promoting and emphasizing other acceptable blessings. Grandmothers need to be systematically enrolled in the program

and need to participate in the discussions and health education sessions on the importance of exclusive breastfeeding. Finally, the IMCI CHWs should demonstrate and discuss proper breastfeeding positions for optimal breastfeeding rather than waiting for the RH CHW or the TBA to discuss it in the Maternal Care Group sessions or when a woman gives birth.

Complementary feeding
Complementary feeding should be reinforced with messages grounded in age appropriate feeding **F**requency, **A**mount, **D**ensity, **U**tilization, and **A**ctive Feeding (FADUA). While food variety has been a strong message, active feeding on the part of the mother/caregiver, cleanliness and hygiene, and frequency of feeding need more emphasis.

Feeding the sick child
Since diarrheal and malaria prevalence in children remain high, the THSP needs to disseminate more messages on feeding the sick child more frequently during and for two weeks after illness to assist the child in catch-up growth.

Growth monitoring
Growth monitoring is the main method to assess proper growth and physical development from a nutrition perspective. The THSP should mobilize and increase awareness for seeking this service. CHWs should also address the question of supplemental food at these sessions: this should not serve as an incentive for assessing a child's health.

Control of Malaria

Activities
Malaria prevention and case management activities consist of health education discussions within Maternal Care Groups and in the wider community. These discussions focus on prevention, early recognition and care seeking, promotion and distribution of Insecticide Treated Nets (ITN), re-treatment of bednets, referral of suspected malaria cases and of pregnant women for Intermittent Presumptive Treatment (IPT).

Health promotion of key behaviors
Community health workers trained in the IMCI community approach and RH CHWs carry out group discussions, home visits to sensitize mothers and caretakers on:

- the prevention of malaria using insecticide treated nets,
- the importance prompt care seeking for fever and other signs of malaria,
- the danger signs of malaria for children and pregnant women
- intermittent preventive treatment of malaria for pregnant women.

Through these activities CHWs and TBAs have reached over 31, 000 women and approximately 6,400 men in the year 2005/2006.

Referral of children less than five and pregnant women
Until June 2006; the Ministry of Health policy stipulated that all treatment of malaria cases including IPT and the new combination therapy with ACT be prescribed by qualified health personnel. To support this strategy, THSP volunteers were trained to refer to the health post all suspected cases of malaria and pregnant women for IPT. In the past year, 645 children less than five and 91 pregnant women were referred to the health post for fever and other symptoms of malaria; as pregnant women referred for prenatal care also receive IPT.

More recently, the MOH decreed that ACT can be administered through the health huts by trained auxiliary health agents (AHAs). The MOH has begun training AHAs in first-line treatment with ACT in some districts, although the districts of Tambacounda and Koumpentoum have as yet to train AHAs.

Community Based Distribution of ITN

The THSP supports local efforts to sell high quality ITNs at a reduced price at the village level through community based organizations. Village Committees (VCs) were asked to raise funds to purchase a starter pack of products including ITNs, to be sold by CHWs and TBAs. Since the start of program activities, Africare's efforts to secure ITNs through UNICEF and the National Malaria Control Program (PNLP) were unsuccessful mainly because of the unavailability of nets nationally. Efforts to secure nets locally through the district were also unsuccessful as the districts also did not have nets. Nets became available in the districts in June 2006. The district has signed agreements with 40 VCs to sell nets on its behalf. The agreement stipulates that the VC buys the net at 800 CFA from the district and resells it at 1,000 CFA to the community, and, that women and children should be given priority. To date the VC have purchased a total of 580 nets from the district of Tambacounda.

National Malaria Control Program Grant

In November 2005, the THSP signed a partnership with the PNLP that provided $20,000 from the Global Fund for malaria-specific activities. The funding was used for activities such social mobilizations, environmental sanitation (inside and outside of the households), and the distribution of insecticide treated nets. In addition to the funds, the PNLP also provided 1,000 bednets.

Activities were essentially focused on:

- Social mobilizations which consisted of mobilization days and community quizzes in 30 villages;
- Theatre performances in 22 villages;
- Village sanitation days known as *set setals* in 20 villages.

The grant also financed a radio programs aired on RTS which has regional coverage.

Through the PNLPP grant the program also provided 45 VC with grants of 40,000 CFA. The grants were provided to each VC upon signature of an agreement. The VC's responsibilities include supervising program activities, fundraising and mobilizing community members. The grant money was used in part to purchase a starter kit of products to be sold in the village.

Progress toward intermediate objectives

KPC data illustrate that malaria/fever prevalence two weeks prior to the survey was at 50 percent. This represents an increase of 25 percentage points from baseline. The most likely explanation for this increase is that the data for the two KPCs were collected at different times of the year. The baseline KPC was carried out in March 2004, the end of the dry season, whereas the mid-term KPC data were collected in September 2006 towards the end of the rainy season.

The Tambacounda Health district data show a substantial decrease between 2003 and 2005 in malaria cases in children under five (from 25% to 11%) and among pregnant women from (18% to 3%). KPC results also show a substantial increase in the percentage of women with access to Intermittent Presumptive Treatment (IPT), from 2% to 68%. In comparison, district records show that only 41% of pregnant women received two IPT doses in 2005, data for

2003 is not available. There was a slight decrease in the percentage of women able to cite a malaria danger sign that necessitates care seeking within 24 hours; the percentage went from 48% to 40% at mid-term with the program's target set at 60%. As for reported ITN use, it increased more than fourfold for both pregnant women (from 18% to 83%) and for children under two (from 21% to 94%).

The decrease in malaria prevalence in children under five and in pregnant women may be attributed to several factors. Due to the program's IEC/BCC activities, there is an increased awareness among women of the means of malaria prevention, its danger signs and the appropriate care seeking behavior. Secondly, the MOH now provides free IPT for pregnant women at the health post, and part of the THSP health promotion activities has been to raise awareness among women of this service. However, according to the program managers, the mid-term KPC's figure for the reported access to IPT by pregnant women (68%) seems high and requires further verification. According to the KPC, only 46% of women surveyed actually possessed an antenatal card and could therefore be confirmed as having attended their prenatal visits.

The large increase in reported ITN use may be explained by various factors. Over the past 18 months, the THSP has implemented an intensive awareness raising campaign on the importance of net use for malaria prevention. The program has also supported the UNICEF-financed Child Survival Days, organized twice yearly throughout the region, during which CHWs distribute nets and re-treat existing nets. More recently, the PNLP launched its accelerated phase for ITN distribution, although it should be noted that the nets only became available in June 2006.

The evaluator recommends that the program take steps to validate the level of net use among its beneficiaries during routine monitoring activities. Traditional healers also report that are treating fewer cases of malaria. According to them, this is due to increased community awareness on how to prevent the disease. It is important to note that this is based on reported cases of malaria, as opposed to confirmed cases. Nevertheless, it is reasonable to conclude that the THSP's malaria-related health promotion activities and logistical support have acted as a catalyst for improved health outcomes.

Effectiveness of the interventions

Overall, the intervention mix which targets pregnant women and young children seems quite effective in reducing malaria cases. Africare, as a participating collaborator in the National Malaria Control Program, mobilizes communities and raises awareness about ITN use.

Changes in the technical approach

No changes in the technical approach.

Special outcomes, unexpected successes or constraints

Constraints: Delays in receiving ITNs have affected the implementation of this intervention. Although the PNLP ordered a supply of ITNs in December 2005, they only arrived in June 2006. Cases of malaria are still quite high (1 in 2 children contracted fever two weeks prior to the midterm KPC.) Village Committees lack equipment such as shovels, wheel barrows and the like to undertake their environmental sanitation activities.

Follow-up and next steps

Malarial prevention

The THSP needs to put in place a system for monitoring and ensuring regular bednet re-treatment. The PNLP reportedly will be promoting indoor household spraying as a complement to ITN use.

Malaria case management

As indicated in the nutrition section, CHWs need to draw attention to feeding the sick, febrile child more food throughout illness and particularly during the two weeks after illness so as to help the child regain its strength and weight it may have lost during loss of appetite.

Control of diarrheal diseases

Activities

Diarrheal control and management activities include health education discussions on causes of diarrhea and methods of prevention, key behaviors for the correct management of diarrhea at the household level including promotion and distribution of Oral Rehydration Salts, and recognition of danger signs for referral. Mothers and caretakers of children are also sensitized on the importance of increased fluid intake during an episode of diarrhea, as well as increased feeding for children who have been weaned. CHWs trained using the community IMCI approach are responsible for carrying out these activities. They also refer all cases of diarrhea presenting danger signs.

At 10% of LOE, the diarrhea intervention is the THSP's smallest component and has the most limited number of activities. Rather than spreading out the planned activities over a 12 month period, program managers instead decided to focus diarrhea specific activities on the cholera/diarrhea months of March to May. This is a time when there is a particular risk of cholera outbreaks due to an annual religious pilgrimage to the northern Senegalese town of Touba. During 2005-2006, the program reached approximately 1,500 women and 323 men with health promotion messages on diarrhea. Volunteers also referred over 200 children to the health post for diarrhea associated danger signs.

Progress towards intermediate objectives

The KPC results reveal that diarrheal prevalence during the two weeks preceding the survey decreased from 45% at baseline to 28% at the mid-term. Roughly one-quarter of surveyed mothers (27%) treated their child with ORS compared to the target of 65 percent. This represents a decrease from baseline results wherein half the mothers (52%) utilized ORS. The target for this indicator stands at 65 percent. Recognition of danger signs doubled from 43% at baseline to 87 percent. Conversely, a lower percentage of mothers (39%) at the midterm evaluation report their child ate the same amount or more foods during a diarrheal episode compared to 48% at baseline. 57% of mothers report giving their child the same amount or more liquids during a diarrheal episode compared to 48% at baseline. In terms of diarrheal prevention, 14% of mothers report washing their hands at the four critical times (i.e., before food preparation and feeding children and after using the toilet and cleaning a child who has defecated) compared to 7% at the baseline.

Tambacounda health district data show that health facilities had only 3% of diarrheal cases for treatment among children 0-5 in 2005. Comparative data for 2003 were not available. Some influential factors that may explain the twofold increase in hand washing include increased awareness for washing hands due to the MOH's hand washing awareness campaign

which occurred earlier this year in 2006 after a cholera outbreak. The intensive hand washing promotion spillover effects would also reduce the diarrheal prevalence, which almost halved (seasonality.) As the mid-term evaluation was conducted during the rainy season, a period of lean times, it may be that mothers offered less to their children during the diarrheal episodes in the past two weeks as they may not have had much to offer. However, their behaviors are probably linked to the nutrition component which may not have addressed or emphasized sufficiently feeding of the sick child.

There are differing views on the decreased use of ORS. According to the Tambacounda District Primary Health Care Supervisor, it may be due to lack of access to ORS due to a Regional ORS stock out, which had been in effect for four months at the time of the evaluation. The THSP program managers, however, are not aware of any recent stock outs for ORS. The TSHP ordered ORS sachets several times between February and July 2006 for Village Committees. Along with UNICEF, the THSP program managers believe the low use may be due to the lack of promotion of ORS use by health facility staff who tend to prescribe antibiotics for diarrhea cases. Some mothers and children also reported disliking the taste of the ORS.

Effectiveness of the intervention

This intervention seems to be experiencing issues primarily due to the late and infrequent introduction of the topic of diarrheal prevention and management in some villages. According to the Program Coordinator, CHW are only required to conduct a minimum of three group discussions a month, for a total of 36 a year. Since CHWs and TBAs work on a volunteer basis, the program managers estimate that a 3 group discussions and 4 home visits are a reasonable workload for people who are working at other occupations. This may explain why some messages are not be well assimilated or retained; if one misses a session, they are more likely not to have the opportunity to get the information in a short interval. For example, at the Koussanar village growth monitoring session, an evaluation team member asked one mother whose child had diarrhea, if she knew how diarrhea was contracted. She indicated that it was from drinking cold milk. The CHW advised her of some transmission modes but not the most critical one of hand washing. Coupled with the low reported use of ORS, this makes it all the more difficult to change behaviors positively in diarrheal management.

Changes in the technical approach

No changes in the technical approach.

Special outcomes, unexpected successes or constraints

During focus group discussion with a group of CHWs and TBAs, some did not know the four critical times hand washing should take place. This is not optimal for dissemination of comprehensive, complete messages for diarrheal prevention.

Follow-up and next steps

Capacity building

IMCI CHWs should receive on the job refresher training on diarrheal transmission modes, prevention and management. The consequences of poor diarrheal management should also be addressed.

Diarrheal prevention
CHWs need to increase their efforts to promote hand washing as a diarrheal prevention method. The THSP should ensure that all CHWs know the four critical times when hand washing needs to take place consistently (two befores: before food preparation and before eating/feeding a child; and "two afters": after defecating and after cleaning a child who has defecated.) The beneficiaries should also increase their hand washing knowledge and practices.

Diarrheal Management
Considering conflicting explanations regarding the reasons for the low use of ORS, the THSP should conduct a qualitative study to find out the reason(s) for low use among beneficiaries. The study could also examine hand washing practices and beliefs. Additionally, CHWs should emphasize increased fluids and breast milk or only breast milk for those younger than six months during diarrheal episodes. As mentioned for the nutrition intervention, CHWs need to underscore that nutrition management is crucial to a child's survival and recovery during illness and especially for two weeks after illness to regain any weight loss.

2. Cross-cutting approaches

1. Community Mobilization

Community mobilization strategies include engaging influential community personalities to mobilize their communities. The community members summon the local Imam to make an announcement on Fridays during the weekly prayer at the mosque. The public crier circulates on foot or by horse-drawn cart through the program villages announcing various THSP activities through his megaphone. Monitoring committees and the presidents of community groups act to mobilize communities for program activities. These strategies seem effective.

Overall, targeted beneficiaries have responded adequately to mobilization activities. Social cohesion seems particularly strong within the Maternal Care Groups. Village Monitoring Committees support CHW activities. Evaluators had the opportunity to observe a *radio crochet* (a community quiz) which comprises an entertainment component such as music or a local dance interspersed with health questions and prizes for correct answers. The latter provides a means of evaluating community knowledge retained from the discussions.

Barriers to social mobilization include the scorching heat for over six months of the year, which can reach temperatures that exceed 40 degrees Celsius (over 104 degrees Fahrenheit.) Understandably, people are not willing to come out to receive a health education session in a public place under such heat. To resolve this constraint, CHWs conduct sessions in the late afternoons or at night when the temperature is cooler. The rainy season also constitutes a barrier to access populations particularly for supervisory visits. The program attempts to deal with this issue by rescheduling sessions.

The turnover rate of CHWs seems to be problematic. Absenteeism and non-committed CHWs impact program activities negatively. Since the beginning of the program several CHWs have left and continue to leave the program in search of better opportunities that are remunerated. This sets the program back as new CHWs have to be identified and trained.

In an informal interview of CHWs, they expressed their frustrations with both the THSP and the communities they serve (despite their current dedication). According to them, the THSP stated that CHW would be compensated through the cost recovery program. The program also promised that when the Maternal Care Groups' microcredit component was launched, the CHWs would be first to benefit from the credit. To date, THSP has not launched the micro-credit program and the cost recovery program earns minute amounts.[4]

The CHWs also feel that the program does not appreciate the time it takes to get from one village to another on foot**,** which, can be as far as five to seven kilometers (3 to 4 miles.) Once communities have been informed and mobilized for activities, they have a tendency to come very late, further "wasting our time." Beneficiaries do not offer to help cultivate the CHWs farms in exchange for their services or to show appreciation.

According to some CHWs, they volunteer ten days a month. The program managers believe they commit only five days. To address some of these frustrations, the THSP coordination team authorizes and encourages public recognition of CHWs with a gift, as a form of motivation and appreciation. However, most supervisors are not regularly taking advantage of this opportunity to motivate the CHWs they supervise. The THSP in collaboration with its community partners needs to put in place a strategy to motivate and show appreciation for the CHWs to boost morale and motivation for their work.

2. **Communication for Behavior Change**

The THSP centers its BCC strategy on the BEHAVE framework. A local dramatic theater troupe, a local community radio program, home visits, group discussions, interviews, community quizzes (*radio crochets*), and meetings comprise the mass communication and interpersonal strategies for behavior change. The program's approach is appropriate and effective given the variety in its strategies and target audiences.

The greatest barrier to behavior change may be attributed to the extremely high illiteracy rate in the district. Beneficiaries and CHWs alike find it challenging to retain and thoroughly understand selected information. Program supervisors have tried to address this problem by closely monitoring and providing assistance and guidance to CHWs with literacy-related problems, but this has been an on-going challenge and will remain so throughout the program.

Another important constraint for behavior change is the conservative and traditional nature of Tambacounda communities. The majority of women in the target villages still rely on decisions made by either their husbands or their mothers–in-law. A woman who is in labor and needs to be evacuated still has to wait for her husband to give the go ahead before she can leave for the health post. Women who seek care at a health facility and are prescribed medication still need to return home to get permission from their husbands to buy the drugs. Men tend not to take part in activities that are attended by women: according to the THSP monitoring records, the program is reaching five times as many women as men with its IEC/BCC activities. The program will have to revisit its approach for enrolling men and incorporate more IEC activities that specifically target them.

The program has dealt with other barriers to behavior change, such as women refusing to seek ante-natal care consultations from male nurses, primarily through small discussions and

[4] Medicines are sold at affordable prices for impoverished communities.

increased awareness. However, the THSP has rarely conducted focus groups to truly assess barriers to behavior change. According to the Program Coordinator, this was due to lack of human resources and also to the late start in program implementation.

With respect to the technical soundness of the messages disseminated, they are in keeping with Ministry of Health's protocols and international best practices. The program's home visits engage husbands and paternal grandmothers and serve as fora to negotiate behavior changes and teach skills. Since its implementation, the THSP has not measured the effects of behavior change activities. Consequently, there is no data to drive programmatic decisions to reinforce or promote other behavior changes. The THSP has focused primarily on increasing awareness and health–related knowledge. Anecdotal accounts suggest that the innovation and piloting of Maternal Care Groups has been successful in changing behaviors among women of reproductive age. These groups are directly responsible for changing such problems as the under-utilization of health services and delayed health care seeking practices. It is safe to say that this has contributed to the reduction of maternal and child morbidity and mortality in the program zone. A more in-depth description of maternal care groups can be found in the Highlight Results of the document.

3. Capacity Building Approach

Strengthening the Grantee Organization

At the field level, due to the program's late start, the THSP staff was unable to benefit from planned capacity building opportunities from KPC baseline data collection, analysis and interpretation or DIP development. These activities took place prior to hiring the program staff. Likewise, at the mid-term evaluation, due to time constraints, program staff focused on focus group data collection while the district concentrated on KPC surveys. Nonetheless, program staff has been monitoring and documenting program implementation and lessons learned. To date, program staff has not had much opportunity for professional development.

With respect to the field office and Africare HQ, at the time the proposal was submitted, Africare had just welcomed Mr. Julius Coles as its new president, who articulated his vision of "Africare being the largest PVO on the African continent," at a 2002 organizational wide strategic planning meeting in Dakar, Senegal. The following organizational development objectives were put forth in the proposal to strengthen Africare namely:

- Promote organizational learning: headquarters and field staff capacity for program design and implementation will be enhanced with increasing cross-fertilization between country programs.
- Develop partnerships between Africare and other PVOs and agencies in implementing child survival programs.
- Improve financial system effectiveness: create real-time interface between HQ and Field operations, avoiding re-work and reducing lag time for production of financial reports.
- Improve human resources aspects: a job classification system and remuneration survey conducted and implemented over time leading to higher staff retention.
- Improved Management Information Systems (MIS): creation of a web-based system allowing country offices for prompt access to resource documentation.

To date, headquarters is in the process of working towards its organizational development objectives. It completed the job classification and remuneration system.

Strengthening Local Partner Organizations

The Tambacounda and Koumpentoum Health Districts, local community-based organizations, and beneficiaries, have been the main partners collaborating with THSP since its launch. The health districts constitute both partners and beneficiaries with respect to capacity building. Their roles and responsibilities include taking the lead in selected health activities such as immunization, vitamin A supplementation, and deworming campaigns, conducting supervisory visits, providing human resources for capacity building and guidance on health-related activities.

In collaboration with the health districts, THSP provided capacity building on reproductive health, obstetric emergencies, contraceptive technologies and Community IMCI with a focus on malaria, nutrition and diarrhea. CBOs and their communities by their sheer numbers comprise the largest partner benefiting from the trainings. Health district staff represents the second largest group. New Health District staff primarily benefited from capacity building on these themes and served as refresher training for veteran health personnel. While most of the District staff had been trained in clinical IMCI, THSP brought a new dimension by introducing community IMCI. This reinforced the Nurse Officer in Charge's (OIC) knowledge and capacity to better supervise CHWs who use these community techniques. In addition to capacity building, Africare Senegal strengthened the Koumpentoum Health district center with some much needed equipment for its set up. Equipment included a fax machine, a universal power source (UPS) machine, a sterilizer and a printer.

The THSP collaborates with UNICEF primarily during its annual Child Survival Days focused on vaccination, vitamin A supplementation, immunizations, deworming, and ITN distribution. UNICEF's role is to ensure child survival through immunization activities, capacity building in immunization and provision of vaccines and equipment. Although the THSP Coordinator attempted on numerous occasions to collaborate with UNFPA, Mr. Babacar Mané, Tambacounda Region UNFPA expert, recognized that he had been unavailable to truly collaborate. Mr. Mané has now taken a position with Population Council beginning in October 2006 and maybe there will be opportunities to collaborate with his successor. Aside from the above, no formal collaboration has taken place with other local partners mentioned in the proposal including TOSTAN, Groupe d'Action pour le Developpement Communautaire (GADEC), Fédération des Groupements Féminins (FGF), Programme de Développement Intégré de la Santé (PDIS).

The program does provide a regular forum for feedback and input from local stakeholders through its Steering Committee. The SC is chaired by the Tambacounda *Prefet* and has 25 members who meet every quarter to discuss the program's progress. Committee members also pay regular visits to project sites and participate in the program's mobilization activities.

As of the mid-term evaluation, THSP had not regularly assessed institutional capacity or its partners' quality of services. The program needs to organize more in-depth discussions with government partners to identify their needs and proceed with an agreed-upon action plan.

Health Facilities Strengthening

To date, the THSP has strengthened health facilities in selected domains. Per the Health Facilities Assessment (HFA) conducted in March 2004, the THSP has focused on the following recommendations: 1. build capacity of community health workers (referred to as lower level health personnel), 2. increase health service utilization by increasing demand

through IEC/BCC; 3. revitalize health committees, 4. provide logistic support for outreach activities; and 5. organize a workshop to sensitize traditional healers on key maternal and child health practices.

The aforementioned activities are in keeping with the program's objectives and adapted to selected facilities' needs for strengthening. Aside from the supervisory tool to assess CHW performance, the THSP has not assessed health facilities since the baseline. Due to budgetary constraints, the THSP opted not to collect any intermediate monitoring data for its health strengthening activities.

The THSP has reinforced linkages between health facilities and communities, though not in all cases. CHWs and TBAs refer cases of malaria, diarrhea, malnutrition, high-risk pregnancies and obstetrical emergencies to health facilities. Health post nurses work together with trained TBAs to deliver normal and high-risk pregnancies as well as obstetric emergencies at the district health facilities. OICs, trained in community IMCI, now have an improved capacity to supervise CHWs and TBAs. They do not always carry out these supervisions on a regular basis. Reasons for irregular supervision include time constraints, lack of organization, and no specified times for activities.

Strengthening Health Worker Performance

Program strategies to strengthen health worker performance concentrate on capacity building and monitoring through supervisory visits. Overall, these strategies have been more effective for some than for others due to the underlying problem of low or incomplete illiteracy. A low level of illiteracy is reflected in the CHW's performance, in the form of incomplete information, misunderstandings and the inability to properly convey health messages. The program's training materials and performance assessment tools are not well adapted for low literacy. For example, the IMCI CHW supervisory tool measures CHW performance, knowledge and ability keep his/her books accurately. The knowledge section fails to test the four critical moments for hand washing, or the definition of malnutrition and some of its causes. During meetings, staff members solve problems and seek solutions with the assessment results to improve service quality. The THSP primarily tries to address these gaps between performance standards and actual performance with more supervisory visits and one-on-one assistance.

Training

The THSP has adopted the cascade training strategy promoted by the MOH. A consultant or senior level specialist trains all senior level district personnel in a training of trainers' session. They subsequently train the next level of personnel who, in turn, train the lower level personnel. The THSP, in collaboration with its partners, has conducted training sessions in the following topics: C-IMCI, reproductive health, contraceptive technology. Below is a summary table of partners who received this training.

Table 1: Capacity Building targets and themes

Target Group	*Total number trained*	*Target*	*Theme*
Community Leaders	***105***		***Reproductive Health***
Health Post Nurse Officers in Charge	***14***		***Reproductive Health***
Traditional Practitioners	***37***[5]	***50***	***Malaria and Reproductive Health***

[5] Traditional Practitioners attended an informational seminar rather than a training.

Trained Traditional Birth Attendants (Matrones)[6]	***25 (Received Refresher training)***	***200***	***Reproductive Health and safe deliveries***
Health Post Head nurses	***16***		***Contraceptive Technology***
Midwives	***2***		***Contraceptive Technology***
CHW, C-IMCI	***186 (C-IMCI), 54 (RH),***	***400***	***C-IMCI***
CHW, RH	***54***		***Reproductive Health***
CHW	***15***	***27***	***Growth monitoring***
Health Post Nurse Officer in Charge and midwives	***51 (21 in Tambacounda and 30 in Koumpentoum)***	***70***	***C-IMCI (51); RH (14); contraceptive Technology (18)***

Pre- and post-test indicated improvement in knowledge. Some participants' skills are assessed through supervisory visits.

4. **Sustainability Strategy**

To date the THSP has focused on five sustainability strategies:

Village Committees
The Village Committees (VC) have been involved in the implementation of activities since the launch of the program. After selecting villages in collaboration with the Districts, the THSP program staff held general assemblies in every participating village. The objective of the general assembly was to:

- Present the program objectives, strategies and activities to community members
- Identify community leaders and other stakeholders, particularly women's groups
- Determine if a Health Committee existed in the village and whether it was active
- Where there was no Health Committee, elect members for a Village Committee
- Together with the members of the VC, select the community health volunteers.

The VCs are the program's representatives in the community. The VCs monitor the work of CHWs and TBAs, and each month receive a copy of the volunteers' monthly report. The VC is also responsible for fund raising and management of funds raised through the cost recovery scheme; they provide a nominal payment to the volunteers from money raised this way. To improve their leadership and management capacities the program will be training VC presidents and treasurers in management and leadership in the coming year. The program aims to progressively capacitate the VCs to take over monitoring of activities in their villages, and to assist them to create viable ways of generating income to support the work of volunteers.

Maternal Care Groups
The THSP has integrated its behavior change activities in already existing networks of women's groups and community-based organizations. The THSP, in collaboration with the

[6] There exists two types of traditional birth attendants: 1. the matrones (trained TBAs) (have completed formal training in reproductive health and delivery); 2. the Accoucheuses traditionnelles (have not received any training in clean and safe deliveries but still deliver in the community, although not recommended by THSP).

presidents of CBOs, divided their membership into smaller groups to create Maternal Care Groups. The program's present 209 Maternal Care Groups (with 18 to 30 members each) have become fora for health discussions, behavior change, monitoring and supporting pregnant and lactating women. They also provide assistance for members who cannot afford transportation costs and or medication. As the groups are within an already existing framework and led by a trained volunteer, this activity seems quite sustainable. Focus group data suggest that women prefer Care Group discussions and have indicated that they were convinced in such a setting to adopt more healthy behaviors. For a more detailed description of the Maternal Care Groups see the Results Highlight section.

Behavior Change Communication

The THSP has established a mentoring system between more experienced mothers and pregnant women to ensure positive behavior change. The strategy relies heavily on trained CHWs for guidance, advice and skills strengthening towards better health management. CHWs conduct home visits and private discussions with husband and wife (sometimes including paternal grandmother depending on the topics) for more attention focused on skills development and negotiating behavior change.

Integration of health service interventions within the GOS health system

The program's premise is to improve the linkage between the community and the district and regional health systems. MOH policies and standards serve as the framework for the program's community health services. Referrals from the community to the health systems serve not only to improve health but also to integrate and link the community with the MOH. Additionally, the MOH integrates the data from community health activities in its statistics.

Community cost recovery of health products

The THSP provided TBAs and RH CHWs with supplies of iron pills, hygiene kits, contraceptives (the pill[7], spermicide, female and male condoms). IMCI CHWs received ITNs, ORS, mebendazole (deworming syrup and pills). CHWs sell these health products at community-affordable prices and restock their supplies. This cost recovery also exists at the health post. However, little remains for CHWs as compensation or motivation for their time and services.

Aside from the cost recovery schemes, the THSP has not yet initiated activities to build financial sustainability. The planned micro-credit component to support health activities and motivate CHWs has yet to be launched. In May 2006, Africare Dakar Assistant Program Manager Ousseynou Samb and Program Manager Gorgui Sène Diallo spent a week in Tambacounda establishing a microcredit action plan.

The THSP staff acknowledge that all steps of the micro-credit action plan have not yet been completed. Although Africare Senegal has sufficient funds to launch the micro-credit component, the Country Representative wants to resolve some outstanding debt issues in the Tambacounda department before releasing additional amounts of credit. The program managers have provided assurances that as soon as these issues are cleared up, the microcredit component of the THSP will be launched.

[7] Women must see qualified personnel at the health post for the first visit and prescription of contraceptive pills. At that time, they receive a three-month supply from the health post and the TBA or RH CHW can refill prescriptions, as long as there are no complications. In the event of problems related to the pill, the TBA must refer the woman to the health post for further check up.

During focus group discussions, the beneficiaries proposed a several alternative funding sources at EOP. Some CHWs suggested that Maternal Care Group members could contribute to a revolving credit scheme where half the members would receive the credit and work and later the other half would benefit from the same. They also stated that income generation activities such as small gardening and trade would help to increase their funds. Other ideas included linking community leaders to financial institutions for increased access to credit and taking advantage of open bank accounts so that Maternal Care Group members and the rest of the community can benefit from financing.

Focus group participants believed that community members and district personnel were the best choices to sustain activities at program end. Village chiefs (for spearheading a decision and endorsing an activity and mobilizing their community), heads of households, women (because they are not as mobile as men seeking employment opportunities), religious leaders (to mobilize men), CHWs (for IEC/BCC activities), Village Committees (responsible for THSP activities, mobilizations, management and inventory of medicines, organizing discussions, encouraging population seek advice and health care from trained TBAs, financial management of products), Maternal Care Group members (to organize microcredit activities) and OICs in Charge (for capacity building) were in the best position to ensure that activities are sustained at program-end.

At present, the program has difficulty evaluating its sustainability factor. The THSP's monitoring system focuses primarily on process data. To date, for instance, the program has established 209 Maternal Care Groups and has enrolled 234 active CHWs. Beyond such process indicators, the program has no system to measure achievement of further sustainability objectives.

C. PROGRAM MANAGEMENT

1. Planning

Since the beginning of the program, the THSP coordination team does most of the planning. The coordination team meets quarterly to plan three months worth of activities. They also meet monthly to assess field activities and resolve constraints. Partners are integrated at various levels and for selected activities. Every program supervisor has a coordination meeting with the community health volunteers of his/her zone to plan activities for the next three months.

The collaboration between program supervisors and District Health Post OICs varies on a case by case basis. Some OICs collaborate more than others. Overall, the Health District and the beneficiaries have been the two main groups involved in participatory program planning.

The THSP field staff, Africare Senegal, Africare HQ personnel, local level partners, and the program communities all understand and have a copy of program objectives. However, not all partners share the program's monitoring and evaluation plan. The program CHWs have tools for data collection. The THSP management team synthesizes program activity monitoring data, discusses problems at monthly meetings and brainstorms solutions to program implementation barriers. As of the midterm, most of the activities are on schedule despite the late recruitment of the Program Coordinator.

Village enrollment seems to be behind schedule. To date, only 123 villages of the 400 have fully launched activities. Another 96 villages in Koumpentoum have recently been enrolled. The late launch of activities, the low number of supervisors (3) during the first two years of the program, and the re-zoning of health districts are among the constraints that have caused delays.

2. Staff Training

The THSP staff received capacity building in C-IMCI (5 days), Reproductive Health (5 days), and supervisory techniques (5 days). They participated in the Training of Trainers. Pre- and post-tests were administered to measure their learning curve during those trainings. Since the initial training no additional assessments have occurred to monitor performance in new skill areas. New supervisor hires as of May 2006 will be fully trained in October of this year.

3. Supervision of Program Staff

The Country Representative directly supervises the THSP Coordinator, who has general oversight of THSP personnel (advisors and supervisors). The MCH and the Communications Advisors manage the supervisors. Per their titles, the MCH Advisor focuses on the technical aspects of the training (i.e., reproductive health and C-IMCI), the Communications Officer concentrates his efforts in social mobilization and IEC/BCC strategies. The supervisors monitor and provide guidance to CHWs in their respective zones.

From a programmatic perspective, supervisory methods include one-on-one consultations, group meetings, and supervisory visits. The THSP advisors schedule several monthly supervisory visits to observe and guide supervisors in their field activities. However, due to logistical constraints, the THSP team supervisory visits are not of optimal frequency. This leaves supervisors without adequate supervision.

In fact, supervision within the THSP constitutes a weak link in the program. The number of staff hired to implement the program remains inadequate. During the first two years of the project, when the THSP had only three supervisors, a single supervisor had up to 27 dispersed villages and more than 50 volunteers to oversee. Currently, with the six newly hired supervisors, each supervisor will be expected to oversee 17 to 20 villages with a minimum of five community workers and committee members per village[8], making a minimum total of up to 100 supervisees per supervisor. The excessive workload and responsibility for training and adequately supervising a low-literate population contributes to making the work all the more labor-intensive. Each supervisor submits a monthly plan of the villages where s/he intends to perform supervisory visits. Each village should receive at least one supervisory visit per month, which means the supervisor needs to travel most days of the month to make the rounds. For various reasons, some CHWs have received more supervisory visits than others since program activities were launched.

In the efforts to supervise and support staff in their work, program staff received technical training in RH and C-IMCI as well as supervisory methods. Three types of planning meetings exist, namely monthly, quarterly and annual. The monthly meetings serve to plan

[8] Supervisors guide Monitoring Committees responsible for THSP activities, mobilizations, management and inventory of medicines, organization of causeries, encouraging communities to seek advice and health care from other community health workers, financial management of products.

activities for the month, review activities implemented in the past month (i.e, compare planned activities to those that were actually implemented) and problem solve through discussion any issues which may have arisen. Quarterly and annual meetings serve only the purpose of planning activities for those periods.

In sum, supervision, at all levels (from the program management staff, to the supervisors, to the community health workers) has suffered due to the program's late start, time constraints, the nature of the terrain, the dispersion of program villages, the excessive workload, and logistical problems.

4. Human Resources and Staff Management [9]

Africare Tambacounda

The Program Coordinator, Ms. Ikupa Akim manages and supervises the THSP team at the Africare Tambacounda office. The rest of the program team is comprised of: the Maternal Health Advisor, Mrs. Kany Sall Diop, the BCC/IEC Advisor, Mr. Saboye Diagne; and nine Project Supervisors, (5 based in Tambacounda health district and 4 based in Koumpentoum health district). The Program Coordinator reports directly to the Africare Country Representative.

Africare Dakar

Africare Country Representative Jim Dean backstops the THSP at Africare Dakar. He also heads the Africare Dakar program team comprised of: 1. Health Program Manager Dr. Mor Ngom, 2. Program Manager Gorgui Sène Diallo, and 3. Assistant Program Manager Ousseynou Samb. The Country Representative reports to Mr. William Noble, Regional Director, Francophone Africa, at Africare headquarters in Washington, D.C.

Washington

Africare's Francophone Regional Office provides the primary operational support to the program. Mr. William Noble, one of Africare's three Regional Directors, now runs this office with the assistance of a team. The Regional Office is responsible for coordinating the technical and managerial inputs of the program.

Africare's Office of Health and HIV/AIDS (OHHA) is the primary source of technical support to the program. The Health Office consists of a technical team of health professionals that assists the headquarters regional offices by providing direct technical support to programs and programs in the field. Mr. Charles De Bose, the unit's director, is a seasoned health professional with many years of experience working in the health sector in Senegal.

Overall, the major human resources and staff changes which have taken place since the DIP include:

- Hiring six[10] additional program supervisors to manage the vastness of the intervention zone.

[9] Adpated from Detailed Implementation Plan: Tambacounda Healthy Start Program in Tambacounda, Senegal, 2004.

[10] Four of the newly hired supervisors since May 2006 are funded under Pfizer funding for Acute Respiratory Infections.

- Appointing a new Regional Director for Africare HQ's Francophone Regional Office. Mr. William Noble now holds this position and has replaced Mr. Myron Golden as of July 2006.
- Nutritionist Jolie Dennis has recently replaced Kendra Blackett-Dibinga as the Office of Health and HIV/AIDS backstop at Africare headquarters.

With respect to the program, all positions have been filled per the proposal. However, there is a need for additional staff namely: a) a Monitoring and Evaluation Specialist; b) additional supervisors to manage the THSP intervention zones, c) a Microcredit Specialist to launch and guide the implementation of the microcredit component and d) a Coordinating Supervisor.

Personnel policies and procedures are available for the Program Coordinator but none are available at the field level for local program staff. Job descriptions for positions are available at the regional and field offices, however, only the Program Coordinator has the version which was distributed to personnel. Other offices have earlier drafts of the job descriptions.

Staff turnover has not been an issue. Some THSP staff members who are veterans of several Africare programs complained about the lack of upward mobility and the lack of salary raises. Morale seems to be low, primarily due to frustrations about low salaries and the excessive workload. While this may impact program implementation, the supervisors remain dedicated to making a difference in the lives of the beneficiaries they serve.

As per Africare's general policy, the THSP will facilitate program staff's transition to other Africare programs when the program ends.

5. Financial management[11]

The Program Coordinator manages the program budget and submits a quarterly request for program activities, salaries and administrative costs to Africare Dakar. The technical team at Africare Dakar reviews the request and compares it with the work plan. Once the request is approved Africare Dakar transfers the requested amount from the THSP account in Dakar to the program account in Tambacounda. The Program Coordinator in Tambacounda signs the checks in payment of all program goods and services.

Monthly program accounting is computerized and forwarded electronically to the Dakar office by the first week of the following month. Hard copies of all receipts and vouchers are also sent. The Africare Dakar accounting office enters its program expenditures into the monthly accounting and then prepares a monthly batch (hard copies) of all program field expenditures. The Financial Manager sends the batch to Africare Washington via DHL by the fifteenth of the following month.

At Africare Washington, the Office of Finance reviews the vouchers, adds any headquarters expenditures and enters the total monthly expenditures into the program's general ledger. On a monthly basis, the Office of Finance reviews fund transfer requests, petty cash imprest and checking payments, petty cash and check disbursement vouchers, charges against expenditure accounts and line item budgets, issuances of advances, and settlement of accounts receivable. Program expenditures are thus tracked at three successive levels: against the monthly activity budget in Tambacounda, against the overall field budget in Dakar and against the combined field and headquarters budget in Washington.

[11] Excerpt adapted from Tambacounda Healthy Start Program Annual Report, Oct. 29, 2005

Africare's Office of Management Services in Washington reviews program recording, the management and use of program and office equipment and supplies, vehicle use, and employee time and attendance records. Africare headquarters provides feedback and specific guidance to the Country Representative and the Program Coordinator resulting from these reviews, to reinforce correct administrative and management practices, and to advise and assist with any needed improvements.

The Program Coordinator does not do financial planning for sustainability for the local partners.

Overall, the financial system seems to pose a problem with respect to delaying program implementation. When the finance department in Washington receives a request, it takes a week or two before the transfer of funds occurs to the Africare Senegal office. By the time the Africare Dakar transfers the funds to the various programs it manages, many Africare programs including THSP have had to interrupt the implementation of planned activities as they await the transfer from the Africare Dakar bank. To further compound the problem, Africare Washington transfers only half the amount requested based on the daily cash balance available the day it is reviewed. While utilizing DHL to expedite batches to the Washington office may have resolved the problem of late batches arriving in Washington, it seems to have created a system of serious over-expenditure for the telephone and mail budgetary line item.

6. Logistics

Not surprisingly, logistics has been a major problem for the program given the difficult nature of the Tambacounda terrain. This has impacted the implementation of the program by delaying supervisory visits, negating planned program activities, and complicating the transportation of program goods and equipment.

Since the beginning of the program, the THSP had been relying on one used Toyota Landcruiser Hardtop for program activities. Three program staff had been juggling the use of this vehicle for work-related purposes, including the support of the Health District's outreach activities. The program team did have access to the PARINS project pick-up truck for emergencies. The logistics office at Africare Dakar would send a spare Landcruiser to Tambacounda when the program vehicle needed repairs or routine maintenance in Dakar.

Since May 2006, Africare has added a second vehicle to the program. The nine supervisors have 125 CC cross-country motorcycles. Most of these motorcycles are second-hand and several are already five years old. They break down frequently. Given the limited mechanical expertise in Tambacounda, the motorcycles must be transported to Dakar for reliable repairs. Spare parts are expensive; repairs can run up to $1,000 and take several weeks. The Africare Dakar logistics office maintains a stock of spare motorcycles that they ship to the field to replace the bikes that are being repaired.

Some program CHWs would greatly benefit from bicycles to transport them from central villages to satellite villages for outreach activities. Although most CHWs work in the village in which they live, some walk a fair distance to neighboring satellite villages for their THSP activities. In sum, transportation logistics will continue to impact program implementation and remain a major challenge for the remainder of the program.

7. Information management

At the midterm evaluation, there was no built-in evaluation system in place to measure progress towards program objectives. The program managers planned to use the mid-term

and the final KPC results to serve this purpose. To date, the program collects only process data and utilizes it to inform decisions on strengthening program activities.

Program staff, partners, and beneficiaries collect and analyze data as follows: CHWs report the types and numbers of activities, as well as the attendance to these activities, on a program-designed form. They also include what types of activities they are planning in the near future. CHWs generate a monthly report for their supervisor, who in turn aggregates all program zone data and submits them to the monitoring and evaluation unit of the program (consisting of the Program Coordinator, the Maternal and Child Health Advisor and the Communications Officer) for synthesis. The program team shares these results at the monthly program coordination meetings, and informs program staff of activity progress, highlights problems and compares planned activities to those implemented.

The program activity data are integrated into the MOH data collection system. In addition to a weekly report on program activities, the Program Coordinator also submits a quarterly technical report to the Africare Senegal office. Most of the data and reports are filed and stored at the Tambacounda program office.

8. Technical and administrative support

As of the mid-term evaluation, the TSHP had not received any external technical assistance. The technical and administrative assistance that it has received has come from the Africare Senegal office and Africare HQ. Africare Dakar has oversight of the Administrative Assistant in Tambacounda and provides administrative support to the program including the translation of documents. The Dakar office has also provided workshops and assistance on the Detailed Implementation Plan, the program implementation plan, a training on the BEHAVE framework, and on the sustainability strategy.

Africare Headquarters (HQ) supports the program by serving as a liaison between the program and the CORE group and with USAID Washington. The Program Coordinator receives information from Africare HQ and CORE updates. Africare HQ provides administrative and technical support, particularly with the annual reports. With the exception of her visit to assist with the DIP, the HQ Health Program Manager has not visited the program since the Program Coordinator was hired. The regional and HQ program backstopping staff devote respectively 25% and 15% time to supporting the program.

9. Mission collaboration

The THSP's technical interventions and activities are in keeping with USAID Senegal's 1998-2006 Strategic Plan for Health. The THSP plays a role in improving maternal and child health through improved service utilization per Strategic Objectives (SO) #3 and Intermediate Results (IR) 3.1 and 3.2. Strategic Objective #3 refers to "Increased and Sustainable Use of Reproductive Health (Child Survival, Maternal Health, Family Planning, and Sexually Transmitted Diseases/AIDS) Services in the Context of Decentralization." THSP contributes to achieving Intermediate Result 3.1, "improved access to quality child survival, maternal health, family planning, and sexually transmitted diseases/AIDS services" through the development of community-level services for maternal and neonatal care and malaria management as well as technical strengthening of the health post level through follow up training and management of obstetric emergencies. It also contributes to IR 3.2 through education and community mobilization including behavior change strategies, training and support of health workers and health committees' capacity building and support, as well as strengthening of referral systems.

Although the Senegal USAID Mission recommended the Tambacounda Department to USAID Washington as an intervention site outside of the USAID Mission's intervention zone to complement and extend the mission's activities in another geographical zone, it has not collaborated with THSP extensively. According to former USAID Child Survival Program Manager, Dr. Mactar Camara, NGOs with USAID Washington funding operating outside of USAID intervention zones should have the freedom to implement their programs without too much USAID Senegal Mission intervention. Dr. Camara, who is now USAID's Policy and Health Financing Specialist,[12] indicated that he had visited the program only once when Mrs. Namita Agravat, the USAID Headquarters Child Survival and Health Grants Advisor came for a visit. Overall, he was impressed with the THSP's Village Committees and Maternal Care Groups. He also indicated that he and the THSP Program Coordinator corresponded electronically to keep each other informed of health-related data or other pertinent information for the THSP program or Tambacounda region.

Considering that the THSP and the USAID mission have had only a superficial relationship, the Mission has not sought to utilize program results and lessons learned. However, during the THSP midterm debriefing, USAID Senegal offered to facilitate a dialogue between the Japanese Agency for International Cooperation (JICA) and Africare to collaborate on strengthening health care facilities with medical equipment and related capacity building. As mentioned earlier in the report, GOS health facilities are ill-equipped to address obstetrical emergencies and third degree malnutrition. JICA has been working in other geographical zones of Tambacounda providing health centers with medical equipment. In the future, USAID Senegal hopes to serve as a liaison to foster collaboration between the two NGOs.

D- OTHER ISSUES

Target Beneficiaries

There seems to be some confusion concerning the target age group for THSP children beneficiaries. The main documents (the proposal, the DIP and the KPC) mention a maternal and newborn health intervention, a target of infants under age one, program activities for children under five, and evaluation of progress towards objectives primarily in the under twos (though the malaria indicator refers to children under five). The lack of consistency and clarity in the program documents has made it difficult to properly limit the boundaries of the evaluation. Considering the initial baseline KPC targeted children under two, the age which is most critical for growth and development, the consultant recommended to continue age appropriate activities for all children under five but measure progress towards final objectives with the KPC and the under twos. However, the program management feels that they need indicators that will capture changes in such areas as stunting for children under five to reflect potential program impact in child beneficiaries that have benefited from interventions at an earlier age. Stunting needs at least 12 months between baseline and comparison measures to reflect improvement in this chronic malnutrition measure. This indicator can therefore be used to capture lag effects in program impact by monitoring stunting percentages in ages 24 to 59 months.

[12] At the writing of this report, Dr. Camara had assumed a new position and title within the USAID Senegal Mission. The consultant chose to interview Dr. Camara as he would have the most current information related to the program. The new Child Survival Backstop, Mrs. Elisabeth Benga De had only assumed her role approximately one month prior to the THSP midterm evaluation visit.

Baseline KPC methodology
According to the methodology utilized for the baseline KPC, the mid-term evaluation consultant is of the opinion that the results may be slightly biased. In section 2.3 Sampling Methodology of the Tambacounda Healthy Start Program Baseline Survey on Knowledge, Practice and Coverage in the field of Child Survival, Final Report, March 2004 (English version); it states "the youngest child within the ages of 0-23 months in each household was recruited [for the survey]." This approach will tend to create a systematic age bias towards the youngest children. Hence, the results may not be as reliable as they might have been and a comparison of both the mid-term and the final results may be impacted. However, it is possible the bias is minimal in the case there are few households with more than one child under the age of two. A more reliable methodology would have been to recruit all children 0-23 months in each household to minimize the age bias. The mid-term evaluation consultant recommended that the mid-term limited KPC address this issue in their methodology.

Budgetary Constraints
The program was under-budgeted for several line items and amply budgeted in the capacity building line item. The original budget allowed for only three supervisors for the 400 program villages. Distances and gas needed to implement activities were not adequately taken into account in the original proposal, particularly for CHW formative supervision. In addition, the initial proposal planned activities on the assumption that there were 200 active TBAs when the THSP launched its activities. At the beginning of the program however, there were only 55 active TBAs in the entire program zone. Another 145 TBAs would need to be trained to meet the proposal's objectives to increase community access to quality services (if the original calculations are correct.) The Tambacounda district health center presently has the capacity to train up to six TBAs per six month period, and thus it would take over four years to train the requisite number. In addition, the program did not budget for any of the six-month training required. The additional funding would need to come from the communities themselves or from a matching grant. In the meantime, as mentioned earlier, the THSP has opted for the less expensive and less-time consuming (but less optimal) alternative of training reproductive health CHWs, who are not officially authorized by the MOH to deliver babies.

To further compound the program's budgetary problems, gas prices have doubled since the inception of the program and the exchange rate has plummeted from 700 FCFA to 500 FCFA to the US dollar. A matching grant from Pfizer to conduct ARI activities in the program zone has allowed the program to hire additional supervisors and to purchase of four new motorcycles.

Communication and Information Sharing
There does not seem to be an effective manner of communicating with all the Africare offices and programs. Some people are informed while others are not; some receive reports while others do not. This creates unnecessary confusion. The Country Representative and the Program Coordinator need to be more consistent in sharing information and reports at meetings at all levels and via email to minimize alienation and increase a sense of team. This problem is not only present with Africare offices but also seems to be a problem with information flowing to and from partners and beneficiaries as well as among themselves.

Establishment of new Health Districts
When the THSP first launched its activities in the Tambacounda Department, Tambacounda was the only health district in the department. Since then, the GOS has divided the

department into three health districts: Tambacounda, Koumpentoum and Maka Koulibantang. When the Koupentoum health district was created in project year two, the program pulled out of Koumpentoum to focus its activities in the Tambacounda district. This was to allow the Koumpentoum health team the necessary time to establish its offices, create a new health center and to hire its staff. In project year three, the THSP has enrolled 96 villages in Koumpentoum. However, the MOH has recently split the Koumpentoum district to create the new Maka Koulibantang district.

E- CONCLUSIONS AND RECOMMENDATIONS

The THSP has progressed well in achieving its objectives. The program has already reached or exceeded the targets for nearly half (9) of the indicators for its seventeen intermediate objectives, with three further indicators near achievement. The program's IEC/BCC strategy mix, combined with the technical expertise of its staff, its productive capacity building, and strong process indicator monitoring have contributed to program successes in each area of intervention.

The THSP has done a particularly good job of implementing the maternal health component, as all intermediate objectives have increased, reached their EOP target, or even exceeded it. The THSP MCH advisor and the Health District's Reproductive Health Coordinator have years of experience in the region and have collaborated closely (even prior to the program); they make a strong team. Under the supervisory umbrella of these two women, the TBAs received a 15-day refresher training and close monitoring to reinforce their skills and knowledge. The TBAs have benefited not only from the initial six-month training with practicum prior to the THSP, but also from many refresher trainings from various programs in the region, particularly from UNFPA which has been active in the area for many years. Altogether, this has contributed to making the THSP's reproductive health component quite strong. The THSP should further strengthen this component by training additional TBAs and providing them with equipment.

While the Child Survival component achieved many of its intermediate objectives in vitamin A supplementation, exclusive breastfeeding, and prevention and management of diarrheal and malaria, these interventions have some weak links. Complementary feeding, nutritional management during **and after** illness, hand washing at four critical times and growth monitoring are all areas where the THSP needs to place more emphasis and effort. Additionally, the program should seek to reduce malaria prevalence by increasing awareness and promoting insect repellants and household sprays.

The Maternal Care Group approach remains the program's most effective behavior change strategy: it stands out as an innovative approach to capturing women's attention and channeling their considerable energy towards improved health seeking practices and the household management of childhood illnesses. Based on the focus group sessions, whether it be women, men, leaders, administrative authorities or the district health personnel, all seem excited about the Maternal Care Group strategy and its potential. Through the Care Groups, the program has managed to overcome difficult cultural barriers, such as the taboo of announcing a pregnancy early. Health discussions within organized women's groups constitute intimate settings where women feel comfortable to express themselves freely and learn at their own pace. This forum empowers women to take the initiative to seek preventive and curative health care for both themselves and their children. The Maternal Care Group serves not only as a forum for education and a source of information, but as an empowering

environment for psychological and social support, and a resource base for those in need of financial assistance.

Overall, social mobilization methods have been successful in mobilizing targeted populations, primarily women of reproductive age. However, the THSP must more consistently engage men and grandmothers. Men control the decision-making power and the financial resources in Senegalese society. After mothers, grandmothers form the largest group of caregivers. They need to understand the premise of exclusive breastfeeding and breast milk composition. The lack of participation in growth monitoring activities, combined with the increase in malnutrition, is also an area of concern. This intervention needs to be improved, and more work must be done to counteract the incentive problems (and other possible factors) that seem to have led to a decrease in growth monitoring. Likewise, the community-at-large would benefit from a session on the importance of actively and frequently feeding young children.

The THSP has been met with a number of constraints including a late start, a vast intervention zone, dispersed villages, inadequate human, financial and logistic resources and health district re-zoning. These constraints have negatively impacted the quality of performance (particularly regarding supervision) and the number of villages enrolled in the program. Given that slightly more than half (219) of the planned 400 villages are enrolled at the program's mid-point, the consultant recommends a scale down of the intervention zone and the number of program beneficiaries, to focus resources on strengthening current program activities.

Despite these odds, the THSP has attained significant results thus far. The program has managed to mobilize populations and to sensitize them towards increased health facility utilization.

The largest concern and barrier to maternal and child mortality reduction remains the inability of district health facilities to accommodate obstetrical and severely malnourished emergencies. The fourth delay is compounded by insufficient and inadequate equipment at the health facilities. There has been a shift in location of maternal deaths from the home to the hospital (or en route to the hospital.) Mothers with obstetrical emergencies are more likely to pass away at the hospital than at home. The quality of care provided to severely malnourished children at the health posts is inadequate. The THSP must locate and collaborate with other donors and programs that can focus on equipping health facilities and providing the necessary capacity building for health personnel.

The THSP has developed strong relationships with its collaborating partners. Program activities including planning, implementation, supervision and evaluation have taken place together at all levels; however, this collaboration is not systematic or consistent for all involved. A more systematic integration of partners (specifically in regard to planning) might strengthen activities with more health district expertise. While the program has increased health district capacity (particularly for newer district employees) in reproductive health, C-IMCI and contraceptive technology, the program should seek to identify other capacity building needs and to expand its institutional strengthening activities.

In sum, THSP has progressed very well towards its intermediate objectives and has overcome a number of constraints. The program's IEC/BCC mix combined with social mobilization

activities have proven successful in changing behavior. The consultant recommends the reinforcement of current activities for increased performance over the rest of the program.

Recommendations

CORE/USAID

Ensure that future maternal health and child survival RFAs allow sufficient financial resources for health systems strengthening. This would allow future programs to procure the medical equipment necessary for obstetric emergencies and the rehabilitation severely malnourished children. Initiating HEARTH child nutrition rehabilitation activities, even as a pilot in the area, could help increase community-based solutions to moderate to severe malnutrition, and could also prevent cases of severe malnutrition needing outside referrals. An alternative would be to assist in linking implementing PVOs with companies who are capable of equipping hospitals and health centers

Tambacounda Healthy Start Program

- Limit program implementation to the 155 central villages and improve coverage of 129 satellite villages to strengthen the current program given the budget, geographical constraints, and logistic issues.

- Realign budget and seek additional funding to support the need for additional human resources and equipment for program implementation.

- Hire or promote a current qualified staff as a Monitoring and Evaluation Specialist whose responsibilities will include assessments in knowledge, behavior change and capacity building among beneficiaries, health facilities and program staff. The M&E specialist will also monitor and manage program supervisors.

- Train program supervisors and district staff in monitoring and evaluation techniques including sampling and survey methodology, data collection and analysis.

- Launch impact evaluation activities to include monitoring of progress towards intermediate objectives and to assess barriers to program implementation.

- Hire more supervisors to alleviate workload for the remainder of program implementation, depending on availability of funds.

- Collaborate further with the Bureau Régional de L'Alimentation et de la Nutrition (BRAN) and explore possibilities for technical reinforcement for the Nutrition component.

- Reinforce the nutrition component with nutrition messages grounded in **F**requency, **A**mount, **D**ensity, **U**tilization and **A**ctive Feeding (FADUA) (See **www.aed.org** for more information).

- Provide refresher training in prevention of infections for TBAs.

- Hire a specialist or promote a currently experienced staff to launch and manage the micro-credit component.

- Study possibilities and solutions to improve logistics for more frequent field visits.

- Supply Trained Birth Attendants outside of health posts with equipment for proper disinfection of obstetric utensils such as pots, gas stoves, timers or watches.

- Provide refresher training to CHWs in RH and IMCI utilizing more hands-on and diversified approaches such as games, creation of songs, and quizzes among others.

- Assist communities to organize appreciation ceremonies in recognition of CHWs.

- Ensure all community work plans have times specified for all activities.

- Increase community awareness about contacting the health post or the Nurse Officer in Charge to mobilize the district's ambulance during emergency situations.

- Plan and ensure that each and every CHW and working in THSP program zone receives formative supervisory visits.

- Better integrate the districts in all levels of planning, implementation, supervision and evaluation of THSP activities.

- Actively engage in mobilizing men and other caretakers including grandmothers to participate in health education and behavior change activities.

- Collaborate with Africare's new community health program to reinforce newborn care activities.

- Ensure that future KPC data collection focuses on children 0-59 months since over the life of the project, child beneficiaries will show potential improvement as they grow older, thus target indicators for under fives could capture this change

Districts

- Ensure that all health posts and the health centers have vitamin A for postpartum supplementation, per MOH guidance.

Community

- Reinforce the maternal health component by mobilizing communities to develop communications and transportation systems for obstetrical emergency evacuations.

- Increase community awareness about contacting the health post or the Nurse Officer in Charge to mobilize the district's ambulance during emergency situations.

- Study possibilities such as micro-credit to provide support to RH CHWs to receive training towards becoming a trained birth attendant.

- Organize appreciation ceremonies in recognition of CHWs.

- Select and replace inactive CHWs.

F- RESULTS HIGHLIGHT

Maternal and child morbidity and mortality in the Tambacounda region are linked to poor health behaviors in the management of childhood illnesses, low utilization of antenatal services, non- or late recognition of danger sign recognition, delayed health care seeking, poor emergency obstetric referral, and poor management of obstetric care. To address these problem, the THSP has used Women's CBOs as a venue to establish Maternal Care Groups; These groups provide a forum for community mobilization, IEC and BCC, microcredit and and the close monitoring and support for pregnant women by more experienced mothers under the guidance of a TBA. Below is a description of the Maternal Care Groups.

Most villages have a CBO of which most of the women of the village are members. This organization is divided into smaller groups of 25 to form the Maternal Care Groups. Women who are not members of the larger CBO may join a Care Group. Criteria to become a member include: 1. monthly financial contributions, 2. regular participation to IEC/BCC activities. Once these two criteria are met, a member can benefit from the microcredit. Maternal Care Group members contribute a monthly minimum of 100F CFA (approximately US$0.20 cents) to the cashbox for the purpose of assisting pregnant women who may need pregnancy-related financial assistance. All borrowed money must be reimbursed.

Pregnant women are identified[13] and paired with a mentor (a more experienced woman who has already had children.) The godmother is responsible for accompanying and ensuring her pregnant mentee attends all her prenatal care sessions, takes vitamins or medicines as prescribed, respects appointments, follows the CHW's advice and doing general home visits. The mentor checks on and monitors her mentee until the latter's child turns two years old (the age when the toddler may be weaned from breastfeeding.)

The Maternal Care Groups are composed of older mothers and women of reproductive age. A group coordinator, a treasurer and an accountant serve on the governing board. Each village has a TBA or a CHW trained in reproductive health, who is responsible for health education and communication reproductive health-related activities which take place within the Maternal Care Groups. In addition to her IEC/BCC obligations, the TBA initiates and draws up a birth plan with family members of the pregnant woman (husband, mother-in-law) beginning at the fifth month of pregnancy and of course, is available for clean and safe deliveries. Each TBA or RH CHW is responsible for a maximum of four or five Maternal Care Groups.

This approach is innovative. Focus group results indicate that women are really excited and motivated by Maternal Care Group activities. The main barrier of seeking prenatal care services from primarily male nurses seems to be overcome with small discussions and awareness activities in the Maternal Care Groups. Prior to Maternal Care Groups, many women hid their pregnancies from the community until their fifth month at which time they would seek their first prenatal consultation. The Maternal Care Group forum seems to create a sense of solidarity and its organization serves as a safety net both from the financial (microcredit) and social support perspectives. At this juncture, it may be too early to confirm quantifiable or impact results directly linked to increased prenatal services utilization and

[13] In Senegal many women hide their pregnancies as long as possible from the community so as to protect their unborn child from the evil eye. Hence, some of the Maternal Care Groups have come up with discreet ways to indicate their early pregnancy status (such as wearing one earring or wearing a certain color pagne), that only Maternal Care Group members would understand, and take them under their wing for antenatal care.

improved health care seeking behaviors. Overall, the Maternal Care Group Intervention reaches 61,624 direct beneficiaries, which constitutes 37% of the population covered by CSHGP at this time.

III. Action Plan

IV. ATTACHMENTS

A. BASELINE INFORMATION FROM THE DIP
B. EVALUATION TEAM MEMBERS AND THEIR TITLES
C. EVALUATION ASSESSMENT METHODOLOGY
D. LIST OF PERSONS INTERVIEWED AND CONTACTED
E. CD WITH ELECTRONIC COPY OF REPORT
F. H. PROGRAM DATA SHEET FORM

ATTACHMENTS

Attachment A: Baseline information from the DIP

The chart below presents THSP objectives, baseline and midterm results by intervention.

Comparative chart baseline and Midterm results

Indicators by intervention	*Baseline KPC %*	*Target %*	*Midterm results %*
Maternal and Child Nutrition /Micronutrients			
Underweight (z score < -2) for children 0-23 months	20	-	24
Percentage of mothers practicing exclusive breastfeeding for six months	24	60	85
Percentage of mothers taking vitamin A forty-two days after delivery	11	60	60
Percentage of children 6-23 months of age receiving vitamin A supplementation in the previous six months	40	80	72
Percentage of households using iodized salt	49	70	59
Control of diarrhea			
Prevalence of diarrhea	45	-	28
Percentage of children aged 0-23 with diarrhea in the last two weeks who received ORS and/or recommended home fluids.	52	65	27
Percentage of children aged 0-23 with diarrhea in the last two weeks who were offered more fluids during the illness.	48	60	57
Percentage of children aged 0-23 with diarrhea in the last two weeks who were offered the same amount or more foods during the illness.	48	60	39
Percentage of children aged 0-23 with diarrhea in the last two weeks whose mothers sought outside advice or treatment for the illness.	31	50	87
Percentage of mothers who usually wash their hands with soap or ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated.	7	50	14
Control of Malaria			
Prevalence of malaria/fever	25	-	50
Percentage of pregnant women with access to IPT	2	60	68
Percentage of caregivers recognizing severe danger signs of malaria and seeking appropriate care within 24 hours	48	60	40
Percentage use of ITNs among pregnant women	18	50	83
Percentage use of ITNs among children under age two	21	50	94
Maternal and Newborn Care			
Percentage of women making at least three antenatal care visits	33	60	60
Percentage of deliveries attended by skilled birth attendants	45	60	55
Percentage of newborns breastfed during the first hour after birth	20	30	33
Percentage of women using at least one modern method of contraception	10	13	21

Attachment C: Evaluation Team Members and their Titles

Tambacounda Healthy Start Program Staff
1. Ms. Ikupa Akim, Program Coordinator
2. Mr. Saboyé Diagne, IEC/BCC Manager
3. Mrs. Kany Sall Diop, Reproductive Health Manager
4. Ms. Yacine Gueye, Supervisor

Koumpentoum Health District
5. Dr. Mamadou Ndiaye, District Chief Medical Officer
6. Mr. Sara Aw, Ex. Primary Health Care Supervisor

Tambacounda Health District
7. Mr. Yoro Baldé, Regional Supervisor for Primary Health Care
8. Dr. Basssirou Ndir, District Chief Medical Officer
9. Dr. Gervais Kabou, District Deputy Chief Medical Officer
10. Mr. Dame Fall, Primary Health Care Supervisor
11. Mr. Lamine Souko, Expanded Programme for Immunization
12. Mr. Papa Saboye M'Baye, Health Education
13. Ms. Fatou Ndiaye Thiamb, Reproductive Health Coordinator

United Nation's Children's Fund (UNICEF)
14. Mr. Fofana Amadi, Tambacounda Regional Health Consultant
15. Mr. Abdoulaye Diop, Kolda Regional Health Consultant

External Consultant
16. Ms. Kim Sanwogou, Team Leader and Evaluation Consultant

Attachment D: Evaluation Assessment Methodology

An evaluation team comprised of 14 members from Africare, UNICEF, the Health Districts of Koumpentoum and Tambacounda and an external consultant conducted the THSP evaluation from September 8 to September 30, 2006. The team utilized a participatory method to develop and validate questionnaires, collect qualitative and quantitative data and provide inputs to the report. Team members divided tasks based on their expertise, interest and availability. The evaluation centered on four main assessment methods namely focus groups, informal interviews, direct observation and surveys for triangulation. A more in-depth description of each method follows.

Focus groups: The evaluation team organized eight focus groups targeting mothers/community-based organizations (2), community leaders (2), men (2) and community health workers (2). The focus groups took place in the villages of Sinthiou Maleme and Botou. The IEC/BCC Advisor provided refresher training to THSP supervisors in focus group methodology. Each supervisor and secretary pair facilitated a focus group from a zone which s/he did not supervise habitually. A number of evaluation team members observed several focus groups. Limitations of this method include the fact that results are not generalized to the wider population.

Direct observation: The evaluation team observed six field activities and sites namely: 1. a growth monitoring session and 2. a culinary demonstration (Koussanar village), 3. a health education session on exclusive breastfeeding and complementary feeding (Koar village), 4. a health post (Missirah village), 5. Radio Crochet and 6. a health education session on diarrheal prevention and management (Medina Sara Khollé village).

Informal interviews: The external consultant conducted individual and group informal interviews of approximately 54 people from the USAID Senegal mission, Africare Senegal, THSP program staff, Tambacounda and Koumpentoum administrative authorities and Health District professionals, as well as local partners.

Survey: A survey team conducted a modified KPC to measure quantitative progress towards objectives. The Program Coordinator as well as survey and evaluation consultants ensured that questions pertaining to CATCH and impact indicators were included in the questionnaire. Thirty villages were selected randomly and a 30 by 10 cluster was utilized to obtain a total sample of 300. A total of 16 questionnaires were not valid and had to be excluded from the original sample of 300, thus reducing the sample size to 284. The evaluation consultant recommended that all children in each household be surveyed and that surveyors over-sample for the 0-6 month age group to ensure a large enough sample for disaggregation by age. This was a corrective measure from the baseline KPC. For a more detailed methodology description, please refer to the full report in Attachment B. The limitations of the midterm survey are three fold: 1. they are based on a limited KPC that 1) did not contain all of the filter questions 2) was done with a limited sample 3) was carried out by a group of interviewers who were not as experienced as those Africare has used in the past.

Attachment E: List of persons interviewed and contacted

Division de l'Alimentation, de la Nutrition, et de la Survie de l'Enfant (DANSE)

1. Dr. Youssou Gaye, Director

United States Agency for International Development Senegal Mission

2. Dr. Mactar Camara, USAID, former Child Survival Program Manager
3. Ms. Ramatoulaye Dioume, USAID HIV/AIDS/TB Chief Technical Officer (CTO)

Africare Senegal (Dakar)

4. Dr. Jim Dean, Country Representative
5. Mr. Gorgui Sène Diallo, Program Manager/Management Information Systems specialist
6. Dr. Mor Ngom, Health Program Manager
7. Mr. Ousseynou Samb, Program Officer
8. Mrs. Aissatou Bakhoum, Financial Manager
9. Mrs. Lacha Fall, Administrative Assistant

Africare Tambacounda Healthy Start Program Staff

10. Ms. Ikupa Akim, Program Coordinator
11. Mr. Saboyé Diagne, IEC/BCC Manager
12. Mrs. Kany Sall Diop, Reproductive Health Manager
13. Mr. Alpha Diallo, Superviseur, Arrondissement Koumpentoum (Rural communities of Koumpentoum and Kouthiaba)
14. Mr. Abdoulaye Diallo, Superviseur, Arrondissement Koussanar (Koussanar, Sinthiou Malème)
15. Ms. Yacine Guéye, Supervisor, Tambacounda Commune and Arrondissement Missirah (Nétéboulou, Hafia, Pont)
16. Mr. Amadou Bassirou Diawara, Superviseur, Arrondissement Missirah (Missirah, Bira)
17. Mr. Kandara Seck, Superviseur, Arrondissement Missirah (Dialocoto, Tessan)
18. Ms. Ndèye Thiab Diouf, Superviseur, Arrondissement Koussanar and Tambacounda Commune (Saré Guilèle, Bohé Balédji)

Tambacounda Medical Region

19. Mr. Mamoudou Tidiane Dia, Chief Medical Officer, Regional Bureau for Immunization and Epidemiologique Surveillance (BRISE)
20. Mr. Yoro Baldé, Regional Supervisor for Primary Health Care

Administrative Authorities-Tambacounda Department

21. Mr. Cheikh Anta Dieng, Deputy Préfet
22. Mr. Balla Ndiaye, Deputy Sous-Préfet, Missirah
23. Ms. Oumou Diallo, President, Association of Locally Elected Women and Deputy Mayor of Commune of Tambacounda

Koumpentoum Health District

24. Dr Mamadou Ndiaye, District Chief Medical Officer
25. Ms. Amy Sarr, Deputy Midwife
26. Mr. Bocar Diallo, Primary Health Care Supervisor
27. Mr. Sara Aw, former Primary Health Care Supervisor

Tambacounda Health District

28. Dr. Basssirou Ndir, District Chief Medical Officer

29. Dr. Gervais Kabou, District Deputy Chief Medical Officer
30. Ms. Fatou Ndiaye Thioub, Reproductive Health Coordinator
31. Mr. Lamine Sonko, Expanded Programme for Immunization
32. Mr. Papa Saboye MBaye, Health Education
33. Mr. Dame Fall, Primary Health Care Supervisor/Health Nurse, Afia
34. Ms. Thérèse Cécile Faye, Health Post Deputy Nurse Officer in Charge, Koussanar
35. Mr. Bra Seye Niang, Health Post Nurse Officer in Charge, Sinthiou Malème
36. Mr. Amadou Doucouré, Health Post Nurse Officer in Charge, Saré Guilèle
37. Mr. Thierno Seye, Health Post Nurse Officer in Charge, Missirah
38. Mr. Thomas Fall, Health Post Nurse Officer in Charge, Dialacoto

LOCAL PARTNERS

Koar Village
39. Mr. Tidiane Tamba, CHW, IMCI

Koussanar Village
40. Mr. Samba Yatassaye, C-IMCI
41. Mr. Aldiouma Diallo, CHW
42. Mr. Gallo Diallo, President, Cases des Tout Petits (Huts for the little ones)

Community Health Workers
43. Ms. Aminata Traoré, Trained TBA, Botou
44. Ms. Awa Sow, RH CHW, Djinkoré
45. Mr. Hamadi Diallo, C-IMCI CHW, Djinkoré
46. Mr. Abdoulaye Diallo, CHW, Madina Dian
47. Mr. Dady Sow, CHW, Sinthiou Malème
48. Ms. Nafissatou Dansouba, Trained TBA, Touba
49. Mr. Mamadou Dansokho, CHW, Guinguinéo
50. Mr. Bou Fofana, C-IMCI CHW, Botou

Association of Traditional Practitioners
51. Mr. Amadou Oury Kane, Tambacounda Regional President of Health Traditional Practitioners
52. Mr. Mamadou Seime, Secretary General of Tambacounda Department
53. Mr. Boubacar Seime, Secretary General of the Region

Bilateral organizations
54. Mr. Babacar Mané, UNFPA Expert, Tambacounda Region
55. Mr. Fofana Amadi, UNICEF, Tambacounda Regional Health Consultant

Attachment F: CD with electronic copy of the report in MS Word 2000

Attachment G: Program Data Sheet form—Updated version

Attachment H: Action Plan (See attached Excel Spreadsheet)

ACTION PLAN THSP (October 2006- September 2007)

			TRIM 1			TRIM 2			TRIM 3			TRIM 4		
			October	November	December	January	February	March	April	May	June	July	August	September
Reccomendation	**Activity**	**Responsible**												
1. Limit program implementation to the 155 central villages and improve coverage of 64 satelite villages to strengthen the current program given the budget, geographical constraints, and logistic issues	Census of villages that can feasibly be covered by CHW on bicycle	Consultant												
	Purchase of bicycles for CHW who regulalry carry out activities in satellite villages	Dakar												
2. Realign budget and seek additional funding to support the need for additional human resources and equipment for program implementation	2.1 Realign THSP budget based on information from accrual.	Dakar												
	2.2 Submit revised budget to USAID for approval.	Dakar												
	2.3 Discuss with USAID the possibility of submitting a concept paper to receive funds from the PMI for	Dakar												
3. Hire or promote a current qualified staff as a Monitoring and Evaluation specialist whose responsibilities will include assessments in knowledge, behavior change and capacity building among beneficiaries, health facilities and project staff. The M&E specialist will also monitor and manage program supervisors.	3.1 Advertise post of M& E Officer in local media (pending budget realignment and approval)	Dakar												
	3.2 Interview and shortlist candidates	Dakar												
	3. 3 Hire M&E Officer	Dakar												
4. Launch impact evaluation activities to monitor progress towards intermediate objectives and to assess barriers to program implementation.	4.1Determine intermediate target indicators for each technical intervention	THSP PC/ M&E Specialist												
	4.2 Identify and plan appropriate evaluation activities	THSP M&E Specialist												
	4.3 Collect data for relevant indicators	THSP M&E Specialist												
	4.4 Feedback of evaluation to program team, partners and other stakeholders	THSP M&E Specialist												
5. Hire more supervisors to alleviate workload for the remainder of program implementation, depending on availability of funds.	5.1 Recruit several supervisors depending on resources available after budget realignment	THSP PC												
	5.2 Determine zones of supervisoin and assign villages to new supervisors	THSP PC												
6. Collaborate further with the Bureau Régional de L'Alimentation et de la Nutrition (BRAN) and explore possibilities for technical reinforcement for the Nutrition component	6.1 Meet with BRAN Regional focal point to discuss areas of collaboration	THSP MHA												
	6.2 Develop a joint plan of action for nutritional intervention	THSP MHA												
7. Reinforce the nutrition component with nutrition messages grounded in Frequency, Amount, Density, Utilization and Active Feeding (FADUA)	7.1 Prepare a technical sheet using relevant FADUA messages	THSP PC/MHA												
	7.2 Orient project Supervisors and OIC in use of the technical sheet for training CHW	THSP MHA												
	7.3 Train CHW and TBAs during coordination meetings	THSP Supervisors and District OIC												
	7.4 Carry out supervisions of nutrion IEC/BCC activities	Supervisors,OIC and Coordination												
8. Hire a specialist or promote a currently experienced staff to launch and manage the micro-credit component	8.1 Recruit a Micro-credit specialist	THSP PC												
	8.2 Complete enrolment of beneficiary groups	MC Specialist												
	8.3 Develop list of incime generating activities and estimation of finacial	THSP, MC Specialist												
	8. 4 Identify partner Micro-credit Institutions and sign MOU	THSP, MC Specialist												
	8.5 Establish monitoring committees at zonal level	THSP, MC Specialist												
	8.6 Traind CBO members and develop business plans	THSP, MC Specialist												
	8.7 Dispensing of loans and financial and technical supervision of micro	THSP, MC Specialist												
9. Study possibilities and solutions to improve logistics for more frequent	9.1 Purchase new motorcycles to replace older motorcycles	Africare Senegal CO												

			TRIM 1			TRIM 2			TRIM 3			TRIM 4		
			October	November	December	January	February	March	April	May	June	July	August	September
	9.2 Plan and carry out quarterly supervision visits with OIC	THSP Coordination team												
10. Retrain TBAs on prevention of infections	10.1 Provide continuous training on prevention of infections during coordination meetings	THSP MHA												
11. Provide refresher training for CHWs in key messages and diversiefied communication techniques	11.1Refresher training of CHW and TBAs using manual developed by THSP supervisors and Peace Corp Volunteers	THSP Supervisors, Health Post OIC, PC Volunteers												
	11.2 Ensure regular supervision of trained CHW	THSP Supervisors, Health Post OIC												
12. Assist communities to organize appreciation ceremonies in recognition of CHW	12. Meet with village committees to plan appreciation ceremonies for CHWs selected as best worker at coordination meeting	THSP Supervisors, Health Post OIC												
13. Increase community awareness about contacting the health post to mobilize the district's ambulance during emergency situations	13. Meet with District and village committees to discuss how ambulance can be contacted regularly	THSP PC, Supervisors												
14. Plan and ensure that CHW and TBAs undergo formative supervision within a calender year	14.1 Develop detailed supervision calender	THSP M&E Specialist												
	14.2 Supervision of field activities including formative supervision	THSP M&E Specialist												
15. Actively engage in mobilizing men and other caretakers including grandmothers to participate in BCC activities	15. 1 Group discussions and other IEC/BCC activities for men and grandmothers	THSP IEC Officer												
16. Collaborate with Africare's WEER community program to reinforce newborn care activities	16.1 The Community health project field activities will effectively start in February 07	The Dakar office will ensure smooth collaboration between both projects												
17. Revise and ensure that all objectives refer to children 0-23 months since KPC focus on that target group	17. 1 Revise project objectives and indicators	THSP Coordination team												
	17.2 Share new indicators and objectibbves with Steering Comittee members and other stakeholders	THSP PC												