



CHILD SURVIVAL PROJECT
'For Di Pikin Dem Wel Bodi'
Koinadugu District, Northern Region, Sierra Leone
CSXIX Standard Category
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A. Acronyms and Abbreviations

| | |
|----------|---|
| ACT | Artesunate Combination Therapy |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| APM | Assistant Project Manager |
| ARI | Acute Respiratory Infection |
| BCC | Behavior Change Communication |
| CARE-SL | CARE Sierra Leone |
| CBGP | Community Based Growth Promotion and monitoring |
| CBO | Community-Based Organization |
| CES | Christian Extension Services |
| CHC | Community Health Club |
| Chiefdom | Third level administrative unit in Sierra Leone, under the District. |
| C-IMCI | Community-Based Integrated Management of Childhood Illnesses |
| COPE | Client Oriented Provider Efficient |
| CRS | Catholic Relief Services |
| CSP | Child Survival Project |
| CSTS | Child Survival Technical Services |
| DC | District Council |
| DFID | British Department for International Department |
| DHMT | District Health Management Team |
| DIP | Detailed Implementation Plan |
| District | Second level administrative unit in SL, under the Region and above the Chiefdom |
| DMO | District Medical Officer |
| EmOC | Emergency Obstetric Care |
| ENA | Essential Nutrition Actions |
| EPI | Expanded Program on Immunization |
| GOSL | Government of Sierra Leone |
| HMIS | Health Management Information Systems |
| HIV | Human Immuno Deficiency Virus |
| IEC | Information Education and Communication |
| IMCI | Integrated Management of Childhood Illnesses |
| IPT | Intermittent Presumptive Therapy |
| ITN | Insecticide Treated Mosquito Net |
| KDC | Koinadugu District Council |
| KPC | Knowledge, Practice and Coverage |
| LQAS | Lot Quality Assurance Sampling |
| MCH | Maternal and Child Health |
| M&E | Monitoring and Evaluation |
| MMR | Maternal Mortality Rate |
| MNC | Maternal and Newborn Care |
| MOHS | Ministry of Health and Sanitation, Government of Sierra Leone |
| MTE | Mid Term Evaluation |
| NGO | Non-Governmental Organization |
| ORS | Oral Rehydration Solution |
| PHU | Peripheral Health Unit |
| PM | Project Manager |
| RDT | Rapid Diagnostic Test |
| Region | The largest administrative unit at the sub-national level |

| | |
|--------|--|
| SCM | Standard Case Management |
| SL | Sierra Leone |
| TA | Technical Assistance |
| TBA | Traditional Birth Attendant |
| TT | Tetanus Toxoid |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VDC | Village Development Committees |
| WFP | World Food Program |
| WRA | Women of Reproductive Age |

B. Executive Summary

Project Description: The CARE Sierra Leone's Child Survival Program (CSP) is a 5-year standard category USAID Cooperative Agreement. The project is implemented in partnership with the Sierra Leonean Ministry of Health and Sanitation (MOHS), District Health Management Team (DHMT) in Koinadugu District in the northern region of the country. Direct beneficiaries include 19,198 children under age five and 27,101 Women of Reproductive Age (WRA) within the five chiefdoms. It should be noted that the beneficiary estimates quoted in the DIP document and the Mid Term Evaluation (MTE) are for the entire district. The project indirectly reaches 39,836 under five children and 56,239 WRA in all eleven chiefdoms of the district through the DHMT.

The goal of the project is to improve the health status of children under five and women of reproductive age (WRA) Principle objectives of the program are: 1) Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to prevent, recognize and manage common diseases; 2) Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms; and, 3) Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services. The project interventions, EPI (15%), nutrition (20%) malaria (35%) and MNC (30%) are designed to be implemented using the C-IMCI strategy¹.

Main Accomplishments – Health Outcomes: The project achieved immense success in improving health outcomes, changing behaviors and increasing utilization of services. ***The indicators which performed beyond project targets*** and demonstrated statistically significant differences include: early initiation of breast feeding (20% - 70%); exclusive breast feeding among 0-6 month infants (8% - 68%); children 6-23 months receiving Vitamin A (68%-82%); women receiving post natal Vitamin A (18% - 67%); children 0-23 months sleeping under insecticide treated bed nets (1%-83%); children 0-23 receiving malarial treatment within 48 hrs of fever (27% - 51%); mothers who took prophylactic malarial treatment during pregnancy (31% - 77%); women of reproductive age group who knew two obstetrics danger signs needing referral (38% - 75%); mothers who knew two neonatal danger signs (7% - 44%); skilled birth attendance (15% - 34%); mothers who received two tetanus toxoid injections during last pregnancy (47%-78%); and children completely vaccinated before first birthday (46%-66%). The only indicators which demonstrated deterioration was proportion of mothers giving increased fluids and feed to a sick child. This deterioration was due to how the indicator was calculated during the baseline. Focus group findings suggest that women and men were found to be fairly aware of the importance of increased fluids and feed and admitted to practicing the behavior.

Strengthened Community Capacities: The project organized the community into health clubs (CHC); trained them in maternal/child survival and general health and rights issues; and promoted community led action and participation in the delivery of health services through the Village Development Committees (VDC). Furthermore the project worked with the local government structures—and the District Council (DC). Project mobilized and organized 54 CHCs in direct intervention communities. The CHC members have been instrumental in revitalizing 394 CHCs across Koinadugu. It must be noted that there were 92 CHCs (with varying degrees capacities) in the district at the onset of the project. Among CHC members, volunteers were selected specifically to provide community-based growth monitoring and counseling services within and beyond their communities. CHC members are also supporting outreach activities of the Peripheral Health Unit (PHU) staff. Communities' participation has matured beyond health and in collaboration with the strengthened

¹CARE SL CS XIX DIP, 2004.

VDCs they are addressing developmental issues as well. For example, community demand has resulted in the construction of wells, latrines and even a PHU in one village.

Health System Strengthening: Using the COPE methodology, and the capacity building approach, the project achieved significant improvements in quality of services; availability of staff; improved logistics and drug availability; network for emergency referral; strengthened accountability; and most importantly community participation in formal health system.

Policy Changes: CARE has made concerted effort at the national level to advocate for the early roll-out of IMCI and development of C-IMCI strategy. This has taken time and will hopefully come to fruition in the next six months.

Sustainability: The immense amount of community participation and ownership generated by the project will ensure sustainability of behaviors. However, this will need to be matched with continuing support to CHCs; continued focus on at least maintaining health systems at the current performance levels; and support to VDCs to ensure their role in providing leadership to health and developmental activities. CARE will be scaling up CHC strategy through its other projects in the region. The strong leadership at the district level has also been instrumental in replicating interventions effectively. CARE will need to document some of the initiatives (for example birth waiting homes) to enable national level advocacy and replication.

Table 1: Impact Model Element for *For Di Pikin Dem Wel Bodi*

| Inputs | Activities | Outputs | Outcome | Goal |
|--|--|--|---|--|
| CHC package and additional IEC material | Formation of CHCs | 54 CHCs formed | Improved antenatal care practices | Improve the health status of children under five and women of reproductive age |
| Weighing scales and counseling material | Training of community group in CHC package | 394 CHCs revitalized | Increased institutional deliveries | |
| ITN, drugs and services through the DHMT and UNICEF | Training of community in Village Savings and Loan scheme | 135 VS&L groups with a savings of USD 10,565 | Improved breast feeding and child nutritional practices | |
| Training of project staff and PHU staff in CHC package, Essential nutrition action, malaria and IMCI | Formation of Pregnant women's Support group | 27 PWSGs formed meeting regularly and promoting positive health practices | Increased number of children utilizing ITNs | |
| Training of 88 vaccinators in immunization techniques | Selection of Community based growth promoters | 324 volunteers carrying out monthly growth monitoring activities and counseling mothers of malnourished children | Increase in utilization of malaria curative services | |
| Monitoring and supervision | Orientation to Village development committees and Koinadugu Development Council | 108 VDCs monitoring and promoting the utilization of ITNs, ANC, immunization and institutional deliveries | Improvement in general sanitation and hygiene in the community | |
| Refresher meetings | COPE assessments and health system strengthening activities | 22 birth waiting homes being supported and utilized by the communities | Community led demand for development – resulting in safe water sources, schools, health centers being established | |
| Advocacy | Community monitored distribution and utilization of services | | | |
| | Outreach programs to un-reached areas | | | |
| | Establishment of referral and emergency transport system through hammocks, radio and ambulance | | | |

C. Assessment of Results and Impact of the Program

1. Results: Technical Approach

The CARE Sierra Leone's Child Survival Project (CSP) is a 5-year standard category USAID Cooperative Agreement. The project is implemented in partnership with the Sierra Leonean Ministry of Health and Sanitation (MOHS), District Health Management Team (DHMT) in Koinadugu District in the northern region of the country. The program was one of the first two CSHGP grants awarded in Sierra Leone following the end of a tragic 11-year civil war and follows several years of direct humanitarian relief activities by international organizations and NGOs in the area. The CS XIX project spans the period from October 1, 2003 to September 30, 2008. The project budget is \$2,013,054 with \$1,488,582 from USAID and \$524,472 from CARE.

This report has utilized quantitative data from the project baseline and end line which included anthropometric surveys; Radio Listener's survey; district HMIS; and national level surveys with district data to arrive at conclusions. Further, the report also refers to qualitative surveys conducted to study the effectiveness of CHC approach and the qualitative data from the special study on nutrition interventions.

a. Brief Overview of the Project

Goal and Objectives: The goal of the project is to improve the health status of children under five and women of reproductive age (WRA) in five chiefdoms of Koinadugu District. Principle objectives of the program are: 1) Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to prevent, recognize and manage common diseases; 2) Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms; and, 3) Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services.

Project Location: The project was implemented in the five chiefdoms of Koinadugu district situated in the northern region of Sierra Leone. Koinadugu district is divided into eleven chiefdoms. The chiefdoms covered by the project include, Wara Wara Yagala, Sengbeh, Folosaba Dembelia, Dembelia Sinkunia and Neini. There are 415 communities in the five chiefdoms with a population of 112,921. The project has intensive interventions in 54 of these '**direct**' communities through field workers and community structures; and implements interventions through the Peripheral Health Unit (PHU) staff in the 361 '**indirect**' communities. Some activities of the project have been replicated in additional 46 communities in four non-CSP chiefdoms through the efforts of the District Health Management Team (DHMT) and CARE's Malaria Outreach and Safety Initiative (MOSI) project and other agencies.

Beneficiary Population: Direct beneficiaries include 19,198 children under five age five and 27,101 Women of Reproductive Age (WRA) within the five chiefdoms. It should be noted that the beneficiary estimates quoted in the DIP document and the Mid Term Evaluation (MTE) are for the entire district. The project indirectly reaches 39,836 under five children and 56,239 WRA in all eleven chiefdoms of the district through the DHMT.

Table 2: Coverage and Beneficiaries

| Basic Information | CS Program Chiefdoms | | | | | |
|--|----------------------|---------|-------------------|-------------------|--------|---------|
| | Wara Wara Yagala | Sengbeh | Folosaba Dembelia | Dembelia Sinkunia | Neini | Total |
| Number of direct communities | 13 | 12 | 12 | 11 | 6 | 54 |
| Number indirect communities | 51 | 57 | 82 | 48 | 123 | 361 |
| Total Population | 24,962 | 21,671 | 13,775 | 12,327 | 40,186 | 112,921 |
| Under 1 years population | 998 | 867 | 551 | 493 | 1,607 | 4,516 |
| Expected Pregnancies | 1,248 | 1,084 | 689 | 616 | 2,009 | 5,646 |
| Under five population | 4,244 | 3,684 | 2,342 | 2,096 | 6,832 | 19,198 |
| Women of reproductive age group | 5,991 | 5,201 | 3,306 | 2,958 | 9,645 | 27,101 |
| Community Health Clubs (CHC) in direct communities | 13 | 12 | 12 | 11 | 6 | 54 |
| CHCs in indirect communities | 55 | 51 | 135 | 40 | 113 | 394 |
| Peripheral Health Units (PHU) in direct communities | 1 | 2 | 4 | 2 | 2 | 11 |
| PHUs in indirect communities | 2 | 4 | 0 | 2 | 3 | 11 |
| Village Savings and Loans Scheme (VS&L) groups in direct communities | 18 | 26 | 16 | 16 | 6 | 82 |
| VS&L groups in indirect communities | 27 | 18 | 7 | 1 | 0 | 53 |
| Community Based Growth Promoters | 78 | 72 | 72 | 66 | 36 | 324 |
| Data Surveillance volunteers | 10 | 10 | 10 | 10 | 12 | 52 |
| Village Development Committees | 95 | 113 | 111 | 88 | 61 | 468 |
| Pregnant women's support groups | 5 | 8 | 5 | 5 | 4 | 27 |

Intervention Mix: The project interventions, EPI (15%), nutrition (20%) malaria (35%) and MNC (30%) are designed to be implemented using the C-IMCI strategy².

Project Strategy: The Project implemented the following four interventions through the Community-Integrated Management of Childhood Illnesses (C-IMCI) strategy:

The **EPI intervention** focused on raising vaccination coverage of children. CARE worked with communities and MOHS to promote EPI outreach through the formation and strengthening of Community Health Clubs (CHC). The project developed the ability of CHCs to use appropriate BCC strategies to increase demand for and utilization of EPI services. Further the project improved the quality of services by supporting the training of vaccinators at the PHU, improving outreach activities of the PHU and linking communities and PHUs for effective implementation of the government's EPI program. The project adopted the COPE methodology for enhancing the quality of services provided through the facilities.

The **nutrition intervention** worked through CHCs and Community Based Growth Promoters (CBGPs), who are CHC members specifically trained for the purpose of promoting the early initiation of breastfeeding, exclusive breastfeeding (EBF), complementary feeding, growth monitoring and improved Vitamin A (VA)/iron intake for women and children. Further the capacity of the PHU staff was built to promote positive nutritional behaviors among mothers and children. Pregnant Women's

²CARE SL CS XIX DIP, 2004.

Support Groups (PWSG) was formed at each PHU to promote positive nutritional behaviors among pregnant women. CARE's complementary multi-sectoral activities like livelihood and food security project (LEAD), and Water and Sanitation project further supported improved nutritional behaviors in the community.

The **malaria intervention** confronted the high prevalence of malaria and self-treatment by training PHU staff in recognition of malaria and standard case management, educating community members about malaria and its treatment through CHCs, promoting intermittent treatment of malaria amongst pregnant women, and promoting and selling insecticide treated mosquito nets (ITNs) through social marketing with the involvement of Village Development Committees. This was further supported by CARE's MOSI project which is focused on malaria prevention and treatment.

The **MNC intervention** focused on improving access to information and basic maternal health care by through PWSG and CHC based educational sessions on danger signs recognition, birth preparedness at the community and household level, promoting TT vaccination and iron supplementation for pregnant women and VA supplementation for postpartum women, and training PHU staff in intermittent prophylaxis of malaria in pregnant women. Further the establishment of Village Savings and Loans (VS&L), which emerged as a response to the need for funds during obstetric emergencies, supported prompt referrals of pregnant women to PHUs and district hospital. Referrals were also supported by establishment of a hammock system in each community and establishment of 22 community contributed/supported birth waiting homes.

In addition to the complementary projects mentioned above, CARE worked in collaboration with other international and national agencies working in the district through the district level health sector coordination committee. Project benefited from the presence of infrastructural projects of Government of Sierra Leone (provision of safe water and sanitation facilities); and USAID supported food security projects and birth waiting homes constructed by Catholic Relief Services. Koinadugu also receives support for malaria interventions funded by the Global Funds

b. Summary Monitoring and Evaluation Table

Table 3: Summary Monitoring and Evaluation Table

| Objectives | Indicators | Baseline | Final | Target | Explanation or Reference |
|---|--|----------|-------|--------|--|
| Strengthened family and household knowledge and decision-making skills related to health of women and children | % of children aged 0-23 months who were breastfed within the first hour after birth | 19.5% | 69.1% | 35% | Achieved, exceeded targets |
| | % of children aged 6-9 months who received breast milk and complementary foods during the last 24 hours | 69.8% | 74.3% | 80% | Improved on baseline but target not achieved |
| | % of children aged 0-23 months who slept under an ITN the previous night. | 0.57% | 81.2% | 15% | Achieved, exceeded targets |
| | % of mothers who took anti-malarial medicine to prevent malaria during pregnancy. | 31.0% | 72.9% | 50% | Achieved, exceeded targets |
| | % of women aged 15-49 who know at least two symptoms that indicate the need to seek referral for emergency obstetric care. | 37.8% | 74.5% | 65% | Achieved, exceeded targets |
| | % of mothers able to report at least two known neonatal danger signs. | 7.4% | 44.1% | 35% | Achieved, exceeded targets |

| | | | | | |
|--|--|-------|-------|-----|--|
| Improved quality and accessibility of services provided by MOHS | % of children aged 12 – 23 months who are fully vaccinated | 45.7% | 66.0% | 60% | Achieved |
| | % of mothers with children aged 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child less than 24 months of age. | 47.2% | 69.1% | 65% | Achieved |
| | % of mothers who received/bought ≥ 90 iron supplements while pregnant with the youngest child less than 24 months of age. | 60% | 86.6% | 75% | Achieved |
| | % of children aged 0-23 months whose births were attended by skilled health personnel. | 15.1% | 34.2% | 30% | Achieved |
| | % of health facilities that received at least one supervisory visit that included observation of management during the previous six months. | 42% | 60% | 57% | Achieved |
| Enhanced community capacity to sustain health initiatives | % of health clubs implementing at least four health promotion activities per year | 42% | 100% | 57% | Achieved, exceeded targets, went beyond project coverage areas |
| | % of HCs with documented female membership of at least 40%. | 0 | 98% | 90% | Achieved |

c. Progress Report by Intervention Area

c.1 Expanded Immunization Program

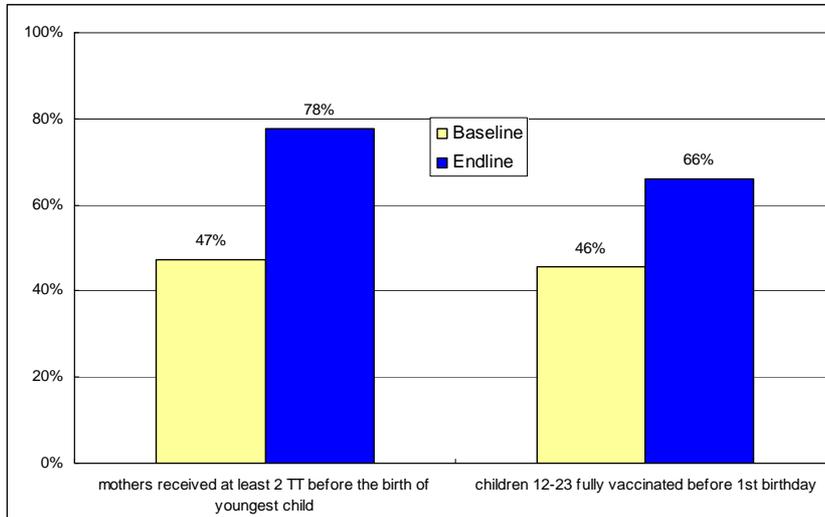
i. Results and Outcomes

The EPI intervention focused on raising vaccination coverage of children. CARE worked with communities and MOHS to promote EPI outreach through the formation and strengthening of Community Health Clubs (CHC). The project developed the capacity of CHCs to use appropriate BCC strategies to increase demand for and utilization of EPI services. Further the project improved the quality of services by supporting the training of vaccinators at the PHU, supporting outreach activities of the PHU and linking communities and PHUs for effective implementation of the government's EPI program. The project adopted the COPE methodology for enhancing the quality of services provided through the facilities.

While the proportion of children aged 12-23 months fully immunized before first birthday increased significantly (45.7% at Baseline to 66.0% at End line), there was no change in the proportion of children aged 12-23 months who received measles vaccine (69.5% at BL to 70.4% at EL). Three fourth of the survey population had an immunization card. The access to immunization services, ascertained by percentage of children aged 12-23 months receiving DPT1 before their first birthday, was high at 94% at baseline and was maintained through the project life (EL 96.3%). The performance of the health systems in providing immunization services demonstrated a significant improvement, as ascertained by the reduction in the drop out rate between DPT1 and DPT3 (39% at BL to 16% at EL). 81% of children were receiving DPT3 vaccine before they turned one compared to 57% at baseline. However challenges to achieving high measles coverage remain. While the general awareness for the

importance of immunization has increased, there are challenges associated with access to immunization services, which are discussed in the next section. Similarly tetanus coverage among women increased significantly (47% at BL to 69.1%). Issues related to Tetanus vaccine are covered under the MNC section.

Figure 1: CSP Achievements in EPI coverage



ii. Factors affecting achievement of the objectives and outcomes

Community members (both men and women) in focus groups displayed a fair knowledge of immunization and were accessing care either through the outreach immunization clinics or the health facilities. While the women were found to have in-depth knowledge about the various vaccinations received, the knowledge levels of men was restricted to understanding the importance of childhood vaccinations and their timeliness. The increased levels of awareness among men facilitated the decision for accessing immunization services.

“I might not know the details of all the vaccines but I ensure that my child attends immunization sessions and receives the vaccination” –father of an infant from Gbentu village

The establishment of Community Health Clubs (detailed in the community mobilization section) in the project direct communities provided an opportunity for both women and men to receive health information hitherto unavailable in such concerted manner. The ‘communicating health, communicating rights’ (CHCR) package is a comprehensive health information curriculum developed by CARE and adapted by the project. The rigorous weekly sessions in key public health issues, followed by certification have been accorded much value by the community members. The concept of CHC promotes volunteerism among the members and this has led to many community led interventions in the district. The CHC volunteers support the organization of outreach, by dissemination of information, gathering of eligible children, follow up of defaulting children and in instances mobility support to the facility provider. The volunteers are actively counseling mothers of drop out children and encouraging them to avail the services. The community led growth monitoring sessions are also utilized as an opportunity to identify unimmunized children. The involvement of CHC members has extended the knowledge and services to the neighboring communities. The FE team asked the FGD participants *“what can be done for a child who has never been immunized?”* The response was *“there is no such child in our community!”*

The project built the capacity of facility providers. The refreshers trainings for the vaccinators at each PHU was especially important as this cadre of workers had not received any in a long time and further helped change the perception of the community towards the quality of services provided by the PHU.

Project actively managed supply related issues in close coordination with the District Health Office. The application of COPE led to identification of gaps, system strengthening activities and strengthened monitoring of highlighted gaps by the DHMT.

Continuing Challenges: Communities which are not close to PHU or the outreach point, continue to have a barrier in accessing immunization services on a regular basis. The timeliness of the vaccination seems to be affected by this factor despite increased knowledge and acceptance of the behavior. Furthermore it came to the FE team's attention (in one community, later confirmed by project staff as more prevalent) that the PHU providers were charging a small fee for each immunization session. This practice needs to be investigated further. Many PHU staff are yet to be regularized and officially do not figure on the government's pay rolls. There is a cost recovery system for specific drugs at the PHU. There may be confusion among the clients about which constitutes a paid service. As community members including VDCs are aware that some of the PHU staff are not on pay rolls, this practice receives tacit social sanction. Ensuring salaries for the PHU staff is out of the project control. This has slowed down the project's efforts though this was one of the action plans agreed upon following the 2005 COPE assessment. CARE should continue to pursue this issue through future project efforts and national-level advocacy, project should have worked on increasing accountability viz a viz the community awareness about cost recovery system.

iii. Main successes and lessons learned

The increased importance for immunization and the support through CHCs resulted in more children completing their required vaccinations before the age of one. However, further improvements in utilization are dependent on ensuring better roads and that the immunization services are free of charge.

iv. Special outcomes, and unexpected successes or constraints.

The district sees immigration from the neighboring country Guinea. The only infant and maternal deaths identified in the communities visited by the FE team belonged to people from Guinea. These short term visitors could also contribute to the load of unimmunized children in the project area.

v. Application to future activities

CARE has two other projects in the region – malaria control (MOSI) and title II (Lead). Further CARE is planning a nutrition project with UNICEF. All these projects are adopting the CHC approach to community empowerment. Lessons learned from the project are already being applied in these projects.

vi. Potential for scale-up or expanding the impact of intervention areas

In addition to the above-mentioned projects expanding the impact and scaling up child survival activities through the CHC approach, the CHCs are self replicating and scaling up activities in neighboring villages. As mentioned earlier, there were 92 CHCs at the onset of the project. CSP organized and strengthened 54. At the time of FE there were 394 active CHCs strengthened by CHC volunteers, other CARE projects, PHU staff and other NGOs using the CHC package. The DHMT has

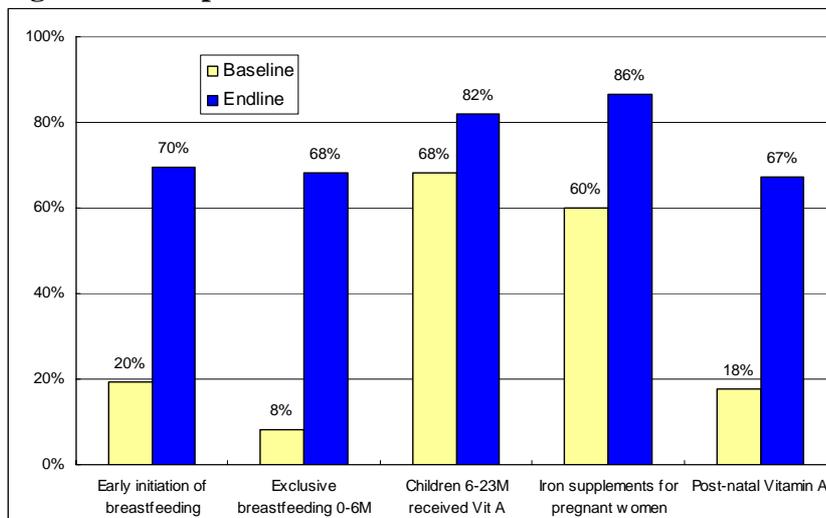
been an active advocate of this approach and some of the project interventions, described in later sections, are being expanded to adjoining districts as well. It should also be noted that this approach was adopted by other NGOs, thus spread out to other districts as well.

c.2 Nutrition

i. Results and Outcomes

The project intervened through CHCs and CHC volunteers - Community Based Growth Promoters (CBGPs), who are specifically trained for the purpose of promoting the early initiation of breastfeeding, exclusive breastfeeding (EBF), complementary feeding, growth monitoring and improved Vitamin A (VA)/iron intake for women and children. Further the capacity of the PHU staff was built to promote positive nutritional behaviors among mothers and children. Pregnant Women's Support Groups (PWSG) were formed at each PHU and out reach point to promote positive nutritional behaviors among pregnant women. CARE's complementary multi-sectoral activities like livelihood and food security project (LEAD), and Water and Sanitation project further supported improved nutritional behaviors in the community. The results and outcomes are depicted in figure 2. There were significant improvements in most indicators. The proportion of children aged 6-9 months who were receiving complementary feeds, however did not improve significantly (70% at BL to 74% at EL). The proportion of children 0-23 months old who were underweight (less than -2SD) came down from 26.5% at BL to 18.8% at EL (statistically significant).

Figure 2: Comparison of Indicators - Baseline to End line



The malnourishment rates are better than national levels for the age group 0-11 months and comparable for age groups 12-23 months (National Nutritional Survey 2007). This is consistent with the results of nutrition behavior indicators (significant improvement in breast feeding practice and non-significant changes in complementary feeding practice).

The women and men in focus groups were found to be very knowledgeable about key nutritional messages. 'Exclusive Breast Feeding' was heard very promptly in response to 'what do you feed your 0-6 month old children with'. While mother said they were introducing complementary feeding (beni mix – a traditional nutritious gruel) at six months of age, they admitted to difficulties in finding the resources to completely formulate the gruel. The economic conditions of the communities prevent the families from buying protein rich elements of the diet. While they are making a conscious effort to

apportion food for children and pregnant women, the barriers to a balanced diet remain. Various respondents in the communities mentioned the waning of food related taboos. More women and children are now receiving (if the family can afford) eggs and meat.

ii. Factors affecting achievement of specific project objectives and outcomes.

The CHCs are active in promoting the adoption of positive nutritional behaviors among the community. The Community Based Growth Promoters conduct a monthly growth monitoring and promotion session, where all the under five children are weighed, counseled and monitored for vaccination status. Analysis of growth charts revealed that the CBGP volunteers were adept at plotting the graphs. Further the mothers in the focus groups could relate the weights of their children (taken within the last month) to the decimal point. The CBGP activities are being extended to indirect communities as well. Mothers from these villages either attend sessions in the direct communities or through the volunteer outreaches. The CBGP activities occur simultaneously with the scheduled visit of the PHU staff, providing an opportunity for additional medical inputs. All children are de-wormed regularly and receive Vitamin A along with their vaccinations.

The Pregnant Women Support Group activities provide a platform for mothers to meet at PHU and at outreach points to not just access antenatal care but share information about good nutritional practices and other pregnancy and child care related issues. Each woman brings food items (vegetables, rice, meat and spices) and they cook together in the presence of the PHU staff. They are taught cooking methods which ensure the nutritional value of food and learn recipes for children as well. This is also a forum for peer support. Younger mothers appreciated the advice and assurance received by older mothers of the group. The group also monitors intake of iron supplements.

The PWSGs and CBGP sessions were utilized to discuss many prevalent food taboos and practices. In Sierra Leone and communities of Koinadugu, pregnant and lactating women are prohibited from eating meat and egg, both rich sources of protein. Furthermore the family meal generally consists of rice and a stew which has small portions of chicken, meat, beans, potato leaves, other greens and green chillies. The portion of protein rich meat or chicken depends on the economic status of the family. The child shares this meal with the family and tends to eat less amount of the stew owing to the presence of the chilly/hot. The younger children (infants) do not find this food mushy enough to eat. The project encouraged the mothers to scoop out portions for children before adding the chilly and include extra pieces of meat and chicken for the child. The project also promoted the preparation of *beni* mix which is a mix of protein and carbohydrate rich powder (roasted and pounded) which can be made into a edible gruel for the infants. Furthermore the PWSG meetings promoted the inclusion of protein rich food in the diet of the mothers.

The increased access to safe water and sanitation has had its role to play in improved nutritional status. Most of the visited communities have access to safe water. Those who do not have access have been negotiating with the district for its provision. Similarly latrines are widely prevalent. FE team found water and soap near latrines for hand washing. The general emphasis on hygiene, promoted by the CHCs has resulted in children wearing footwear, used utensils being placed on racks which are high above the ground and clothes which are now being hung on a line instead of on the ground.

iii. Main successes and lessons learned

While the mothers have adopted behaviors in their control, poverty still prevents many in converting knowledge into practice. There is a dire need to support these communities with livelihood and food security avenues. The FE team recommends that similar to the saving and loans scheme, the future

projects in the region should include a grain bank scheme, where each member contributes a designated amount of grain in the bank which becomes the source of loans for families in need. This strategy has worked well in improving nutrition in low economic areas elsewhere in the world. The PWSG strategy needs to be studied further to ascertain its impact on promotion of positive nutritional behaviors among women.

iv. Special outcomes, and unexpected successes or constraint

The CHCs in indirect communities do not have weighing scales or growth monitoring registers. The increased capacities of these groups need to be complemented by inputs to ensure continuing interest in community development.

v. Application to future activities and potential for scale-up

As mentioned in the previous section, CARE has two other projects in the region – malaria control (MOSI) and title II (Lead). Further CARE is planning a nutrition project with UNICEF. All these projects are adopting the CHC approach to community empowerment. Lessons learned from the project will be applied to these projects. The PWSG are generating interest in adjoining districts, thanks to advocacy of the DMO. With his continuing leadership the project activities may well see scaling up in the region and in the country.

c.3 Malaria

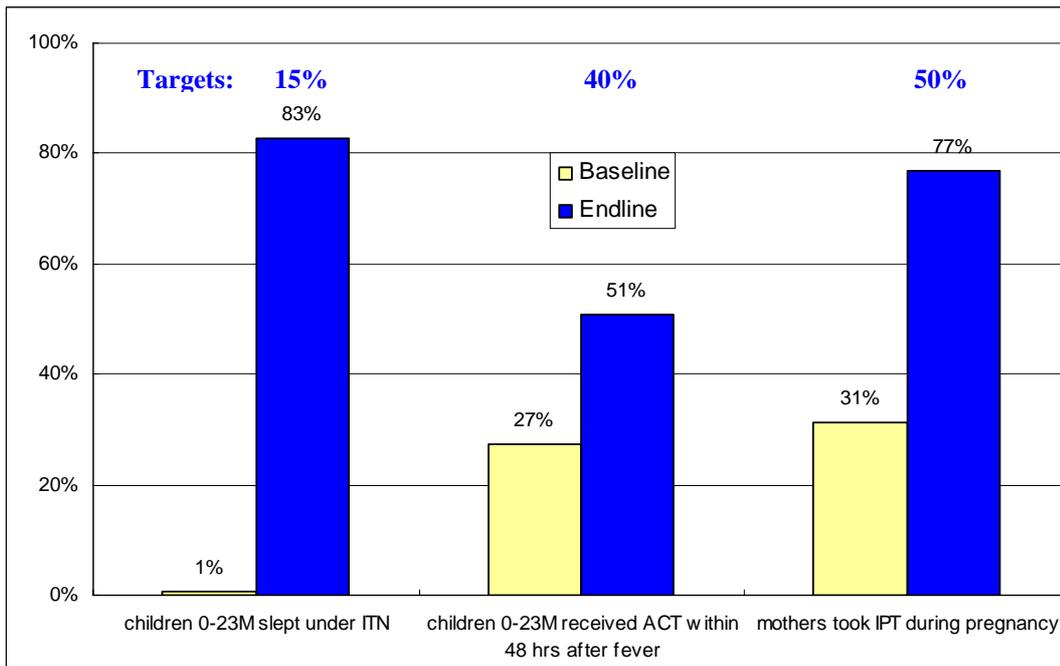
i. Results and Outcomes

The malaria intervention confronted the high prevalence of malaria and the practice of self-treatment by training PHU staff in recognition of malaria and standard case management; educating community members about malaria and its treatment; promoting intermittent prophylactic treatment for malaria amongst pregnant women, and promoting utilization of insecticide treated mosquito nets (ITNs) with the involvement of Village Development Committees. This was further supported by the introduction of CARE's MOSI project which is focused on malaria prevention and treatment.

A new national MOHS malaria policy was developed in 2004 and closely follows international RBM protocols. This change impacted the CSP in several ways: 1) the first line malaria treatment was changed from chloroquine to artesunate-amodioquine combination therapy (ACT) 2) Intermittent Presumptive Therapy (IPT) using S/P was officially adopted and 3) increasing ITN coverage took on importance as the major malaria prevention strategy. Free distribution of ITNs for children under 5, pregnant women and lactating mothers through MCH programs is now promoted.

The comparison between the baseline and the end line surveys of the key indicators for malaria is depicted in Figure 3. All three indicators exceeded the project targets.

Figure 3: Malaria Indicators: Baseline and End line Survey Comparison

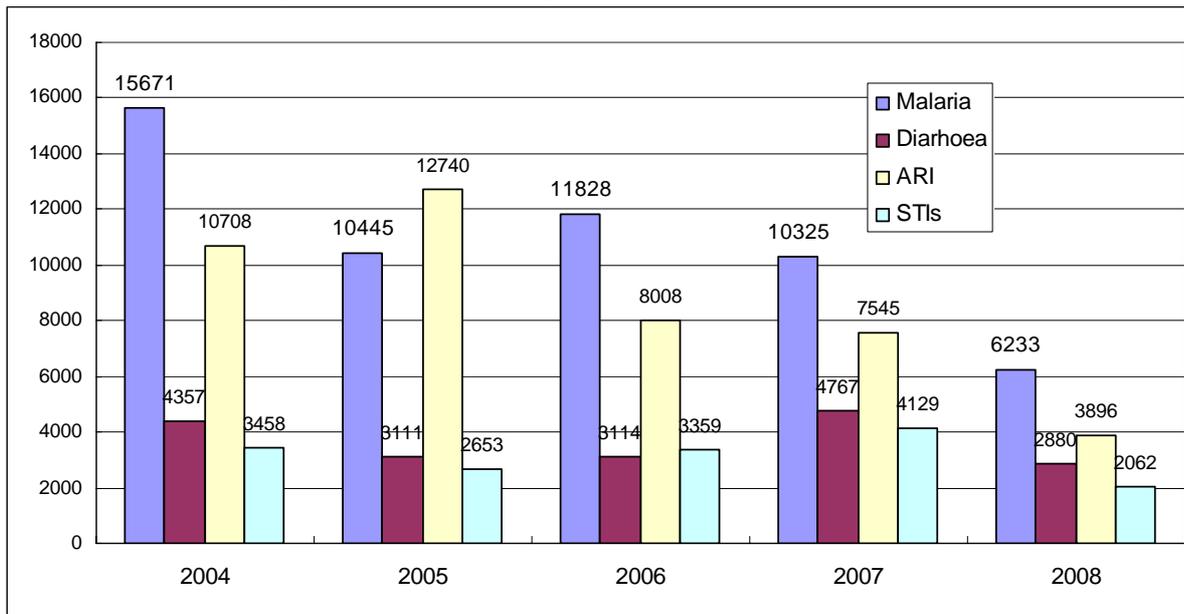


A survey conducted in March 2007 to evaluate the malaria outcomes in eight districts supported by Global Funds shows an overall improvement of malaria indicators between 2005 and 2007. The results of the final evaluation and this survey are comparable. Additional data from the survey is detailed below.

On an average, each household in Koinadugu has 1.6 ITNs. (ref: Global Funds survey march 2007) 88% of children under five who slept under an ITN (comparable to CSP FE). Of the 7,480 lives saved in the project, 50% were malaria related. The interventions which had the largest impact in saving lives were ITN and prompt anti-malarial treatment (Attachment 1). 81% of those who did not sleep under the ITN, did not possess a net. More than one third (37%) of under five children with fever were taken to health facilities and a similar (35%) proportion accessed care from drug peddlers. In general, caregivers were more likely to take children under two years to a health facility (19%), than they were for older children (14%). Two thirds of (66%) pregnant women slept under an ITN. Only 12% of pregnant women in Koinadugu had malaria compared to 99% in the neighboring district of Tonkolili. All Koinadugu facilities visited have ACT and SP/Fansidar; however, 12.5% of facilities still stock chloroquine. Two thirds (62.5%) have malaria diagnostic services (rapid diagnostic kits), while an additional 13% have at least a microscope.

The FE team found high levels of knowledge among focus group respondents. Women and men alike knew about malaria, its causes, mode of prevention and even recognized the drugs used to combat the disease. The knowledge was similar in direct and indirect communities. There is high demand for ITNs and men who are not covered under the MOHS's free distribution scheme are buying the nets if they are able to afford it. The communities have experienced the benefits of malaria interventions and say 'we have not seen a malaria death in nearly four years now'. Figure 4 depicts the district HMIS data, which clearly indicates a decrease in incidence of malaria cases.

Figure 4: Morbidity patters in Koinadugu District (Facility based data: 2004-June 2008)



* Note: Data for 2008 is for six months.

ii. Factors affecting achievement of specific project objectives and outcomes.

The success of malaria intervention is attributed to increased community knowledge; strengthened community and local government participation; the quality of services from the PHUs; and the DHMT leadership. The ITNs for the project were provided by the DHMT and UNICEF. The involvement of VDCs in the distribution of ITNs brought accountability to the process and greater acceptance from the community. The ITN utilization was monitored through VDCs and CHCs. There are bye-laws instituted by the VDCs to prevent non-utilization of ITNs. Each pregnant woman is given an ITN upon promptly registering for ante natal care. She is given another ITN when she completes her two TT injections. She gets a final ITN when she delivers the child at a facility. PWSG meeting are also used to monitor ITN utilization and IPT consumption. The drug logistics is managed by the DHMT and CARE has weaned its support, acting upon the mid term evaluation recommendation.

iii. Main successes and lessons learned

The community monitoring of ITN utilization has been much appreciated by development partners in the country. Meetings during the FE with UNICEF revealed that CARE’s inclusion of community monitoring efforts as an indicator in formats were being applied in the other regions of the country by UNICEF. This unique and strongly prevalent community monitoring systems in service utilization as well as promotion of positive behavior has been possible due to the quantum of capacity building inputs that CHCs have been provided. This needs to be documented to demonstrate the role of the CHC model in attainment of national RBM goals.

iv. Special outcomes, and unexpected successes or constraints.

In the Malaria endemic district of Koinadugu, while free distribution of ITNs to pregnant women and under five children have helped bring down malaria incidence, the unavailability of ITNs through widespread social marketing or other avenues has prevented benefits to men, older children and adolescent girls. This is being addressed through CARE’s MOSI project which will not only have a social marketing component, but will also promote home based management of Malaria.

v. Application to future activities and potential for scale up.

Lessons learned from this project are being applied to the MOSI project and being expanded to other districts as well. The intervention, successes and outcomes - reductions in Under Five Mortality due to malaria are being shared between different CARE projects.

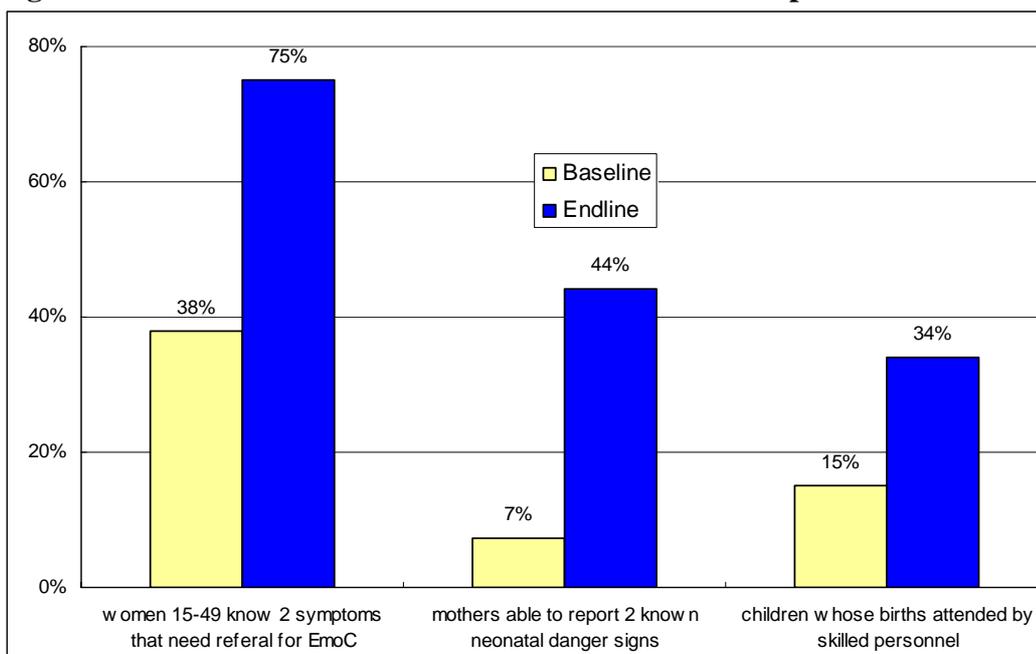
c.4 Maternal and Newborn Care

i. Results and outcomes

The **MNC intervention** focused on improving access to information and basic maternal health care by through PWSG and CHC based educational sessions and radio on danger signs recognition, birth preparedness at the community and household level using birth planning cards; promoting TT vaccination and iron supplementation for pregnant women and community-based Vitamin A supplementation for postpartum women by TBAs; and training PHU staff in intermittent prophylaxis of malaria in pregnant women, support for skills building of PHU staff in EmOC, and support for the district coordination mechanism through active participation in monthly MNC working group meetings.

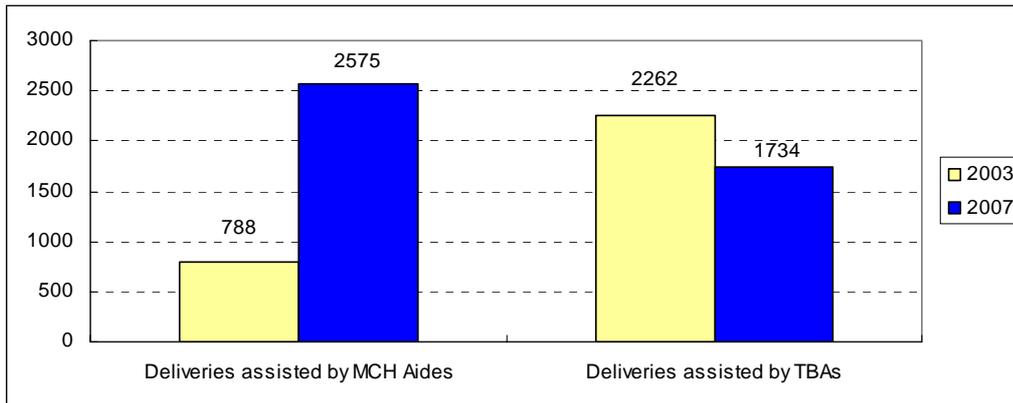
Further the establishment of Village and Savings Loans (VS&L), which emerged as a response to the need for funds during obstetric emergencies, supported prompt referrals of pregnant women to PHUs and district hospital. Referrals were also supported by establishment of a hammock system in each community and establishment of 22 community contributed/supported birth waiting homes. MNC interventions included birth planning, skilled birth attendance, care of the newborn, exclusive breastfeeding and identification of neonatal emergencies needing referral. The key indicators for maternal and neonatal health are depicted in figure 5. Indicators pertaining to nutrition and malaria have been covered in the previous sections. The most significant achievement is perhaps the skilled birth attendance given that there is limited health staff in Koinadugu and the district lacks roads.

Figure 5: Maternal Indicators – Baseline to End line Comparison



More women (57% at BL to 84% at EL) are accessing antenatal care. This has been made possible through increased outreach sessions and PWSG sessions. The PWSG meetings are a forum for ANC services, monitoring TT vaccination, IPT, ITN utilization, positive nutritional practices and development of a birth plan. Since the MTE, the establishment of VS&L has strengthened the implementation of the birth plan by the pregnant women. The resource for ambulance services was flagged as one of the issues needing resolution, during the MTE. Community now bears the cost of the fuel through loans from the VS&L. Furthermore establishment of birth waiting homes have enabled the facility based deliveries. Analysis of HMIS data reveals that more women (Figure 6) are now being delivered by PHU staff as compared to 2003.

Figure 6: Skilled Birth Attendance: HMIS Data Comparison 2003 to 2007



One of the significant achievements of the district has been promotion of skilled birth attendance. The MCH Aides are trained to carry out safe and skilled deliveries. However, the presence of TBAs closer to the communities was acting as a barrier to women accessing care from the MCH Aides situated further away from the community. The project was able to resolve the conflict of TBA's role by involving her in the promotion of skilled and institutional deliveries. By redefining the role of the TBA as a facilitator, companion and advisor of the pregnant women and instituting the role of the MCH aide as one who actually conducts the delivery, the project with immense support from the DMO managed to overcome community resistance to traditional behaviors. The VDC sanctions a fee to the TBA (payable by the family) to recognize her role in facilitating the institutional delivery which is very akin to the gift (cash or kind) that she would earlier receive from the family.

The TBAs accompany the woman to the PHU and at times stay with her in the birth waiting home, providing the much required support to the pregnant woman and decreasing the loss of wages to the immediate family members.

The adjoining districts have had to face immense resistance from TBAs while promoting institutional deliveries. Koinadugu's model of redefining roles should be documented as it has potential for success and scale up. As the role of TBAs is being discussed at the national level the project should utilize its experiences for advocacy and scale up opportunities.

Improved practice of exclusive breast feeding, improved skilled birth attendance combined with increased knowledge of neonatal danger signs may have averted many neonatal deaths in the community. The FE team found records for five neonatal deaths in the last year within the coverage areas of ten visited PHUs. However, the proportion of skilled attendance continues to be low at 34% and may improve with the growing popularity of birth waiting homes and will see substantial improvement with better roads.

It must be noted here that early age at marriage and first pregnancy is highly prevalent in Koinadugu (and in Sierra Leone). Any strategy which addresses maternal and neonatal health in this country should include interventions to delay the first pregnancy. This should have been a part of the project design.

ii. Factors affecting achievement of specific project objectives and outcomes.

Pregnant Women Support Group: Described in the previous sections contributed to increased access to ANC services, message being reinforced and provided the much needed peer support to women.

Increased outreach activities: This contributed to more women accessing antenatal care. PWSGs were formed even at outreach points as demand for PWSG activities came forth from the communities.

Referral system: Recognizing the need for the transport of pregnant women to the PHUs during emergencies, as a component of COPE exercise and birth planning process, community hammocks were established in all the project communities. The hammocks are basically stretchers made out of locally available material which could carry the woman to the facility. Each birth plan designated the hammock carriers as well to ensure availability of an emergency transport system. While there is no collated quantitative data on the usage and application of the hammock, focus group respondents referred frequently to the presence and usage of the hammock. In addition to the hammock, the presence of ambulance at the district level facilitated the arrival of a woman for emergency care (including cesarean sections and assisted deliveries) from the PHU to the district hospital. One of the PHUs which was identified (during the COPE workshop) to lack telephone connectivity was provided with a radio set to be able to requisition ambulance services.

TBA Involvement: With the support of VDCs and the PHU staff, project was able to tactfully resolve the participation of Traditional Birth Attendants (TBAs) in facilitating institutional deliveries. The TBAs who used to receive a gift from the families now receive an incentive (also from the family) for escorting a woman to the facility and assist PHU staff during deliveries. This has made them an important member of the woman's support system while dissuading their participation in active delivery at home. However, the family is also expected to pay an incentive to the PHU staff. While this ensures the continuing support of the PHU staff, some of whom have not been paid a salary for months; it creates an additional burden on the impoverished families. These families are currently accessing the funds from the VS&L groups; in the long run however, systemic changes need to be established to ensure provision of free services as envisioned in the national public health strategy.

VS&L was a major contributing factor to the success of the MNC intervention and is described in detail below.

iii. Main successes and lessons learned

The successes have been amply described in earlier sections. Scaling up of MNC interventions should be done as a package of 'introduction of VS&L scheme to provide safety net to cover the unpredicted cost relating to MNC; formation of PWSG for health education, ANC services, and peer support; Continued health education for behavior change through radio and community structures (CHCs, VDCs); Redefining the roles and responsibilities of TBAs (TBA support to institutional deliveries); strengthening referral (including hammock system); establishment of birth waiting homes to eliminate the first delay; and upgrading the skills of Maternal and Child Health (MCH) Aides' within future program efforts.

iv. Special outcomes, and unexpected successes or constraints.

Village Savings and Loan Groups: It is a system that organizes community members to contribute and manage their own funds with little or no external support and is aimed at addressing economic barriers to health and development. The CSP VS&L focuses on emergency referrals from the health facilities to the district referral hospital. The project oriented the district and chiefdom level stakeholders followed by orientations for CHCs and VDCs. S&L groups were formed in all 54 direct communities. Executive members of each group (4 per group) were trained on the methodology and initial inputs in the form of cash drop-in buckets, ledgers and savings box with lockers were provided by the project. Project facilitated the development of group bye-laws and carried out initial monitoring of savings activities. Teachers, students, or other literate persons were designated as the record keepers.

At the time of FE there were 82 functional groups (7 female and 75 mixed) in the direct communities; 53 in indirect communities; and 32 in non-CSP chiefdoms. These groups have promoted community cohesion and social interaction destroyed during the ten years of brutal war. Project encouraged the participation of women thereby increasing their involvement in the decision making process on referral of emergency obstetric cases (loans are easily available to female members/their relatives with little involvement of the husband). Fourteen referrals were recorded during the period between April to June 2008 using funds from the loan scheme and all the referred cases have been treated successfully and have survived. Interested local and international NGOs in the country have expressed interest in adopting the scheme. The communities have been using the fund for the purpose of identified developmental priorities as well. Some examples include procurement of school benches and desks in Koromasilaya and the procurement of seed rice in Yiffin, Soya and Manah. An agreed proportion of the fund is always left behind in the treasury to aid emergency referrals. The current holding of the VS&L groups add up to USD 10,565.

Challenges pertaining to the VS&L: About 90% of the record keepers are community school teachers, who are also enrolled in distance learning courses. They travel out of the community to attend some course sessions thus weakening the group. Inaccessibility of some communities during the raining season and the poor road network continues to be the most serious impediment to the referral of emergencies even when there are funds to pay for the means of transportation. There is a lot of cash being held in the villages which needs to be deposited in a bank. The establishment of a community bank in Kabala has now made this option available to the CSP communities. Furthermore, there is a need to build the financial management capacity of the communities to enable the investment of funds in developmental activities.

v. Application to future activities and potential for scale up.

As described in previous sections the CHC strategy, PWSG, birth waiting homes and the VS&L is being scaled up and replicated across the district and has taken roots in the adjoining districts as well.

c 5: Childhood Illnesses

While the project planned to utilize the C-IMCI approach, thus other childhood illnesses such as diarrhea and ARI were addressed through the CHC curriculum; the project did not focus intensely on these two subjects.

Results for childhood illnesses are given in Table 4:

Table 4: Progress on Childhood Illnesses

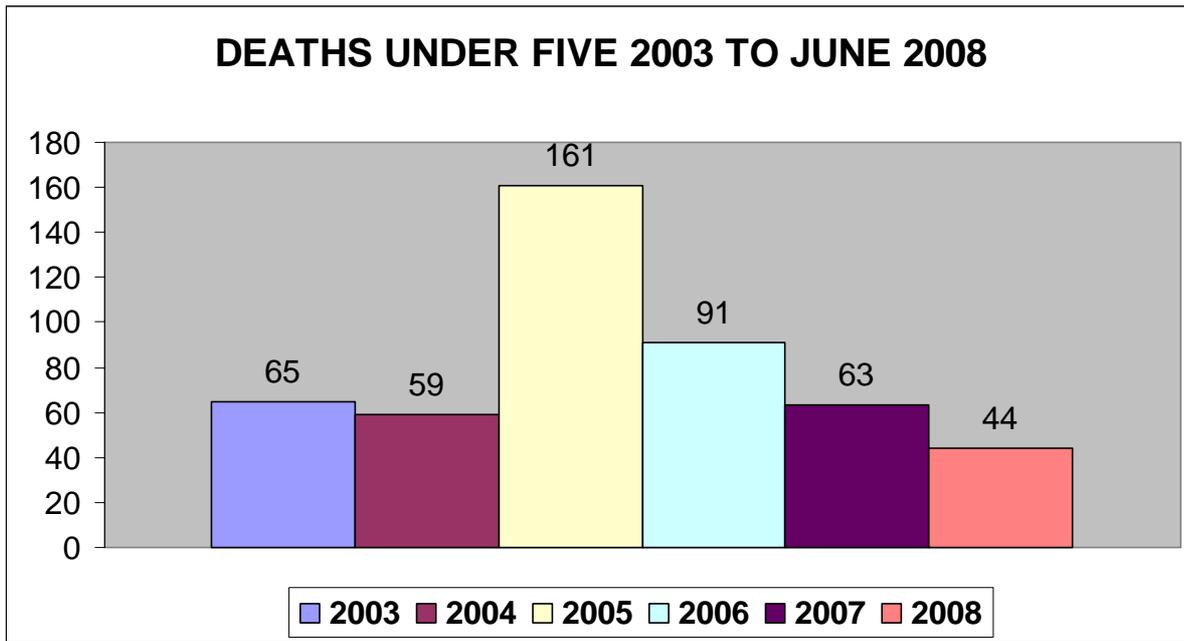
| Indicator | BL | EL |
|---|-----------|-----------|
| Percent of children (0-23) months with an episode of diarrhea in the past two weeks | 28.2% | 23.3% |
| Percent of children aged 0-23 months with an episode of diarrhea that ended during the last two weeks who were effectively treated with an ORS or SSS | NA | 38.5% |
| % of children aged 0-23 months that received increased fluids and continued feeding during an episode of diarrhea in the past two weeks | 48.7%* | 9.6% |
| Proportion of mothers who could were able to correctly describe the preparation of ORS | NA | 56.7% |
| Percent of children aged 0-23 months with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug (ACT) within 48 hours after the fever began | 27.4% | 55.5% |
| % of children aged 0-23 months with a febrile episode during the last two weeks who were taken to an appropriate health care | NA | 48.9% |
| Percent of children (0-23) months with an episode of cough/fast breathing during the last two weeks | 41.7% | 19.7% |
| Percent of children (0-23) months with an episode of cough/fast breathing during the last two weeks who were taken to an appropriate health care facility | 26.0% | 53.4% |
| Percent of mothers of children aged (0-23) months who know at least two signs of childhood illness that indicate the need for treatment | 79.0% | 79.9% |
| Percentage of sick children age (0-23) months who received increased fluids and continued feeding during an illness in the past two weeks | NA | 7.7% |
| Percent of mothers with children aged (0-23) months who report that they wash their hands with soap/ash before food preparation, before feeding children, after defecation and after attending to a child who has defecated | NA | 20.4% |

* Calculated incorrectly during the baseline. The end line figure compares to the last LQAS estimates.

While the community members understood diarrhea prevention and were preparing salt sugar solution at home and accessing ORS from the PHU, they lack an in depth understanding of ARI and pneumonia. Although this was not a committed intervention area, the project meant to have adapted C-IMCI approach would have focused on ARI/Pneumonia. Given that the national level roll-out of IMCI approach has taken time and the ‘IMCI’ trainings of PHU staff through the MOHS have been limited to standard case management of malaria due to lack of understanding on holistic nature of IMCI, this became the weak link in addressing childhood illnesses.

However, the general improvement in environmental hygiene, prompt utilization of care during fevers, successes of malaria control has led to perceptible decreases in morbidity and mortality. Figure 7 depicts under five deaths reported from PHUs of Koinadugu. It should be noted that the district HMIS system was revamped in 2005; this in addition to improved supervision by recruitment of zonal supervisors caused the surge in reporting in 2005.

Figure 7: Mortality trend in Koinadugu District (Facility based data: 2003-June 2008)



- Note: The data for 2008 is for the first six months.

The FE team in an attempt to understand whether mothers gave their children increased fluids and feeding during sickness included a specific question in the focus groups. It was found that infants who were less than 6 months old were indeed offered more breast milk during sickness, while mothers of children more than six months were giving the children whatever the child desired. While they admitted difficulty in feeding a sick child, they were aware of the need to feed the child more. This was similar for both direct and indirect communities. The low coverage level for this behavior as measured during end-line KPC survey may lead one to believe that the question was not asked properly by the survey investigator. However, since there is no documented evidence to prove either of the assumptions, it would suffice to say that future programs addressing childhood illnesses as an objective should implement the entire community based IMCI package for ensuring the completeness of the intervention.

The CHCs promoted the selection of positive behaviors, timeliness of seeking care and utilization of services. However, the lack of ORS at the community level is unfortunate given that there high demand among members. This was brought to the notice of the DMO by the FE team and will be resolved through the implementation of community-based treatment of childhood illnesses as a follow-up to home based management strategy MOSI project has already introduced in the district. DMO plans to equip CHCs with ORS and chlorine tablets as an initial step towards improving access further. The lack of emphasis on pneumonia within the CHC curriculum, compounded by lack of IMCI training to PHU staff has resulted in over medication of children with antibiotics. This has been detailed in the health system strengthening section. Mothers were washing their hands after defecating or cleaning a child who had defecated. However, this emphasis was lost for before cooking food and before feeding a child. The project perhaps was not able to get this message across. Furthermore it is difficulty of monitoring change in personal hygiene practices. It is noted that the 2006 draft list of rapid catch indicators requires the demonstration of hand washing for any two conditions, perhaps taking into consideration the difficulty in changing this behavior. Similar findings were reported by the consultant while evaluating the CSP in Nepal in 2007.

d. Innovative Tools

The Community Health Club strategy (CHC) has been detailed in the community mobilization section.

2. Results: Cross-cutting approaches

a. Community Mobilization

CARE used the community ‘health’ club approach to achieve both community mobilization and behavior change in the project communities. In the recent times clubs have been increasingly incorporated into health promotion programs. Since community engagement and community cohesion are correlated with improved health, clubs are used not only to provide a forum for participatory learning and action, but also to strengthen community participation that leads to improved health. Clubs are in line with traditional forms of organization in many communities, and are also seen as a way to develop local leadership. Club approaches have been used for a variety of public health goals including tuberculosis control, promoting insecticide treated bed nets, breastfeeding, promoting the use of health services, as well as creating demand for sanitation, among others. By expanding CHC mandates from health promotion to community management of health programs, income generation, and finally to other social development initiatives, CHCs seek not only to provide improved health outcomes through culturally sensitive health information, but also to transfer organizational and capacity skills so that the community can begin the transition to self-initiated development.

CARE commissioned a study (May 2007) to understand the effectiveness of CHC approach in improving health outcomes, promoting community development and leadership in this project. The following section incorporates the findings of the study and the FE qualitative evaluation. This description includes comments on equity, contribution to scale up and development of civil society.

At the onset of the project 92 CHCs had been established in collaboration with other CARE projects in the District. Building on this experience, CSP organized and trained 54 CHCs in Koinadugu District. Working alongside MOHS, project staff used both rapid and in-depth assessments to identify communities with sufficient population size to attract at least 15 club members that are accessible by road on a year-round basis. After identifying target communities, the project staff worked closely with local leaders to organize the CHCs. As a first step, CARE revitalized the Village Development Committees (VDCs). VDCs are a traditional community leadership mechanism in Sierra Leone, although many VDCs became dormant throughout the civil war period. VDC size varies, but a typical VDC has about seven members. In the CSP communities the VDCs are responsible for overseeing CHCs and undertaking complementary activities. CARE held orientation meetings in the community and invited interested people to attend weekly CHC sessions, held at a time set by the community members. Subsequently CARE encouraged the community to develop a CHC leadership structure and identify CHC leaders.

Twenty five weekly (two hours each) CHCs meetings were utilized to provide interactive health lessons on topics ranging from personal hygiene to malaria to HIV/AIDS to nutrition. Following these 25 sessions, community members who have attended at least 20 sessions are issued a membership certificate. The certified members were then encouraged to develop an action plan to address the health issues in the community. While CSP staff provided initial support and guidance, as the community developed its capacity, the process of prioritization became community driven. CHC members have been undertaking community improvements, outreach sessions to other communities to share health messages, and help non-CHC communities establish their own health clubs. In addition,

they have been working with the PHUs to ensure success of formal sector health outreach activities such as antenatal clinics and immunization sessions.

How effective was the approach?

All the objectives for the community mobilization were achieved beyond set targets. The CHC approach to community mobilization was very effective as evidenced by demand for CHC like activities in neighboring communities. The approach promoted community cohesion; linkages between VDCs, PHUs and the community members; increased accountability of the health providers; improved participation of women in health and developmental activities; resulted in community led interventions; and contribution to scaling up.

The FE team was also able to observe significant transfers of health related knowledge and evidence of behavior change. The CHC members, as well as the PHU staff indicate that CHCs have greatly improved health outcomes in the region. In terms of community development, the team found evidence of improved community cohesion, strengthened leadership, and increased undertaking of self-initiated activities. CHCs are integrated with other formal community organizations, although increased integration with existing community groups, as well as with local government institutions could help to improve sustainability.

Participation: Across the communities visited, participation in CHCs was widespread and largely representative of the community. In addition, there was a diverse representation of ages among CHC members. In ethnically mixed communities, such as Gbindi, both majority and minority ethnic groups participated. CHC membership also included people with a wide variety of educational backgrounds, from those who had no formal schooling to the local teachers. The same patterns were observed with regard to CHC leadership, where both men and women, young and old, educated and illiterate served. A women's focus group in Dogoloya explains: *"At the CHC you can learn even if you haven't been to school ... even some of the executives have not been to school. The secretary must be able to write, but others like the Chairlady have never been to school."*

Health outcomes: There was an apparent increase in knowledge and change in behaviors as described in earlier sections. By emphasizing women's involvement and the role that education plays in improving health status, CHCs are mobilizing community decision-making processes to overcome prevailing cultural norms and behaviors. Health and nutrition behavior change promoted through the CHCs (especially CBGP groups) are overcoming taboos, especially with regard to foods that are fed to young children and pregnant women. Community led monitoring of service utilization is bringing the defaulters back into the system. The CHCs are extending outreach services to neighboring villages improving access. Neighboring communities attend growth monitoring sessions being organized by the community. *'They are our brothers and sisters – said a CBGP volunteer from Hamdalai, we want them to receive the benefits we have experienced'*

Self-initiated activities :The evidence of community action planning is visible in omni prevalent plate racks and clothelines, source of safe drinking water; use of latrines in each community; and levels of cleanliness. CHCs are able to decide upon and implement a variety of activities without field staff supervision. CHC monthly planning sessions have been taking place without CARE presence. Communities now identify their own needs and potential solutions. This process has led to a more holistic understanding of the factors affecting their health. Yataya villagers expressed their interest in building a secondary school, fixing the roads, and expected to purchase a truck in approximately three years time to transport their products to Freetown. Community members often recognize the value of these activities for their health as well as for overall development. Like drawing a problem tree, CHC

members are seeking more distant causes of poor health. Consequently, road improvements, such as the ones currently being carried out by the CHC members in Yataya and Koromasilaya, are seen as a way to facilitate emergency transportation as well as facilitate trade and improve economic opportunities. Similarly, improving schools is seen as a way to ensure an able next generation of leaders, and a source of continued knowledge for CHC members.

Strengthened Governance: VDCs have been involved in the distribution of ITNs to the eligible members of the community. This has promoted transparency, accountability and added value to the product in public perception. Consequently VDCs also feel responsible for the appropriate utilization of the ITNs. Increased participation of CHC members in the formal health sector is also contributing to strengthened governance. CHC members are actively involved in facilitating a variety of PHU activities including ANC services, maternal-child health clinics, vaccination outreaches, and growth monitoring. For these activities, CHC members help notify community members about these important events ensure attendance, facilitate activities, and use the opportunity to share health messages.

Lessons Learnt: There is ample evidence to assert that the CARE's CHC strategy which applied the rights based approach not only promotes positive health behavior but creates immense community cohesion and community development.

The concerted effort to involve men in more than 'token' numbers worked positively. The informed and aware men were taking positive health decisions.

The strengthening of VDCs deepened the linkage between the community and the PHU. CARE's approach promoted good governance practices and improved accountability as well.

The CHCs will require continued information and inputs to sustain their interest and activities. For example, the weighing scales and growth monitoring registers will have to be replenished and replaced regularly. There is also a need to equip them with ORS and chlorine tablets. '*We have to go to the PHU to get ORS, why can't we stock it in the community*' – a CHC member in Koromasilaya. The DMO is planning to build on the home management of malaria initiative supported through MOSI project and make ORS available at community as well.

The newer CHCs scaled-up in the neighboring communities by the CHC volunteers have the capacity to carry out awareness and growth monitoring activities. However they lack the tools. To sustain their interest and their participation, it would be vital to equip them with IEC material and other relevant tools.

There are various linkages between other community groups (formed around the issues of farming/water/livelihood) as reported by the CHC study. Future projects should look at strengthening these linkages to address areas impacting health.

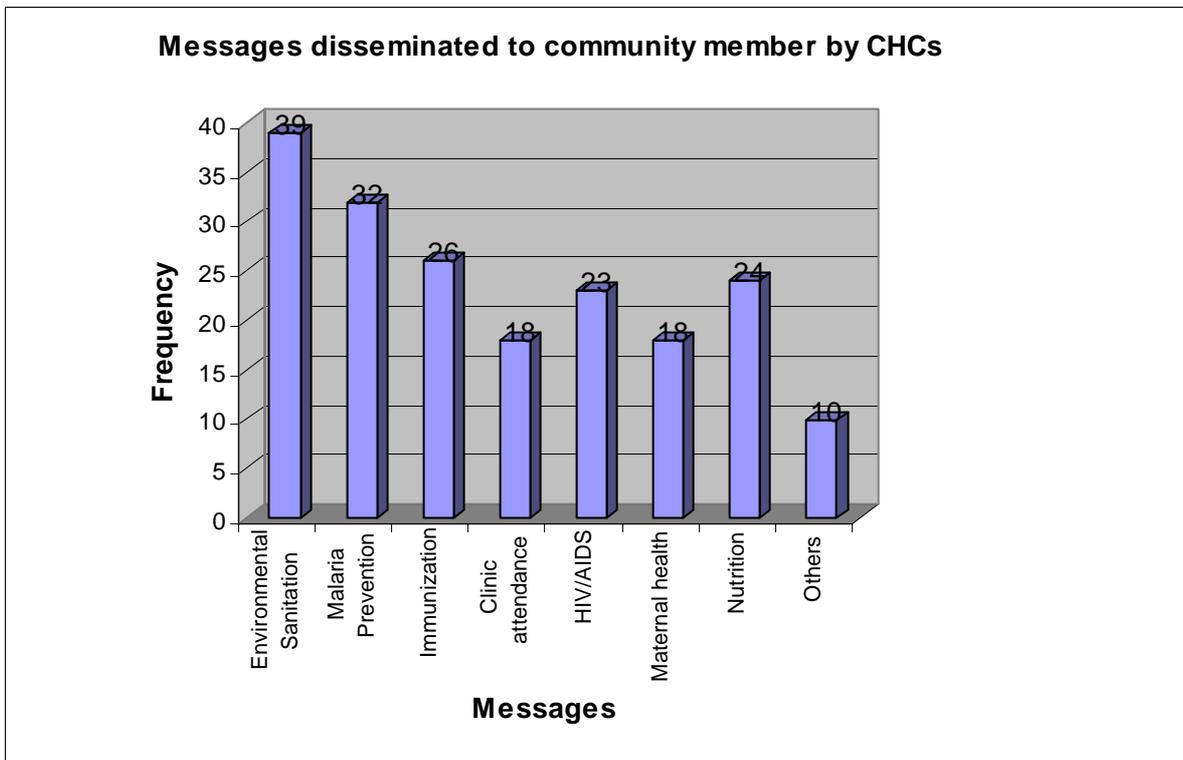
Sustainability: CHCs are being replicated by CHC volunteers in neighboring communities. The demand for CHC like activities is high and benefits are apparent. The CHC approach is also being adapted by other CARE projects in the region and other organizations in the country. The CSP communities are well linked with the PHU and the VDCs and will probably continue to receive their support. However, continued support from the DHMT and MOHS is required to ensure that the intensity of outcomes achieved sustains through inputs, opportunities for further learning and development.

b. Communication for Behavior Change

Strategy: The project's key approach to behavior change at the household and community level was through the CHCs as well as community radio. BCC strategy was developed using the BEHAVE framework. All 54 CHC members (1882) were trained and certified in the 'communicating health – communicating rights' package. This training package addresses various health issues ranging from general hygiene, environmental cleanliness to maternal child survival needs and incorporates sessions on gender inclusion, democratic practices and transparency. The content and limitations of the package has been well documented in the MTE report.

Community Change Agents: The communication for behavior change was targeted at DHMT staff, PHU staff, CHCs and individual community members. Through the training of CHC members the project enrolled change agents in each community. Figure 13 details the number of health education sessions conducted by the 54 CHCs in the period between 2004 and 2006 and the topics covered during these sessions. This was complemented through advocacy meetings with VDCs, opinion leaders and additional BCC session through the PHU staff during outreach.

Figure 8:



Source: Radio Listener's Survey 2006

CHC volunteer led BCC interventions: The CHC volunteers are active disseminating messages to individuals and to groups through forums such as CBGP sessions. The various communication modes used include health talks to groups; counseling at CBGP sessions, interpersonal communication during follow-up home visits, counseling during CHC outreach sessions and discussion following radio programs. Mothers in focus groups cited examples of support received during such sessions; taboos around child feeding and food restricts for pregnant women are being denounced vociferously in the community. The involvement of older women as well as men in the CHCs has ensured that the positive behaviors learnt by women are not being opposed at the household level by the traditional decision makers.

Radio Programs: CSP also implemented radio programming activities in partnership with local broadcaster Radio Bintumani to reinforce the messages and to reach people who may not be accessible through direct program delivery. Project staff, Radio Bintumani, Ministry of Health staff and CHC members participated in the successful design and production of appropriate health communication messages. Jingles and songs recorded by the community members; panel discussions; and interviews have been aired in the local languages. The jingles and songs were a great hit in the community and motivated them further to adopt the positive behaviors. The FE team was treated to a new song in every community visited. These songs and ditties were around various issues of maternal and child care. To increase the number of listeners, 1,336, handheld portable radios were distributed to CHC members who attended more than 20 of the scheduled 25 health sessions facilitated in their clubs. A radio listener's survey carried out in 2006 revealed that 52% of the respondent's had ever heard the health programs on Radio Bintuimani, although 95% were listening to other programs on radio stations.

Community monitoring: The positive and negative pressures and sanctions from the VDCs combined with community monitoring is an essential component of the communication for behavior change and is detailed through this document in relevant sections.

How effective was the strategy?

Health outcomes: The changes in the behavior have been detailed in the technical intervention sessions. The program has gone beyond increasing knowledge and has succeeded in changing social norms, especially related to women speaking in public and participating in public decisions and removing food taboos for pregnant women and small children. CHC communities are spontaneously scaling-up CSP BCC by communicating CSP messages to non-CHC communities. However, poverty is the continuing barrier to behavior change especially in adopting nutritional behaviors and accessing PHU services.

Behavior Change in non-CHC Communities: While the 54 direct communities received intense interventions, the FE team found comparable levels of knowledge and practices among indirect communities. The source of the information as revealed by the FGD members in indirect communities, were the CHC volunteers from the neighboring communities and the PHU staff, also through radio.

Involvement of PHU staff: The PHUs have been equipped with IEC material, which were hitherto unavailable. Furthermore the project built the capacity of PHU staff in areas of communication and community mobilization. The value addition has enabled the staff to carry out effective BCC sessions during outreach and also host the PWSG meetings. These meetings form a peer support to the new mother and a retrieval mechanism for defaulters as described in earlier sessions.

Lessons learnt and sustainability: Deliberate involvement of men and older women in CHCs has enabled the adoption of positive health behaviors among mothers. The strategy of CHC is effective in sustaining behavior change as evidenced by the resultant community led advocacy and behavior change activities. CHC will require continued educational inputs, IEC material along with community based management inputs (ORS, chlorine tablets, registers) to sustain and monitor changed behaviors.

c. Capacity Building Approach

i. Strengthening Local Governmental, NGO and/or Private Sector Partner Organizations

The project partnered with the VDCs, the KDC, Community Based Organizations (CHCs) and Radio Bintumani a private radio service provider. The project planned to involve Christian Extension Services (CES) to support community mobilization. At the time of MTE CARE was planning to train CES on the use of the new participatory health communication toolkit. However, CES reneged from the partnership when they found that the partnership would not yield any financial benefits for CES. This was partly due to the fact that the type of partnership was not defined clearly at the design stage of the project and created unrealistic expectation (i.e., provision of funds) from the side of CES. CES also shifted their program focus to education and it does not have any health-related interventions at present. This is a missed opportunity as a partnership could have resulted in sustained local capacity. The project did compensate for this by including local (or community-based) partners in scheduled training programs detailed in the next section.

Capacity Building of VDCs and DDCs: CHC and VDC training has been the major emphasis of the CSP and has been quite successful. Due to decentralization of health services in Sierra Leone in 2003, partnership with the local District Council became an important component of the CSP. The Council now plays a much more significant role in PHC programs, including resource allocation. The project trained 108 VDC chairpersons in their roles and responsibilities. They were also oriented to the project, health information and the VS&L scheme. Many VDC chairpersons are members of the CHC as well. The built capacities have resulted in inclusion of health as an agenda in VDC activities. The VDCs actively monitor community utilization of services. Increased involvement of DDC and VDC reflected by the various bye-laws that have been formed to promote positive health behavior and prioritization of activities. Some positive bye-laws include fine for littering the environment; fine for home based delivery; and fine for not using the ITN. While bye laws of VDCs have helped promote health, they require monitoring to ensure appropriateness. For example one bye-law states that if a woman does not make her first antenatal visit in a timely manner then the ITN which is due to her will be delayed by a month. Another bye-law calls for a larger incentive to the PHU staff and the TBA on the birth of a girl child than a boy child.

Capacity Building of DHMT, Koinadugu: CARE's major contributions to DHMT capacity building are in the areas of improving quality of care at the first line health facilities and integrating community-level data into the District HMIS. This was facilitated by the COPE assessment which brought partners together and resulted in specific actions to be taken by each partner. Furthermore the project provided technical inputs in areas of essential nutrition action and MNC package, the latter with the technical assistance of CARE Atlanta. Additional inputs from UNICEF and trainings from MoHS have also contributed in the improved capacities at the district level. The current state of district capacities is largely also attributed to the strong leadership being provided by the DMO. He has been instrumental in promoting collaborative planning, effective utilization of available resources and advocacy for scale up.

Lessons Learnt: The participation of the VDCs and the DDC while laudable leans towards negative advocacy. There are a lot of fines for not practicing positive health behaviors, but no incentives for promotion of health. This needs to be focused on when CARE expands their partnership with the VDCs. Furthermore, the bye laws need to be monitored for their appropriateness. A strong leader at the district helm has made a huge impact on the outcomes of the project. CSPs could consider instituting leadership trainings as an intervention in future project designs.

ii. Training

Community: CHC training participants underwent post training evaluations and were certified as well. The outcomes of these training have already been described in detail. Total of 2339 CHC members were trained in health related topics; 324 CBGP volunteers in growth monitoring /promotion; and 52 volunteers trained in community data surveillance. The data surveillance volunteers are gathering household level information which was shared to PHU and up to DHMT in order to encourage data-based decision making by stakeholders at district and community levels and to involve community members in monitoring vital health statistics within their localities. However, their effectiveness could not be assessed by the FE team. Table 5 captures the training inputs at community level. The measurement of improved community capacities have been discussed adequately elsewhere.

Table 5: Trainings conducted during the child Survival Project's life span.

| Type of training conducted | Category of participants | Number trained |
|--|----------------------------------|----------------|
| Training at community level | | |
| PD/Hearth implementation strategy | VDCs | 5 |
| | PD/Hearth mothers | 15 |
| | Sub-total | 20 |
| CBGP Initial training | CBGP Volunteers | 324 |
| CBGP training (1 st refresher training) | CBGP Volunteers | 324 |
| CBGP training (2 nd refresher training) | CBGP Volunteers | 324 |
| VDC training on roles and responsibilities and good governance | VDC secretaries and Chairpersons | 108 |
| Data collection skill | Data surveillance volunteers | 52 |
| Disease prevention at community level | CHC volunteers | 1,882 |
| VSL methodology with focus on obstetric emergency initial training | VSL secretaries and chairpersons | 146 |
| VSL methodology with focus on obstetric emergency refresher training | VSL executives | 216 |
| Training at District Level | | |
| Training of Trainers on Positive Deviance/ Hearth model | CSP | 11 |
| | DHMT staff | 3 |
| | LEAD | 1 |
| | PHU staff | 21 |
| | Local Council | 1 |
| | Sub-total | 37 |
| Basic computer skills | DHMT staff | 12 |
| IEC material development training | MOHS | 16 |
| | CARE | 14 |
| | Kabala Theater company | 1 |
| | Radio Bintumani | 1 |
| | CAUSE Canada | 1 |
| | Local Council | 4 |
| | Daindemben Federation | 1 |
| | Sub-total | 38 |
| CBGP training (Initial TOT) | CARE - CSP | 12 |

| | | |
|--|-------------------|-----------|
| | MOHS | 24 |
| | Local Council | 1 |
| | Sub-total | 37 |
| CBGP training (1 st TOT refresher) | CARE | 10 |
| | MOHS | 24 |
| | Local Council | 1 |
| | Sub-total | 35 |
| ENA | CARE-CSP | 11 |
| | CARE-LEAD | 1 |
| | CAUSE | 1 |
| | Local council | 5 |
| | DHMT | 5 |
| | PHU staff | 22 |
| | Sub-total | 45 |
| COPE methodology (conducted in 2005) | MOHS | 3 |
| | CARE-CSP | 12 |
| | Sub-total | 15 |
| VS&L methodology with focus on obstetric emergencies orientation for staff | CARE-CSP | 12 |
| LQAS survey Methodology | CARE-CSP | 9 |
| | MOHS | 3 |
| | Local council | 1 |
| | CARE-MOSI | 2 |
| | Sub-total | 15 |
| Radio Listener's Survey | CARE | 12 |
| | Radio Bintumani | 1 |
| | MDM | 1 |
| | CES | 1 |
| | CRS | 1 |
| | Sub-total | 16 |
| New treatment guideline on malaria using ACT | PHU staff | 44 |
| Malaria case management and participatory ITN distribution | PHU staff | 22 |
| PHU data collection and reporting | PHU staff | 44 |
| Defaulter tracing (Use of the tickler box) | PHU staff | 44 |
| EmOC training | PHU staff | 22 |
| | Zonal Supervisors | 3 |
| | Sub-total | 25 |
| Mobilization skills and vaccine administration | Vaccinators | 80 |
| Data collection skills training (TOT) | CARE | 12 |
| | MOHS | 27 |
| | District council | 1 |
| | Sub-total | 40 |
| COPE methodology (conducted in 2008) | CARE | 20 |
| | DMHT | 3 |
| | District Council | 1 |
| | Sub-total | 24 |

Local government: Total of 108 VDCs were oriented to their roles and responsibilities and many VDC representatives were also member of the CHCs and therefore received health trainings as well. Furthermore, 146 community members were trained to act as Secretaries and Chair persons trained in VS&L groups. Some of these are VDC representatives. In addition several orientation and advocacy meetings were carried out to build the governance and health capacities.

PHU Staff, DHMT and other NGOs: Several trainings were carried out by CARE and many other topics were covered by UNICEF and MoHS. This was combined with several follow up meetings, technical updates and orientation sessions to promote health leadership. The training in IMCI package could however not be conducted as CARE waited for the national roll-out of IMCI. The outcomes of the trainings and how they relate to improved services have been covered under the next section.

Table 6: Training at District Level.

| Target group | Training topic |
|---|--|
| CSP and DHMT staff | Positive Deviance Hearth implementation strategy |
| DHMT staff | Basic computer skills |
| CSP & DHMT staff | Growth monitoring and promotion |
| CSP, LEAD*, CAUSE Canada, Local council and DHMT staff | Essential nutrition action |
| CSP and MoHS | CHC implementation on the use of the tool kit |
| MoHS, CSP, HAPP*, MOSI and Local council | COPE survey methodology |
| CSP, MoHS, Local Council and MOSI* | LQAS survey methodology |
| CARE, Radio Bintumani, Medicos Del Mundo, CES and CRS | Mapping out radio program in CSP BCC implementation (Radio listener survey) |
| 44 PHU staff in 11 chiefdoms | New treatment guidelines on malarial, using ACT |
| 22 PHU staff in 5 chiefdoms | Malaria case management and participatory ITN distribution |
| 44 PHU staff in eleven chiefdoms | PHU data collection and reporting |
| 44 PHU staff in 11 chiefdoms | Defaulter tracing using tickler box |
| 22 PHU staff, Zonal supervisors in 5 chiefdoms and DHMT | Comprehensive emergency and obstetric care |
| 80 Vaccinators in 22 communities | Mobilization skills and vaccine administration |

CARE projects: LEAD- Livelihood Enhancement and Asset Development; HAPP – HIV AIDS Prevention Program; MOSI – Malaria Outreach and Safety

(d) Health Systems Strengthening

The Project involved the district health office through the District Health Management Team; the Koinadugu District Council; the health facilities; the PHU staff; the Village Development Committees and the community to strengthen the health systems. The wide range of stakeholders involved resulted in an institutionalized mechanism of identifying systemic gaps; improved logistics; local government's

involvement in health activities; service utilization; and community feedback/participation ultimately facilitating good governance practices.

District Management Level Activities: The project applied the Client Oriented Provider Efficient (COPE) tool to analyze systemic gaps and implement remedial action plans. The first COPE workshop was held in May 2005 with participation from DHMT members, NGOs working in the district, facility providers and community members. A district coordinating committee was constituted with the aim to monitor the progress on the district action plans. The coordination committee included members of DHMT, KDC and project staff. Key challenges identified included under staffing, need for improving supervision and monitoring, strengthening HMIS, establishment of referral mechanism, availability of key drugs and under utilization of services by the community. A concurrent client satisfaction and perception analysis highlighted areas requiring facility and provider improvement.

In depth interviews of DHMT members and the DMO during the final evaluation revealed that they had benefited from the COPE analysis. There has been a concerted effort, under the strong leadership of the DMO, to improve the availability of health staff in the district.

Infrastructure: Number of PHUs in CSP operational chiefdoms has increased from 14 to 22 during project period. Cold chains exist in all the PHUs, including those under construction (using private homes). All are solar-powered fridges supplied by UNICEF or directly by the MOHS as some of those supplied by Christian Children's Fund (CCF) are non functional. There is a stand-by team (from the DHMT) who conduct regular repairs of the solar refrigerators. Community referral mechanism is in place through the hammock system, satellite radio connectivity and establishment of ambulance system at the district. All PHUs display facility information along with health education material.

Health Human Resources: An additional Medical Officer has improved district capacity to manage the administration of health and provide clinical care at the hospital. A system of supportive supervision has been established through the recruitment of zonal supervisors based in the Chiefdoms. The number of CHOs and MCH Aides has also improved.

Management: The DHMT coordinates the utilization of available resources efficiently. For example no allocated funds are available for the construction of birth waiting homes. DHMT in partnership with the CSP and District Council garnered community support in designating existing structures or building new structures as birth wait homes. It also leveraged support available through the community development program of the INGO Catholic Relief Services to construct additional structures.

Drug supply: There has been a measured improvement in the drug supplies. Drugs are supplied by the District Hospital. They are supposedly sold at a minimal price even though the cost recovery system is not functioning in the whole district. According to PHU staff interviewed, PHU revenue is spent as follows: about 40% will be returned to DHMT; the remaining 60% is utilized for the maintenance of the PHUs, free treatment of vulnerable groups (destitute) and incentives for PHU staff that are not on pay roll. Cost-recovery drugs are only replenished if PHU staff fully pays for those previously supplied (note that some donors such as UNICEF provide free drugs through DHMT). FE teams did not find price list for drugs displayed in any of the visited facility. All PHUs have regular supply of Vaccines and equipment with the exception of under five cards which are sometimes not available at PHU level. Vaccines administered to children or pregnant women are entered in the child's / pregnant woman's vaccination card. Defaulter tracing is done using tickler boxes supplied by the Child Survival project.

Performance of health providers: The performance of health providers was strengthened through the capacity building activities. These included trainings, joint monitoring and supervision, joint community outreach, garnering of community support to the PHUs and advocacy and capacity building at the district level. PHU staff has received variety of training from the government, UNICEF and NGOs which cover the areas of community based growth promotion, data surveillance, 'communicating health, communicating rights', emergency obstetrics care, births and deaths registration, onchocerciasis, drug management, HIV/AIDS including PMCT, and standard case management of malaria. The FE team however, found that the PHU staff may not be following the correct protocols for ARI /pneumonia treatment. There was one instance where an MCH Aide in Gbentu admitted to prescribing antibiotic for every child with ARI. The increased levels of service utilization, detailed in the previous sections are the benchmarks for improved provider performance. With support from the child survival project Field Agents, MCH Aides, EDC Unit Assistants, vaccinators and sometimes CHOs are conducting outreach clinics in ensuring that children and pregnant women receive their respective vaccines. Vaccinators have been trained with funds provided by the Koinadugu District Council and assistance from Medicos Del Mundo. The major deterrent in provider performance is the lack of remuneration. Many providers are yet to be put on official pay rolls and continue to perform without any remuneration. This leads either to underperformance or in cases corruption. The incentives system instituted by the VDCs address this issue to certain extent. However, this further marginalizes the poorest, who may not have the ability to pay the incentives.

PHUs and Communities: Community participation with PHUs exists mainly in the forms of maintenance, cleaning of the PHUs, outreach support, and sometimes participatory ITN distribution with village development committee members. Community members are not directly involved in the day-to-day running of the health facility. Cost recovery is not functioning in the entire district. Village Development Committees do exist in all PHU communities but have not been able to take a proactive approach in PHU management especially cost recovery controls, while they support PHU activities through facilitating ITN distribution and conflict resolution between community members and PHU, and provision of shelter for PHU staff and vaccinators in the communities. Community Health Club members, Community based Growth promoters and Data surveillance volunteer trained by the Child Survival project are actively involved in health activities at PHU as well as community level (such as conducting health education sessions / health talks during outreach, sensitization and mobilization for campaigns, etc.)

Utilization of the health facilities: Availability of additional health human resources, drugs and facilities together with community sensitization and mobilization has improved the utilization of services. Furthermore, improved outreach services have also contributed to the improved utilization. There is an improvement in deliveries performed at the PHUs because of the establishment of the pregnant women support group, the construction/ provision of the birth waiting homes and continuous joint sensitization (CSP staff, DHMT, District Councils, VDCs, and CHCs) of community members on the importance of skilled birth attendance. The district council has also played a significant role in mobilizing communities for the establishment of birth waiting homes. Before now more than 60% of all deliveries were conducted by TBAs. Now TBAs work collaboratively with the PHU staff in carrying out ANC services as well as deliveries. TBAs have been encouraged to take pregnant women to the PHUs for delivery. During the pregnant women support group session any woman found to be at term is encouraged to be admitted to the birth waiting home. All complicated and emergency cases are referred to the District Hospital. Usually emergencies are conveyed to the PHU using either traditional hammock or the ambulance is called upon when there is need for that person to be conveyed to the district hospital.

VDC and DC Involvement: Many aspects have been covered in previous sections. The VDCs are actively monitoring health activities. However, their contribution to the functioning PHUs can be expanded in its scope. The level of KDC's involvement in health has been strengthened as evidenced by prioritized allocation of developmental funds to health in the neediest communities. KDC has a health committee and meets every month with all stakeholders in the district to discuss gaps and identify solutions. The linkages between the KDC and the VDCs have also improved through the capacity building approach of the project. Some VDCs successfully attracted funds from the National Commission for Social Action (NaCSA) for construction of PHUs, meeting halls and building markets.

Lessons learnt: PHU staff needs to be trained on the full package of the IMCI so that staff will strictly adhere to the standards in assessing children. Community members should be encouraged to take full ownership in the management of the day to day running of the PHUs. The VDCs and KDC need financial management and resource mobilization capacities. Strengthened advocacy is required for the implementation of the cost recovery system in the whole district. The country needs to make a concerted effort to streamline the remuneration of PHU staff to ensure that the services which are meant to be free remain so and are being provided to the poorest. There is a national effort to reduce out of pocket expenditure of the poor. A study on feasibility of establishing a health financing scheme has been submitted to the government recently.

Sustainability: CARE will continue to participate in system strengthening through the other projects it is implementing in the district and the region. Critical issues like remuneration and adequacy of staff require national level advocacy.

(e) Policy and Advocacy

CARE in Sierra Leone is a member of the health task force at the national level. This task force is a forum for information sharing between health NGOs, international agencies and the government and provides an opportunity to leverage participation in technical forums. CARE is also a member of technical groups addressing Malaria, IMCI and Reproductive Child Health. CARE has been active in promoting the adoption of C-IMCI strategy in the country which will reach fruition perhaps this year. Similarly, it works closely with UNICEF, donor groups and other INGOs active in the area of maternal child health and malaria.

While CARE utilizes opportunities for sharing and disseminating information, it does not have a concerted national level advocacy strategy. A higher level of advocacy effort would complement the translation of CARE's successful initiatives into national level strategies.

(f) Contribution to Scaling Up

Effectiveness of scale-up strategy: The project adopted the strategy of working intensely in 54 chosen communities. Project field staff worked directly with these communities establishing or revitalizing the community health clubs. Each CHC has membership ranging from 20 to 50. Almost each household was represented in the CHCs in most of these 54 communities. Simultaneous capacity building of PHU staff and the project's strategy for enrolling PHU participation in community mobilization helped translate similar activities in the indirect communities.

This intensity of focus ensured sustainable behaviors in chosen communities and resulted in scaling up of activities in neighboring. The volunteers from the CHC communities proved to be effective change agents and this resulted in revitalization of CHCs in indirect communities as well. The PHU and

community led scaling up was part of the envisioned strategy and worked well. The benefits of community support are apparent to the PHU staff which in turn motivates them to work closely with the community.

However, the CHCs strengthened by the community volunteers did not receive the quantum of inputs received by the direct communities. For example, in the direct communities, CHC member underwent weeks of training; received certificates; and have been given salter scales and records for growth monitoring. The CHC members of the indirect communities have been exposed to the CHC education material, but have not been 'trained' formally; neither have they been provided with tools for action oriented interventions. It may be expected that there would be a difference in levels of capacities and levels to which behaviors were internalized. The quantitative survey does not answer these questions and further study is required to comment on such a scaling up strategy.

The CHC approach is being adopted by other CARE projects, including USAID funded Title II project, in the region and will utilize the same comprehensive curriculum, ensuring further scale up in adjoining districts. The strong leadership at the district level has also contributed to scaling up beyond the project chiefdoms and replication beyond district borders. The success of VS&L scheme is being replicated in at least three adjoining districts.

The strategy of birth waiting homes has generated much interest in the region and at the national level. However, it needs to be documented well to enable advocacy at national level. The MOHS representatives raised some of these concerns during the dissemination meeting. While the benefits of the strategy are apparent to the MOHS, they would need well documented evidence before committing resources to the scaling up of the strategy. They requested CARE to document the costing of the intervention and details of experiences from community contributed birth waiting homes as well.

CARE and IRC benefited from cross visits and cross learning between the two projects. CARE has also been disseminating information to other INGOs in the area which has resulted in transplantation of the CHC and the VS&L strategies in other projects in the region.

Lessons Learnt: The CHC strategy promotes community action. The strategy for scaling up CHCs (direct project capacity building efforts versus cascade approach of training community volunteers) needs to be studied further.

CARE should document successful interventions and advocate for their scale up in the region and the country. There is also a need for CARE to strengthen their advocacy strategy to enable dissemination of successful strategies.

(g) Equity

Geographic Equity: In 2003, Koinadugu was identified as the least developed districts with the lowest health indicators in the country. CARE chose to work in the district to ensure that health services and capacities are made equitably available to the impoverished district. More than three quarter of the district population live on less than a dollar a day and the communities chosen for intensive implementation were those which were geographically inaccessible to the health system and therefore identified as most disadvantaged. The project, as described in earlier sections was not only able to empower these communities with health information, but also facilitated their linkages with the PHUs thereby increasing utilization of services which has resulted in decreased morbidities in the area.

Gender Equity: Besides addressing geographical equity, the project addressed gender inequities prevalent in the predominantly Islamic communities of Koinadugu by committing to achieving at least 20% women participants in the community health club. The FE team witnessed the changed power structures during the introductory meeting at each of the communities visited. Abiding by the cultural requirements, the FE team met with a group of important people in the community and this meeting would be attended by additional community members. The team would request introductions from selected members to ensure adherence to the tightly packed schedules. In each village equal number of men and women were introduced as important community members.

“We could not imagine talking in the presence of men folk earlier; we now take pride in the work we do and in our contributions to the community” – CBGP volunteer from Yadia.

Involving men in the CHCs has also enabled promotion of positive health practices among women. Women admitted to receiving support from their husbands during pregnancy and with child rearing. Women said that the involvement of the VDCs have also facilitated the adoption of positive decision making at the household level.

However, as described in the earlier section, there are examples (a larger incentive paid to the TBA for the birth of a girl child) of community level decisions which appear discriminatory. However, this needs to be examined in the cultural context of Sierra Leone.

CARE’s CHC model scales up innovative approaches that strengthen civil society, and address equity (especially with regard to women’s participation in public meetings). Complementary activities undertaken by the Village Development Committees (VDCs), with encouragement from the CSP, include construction of schools and mobilizing support for girls to go to them. In some communities, Child Welfare Committees were formed as a sub-committee to CHC to specifically promote children’s rights. Committee members sometime visited from house to house to ensure that girls go to school. There is a perception that girls attendance in schools has significantly increased.

Economic Equity: The Village Savings and Loans Scheme was an innovation to address the economic inequities prevalent in the project communities. They have been applied successfully by the communities. The benefits of having a emergency resource available close to their households in these resource-deprived communities has been apparent through the speedy scale up in adjoining chiefdoms and districts.

The quantitative results of these strategies have been described in earlier sections in detail.

(h) Sustainability Strategy

The project sought to sustain improved health outcomes through strengthened local governance; bringing positive changes in community health practices; and improved technical and managerial capacities of the government and health care providers. The project inputs to this effect have been adequately discussed in preceding sections of this report.

Community structures are strong and will ensure sustenance of positive behaviors and demand for services. The project performed immensely well in strengthening community capacities. The CHCs are functioning independently, are advocating actively for adoption of positive health behaviors; and are supporting the community based child survival activities. The CHC volunteers are extending their activities beyond their own communities, generating demand for services and monitoring community utilization of services.

The project achieved an immense increase in **demand for services** and this has tremendously influenced the quality of services. This has been well explained in the previous sections. Though behaviors will sustain as benefits are very apparent to the community, focused plans for supervision and monitoring from MoHS and DHMT is imperative. The District HMIS needs to capture levels of community support through simple indicators.

Strong savings and loan groups serve emergency needs, however mobility, outreach, access suffers due to road conditions. The promotion of the loans scheme has created economic buffers in the community, which is being used for health and developmental purposes. Currently the scheme is designed such that all members share out the annual savings according to their contributions so as to curtail the amount in the pool. However, with increased capacity to manage funds effectively will allow for utilization of additional funds for developmental activities. It is recommended strongly that CARE explore avenues for supporting financial management and leadership training to VS&L groups to ensure appropriate investment of this fund.

Health providers are capable, competent and confident, will however require refresher trainings, continued supportive supervision and payment of salaries to maintain level of activities. Project built the capacity of the PHU staff, strengthened their linkages with the communities ensuring continuing provision of quality services. However, the intensity of outreach programs through the PHUs may suffer with the phase out of the project. Although there is a district level plan to provide all PHU staff with motorcycles; the project should have phased out the outreach support provided by the field officers earlier and established alternate means of carrying out the activity. The period between the phase out of the project and provision of motorcycles to PHU providers will probably witness the decline in the outreach activities.

Continued **engagement of VDCs** and KDC by the DHMT will ensure the monitoring of community level activities. The VDCs have included health as an agenda for development; monitoring and supporting community based health activities.

Project enrolled the **participation of DHMT** and built their capacity to provide leadership and adequate supervision to the health staff in the district. Project has discussed phase over plans with the DMO. Continuation of the MOSI project (malaria) in CSP communities will be utilized to sustain the intensity of activities in the district. CARE plans to continue collaborative activities at district to support planning and supervisory capacity of DHMT to sustain the outcomes. Furthermore, the DMO has planned for continuing activities through support of other agencies.

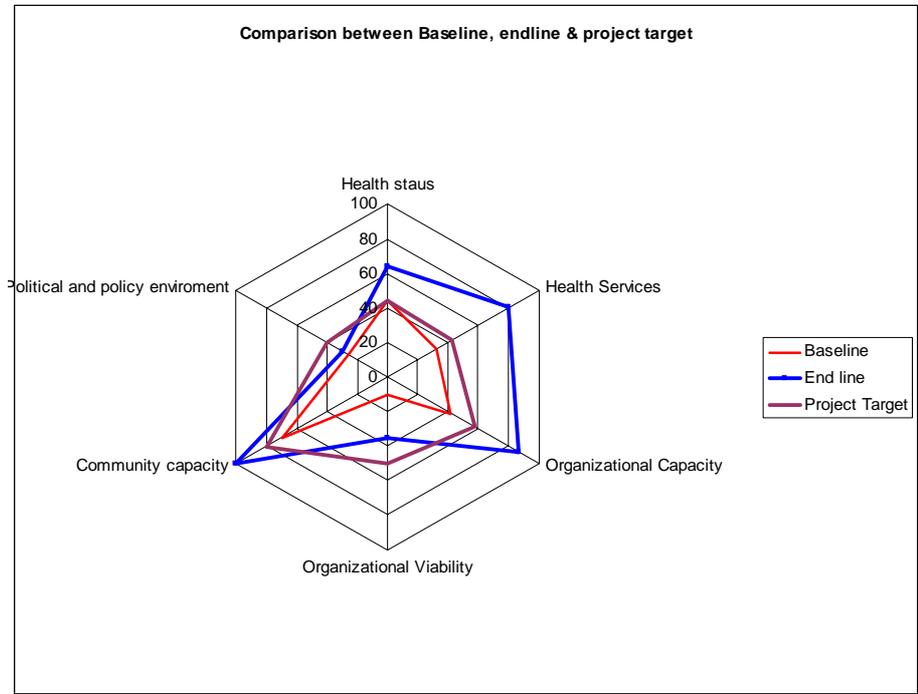
The project did not **partner with any local NGO** missing out on the opportunity of building local capacities. Radio Bintumani, the sole partner of the project, received technical capacity building. However the project did not focus on building their organizational capacity. The sustainability of health programs on radio will depend on availability of resources from other donors and Bintumani's capacity to do so.

Measuring Sustainability: This project, along with the International Rescue Committee (IRC) Child Survival Project in Kono District, was selected for Technical Assistance (TA) from the Child Survival Technical Support Project (CSTS+) on the Child Survival Sustainability Assessment evaluation methodology. Prior to setting up a Sustainability Working Group with the DHMT, CARE Sierra Leone conducted a Country Office-wide program review. A major focus of this meeting was to review the current and upcoming activities in the Koinadugu District.

Through the joint workshop with IRC, the three dimensions of CSSA were introduced and indicators for elements under each dimension were identified. Twelve indicators were established and refined during the stakeholder workshop. The progress on sustainability indicators are detailed in Annex 4. Figure 14 depicts the sustainability dashboard which compares the baseline, end line and project

targets. As described in earlier sections, the project could not achieve the set targets for the element of political and policy environment as the Sierra Leone is yet to fully roll out the IMCI as national strategy.

Figure 9: Sustainability Spider Chart for CSP, CARESL



D. Changes in Grantee Organization Capacity

This section is not applicable to CARE.

E. Mission Collaboration

The USAID mission has been supportive of CARE in general and the CSP in particular. CARE has other USAID-funded programs in Koinadugu District, including Title II and the LINKS project that address food security and income generation. The local USAID mission’s new strategy does not have a health focused objective as speculated during the MTE. The mission is focused on strengthening governance systems. However, with the arrival of the new Ambassador, there has been a renewed interest in health. The Ambassador has garnered Pefpar funds for the country, which have been allocated to laboratory strengthening in the country. Recognizing that health is still a serious development concern in the country, CARE is interested in influencing the local mission’s support to health programs. Consultant and CARE’s Health Sector Coordinator met with the Mission staff prior to the field work and utilized the opportunity to invite the participation of the Ambassador in the final dissemination meeting. While the Ambassador was expected to be out of the country on the proposed day, such an invitation created an opportunity for the mission staff to share information and provide feedback to the Ambassador through her representative at the dissemination meeting. The mission staff appreciated the strong linkages that the project created between CSP and other USAID projects. CARE Freetown senior management is expected to take the discussions forward through follow up meetings. The FE team recommends that CARE document the successes in improving governance mechanisms and health system strengthening and share it with the mission and other stakeholders to develop a common platform for initiating discussions on support to health programs.

F. Contextual Factors that Influenced Results

Sierra Leone emerged in 2002 from a decade of civil war which resulted in tens of thousands of deaths and the displacement of more than two million people (one-third of the population). With the support of a large UN peacekeeping force, national elections were held in May 2002 and the government continues to slowly reestablish its authority. Sierra Leone also faces the challenge of reconstruction. The problems of poverty, ethnic rivalry and official corruption that contributed to the war have not been overcome completely.



The Koinadugu district is one of the least developed parts of the Nation. The district is located in the mountainous region and has poor infrastructure. There is exactly one paved road (700 meters) in the entire district which is in the capital city of Kabala. The muddy tracks connecting the villages and communities are uneven and extremely difficult to travel, even with a four wheel drive. During the rainy season (lasting five months – SL receives one of the highest rainfalls in the world), most villages are almost impossible to reach. The district lacks electrical connectivity as well. Due to mountainous terrain and poor roads, the district's population is the most dispersed and least accessible in the nation and with its high illiteracy rates; it faces some of the steepest barriers to development.

The physical accessibility formed a barrier in achieving higher levels of utilization for services which required traveling to the PHU or the district hospital. Though under the leadership of the DMO, the district now has an ambulance service, the time taken to transport the patient from the farthest community to the referral hospital in Kabala would take more than 7-8 hours given the terrain.

There is a generalized shortage of health human resources in the entire country, which affects the district as well. This is compounded by the fact that many of these providers are not being paid salaries. However, the intensity of community participation generated within this project has overcome at least some resultant barriers connected to health staffing.

G. Conclusions and Recommendations

Key findings – Behavior Change

- The knowledge levels were high for each intervention area (except ARI) and were similar for men and women (except maternal and newborn health).
- The engagement of the non-CHC communities by CHC groups and support to outreach activities to indirect communities ensured similar knowledge levels where activities were not intense.
- The knowledge translated into positive behaviors, supported, monitored and maintained by strong community groups, volunteers, PHU inputs and VDC advocacy and bye laws. The project achieved immense success in promoting ITN usage and exclusive breastfeeding.
- Health seeking improved with a perceived reduction in morbidity and the mortality levels, although challenges of access to PHUs and safe drinking water and sanitation remain.

Key findings – Access to services and quality care

- Initial project support and later community support has led to increase of PHU outreach activities
- Community based activities has improved access to nutritional monitoring and counseling.
- Birth waiting homes (22) have facilitated access to institutional deliveries.
- Inputs from various agencies in the past and during project duration have enabled access to safe water and sanitation facilities.
- The availability of loans and savings groups (135) has improved access to emergency cash and therefore prompt seeking of emergency services.
- Presence of structured referral system (hammocks, radio communication, and an ambulance at district hospital) has also immensely improved access at times of emergency.
- Unpaved roads remain a major deterrent in reaching PHUs.
- Unclear entitlements may be causing a barrier in accessing immunization services.
- The community not only received treatment, but also received education, preventive care and outreach through PHUs.
- The Pregnant Women’s Support Group facilitated by the PHU staff is much appreciated for the package provided during the sessions (free ITN distribution, free ANC services, nutrition demonstration, and health talk) and the peer support to younger mothers.
- Owing to the fact that most PHUs are manned by a single provider, availability of the provider at all times continues to be barrier.
- Drugs, vaccines, ORS and ITNs are being supplied without interruption and will sustain through strengthened leadership and management capacity at the district level.
- ORS is not available at community level (except in some areas at local shops) and there has been a recent dearth of chlorine tablets in the district.

Key findings – System Strengthening

- The number of health providers available to the district has improved tremendously in the last two years owing to strong district level leadership - MCH Aides (80), Vaccinators (80) and the CHOs (9).
- The **knowledge and skills** of the provider are adequate and has been a result of regular training sessions by MoHS and the project. However it is important to refresh the knowledge on a regular basis as well.
- The capacity is further built through **supportive supervision** and joint monitoring of activities.
- The providers further receive immense **support from the community groups** and volunteers in conducting outreach activities, growth promotion and dissemination of information.
- PHU staff are also building the capacity of community level providers like the CBGP volunteer, the CHC volunteer and the TBAs.

Key Findings – Local Capacity

- Immense amount of community cohesion and ownership was experienced by the qualitative evaluators.
- Increased involvement of DC and VDC reflected by the various bye-laws that have been formed to promote positive health behavior and prioritization of activities.
- The CHC and CBGP volunteers extending services to nearby communities as well.
- VDCs and PHU staff have ensured that TBAs are included efficiently in caring for the pregnant woman and facilitating institutional deliveries.
- There are 394 CHCs in various states of formation in the five chiefdoms. The 54 CHCs formed and strengthened under the project are rolling out activities to 4-9 neighboring CHCs or communities each.
- In the last three months 37 CSP CHC communities have reached 1056 non-CSP CHC community members with various outreach activities

Challenges

- Roads
- Water sanitation facilities
- Economic constraints and shortage of food
- Uniform availability of all the entitlements
- ITNs for males and older children
- Availability of adequate trained human resources and their remuneration in the formal health sector
- Adequate material support to capable and motivated community groups
- Continued monitoring of activities and continued capacity building
- Diminishing cohesion in peri-urban and urban areas

Key Lessons Learnt

- CHC strategy led to an amplified community action, promoted community led advocacy and scaling up of activities.
- Involvement of men ensured that positive health decisions were being made for mothers and children.
- VS&L is a good strategy to overcome economic barriers to health care and provides resources for other developmental activities.
- While bye laws of VDCs have helped promote health, they require monitoring to ensure appropriateness.
- Complementary activities by other NGOs and governmental bodies contributed to the impact of the program.
- The partnership of TBAs and PHU worked positively for both partners.
- Involvement of local authorities made maternal and child health as everybody's agenda

Key Recommendations

- Scale up MNC intervention package (VS&L, PWSG and TBA support to institutional deliveries, birth waiting homes, upgrading PHU staff skills in EmoNC) within future program efforts.
- Support new/reactivated CHCs with weighing scales, ORS, Chlorine and IEC material, replenish material regularly.
- Enroll and utilize community resources (motorbikes) for continuing outreach activities.
- Application of child to child activities worked anecdotally in the project areas. This strategy can be explored to improve community capacities in future programs.
- The mature VS&L groups need support and capacity building to ensure that their funds are invested in developmental activities aimed at improving their standards of living.
- Grain banks are considered an effective strategy to overcome food shortages and should be promoted in Koinadugu communities.
- Community based management of childhood diseases would play an important role as physical access to PHU continues to be an issue due to poor road conditions and can be introduced in strengthened communities.
- Institute Citizen Charters to ensure communities are aware of their entitlements.
- Strengthen the cost-recovery system, delineate policy, and enroll community participation in strengthening its implementation.
- Explore training of PHU staff on full package of IMCI (not just malaria management) to ensure holistic treatment of the child.
- Scale up partnership between TBA and PHU to include TBAs who are not yet participating in promoting institutional deliveries
- Continue to provide logistical and technical support to PHU through DHMT, monitor community participation through simple indicators

Annex 1: Results Highlight: CHC Approach (Promising Practice)

Problem being addressed: CARE's experiment with CHC has paid good dividends. Though created for the purpose of initial community mobilization designed to be the key instrument both for community participation and as an active link between the HF and the community, the CHC evolved into more diverse areas of operations. It became the impetus for greater social cohesion, empowerment of women, vehicle for BCC activities, and good governance. Because of its proactive spirit, the community thus self-mandated itself to build its own capacities through internalization of its experiences and was seen by the CHC itself, neutral observers and evaluators that the CHC had metamorphosized as a great 'self-learning' and self replicating body and a microcosm of representative democracy at the grass-roots.

Project's input: As a first step, the project revitalized VDCs as important partners in the development process. With the help of VDCs, the project initiated the CHCs by holding community meetings to explain the approach. Interested community members were then invited to attend weekly CHC sessions, held at a time set by the community members, this was the beginning of 'self rule' geared at self benefit.. After several weeks, the project encouraged the community to develop a CHC leadership structure and identify CHC leaders. Since this process is community-driven, each CHC may have a different structure, but most CHCs elect about six officers to lead their CHCs.

For 25 weeks, participatory sessions on basic health were facilitated by the project. Community members who have attended at least 20 sessions out of 25 were issued a membership certificate. After the completion of the lessons, CHCs were encouraged to mobilize their communities around health issues through the creation of monthly action plans. As part of their plans, CHC members implement community development initiatives, review health lessons, conduct outreach sessions to other communities, and work with the PHU to ensure success of outreach activities.

Magnitude of intervention: CHCs are organized all 54 project operational communities. The project has trained 2,339 CHC members (62% female) to date and the trained CHC members are now reaching their peers through outreach activities in the neighboring communities. A total of 268 males and 432 females benefited from such rollout sessions last year.

Results: Widespread participation in CHCs among all strata of society has led to increased knowledge, behavioral change, and community participation in the formal health sector, which created an atmosphere of enthusiasm and empowerment to continue with positive health behavior. Capstone assessment (Annex 2) indicated CHC as major source of health information and the significant improvements in project indicators (e.g., exclusive breastfeeding: 19.5% (2003), 55.3% (2005), 97.5% (2007)). PHU staff and CHC members see these improvements as a direct result of CHC training and activities. Improved community cohesion, strengthened leadership, and increased undertaking of self-initiated activities are other outcomes highlighted by the Capstone assessment. Community members indicated that CHC helped to create unity, stimulate a collective spirit, increase women's participation in decision-making, and enable an environment where everyone's ideas were valued. The CHC approach is now a model that is already being incorporated into other programs, both within CARE and in other organizations. CARE sister projects alone trained additional 2,423 CHC members in non-project operational communities.

In conclusion, the inclusive mandate, ranging from health promotion to community management of health programs and to other social development initiatives, has helped the CHC approach not only to provide improved health outcomes, but also to transfer organizational capacity so that the community can begin the transition to self-initiated development.

The CHC deviates from most community participatory models in that the CHC approach is gender neutral. This approach is more inclusive and hence raises greater sensitivities and respect for either sex. This mechanism forces discussion amongst participants to look at the same issues/problems from different perspectives addressing key concerns, this can be seen in involved participation by men in supporting the idea of birthing facilities and the hammock ambulance.

Annex 2: Publications and Presentations

Project presentations

1. Health operation presentation for DHMT annual review and planning meeting, Feb 2007
2. CSP – Working with partners – Cross learning visit in Kabala with IRC, September 2005
3. CS annual conference presentation May 2004
4. CS annual conference presentation, Malawi 2005
5. CS annual conference presentation June 2006
6. CS annual conference presentation April 2007
7. Birth Waiting Home, Lessons learned workshop with IRC in Kabala, Nov 2007
8. CSP sustainability 2007 –Lessons learned workshop with IRC in Kabala, Nov 2007
9. “Belleh Woman Support Group” – lesson learned workshop with IRC in Kabala, Nov 2007
10. Feedback on cross visit to IRC Kono with DHMT, VDC rep and Local Council rep., Feb 2007 to a larger forum (DHMT, Local Council, Community reps, CARE-CSP) in Kabala district hospital
11. PD/Hearth M & E presentation, Jan 2008 with DHMT, local council and CARE staff.
12. Health Management Information System- Lessons learned workshop with IRC, Nov 2007 in Kabala
13. CSP achievements and factors responsible – Lessons learned workshop with IRC, Nov 2007 in Kabala
14. Gaps in the current implementation – Lessons learned workshop with IRC, Nov 2007 in Kabala
15. CARE CSP Baseline Survey findings with partners in Freetown, Feb 2004.
16. Measuring sustainability – in collaboration with IRC, March 2004 in Freetown and present were: IRC, CARE-SL, CARE-Atlanta, DHMT Kono, DHMT Koinadugu
17. Sustainability framework – in collaboration with IRC, March 2004 in Freetown and present were: IRC, CARE, DHMT Kono, DHMT Koinadugu

Project publications

1. Assessment of the Community Health Club approach by M.A candidates, International Development Studies. The Elliott School of International Affairs
2. Community Health Club Toolkit “Communicating Health; Communicating Rights” 2005

See Attachment 3 – 5

- 3: Assessment of the Community Health Club Approach
- 4: CARE Sustainability in the Child Survival Project
- 5: CARE and DHMT (10 Feedback of cross visit to Kono)

Annex 3: Project Management Evaluation

a. Planning

i. The planning process was very inclusive and the project in line with CARE's vision and programming principle involved the poorest of the poor, especially the women and children. This was done through regular meetings at community level – the project instituted the coordination meetings between community representatives including Village Development Committees (VDC) members, PHU staff and the project staff to facilitate the participatory planning and monitoring of the activities. The project further supported the Community Health Clubs (CHCs) to develop and implement their own monthly action plans, which helped communities to take control over their own health and to take ownership of the project interventions. Similarly, the MOHS was fully involved at all levels (i.e., national; district; and community) from onset of the project. DHMT, in particular was heavily involved in the process and their capacities were built at each level. Involvement of key stakeholders was brought to bear at project proposal stage, DIP stage, MTE and FE stages. During the MTE, involvement of key stakeholders such as MOHS and UNICEF ensured that the follow-up action plan developed was comprehensive and coordinated as opposed to the plan to be solely owned / implemented by CARE. Collaboration between UNICEF, CARE, and MOHS in improving the referral system for EMOC was one such example – each agency played its own part to maximize the impact of the intervention. During the FE, neutral observers as a part of the data collection team from the community were also brought on board to ensure data neutrality. As noted, CARE worked with UN agencies at the national level especially, UNICEF and reported frequently to the USAID local Mission. With the MOHS the planning for COPE and its follow up was crucial and successful.

ii. DIP was largely a participatory exercise, inputs enriched the DIP formulation and the project remained consistent to the DIP. There were significant changes in the external operation environment like change of leadership at the DHMT level as well as MOHS national level and a significant change in the treatment of malaria during the life of the project moving from chloroquine and sulphonamide combination therapy to ACTs. These or similar changes were expected during the DIP time and with the support of MOHS these were taken in stride.

iii. One of the gaps in the DIP was the vague definition of the project's partnership with local NGO, CES. While CES was originally identified as project's implementing partner, it was later found that the organization's interest was in financial inputs from the project rather than in 'partnership'. It was also noticed that the organization shifted their focus away from health sector. Lack of common understanding and expectation between CARE and CES at the onset of the project resulted in the absence of local NGO partner for the project. In a response to this situation, the project rather intensified the partnership with the existing government health structure – DHMT and PHUs, which actually contributed significantly to the project success and sustainability.

Another gap was the fact that the DIP somewhat undermined the programmatic risks associated with some of the project activities, thus the mitigation measures were not planned in time. For example, while the project intended to use C-IMCI approach as an overarching strategy, the possible delay in nationwide IMCI rollout by MOHS was not taken into consideration. Similarly, one of the project activities (i.e., the re-establishment of medical stores) had to be compromised due to the government's plan to rehabilitate the district hospital structures during the project period. Nonetheless, the project employed flexible approach to compensate the planned activities with the alternative. As regard to IMCI, while CARE continued to advocate with the national-level MOHS for the speedy rollout of the approach, the project rather focused on elements 1 and 3 of the C-IMCI (i.e., improving partnerships

between health facilities and the communities; integrating promotion of key family practices). For the medical store, the project modified its strategy from hardware inputs (construction) to software inputs (e.g., capacity building of DHMT members, strengthening HMIS, facilitating cross learning through study tour to Kono to observe functioning medical stores, etc.).

b. Supervision of Project Staff

i. Supervision was adequate done, partly due to the project's focus on capacity building at all levels and partly due to the institutionalization of the rigid supervisory system. The project further strengthened the supervision capacity of the partners: The joint supervision exercise conducted with DHMT and later zonal supervisors to the PHUs using standard supervision check list increased the supervisory skills of the DHMT and zonal supervisors. Moreover, after a number of capacity building interventions and constant support received from the project, VDC members started to provide adequate oversight function for all the community-based health and development initiatives as well as supervise community volunteers such as CBGP and CHC volunteers. Similarly, PHU was able to provide technical supervision and support to these community health volunteers.

ii. Within the CARE project team, a comprehensive community supervisory check list was developed and filled monthly by field supervisors who conduct frequent supervisory visits to the field. The findings of the monthly supervisory check list was reviewed and discussed with the entire project team in a monthly meeting facilitated by assistant project manager (APM) or project manager (PM). APM and PM also often conducted field visits to ascertain the progress and quality of the project implementation.

Within the DHMT level, monthly joint supervision exercise the project initiated (mentioned earlier) prompted to institutionalization of the supervisory system within the district. It should be noted that, at later stage of the project implementation, DHMT members or zonal supervisors started conducting monthly supervision without CARE project staff presence.

At community level, the supervisory or support system was institutionalized with active involvement of the VDC members, and CHC and CBGP volunteers, who are supported by PHU staff.

iii. As noted earlier, now the monthly supervision became a norm to the DHMT / zonal supervisors. This practice is closely monitored by District Medical Officer (DMO) as well as all the health development partners in the district, as presentation of the findings from supervisory visits is now the standing agenda for the monthly district coordination meetings. Zonal supervisors or DHMT members are obliged to conduct at least 2 supervisory visits before any each of the monthly health coordination meetings.

At community level, by the end of fourth year of project implementation, it was observed that the community-based health interventions were conducted without much assistance from the CARE project team, as community volunteers (e.g., CHC and CBGP volunteers) received adequate supportive supervision from VDCs, PHU staff and other community leaders. Moreover, it should be noted that various bye-laws were instituted at community level to monitor and supervise the community-based health interventions and/or individuals health behaviors such as use of bednets, institutional deliveries, and immunization uptake.

c. Human Resources and Staff Management

i. Human resources (HR) and staff management within the project team was all done in compliance with CARE Sierra Leones's HR policies and procedures. That includes, but is not limited to: transparent recruitment procedures; performance management system; staff development; talent identification and succession planning; and wellness policies. These policies, procedures and system in

place will continue to support the implementation of the future interventions that are intended to be sustainable.

The fact that the project, through the strong leadership played by DMO, succeeded to advocate with the increase in the number of MOHS staff working in the district (i.e., zonal supervisors, and MCH-Aides, etc.) further strengthened the sustainability of the project operations.

ii. The FE consultant had a discussion with the entire project team and found that it was the happiest team that she has ever met in a sense that there was trust and a strong sense of team spirit between the team members. It was also noticed that the team was cohesive, made up of highly motivated staff members who support from each other.

iii. There was quite high staff turn over throughout the life of the project. An expat PM left after the local PM was mentored to manage the project and later he left towards the end of the project life and another local PM was brought in, delineating the success of the objective of the project being able to bring sufficient local talent for Project Management activities. Likewise, staff turn over for the less senior positions including field positions was also high; nevertheless, it did not have much negative impact on project implementation because of the strong team spirit described earlier. There was a strong support system for the newly joined staff so that there will be no gaps to be felt by the team.

The Atlanta technical back support also had two change of hands during the project life.

iv. CARE Sierra Leone has plans to help staff transitions.

Given that many of the project staff excelled their performance due to the intensive capacity building efforts the project made and they often acted as role models to the rest of the personnel within CAER Sierra Leone, deliberate efforts were made to retain those project staff. With the plan to start up new projects that will actually build upon the CSP best practices and lessons learned, CARE Sierra Leone received the bridge funding from HQ to retain the entire project team during the transitional period (3 months) until the start-up of the new projects. Many of them are anticipated to work under different capacity within CARE Sierra Leone from January 2009.

d. Financial Management

i. The project budget were not adjusted in any significant manner. The project met its match obligation. The Financial system in CARE which operates through a double entry system called Scala is monitored closely at the project, national and headquarters level.

ii. Despite the difficult funding environment in Sierra Leone health sector, CARE-Sierra Leone is making every effort to raise funds from different sources to continue the child survival and maternal health interventions, especially those proven effective.

iii. This part of the sustainability planning remained weak.

e. Logistics

i. Project vehicles and motorbikes helped immensely on the smooth implementation of the field activities. They further enabled the project to contribute significantly to the MOHS activities within the district. As the MOHS (including DHMT members and PHU staff in the district) was severely constrained with mobility, the project's logistical support to community outreach sessions; vaccination campaigns; and prepositioning of the bednets was much appreciated. Similarly, the project's supply inputs also contributed the achievement of the project objectives; the benefit of the IEC materials was obvious for the project's health education objectives, for example.

On the other hand, the project did not directly procure medical supplies but instead they were made available through partnership approach. For example, bednets from UNICEF and DHMT under the

agreement between CARE and those partners; Vitamin A was donated from Helen Keller International (HKI); vaccines from UNICEF through DHMT; ACTs from National Malaria Control Programme (NMCP) through DHMT, etc. Because of the strong relationship built between the project and the DHMT, there were no significant challenges experienced due to this approach.

ii. Clearly the relatively weak logistics system at all levels was one of the challenges Sierra Leone faces in general – due to the absence of viable private sector and the effective public services such as electricity, communication, water, and road network. This is why the newly launched national reproductive and child health (RCH) strategy emphasizes the strengthening of logistics system amongst others, and recently significant inputs were made (purchase of vehicles and motorbikes for the PHUs, DHMT in the district, etc.). The project also worked over the year with DHMT in health system strengthening, including the logistics system.

f. Information Management

i. The project greatly strengthened the HMIS by identifying the gaps in the system, followed by the capacity building of the DHMT staff. Capacity building activities included training of DHMT members with focus on M&E officers on computer skills, basic filing system, and M&E. The involvement of all assessments project facilitated such as LQAS surveys, COPE assessments, MTE and FE exercises further contributed to the familiarization and better understanding of the M&E issues among DHMT members. Moreover, the intern and local consultant the project contracted helped the establishment of filing system and design / development of the district health database. DHMT members (M&E officers) were trained on the use of this database, as well.

In addition to the facility level statistics, the project further tried to capture community based data. With assistance from Emory University Intern, the project in collaboration with DHMT, instituted the community data surveillance system. The system involved monthly basic data collection and quarterly LQAS surveys, and community volunteers, PHU staff, and DHMT members were trained in concept of HMIS, community data surveillance, basic techniques in data collection and analysis.

ii. At the project level within CARE Sierra Leone, monthly report was instituted. First, field staff wrote up the report outlining the project achievements within the past month, after which the field supervisors consolidated all the reports under different activity heading. The report findings were discussed together with challenges encountered during the monthly reflective meetings. These discussions guide the planning of the following month's interventions. Similar discussions were held after each of the special assessments / surveys conducted. LQAS that was conducted twice (in 2005 and 2008) in particular provided the project with much needed insight as it clearly indicated the progress toward the project target in each of the supervisory areas (i.e., each of operational chiefdom) in quantitative term, and facilitated the cross-learning between the different chiefdoms.

As noted earlier, MOHS partners and other stakeholders are also fully involved in all the assessments / surveys conducted; database and M&E system was established within the DHMT; and service statistics collected and information collected through the supervision visits were discussed during the monthly coordination meeting followed by the development of action plans.

iii. The project staff and partners including MOHS staff (DHMT members, PHU staff) are skilled in data entry, simple analysis and give a good managerial feed-back to the project. As developing the staff capacity in design, monitoring and evaluation (DME) is one of the priority areas for the CARE Sierra Leone, the project staff had an opportunity to benefit from a several in-house DME trainings. CARE Sierra Leone's DME unit also provided an ongoing technical assistance to the all projects including the CSP. With the possible new projects, it is projected that these skills will be fine tuned and tweaked to make more meaningful assessments possible.

iv. The project conducted a number of assessments and studies. One of such was assessment of community health club (CHC) approach. The assessment actually highlighted the effectiveness of the approach, but also made a number of recommendations for enhancing sustainability. The project took into consideration these recommendations in developing project exit plans. Another example was participatory communication appraisal and the radio listener survey the project conducted. Based on the findings from these studies, the project was able to strategize its BCC interventions, taking into consideration the power relations that exist at household and community levels. The findings also facilitated the development of appropriate IEC materials tailored to non-literate population.

v. Please see (i) above

vi. The local level partners have a great sense of accomplishment and so do the MOHS staff at PHU and DHMT. They are very happy to share lessons learnt for cross-visits. Their participation in different fora (especially for women) is a great sign of progress for them. They do take pride in the project's maternal and newborn care interventions in particular such as birth waiting home initiative and VSL scheme as it was done without donor money. The MOHS at the national level is appreciative of the various systems that have been set in including the VSL groups and CHCs.

This is as a result of the inclusive partnership approach that the project adopted – involving every stakeholder at all levels (District Council, DHMT, PHU, other NGOs, community representatives) in the process of the assessments/studies/surveys; instituting the coordination meetings at different levels – community; chiefdom; and district, where the project achievements, bottlenecks, lessons learned, way forward to address challenges, were discussed, among others.

vii. At CORE CARE has shared its work on communicating health and communicating rights, also in the same forum it has shared its work on CSSA. After this evaluation CARE will be share impact of the project through the LSC.

CARE's work in country, especially maternal and newborn care intervention package, was appreciated as comprehensive and innovative by UNICEF and MOHS and there are talks to see if it can be replicated. Some of the interventions initiated by project such as CHC approach, birth waiting homes, etc., have already been replicated by other NGOs and DHMTs in other districts. Furthermore, lessons learned from the CSP are now being used for the new program development and advocacy agenda.

g. Technical and Administrative Support

i. The project has received tremendous support from different levels during the life of the project. Central to this was the annual CS workshops that are held, the last one was held in SEARCH Gadchiroli where project staff learnt first hand, interventions needed for Neonatal survival. In addition, significant amount of technical assistance was made available from CARE HQ; notably in the areas of nutrition (i.e., ENA workshop); MNC (i.e., participatory development of the MNC strategy); and sustainability (i.e., CSSA with support from CSTS+). The MTE and FE preparations were also assisted by CARE HQ.

Moreover, partnership with universities (George Washington and Emory universities, in particular) and acceptance of interns also supported the CARE country office. As noted earlier, much of the work done within HMIS and documentation of the best practices such as CHC approach was assisted by interns.

ii. TA in the use of PDAs (the new survey device) and facility IMCI, if made available, could have benefited the project. As noted earlier, in-depth analysis of the programme context and risks associated with project activities at the onset of the project as well as the close monitoring of the operational context on an ongoing basis could better plan for the TA needs of the project.

iii. The Child Survival project staff continued to receive technical backstopping both from the CARE's Sierra Leone CO head quarters and from CARE Atlanta. Timely implementation of project activities was well supported in administrative and technical terms from the in-country Health Sector Coordinator and the Atlanta based Child Health Team. The Health Sector coordinator based in Freetown paid frequent supportive visits to the field site and made vital recommendations for the quality implementation of the programme.

h. Strengthening the Grantee Organization

i. The grantee organization capacities have been built at all levels.

The level of growth observed in each of the staff who got involved in the project was remarkable. It is evidenced by the fact that all staff initially recruited by the project got promoted within or outside the project and now assumed the positions with greater responsibilities.

Furthermore, with this project, CARE Sierra Leone successfully learned the process of transition from 'relief' approach to 'development' with emphasis of rights based approach as well as partnership approach.

The specific technical areas that the capacities have been built include but not limited to:

- a. Participatory health facility assessment, using COPE methodology
- b. CSSA
- c. Use of LQAS for programming
- d. BCC with emphasis on community ownership and empowerment
- e. Each of the technical intervention areas: malaria; nutrition; MNC; and EPI

i. Other Issues Identified by the Team

No other issues were identified by the team.

Annex 4: Full M&E Table

| Objectives | Indicators | Base line Percent 2004 | End line Percent 2008 | Revised Project Target |
|---|---|---------------------------|--------------------------|---------------------------|
| Objective 1: Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to improve maternal and child health and prevent, recognize and manage common diseases. | Nutrition | | | |
| | % of children aged 0-23 months who were breastfed within the first hour after birth. | 19.5% | 69.1% | 35% |
| | % of children age 0-23 months who are under weight | 26.5% | 18.8% | - |
| | % of children aged 0-5 months who were exclusively breastfed during the last 24 hours. | 8.3% | 68.3% | 15% |
| | % of children aged 6-9 months who received breast milk and complementary foods during the last 24 hours. | 69.8% | 74.3% | 80% |
| | Malaria | | | |
| | % of children aged 0-23 months who slept under an ITN the previous night. | 0.57% | 81.2% | 15% |
| | % of children aged 0-23 months with a febrile episode that ended during the last two weeks who were treated with an effective anti-malarial drug within 48 hours after the fever began. | 27.4% | 48.2% | 40% |
| | % of mothers who took anti-malarial medicine to prevent malaria during pregnancy. | 31.0% | 72.9% | 50% |
| | Maternal and Newborn Care | | | |
| | % of women aged 15-49 who know at least two symptoms that indicate the need to seek referral for emergency obstetric care. | 37.8% | 74.5% | 65% |
| | % of mothers able to report at least two known neonatal danger signs. | 7.4% | 44.1% | 35% |
| | Other | | | |
| | % of mothers of children aged 0-23 months who know at least two signs of childhood illness that indicate the need for treatment. | 79% | 79.9% | 95% |
| % of mothers with children aged 0-23 months who cite at least two known ways of reducing the risk of HIV infection | 3.8% | 45.0% | 25% | |
| Objective 2: Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services | EPI | | | |
| | % of mothers with children aged 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child less than 24 months of age. | 47.2% | 69.1% | 65% |
| | % of children aged 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before first birthday. | 45.7% | 66.0% | 60% |
| | % of children aged 12-23 months who received a measles vaccine. | 69.5% | 70.4% | 80% |
| | Nutrition | | | |
| | % of children aged 6-59 months who received a high dose Vitamin A supplement during the last six months. (68.2: 85) | 68.2% | 73.6% | 85% |
| | % of mothers who received/bought \geq 90 iron supplements while pregnant with the youngest child less than 24 months of age. | 60.0% | 86.6% | 75% |
| | % of mothers who received a Vitamin A dose during the first two months after delivery. | 17.8% | 67.3% | 50% |
| | Maternal and Newborn Care | | | |

| | | | | |
|--|---|--------------|--------------|------------|
| | % of children aged 0–23 months whose births were attended by skilled health personnel. | 15.1% | 34.2% | 30% |
| | IMCI | | | |
| | % of children checked for three general danger signs. | 0 | - | 80% |
| | Other | | | |
| | % of health facilities that received at least one supervisory visit that included observation of management during the previous six months. | 0 | 60% | 90% |

| | | | | |
|---|--|--------------|--------------------|-------------|
| Objective 3: Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms | Number of health clubs (CHCs) formed that: | 0 | 54 | - |
| | CHCs that Have a documented set of organizational bylaws. | 0 | 54 (100%) | 59% |
| | CHC that conduct 10 documented meetings per year. | 0 | 54 (100%) | 40% |
| | CHC that demonstrate documented conduct of health-related activities in the previous 3 months. | 0 | 54 (100%) | 40% |
| | % of CHCs with documented female membership of at least 20% | 0 | 98% | 90% |
| | Number of villages that have designated an individual to provide information to community members about EPI outreach and assist outreach activities. | 0 | 54 | 40 |
| | # of CHC members who have participated in CARE health promotion mobilization training. | 0 | 2339 | 1000 |
| | # of respondents who state an action that was done by community or CBO to improve health of community. | 0 | 100% | 90 |
| Objective 4: CSSA framework indicators (work in progress, to be further refined) | Percent of PHU staff following standard case management protocols. | 32.3% | 50% | 43% |
| | Percent of households that have access to safe drinking water all year round. | | 54.2% | |
| | # of PHUs receiving feedback from DHMT on the returns collected (functioning HMIS). | | 50% (51.4%) | |
| | % of CHC implementing at least 4 health promotion activities per year. | 42% | 100% | 57% |
| | Quality Supervision of health service cadres at least twice a month. | | 60% | |
| | % of health related organizations attending Koinadugu Quarterly co-ordination meetings per year | | 95% (85%) | |
| | Annual Revenue Generated | | 35% | |
| | Number of trained village health volunteers that actively participate in village health activities. | 70% | 2339 (90%) | 80% |
| | Percent of girls who have completed JSS | 26% | 28.1% | 40% |
| | IMCI strategy adopted by government | | 30% (29.1%) | |
| | % of health service provider with at least 50% knowledge in the skill area. | - | - | - |

Annex 5: Work plan Table

| Objectives/Activities | Objective Met | Activity Status |
|--|--|--|
| Objective 1: Strengthened family and household knowledge and decision-making skills related to health of women and children resulting in the practice of positive behaviors to improve maternal and child health and prevent, recognize and manage common diseases. | | |
| Household | | |
| 1. Formative research on feeding practices and food availability, health beliefs, social norms (including positive deviance behavior), perception of and management of disease, care-seeking practices, profile of community-based health providers. | Yes | Completed as scheduled |
| 2. KPC baseline study on key family health practices. | Yes | Completed as scheduled |
| Community | | |
| 3. Project presentation to and initiation of dialogue within communities. | Yes | Completed as scheduled |
| 4. Formation of health clubs (including pre-existing CBOs, as appropriate) | Yes | Completed as scheduled |
| 5. Implementation of health promotion/education campaign through CHCs targeting HH knowledge, beliefs and practices. | Yes | Completed as scheduled |
| Health Facility | | |
| 6. Develop a productive interface between community surveillance systems developed through the CHCs and DNO/PHU that results in problem identification and response. | This activity was introduced later in the project and saw active participation of community members in data gathering. | Incomplete, Community surveillance systems pilot tested in 25 communities and DMO to work towards the scaling up of this activity. |
| District | | |
| 7. Development of BCC strategy and materials for communication | Yes | Completed as scheduled |
| 8. Conduct training needs assessment (TNA) for community-based organizations, local partner organizations and MOHS and CARE staff | Yes | Completed as scheduled |
| 9. Training of PHU staff, and health club members to implement BCC strategy to HH members of community resulting in decrease in harmful practices; increase in practice of beneficial preventive practices; improved recognition of danger signs; and increase in appropriate care-seeking behavior. | Yes | Completed as scheduled |
| Objective 2: Improved quality and accessibility of services provided by MOHS personnel and MOHS extension services | | |
| Health Facility | | |
| 10. Promote dialogue between communities and DHO/PHUs. | Yes | Completed as scheduled |
| 11. Conduct Quality of Care assessment with MOHS and UNICEF. | Yes | Completed as scheduled |
| 12. Facilitate training and implementation in supervision, training of trainers, and quality assurance for DHO/PHU staff. | Yes | Completed as scheduled |
| 13. Facilitate initial and refresher IMCI training. | The entire IMCI approach to child survival had to be revisited owing to national level delays in rolling out the IMCI implementation. However, the CHC strategy addressed key elements of child survival except ARI/Pneumonia and to a certain extent diarrhea. As the | Incomplete, delay in IMCI policy development made the project to only facilitate the malaria case management protocol training |

| | | |
|--|--|---|
| | project concentrated on newborn care, this does not reflect as a project failure | |
| 14. Conduct quarterly quality assurance (QA) workshops for PHU staff. | The project conducted two COPE assessments and followed-up on COPE action plans and training plans for DHMT was investigated and action plans accomplished. | Incomplete. |
| 15. Build nutritional counseling and services for pregnant women into outreach services provided by PHUs and CHCs (supervised by PHUs). | yes | Completed as scheduled |
| District | | |
| 16. Work with DHO to identify and prioritize problems in district health services (including HMIS) and design and implement solutions that are based on qualitative and quantitative data. | yes | Completed as scheduled |
| 17. Assess organizational development and physical needs of MOHS in Koinadugu and support capacity-building activities. | yes | Completed as scheduled |
| 18. Conduct training needs assessment (TNA) for community-based organizations, local partner organizations and MOHS staff. | yes | Completed as scheduled |
| 19. Adapt/develop curricula for training of community health workers in collaboration with MOHS. | yes | Completed as scheduled |
| 20. Development and implementation of Social Marketing Plan for the promotion of purchase and use of ITNs. | This is however being taken up extensively under the MOSI project | Incomplete, one of the strategies of the new MOSI project, coordination and collaboration between CSP and MOSI defined. |
| 21. Work with partners (UNICEF, MOHS) to develop strategy/plan for ensuring supply of essential drugs in PHUs to support IMCI. | The project initially supplied UNICEF drugs to PHUs but this was discontinued to avoid duplications with UNICEF's direct supply. MOHS has its own plan at district level and is dependent upon the DMO's decisions; CARE continued to work on governance and BCC activities that strengthened transparency and accountability. | Incomplete |
| 22. Conduct ongoing monitoring of CS Project results in collaboration with DHO/PHU colleagues and feed results back into project including the use of LQAS. | yes | Completed as scheduled |
| Objective 3: Enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms | | |
| Community | | |
| 23. Formative research on attitudes and beliefs of community members regarding rights, civil society, community action to identify and act on communal problems, community support for GOSL health services, etc | yes | . Completed as scheduled |
| 24. Present project to communities and begin a dialogue with all community members regarding community action, governance, health rights, etc. | yes | Completed as scheduled |
| 25. Formation of health clubs (CHCs, including pre-existing CBOs, as appropriate | yes | Completed as scheduled |
| 26. Facilitate community dialogue regarding health volunteers and their roles and responsibilities both to community and to PHU. | yes | Completed as scheduled |
| 27. Assist well-run CHCs to identify needs of their organization and provide TA to build their capacity. | yes | Completed as scheduled |
| 28. Facilitate the formation and training of community based growth promotion groups emerging from CHCs. | yes | Completed as scheduled |
| 29. Collaborate with communities in a participative | yes | Completed as scheduled |

| | | |
|--|-----|---|
| evaluation of their own efforts. | | |
| 30. Assist communities and CHCs to access multi-sectoral development opportunities to improve their communities. | yes | Completed as scheduled |
| District | | |
| 31. Advocate with GOSL at national and district level to develop policies/processes that support responsibly managed community-level initiatives in remote areas where GOSL does not provide adequate services (e.g., sell GOSL-provided ITNs or essential drugs). | no | Incomplete, Government was slow in developing policies but some advocacy initiatives were undertaken at district and community levels |
| Sustainability of the CS project. | | |
| Community | | |
| 32. Facilitate cross visits for DHO/community leaders from Koinadugu, Kono and Kailahun districts. | yes | Completed as scheduled |
| 33. Community, District and national level monthly, quarterly and annual collaboration on issues pertaining to CS, Malaria, Nutrition, Maternal and Newborn Care (MNC) and EPI. | yes | Completed as scheduled |
| District | | |
| 34. Provide TA for organizational development and capacity building. | yes | Completed as scheduled |
| 35. Create opportunities for partner organizations to develop inter-organizational links, access to information and assistance, and accountability. | yes | Completed as scheduled |
| 36. Advocate for opportunities for partners to achieve or work towards financial viability. | | Partially completed, See Numbers 20, 21, 30, 31, 32 and 35. |
| 37. Support the planning process for the re-establishment of the District Medical Store. | | Incomplete, This was completed as scheduled but then torn down, due to national MOHS construction plan that was not shared with DHO/CARE. |

Annex 6: Rapid CATCH Table

| Indicator | Baseline | MTE | Final |
|--|-----------------|------------|--------------|
| % of children age 0-23 months who are underweight | 26.5% | - | 18.8% * |
| % of children age 0-23 months who were born at least 24 months after the previous surviving child | 95.1% | - | 82.9% |
| % of children aged 0-23 months whose births were attended by skilled health personnel. | 15.1% | - | 34.2% * |
| % of mothers with children aged 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child less than 24 months of age. | 47.2% | - | 69.1% * |
| % of children aged 0-5 months who were exclusively breastfed during the last 24 hours. | 8.3% | - | 68.3% * |
| % of children aged 6-9 months who received breast milk and complementary foods during the last 24 hours | 69.8% | - | 74.3% |
| % of children aged 12 – 23 months who are fully vaccinated | 45.7% | - | 66.0% * |
| % of children aged 12-23 months who received a measles vaccine. | 69.5% | - | 70.4% |
| % of children aged 0-23 months who slept under an ITN the previous night | 0.57% | - | 81.2% * |
| % of mothers of children age 0-23 months who cite at least 2 ways of reducing the risk of HIV infection | 3.8% | - | 45.0% * |
| Hand washing | NA | - | 20.4% |
| % of mothers of children age 0-23 months who know at least two signs of childhood illness that indicate the need for treatment | 79.0% | - | 79.9% |
| % of sick children aged 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks. | NA | - | 7.7% |

Annex 7: Final KPC Report

Final Quantitative and Anthropometric Survey in Five Chiefdoms
Appendix 2 and 3

Annex 8: Evaluation Team Members and their Titles

| Name | Designation |
|-------------------------------|---|
| Ranjani Gopinath | Consultant, external evaluator |
| CARE Sierra Leone Team | |
| Yuki Suehiro | Health and HIV Sector Coordinator, Freetown |
| Sowo Lebbie | Project Manager, CSP |
| Francis Sayoh | Assistant Project Manager, CSP |
| Bockarie Sesay | M&E Officer, CSP |
| Joseph Davies | Field Coordinator, HAPP |
| Princess Hawa Lahai | Health Education Officer, CSP |
| Iysattu Kamara | Field Supervisor, CSP |
| Edmond J. B. Brandon | Field Supervisor, CSP |
| Momoh Koyanday | Field Supervisor, MOSI |
| Abu Bakarr Jalloh | Community Health Mobilizer, CSP |
| Daniel Kamara | Community Health Mobilizer, CSP |
| Andrew T Koroma | Community Health Mobilizer, CSP |
| Abu Bakarr Marrah | Community Health Mobilizer, CSP |
| Alhaji Tejan Bah | Community Health Mobilizer, CSP |
| NGO Partners | |
| Mohamed Juana | Project Officer, Cause Canada |
| Abdul Conteh | Field staff, Community Action for Development, SL |
| Jefferson F. Boyna | CBT Supervisor, IRC |
| Bintu Kamara | Presenter, Radio Bintumani |
| Other Stakeholders | |
| Sam Grovesnor | Researcher MOHS/Directorate of Planning and Information |
| Konjo Marah | District Social Mobilization Officer, DHMT, MOHS |
| Aloysious Moriba | Monitoring and Evaluation Officer, MOHS |
| Amid Sesay | Environmental Health Officer, DHMT, MOHS |
| Andrew Papayo Sesay | Ex- Health Committee Chairman, District Council representative |
| Foday B S Mansaray | Community Representative, CBGP Volunteer, Wara Wara Yagala, Chiefdom |
| Kallie Koroma | Community Representative, CBGP Volunteer, Neini Chiefdom |
| Abu Mansaray | Community Representative, CHC Volunteer, Dembelia Sikunia Chiefdom |
| Lahai Marah | Community Representative, CBGP Volunteer, Sengbeh Chiefdom |
| Fatmata Jalloh | Community Representative, CBGP volunteer, Follosaba Dembelia Chiefdom |

Annex 9: Evaluation Assessment methodology

The final evaluation involved a) KPC survey including anthropometric measurement; b) COPE Assessment Study c) qualitative nutritional assessment d) literature review such as radio listener's survey; e) qualitative survey; f) interviews with key stakeholders at national level; and g) dissemination at the district and National level.

CARE carried out a final KPC survey in June 2008 with the support of a local consult. The final report of the survey is attached as Annex 7.

To carry out the qualitative survey, CARE shared key documents with the consultant and provided clarifications for questions arising out of review of these documents. Consultant discussed and listed key stakeholders who were to be contacted for assessments. Based on this listing draft tools for the community level FGDs/IDIs/meetings were drafted and shared with CARE SL team for review and translation. However, CARE CSP team decided not to translate the tools as it would have needed translation from Kreole to at least 2-3 other languages, depending on the chiefdom and communities met. Since all evaluation team members were comfortable with English and had the capacity to interpret from English to Kreole to the other languages, it was eventually decided to retain the tools in English.

While in Freetown, consultant met with USAID local mission staff, Ministry of Health and Sanitation representatives, UNICEF child survival staff and the CARE SL Assistant Country Director to understand the questions they needed answered through the evaluation process. CARE Atlanta could not participate in the evaluation; however, Dr. Khrist Roy and Ms. Anna Coghill were available for discussions before and during the evaluation process through email and telephone.

CARE invited various stakeholders (MOHS representative, DHMT members, IRC representative, CARE staff from complementary projects, other NGOs/INGOs implementing programs in the area, Radio Bintumani representative and one community representative from each of the five Chiefdoms to be part of the evaluation team. The participants of the tool finalization workshop were oriented to the objectives of the workshop, given an overview of the project strategies and KPC findings and oriented to the qualitative methodology. They were informed about the differences between the questions asked during a quantitative and a qualitative survey. They were also oriented to various final evaluation methodologies like Focus Group Discussion, In Depth Interview and Key informant interview. The participants reviewed the tools and suggested minor changes which were incorporated during the evening. One common question which figured in all the tools was the perspective on sustainability. On the second day of the workshop five teams were constituted, with the mandate to cover one Chiefdom each. Each team comprised of CARE staff and had ample representation of various stakeholders and underwent training in interviewing techniques through role play.

Most of the team members had prior experience in survey methodology, however, each Chiefdom team leader was asked to spend time with their teams to review the tools further. The teams were given a synthesis format so as to maintain consistency on Chiefdom reports. List of various tools used is at the end of this section.

Purposive stratified sampling was carried out to identify field areas. A list of direct/indirect communities; and well/not well functioning communities were prepared by the CSP staff. Two direct communities (one well functioning and one not functioning to the desired level) and one indirect community were chosen in each Chiefdom.

Over the next six days, five teams with five members each formed sub teams and visited 15 communities and met a total of 334 people. The consultant visited the Folosaba Dembaliya Chiefdom. The full list of communities and the health facilities visited, and list of persons interviewed by the consultant is included in the Annex 10. The Project Manager and the M&E Officer were given the task of tabulating project MIS and gathering district HMIS for use during evaluation.

Each district team synthesized the findings in a participatory manner and listed the key findings and lessons learnt. The teams also came up with recommendations for consideration at national, district and community level. A district level dissemination was held at Kabala, which was attended by the evaluation team members, DHMT, District Council representatives and other stakeholders.

A national level dissemination meeting was organized and saw the participation of key stakeholders including USAID representative and senior MOHS officials. The dissemination focused on sharing project achievements, strategies, special initiatives, sustainability assessment and findings. The presentations were made by the CSP staff, the District Medical Officer and the consultant. Some important recommendations emanated as a result of this meeting as well.

Annex 10: List of persons interviewed and contacted during Final Evaluation

Interviews conducted by the Team Leader

| Name | Designation |
|---|---|
| CARE Atlanta/Sierra Leone | |
| Khrist Roy | Technical Advisor Child Health, CARE Atlanta |
| Chris Necker | Assistant Country Director |
| Yuki Suehiro | Health and HIV Sector Coordinator |
| Sowo Lebbie | Project Manager, CSP |
| Alfred Makavore | Assistant Project Manager, MOSI project |
| All CSP staff | |
| Central Ministry of Health Officials | |
| Ibrahim Fofanah | Donor/NGO Liaison Officer |
| Boi-neneh Charles | Public Health Sister, National Malaria Control Program |
| District Level Government Counterparts | |
| Dr S.A.S Kargbo | District Medical Officer, Koinadugu |
| Konjo Marah | District Social Mobilization Coordinator, Koinadugu DHMT |
| Pity Kanu | District Health Sister 1, Koinadugu DHMT |
| Hawa Turay | HIV/AIDS Councilor, Koinadugu DHMT |
| Denis Rucyaha | Monitoring and Evaluation Officer, Koinadugu DHMT |
| Andrew Papayo Sesay | Ex- Health Committee Chairman, Koinadugu Local Council |
| USAID Local Mission | |
| Boi Jeneh Jalloh | Programme Development Specialist, USAID |
| Other Stakeholders | |
| Rumishael Shoo | Chief Child Survival and Development Programs, UNICEF |
| Dr. Samuel Pratt | Health Specialist, UNICEF |
| Fredrica Wyse | Health Officer, UNICEF |
| Sue Clarke | Health Sector Coordinator, International Rescue Committee |
| Bobson Mansaray | Production Manager, Radio Bintumani |

Interviews conducted as evaluation teams

Dembelia Sinkunia Chiefdom

| Interviews | Numbers | Community | Participants | | Total |
|-----------------|---------|--------------------------------|--------------|----|-------|
| | | | M | F | |
| CHC member FGDs | 4 | Gbindi, Yadia | 17 | 20 | 37 |
| Non-member FGDs | 2 | Herekoh | 8 | 9 | 17 |
| CBGP IDIs | 2 | Yadia, Gbindi | 2 | 0 | 2 |
| VS&L IDIs | 4 | Yadia, Gbindi | 2 | 0 | 2 |
| TBA IDIs | 3 | Yadia, Manah, Sinkunia, Gbindi | 0 | 4 | 4 |
| VDC IDI | 2 | Yadia, Gbindi, Herekoh | 3 | 0 | 0 |
| PHU IDI | 2 | Herekoh | 0 | 2 | 2 |

Sengbeh

| Activity | Numbers | Community | Participants | | Total |
|-----------------|---------|---------------------------------|--------------|----|-------|
| | | | M | F | |
| CHC member FGDs | 4 | Bambukoro 1, Bambukoro 2, | 17 | 18 | 35 |
| Non-member FGDs | 2 | Yirafilaya | 9 | 10 | 19 |
| CBGP IDIs | 2 | Bambukoro 1, Bambukoro 2, | 0 | 2 | 2 |
| VS&L IDIs | 2 | Bambukoro 1, Bambukoro 2, | 1 | 1 | 2 |
| TBA IDIs | | Koinadugu, Kondaya | 0 | 2 | 2 |
| VDC IDI | | Bambukoro Yirafilaya, Koinadugu | 3 | 0 | 3 |
| PHU IDI | 2 | Koinadugu, Kondaya | 0 | 2 | 2 |

Neini

| Activity | Numbers | Community | Participants | | Total |
|-----------------|---------|-----------------------|--------------|----|-------|
| | | | M | F | |
| CHC member FGDs | 4 | Kulaya, Fankaya | 20 | 20 | 40 |
| Non-member FGDs | 2 | Yebe | 10 | 8 | 18 |
| CBGP IDIs | 2 | Fankoya, Yebe | 0 | 2 | 2 |
| VS&L IDIs | 2 | Fankoya, Yebe | 1 | 1 | 2 |
| TBA IDIs | | Fankoya, Yebe | 0 | 2 | 2 |
| VDC IDI | | Kulaya, Fankaya, Yebe | 3 | 0 | 3 |
| PHU IDI | 2 | Fankoya, Yebe | 0 | 2 | 2 |

Folosaba Dembalia

| Activity | Numbers | Community | Participants | | Total |
|-----------------|---------|--------------------|--------------|----|-------|
| | | | M | F | |
| CHC member FGDs | 4 | Kormosalai, Gbentu | 20 | 21 | 41 |
| Non-member FGDs | 2 | Amadia | 8 | 10 | 18 |
| CBGP IDIs | - | - | - | - | - |
| VS&L IDIs | - | - | - | - | - |
| TBA IDIs | 2 | Dogolai, Gbentu | 0 | 2 | 2 |
| VDC IDI | | Kormosalai, Gbentu | 3 | 0 | 3 |
| PHU IDI | 3 | Kormosalai, Gbentu | 1 | 2 | 3 |

Wara Wara Yagala

| Activity | Numbers | Community | Participants | | Total |
|-----------------|---------|------------------|--------------|----|-------|
| | | | M | F | |
| CHC member FGDs | 4 | Igaia, Alusainya | 18 | 21 | 39 |
| Non- | 2 | Tonkoya | 8 | 11 | 19 |

| | | | | | |
|----------------------|----------|-----------------------------------|----------|----------|----------|
| member FGDs | | | | | |
| CBGP IDIs | 2 | Igaila, Alusainya | 0 | 2 | 2 |
| VS&L IDIs | 2 | Igaia, Alusainya | 1 | 1 | 2 |
| TBA IDIs | 2 | Heremakono, Alusainya | 0 | 2 | 2 |
| VDC IDI | 3 | Igaia, Alusainya, Tonkoya, | 3 | 0 | 3 |
| PHU IDI | 1 | Heremakono | 0 | 1 | 1 |

Annex 12: Project Data Form

Child Survival and Health Grants Program Project Summary
Attachment 6

Attachments

Attachment 1: Results Tables: Lives Saved Calculator

Attachment 2: Final Quantitative and Anthropometric Survey in Five Chiefdoms FINAL REPORT

Attachment 3: Assessment of the Community Health Club Approach

Attachment 4: CARE Sustainability in the Child Survival Project

Attachment 5: CARE and DHMT (10 Feedback of cross visit to Kono)

Attachment 6: Child Survival Health Grants Program Project Summary