LESSONS LEARNED ON VITAMIN A SUPPLEMENTATION IN 6 URBAN HEALTH DISTRICTS IN CAMEROON FROM 2011 – 2013

June 2014

SUMMARY

LIST OF ABBREVIATIONS

VAS	Vitamin A Supplementation
VAD	Vitamin A Deficiency
VAC	Vitamin A Capsules
UNICEF	United Nation's Children Fund
WHO	World Health Organization
NIDs	National Immunization Days
EPI	Expanded Program for Immunization
MOH	Ministry of Public Health
MCHNAW	Maternal and Child Health and Nutrition Action Week

I.1 SUMMARY OVERVIEW

With all the activities that have been carried out through the years and the results that followed, the following report seeks to:

- Examine progress, challenges and document lessons learned in the implementation of the MCHNAW in the town of Douala so as to provide for ongoing improvement of best practices and help deter the recurrence of adverse events/trends
- Provide a document which would serve as a best practice[1] reference for similar projects or in the event of scaling up of the current project

II BACKGROUND

II.1 Vitamin A deficiency in Cameroon

Vitamin A deficiency (VAD) is the principal cause of preventable blindness in Africa (UNICEF 2007). VAD increases the risk of mortality and morbidity especially in children and women. Even mild VAD will weaken the immune system of children, reducing their resistance to infection and increasing their risk of dying from childhood illnesses (Sommer, 1996). Vitamin A is equally indispensable for growth and the maintenance of epithelial cells. Vulnerable groups include children under five and lactating mothers. UNICEF and WHO recommend vitamin A supplementation every six months for children under five in countries where VAD is a public health problem (prevalence > 10%) and/or where under-five mortality rate is greater than 70 per 1000 children. In Cameroon both vitamin A deficiency prevalence and mortality rates are higher than these thresholds: 35% of children are estimated to be vitamin A deficient (national survey of micronutrient status and consumption of fortified foods, 2009) and according to the Demographic Health Survey carried out in 2011, under-five mortality rate is 132 per1000 thousand children.

II.2 Vitamin A supplementation in Cameroon

It has been demonstrated that in regions where VAD is prevalent, vitamin A supplementation (VAS) of children 6-59 months twice yearly will reduce all-cause mortality by 24% and diarrhea associated mortality by 28%. (Imdad, Cochrane Review 2010 In Cameroon, VAS commenced in 1998 in the 3 northern regions of the country (Far north, North and Adamawa.) where there was available data on vitamin A status of children.

1 Best practice can be defined as the most efficient (least amount of effort) and effective (best results) way of accomplishing a task, based on repeatable procedures that have proven themselves over time.

In 2000, following the results from the national survey on VAD and anemia, VAS was introduced in the southern regions of the country. VAS was integrated into National Immunization Days (NIDs) for polio eradication and this ensured one annual high-potency vitamin A dose to over 90% of children 6-59 months old (according to administrative results).

However, to maximize the child survival benefits of VAS, at least 80% of children 6-59 months old need to receive two doses of VAS annually (4-6 months apart), as opposed to the single annual distribution under the NIDs. Therefore, new strategies needed to be developed to ensure that VAS would lead to the reduction in mortality it has the potential to create. Needs for new approaches became even more obvious with the phasing out of NIDs in 2004.

At that time, VAS was administered routinely in health facilities through the Expanded Program of Immunization (EPI) but coverage was known to be very low.

In 2005, HKI assisted the MOH in optimizing routine VAS in health facilities by co-authoring a national protocol for the administration of VAS. HKI also trained health personnel on VAS and quality of care based on the national protocol, which included the administration of VAS in health services as a curative as well as preventive measure.. Vitamin A was to be given systematically to children aged 0-59 months with measles, malnutrition, persistent diarrhoea, xerophthalmia, HIV/AIDS and acute respiratory infection.

In 2006, several new strategies were utilized to deliver vitamin A to children. VAS was introduced into Community-Directed Treatment with Ivermectin (deworming drug) and Local Vitamin A Days. These approaches were effective in reaching more than 80% of children but covered only one dose annually instead of the two needed.

The initiation of the first Maternal and Child Health and Nutrition Action Week (equivalent of Child Health Weeks) in 2008 finally made twice yearly delivery of VAS possible for children aged 6-59 months. Maternal and Child Health and Nutrition Action Weeks

In order to achieve and/or maintain high coverage for twice yearly distribution of VAS, governments in a number of countries in sub-Saharan Africa have adopted “Child Health Weeks”. In Cameroon Child Health Weeks go by the name of Maternal and Child Health and Nutrition Action Week (MCHNAW). These distribution events are organized bi-annually to deliver an integrated package of high impact low cost preventive services for maternal and child health and survival. The MCHNAW consists in health personnel reaching people at their home through a door to door approach. The package of preventive services usually includes:

- VAS (for children 6-59m and lactating mothers within 8 weeks of delivery);
- Deworming tablets (for children 12-59m);

- Intermittent preventive treatment against malaria (for pregnant women)
- Other interventions such immunization and insecticide-treated bed nets may be included depending on the circumstances and needs.

Despite the significant input by the Government and other partners toward the success of MCHNAW, results from post event coverage surveys indicate that national coverage is still below 80% and that in major cities like Douala and Yaounde, coverage rates are well below national estimates (Table 1). It is worth noting that these two cities alone are home to 20% of the entire population of children aged 6-59 months in Cameroon.

Table 1: Coverage rates of interventions during campaigns

		Coverage		
MCHNAW	**Intervention**	**Douala**	**Yaounde**	**National**
MCHNAW 1 2011**	VAS	46.9%	29.2%	71.9%
	Deworming	41.6%	30.7%	59.1%
MCHNAW 1 2009*	VAS	61.3%	38.3%	73.4%
	Measles Vaccination.	53.9%	34.4%	70%
	Deworming	53.2%	47.4%	61.1%

*post event coverage survey measles vaccination 2009. National Institute of Statistics 2009
**post event coverage survey MCHNAW/NIW 2011. NIS 2011

Since 2011, HKI has provided technical support for VAS programming to the MoH. HKI is also an active member of the Inter-Agency coordinating body chaired by the Minister of Public Health who oversees the immunization and Vitamin A supplementation activities and collaborates with the Ministry of Health and other stakeholders to plan, budget, implement and monitor the MCHNAW.

To address the specific problem of low VAS coverage in urban settings, HKI chose to implement strategies that can be used to reach the unreached and hard-to-reach. The town of Douala hosts 76% of the entire population of children aged 6-59 months in the littoral region. Since 2011, HKI under the Hard-to-Reach project has been providing both technical and financial support to six urban health districts in Douala in order to improve coverage of interventions

III OBJECTIVES AND METHOD

III.1 Methods

Two major sources of data and information were used to capture lessons learned:

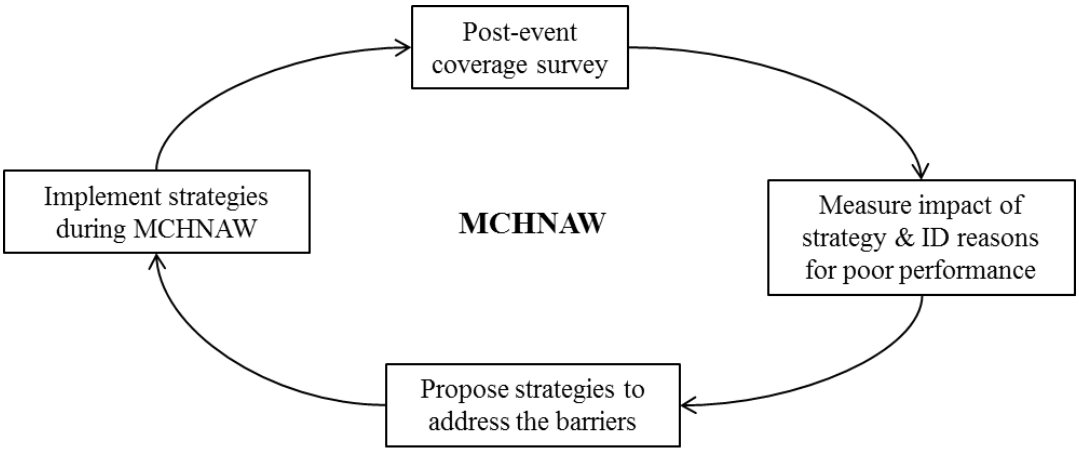
- Reports of project activities and post event coverage survey results
- Interviews using semi-structured questionnaires (see annex) and exchanges with stakeholders involved in the implementation of the MCHNAW in Douala (regional

level actors (1), district and health area level actors (27) and the HKI project team (3).

III.2 Problem Analysis

To improve coverage during MCHNAW in Douala, HKI has been implementing the problem solving approach summarized in the figure below:

Figure 1: HKI approach to improving coverage rates in Douala



This approach involves collecting the perspectives of the different key actors in the implementation of the MCHNAW (parents/caregivers of children 6-59m, health personnel, community volunteers) on why children did not receive interventions. Priority problems are then identified and strategies developed to address these problems.

Four principal reasons were identified by the different actors about why children did not receive interventions during MCHNAWs:

<u>Parents/caregivers</u>

- Not informed about the campaign
- Distribution team did not pass
- Parent/caregiver absent
- Child absent

<u>Health personnel</u>

- Communication / social mobilization
- Insufficient financial motivation

- Supply (quantity, time)
- Insufficient number of teams

Community volunteers

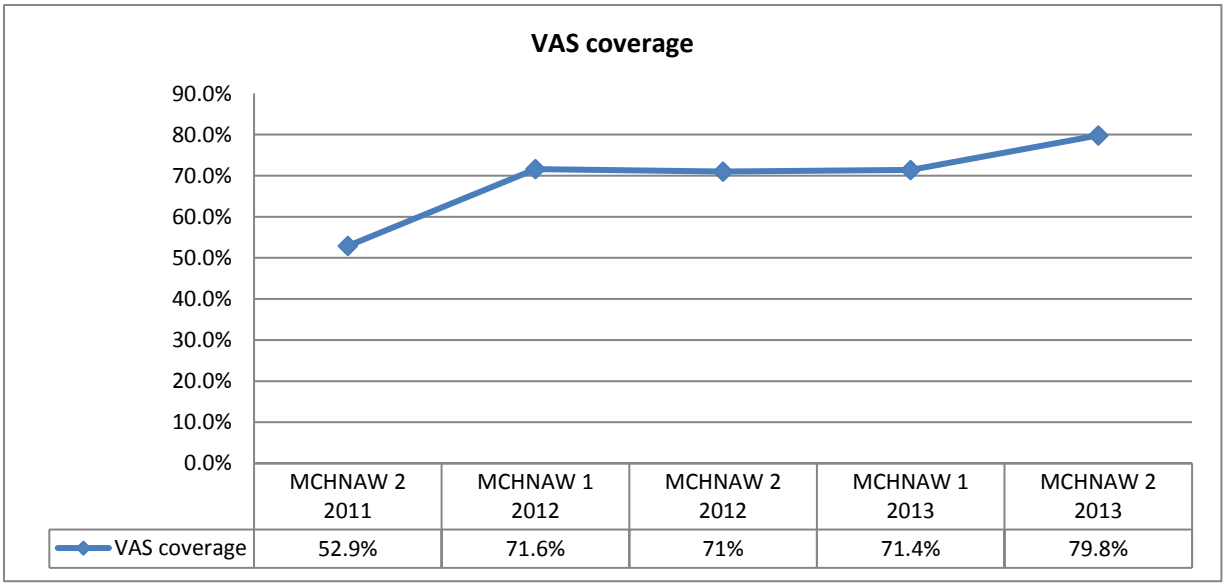
- Communication / social mobilization
- Insufficient financial motivation
- Insufficient number of distribution teams
- Inaccessible/ hard-to-reach areas

IV HKI ACTIVITIES FROM 2011 TO 2013

From 2011 – 2013 HKI has gained substantial expertise in the planning and management of MCHNAW at district and community levels to increase the reach and coverage of interventions in Douala.

HKI activities to improve coverage during MCHNAW engage with every stage of the process (planning, implementation, monitoring and evaluation) and run through every stratum of the health system – from central and regional to district and health area levels. Significant progress has been made to date in raising coverage during MCHNAWs in Douala, with urban coverage rising from just over 50% in 2011 to 80% in the second half of 2013.

Figure 2: Progress made in VAS and Deworming coverage in Douala



	MCHNAW 2 2011	MCHNAW 1 2012	MCHNAW 2 2012	MCHNAW 1 2013	MCHNAW 2 2013
VAS coverage	52.9%	71.6%	71%	71.4%	79.8%

IV.1 Planning

IV.1.1 Central-level preparation

At central level, preparation for the MCHNAW begins at least three months before the set date for the campaign. The MOH and its partners meet twice every week to decide on the official launch date of the campaign, budgetary allocations, the package of interventions that will be made available to the population, as well as to monitor progress in the various regions of the country. The National Organization Committee is responsible for the overall coordination of these meetings and different sub-committees are assigned different tasks. Feedback from these meetings is then shared with the different regions.

IV.1.2 Regional level preparation

About two months before the advent of the MCHNAW, preparatory activities are initiated at regional level. The coordination committee establishes a work plan of activities to be carried out before, during and after the MCHNAW. The work plan specifies the activity, the person(s) in charge and the time frame for the completion of the activity. Weekly meetings are organized untill the commencement of the MCHNAW to evaluate progress made against assigned tasks. Tasks include: planning, mobilization of resources, training and supervision, communication and social mobilization, logistics, implementation and evaluation of MCHNAW. The committee is responsible for monitoring the progress of the activities specified in the work plan and reporting to central level.

In the Littoral region where HKI provides both technical and financial support, HKI ensures that the funds and resources allocated arrive on time. Funds are made available to the region about 2 weeks before the start of the MCHNAW and the supplies about 1 week before.

IV.1.3 District level preparation

Preparatory meetings at district level are held twice a week. The coordination team at district level is responsible for monitoring activities and reporting progress made against the work plan at regional level.

IV.2 Supply

In 2012 (MCHNAW 1), HKI worked with EPI program to ensure that adequate quantities of vitamin A capsules and deworming tablets were allocated to Littoral region and sent three weeks before the launch of the SASNIM. Survey results reveal that operational level actors agree that there are no longer any problems with supply. Supplies (vitamin

A capsules, deworming tablets, tracts) arrive on time and in adequate quantities for the MCHNAW.

IV.3 Training

During MCHNAW, VAC are distributed by a team of _____ distributors. These actors are trained using the cascade training system, where central level actors train those at regional and district level. This exercise usually takes place at least 10 days before the start of the MCHNAW and is repeated for each event. Training covers the different aspects of the campaign: the importance of the interventions to be delivered, logistics, volunteer selection, monitoring and supervision and follow-up. Once trained, the district trainers assign actors as trainers in each of the health catchment areas. They will then train the community-level volunteers who have been identified to implement the campaign activities in the field (distributors, 'registrars' and mobilizers). The latter are usually trained one day before or on the eve of the MCHNAW.

Results from a study carried out in 2013 to evaluate the team performance and factors influencing distributors' efficiency showed that there were too many participants per training session. Only 27% were trained in sessions comprising of less than 30 participants. 45% were trained in groups of 30 and 60 participants while the remaining 27% were trained in groups of 60 and 100 participants. With too many people in a training session, it was difficult for the facilitators to ensure full participation by all trainees. This type of training environment is not suitable for question and answer sessions, plenary discussion and practical exercises.

Another problem identified was the difficulties distributors faced to enter data into the tally sheets prepared for the distributions. HKI developed new tally sheets which were simpler and easier to use.

HKI also produced and continues to revise the modules used to train the different actors.

IV.4 Mapping and zoning exercise

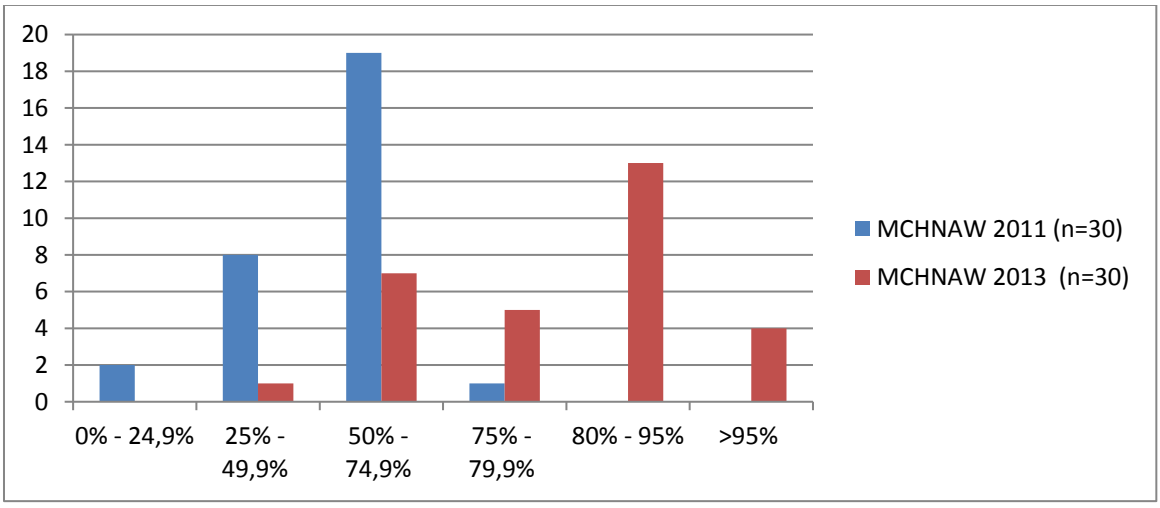
In 2012 HKI carried out a mapping of all the health catchment areas in the six districts of Douala. This exercise was necessary to solve the problem of poorly defined distribution areas and of invisible boundaries. Unclear boundaries between health catchment areas led to groups of children being left out because each of the health catchments assumed they belonged to another. In such cases, neither catchment would deploy distribution teams to these areas. The maps of the health areas that HKI produced illustrates key landmarks such as health facilities, schools, churches, markets, junctions and other popular meeting places.

With the help of these maps, health catchment boundaries were clarified, solving the problem of 'pockets' of children that had historically been missed. The maps facilitated route planning which in turn improved supervision.

Owing to the mapping exercise, there has been a net improvement in geographic coverage during campaigns as observed during PECS, with no enumeration area registering 0% coverage of children. Table 2 shows the progression of coverage per enumeration areas during campaigns.

Table 2: progress made in geographic coverage during campaigns in Douala

Coverage	Number of enumeration areas	
	MCHNAW 2011 (n=30)	MCHNAW 2013 (n=30)
0% - 24,9%	2	0
25% - 49,9%	8	1
50% - 74,9%	19	7
75% - 79,9%	1	5
80% - 95%	0	13
>95%	0	4



The lessons learned survey showed that stakeholders at all levels unanimously agreed that the availability of maps was one of the factors that explained the improvement of distributions coverage. The maps provide for a general mastery of the area of work and allows for the establishment of realistic itineraries for distribution teams. is the result consisted in a net improvement in geographic coverage no areas being anymore left out during the MCHNAW campaign.

In 2013 HKI also assisted the MoH with a zoning exercise to address the issue of expansive health catchment areas where distribution teams found it difficult to adhere to the routes and itineraries established . This exercise aimed to improve /ensure

quality geographic coverage of the area of work and also supervision. The zoning exercise consisted of sub-dividing the health areas into sub-zones and attributing one supervisor per zone. Consequently, the maps for each sub-zone were more detailed, illustrating paved and dirt roads and paths.

This exercise began in the health district of Nylon. Nylon is known for its expansive health catchment areas and hosts alone more than half of the target population, all 6 health districts put together.

IV.5 Implementation

IV.5.1 Communication and Social mobilization,

From 2011 through 2013, HKI has been involved in strengthening communication activities related to the twice-yearly distribution of VAS at regional, district and health area levels. For the first round of the MCHNAW in 2012, with technical and financial support from HKI, an intensive communication and social mobilization strategy was put in place. The resulting sensitization campaign targeted caregivers, political, social, religious and traditional leaders and associations. HKI developed a micro planning tool to follow up activities and this was made available to all the health districts (see Annex 1).

The strategy involved: mass media communication using radio and television, social mobilization by community volunteers (social mobilizers) in the communities, distribution of flyers and posters, and the use of megaphones and loud speakers on vehicles. The messages were spread in markets, at public meeting places, and on church grounds.. Awareness raising letters were also sent to administrative, religious and traditional leaders leading to increased number of social mobilizers. In 2012 HKI procured 152 megaphones for all 19 health areas in the Littoral region. In Douala each health area was given at least 2 megaphones to use for social mobilization.

While the above-mentioned strategy continued to be employed during subsequent rounds of the MCHNAW, for the first round of 2013, communication and social mobilization activities were further intensified with special emphasis on the use of TV and on communicating the benefits of VAS, age of first receipt and frequency of VAS to caregivers.

Caregivers' awareness about the campaign increased from 53% in 2011 to 66.6% in 2013 with over 80% of caregivers correctly identifying the target group for the campaign and the place(s) where the interventions were to be delivered.

The reach of the different communication channels has also expanded considerably with TV showing great potential to reach the target audience in Douala compared to radio (Table 3).

Table 3: Reach of some communication channels during MCHNAWs

Communication Channel	2011	2013
Social mobiliser	52.4%	63.3%
Television	20.5%	33.6%
School	2.7%	8.4%
Tract	7.1%	9.9%
Radio	6.3%	7.2%
Poster	1.5%	2.5%

IV.5.2 Delivery strategy

The main delivery strategy for the MCHNAW is the door to door distribution. Secondary strategies include fixed posts in health facilities, temporary mobile posts also used for vaccination, and school distribution which involves distribution in nursery schools and day care centers.

During the MCHNAW distribution rounds, one of the most frequently mentioned reasons when caretakers were asked why children didn't normally receive interventions was that "the distribution team did not pass". Results from post event coverage surveys and interactions with key health personnel and volunteers at the community level indicate that one of the reasons that teams might not have passed was that the number of distribution teams was insufficient to reach all of the population. Distribution teams are normally made up of two people: one distributor to administer the interventions and one 'registrar' to record the dose given on the tally sheet.

With the above results in mind, in 2012? HKI invested in increasing the number of distribution teams to effectively deliver the interventions in the population. By the second round of the MCHNAW in 2012, the number of door-to-door distribution teams had quadrupled compared to - those that were in place in 2011?. Teams were allocated on the basis that each team had to reach 150 children per day as opposed to the minimum of 200 previously set by the ministry of health. As described above, the first round of MCHNAW of 2013 also saw the start of a school strategy whereby teachers of day care centers and primary schools were trained to administer the interventions to children in school. This strategy later evolved during the second round of the MCHNAW to the allocation of additional distribution teams whose sole task was to distribute in schools. The school strategy was put in place to enable the door-to-door distribution teams to go directly into the communities to find the younger children. In previous campaigns it had been observed that distributors would normally spend more time in schools, neglecting the younger children left in the communities

HKI also lobbied for the MCHNAW to take place during the weekend (Friday, Saturday, and Sunday) to address the issue of distributors not finding parents at home. Parents are more likely to be present at home during weekends than during week days when they usually go out to work.

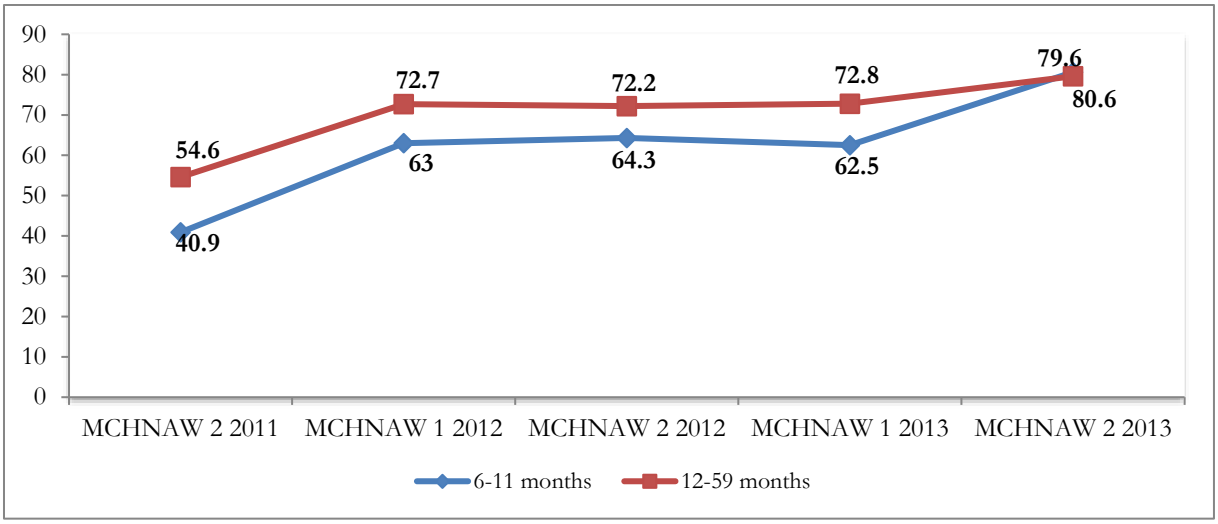
Results indicate that these interventions contributed to improvements in the reach of the door-to-door strategy (Table 4).

Table 4: Reach of delivery strategies employed during MCHNAWs

Delivery strategy	2011	2013
Door-to-door	56.8%	64.4%
School strategy	33.8%	29.4%

In addition to the changes mentioned above, HKI was able to improve equity in access to services between age groups by closing up the gap in coverage rates between the 6-11m and 12-59m age groups (fig3).

Figure 3: Gap in coverage rates between two age groups



IV.5.3 Supervision

In 2011, HKI became actively involved in the supervision process for MCHNAW. The percentage of community volunteers attesting to having received a visit from a supervisor during the campaign went from 69.7% in 2011 to 95% in 2013.

In 2013, HKI sought to understand the reason why, despite the increase in manpower, the door to door distribution was not attaining at least 80% coverage. A study was carried out to evaluate the performance of distribution teams and also to identify the factors that influenced their efficiency. Results from this study revealed that the teams were not performing efficiently with up to 70% of teams not attaining the targeted 150 children/day/team (from tally sheets).

these results led to questioning the quality of the supervision. HKI therefore adopted the approach of field supervision, which involved closely monitoring the teams in the

field and not just randomly passing by to check on them, and tested the approach first in one health district.

According to community level health personnel in the Nylon, which served as the pilot district for the zoning exercise, the division of the health areas into subzones and assignment of one supervisor per subzone allowed for a reasonable number of teams per supervisor and hence more effective monitoring and support during distribution..

IV.6 Monitoring & Evaluation

IV.6.1 Internal and external monitoring

Since 2011?, HKI has allocated funds to internal monitoring and supervision during the campaign and is actively involved in evaluation meetings held at regional level at the end of each working day. Information from these meetings flows upward, meetings are first held at district level with each catchment and then the district medical officers bring the feedback from these meetings to regional level.

Strengths and weaknesses are discussed and resolutions and recommendation are reached. These meetings are key to identifying and resolving issues as they arise. Solutions to problems encountered the previous day are sought and the problems are rectified the next day.

HKI also carries out external monitoring activities at the household level in Douala during the MCHNAW. A team of external monitors is sent out to the field to monitor the work of distributors. Children who have not received interventions are referred to the nearest distribution post. If the number of households missed is very high, the team assigned to that area is asked to return to the catchment. Stakeholders agree that both external and internal monitoring allow for immediate remedial action in the event that an area has been missed.

IV.6.2 Post Event Coverage Survey (PECS)

After every round of the MCHNAW, HKI conducts a post event coverage survey to measure coverage and also to seek to understand the barriers to coverage and the quality of services provided. The survey targets caregivers of children aged 6-59 months, health personnel and community volunteers involved in the MCHNAW. When a PECS has been conducted, HKI organizes meetings with actors to review survey results, analyze barriers to coverage and brainstorm possible solutions to overcome these barriers and improve coverage in the subsequent rounds.

V LESSONS LEARNED AND RECOMMENDATIONS

Lesson learned: Analysis of results from post event coverage surveys enables the identification of priority issues and possible approaches to solve these problems

Recommendation

- Carry out post event surveys to evaluate the campaign and identify barriers (this recommendation is already being implemented nationally)
- Post event survey results should be shared with all the actors at each level that the MCHNAW organized.
- Analysis should engage all actors involved during the campaign from health personnel to community volunteers.

Lesson learned: Holding evaluation meetings at the end of each working day is a key success factor in attaining high coverage during the MCHNAW since it allows for a rapid response in poor performing areas. According to the actors it is a time to share and learn from others experiences, to identify strengths, weaknesses, come up with resolutions and make recommendations which will be applied the next day.

Recommendations

- Hold daily evaluation meetings during the campaign at all level health area, district and regional level

Lesson learned: Monitoring coverage rates by age group (6-11m and 12-59m) is important to identify gaps and to ensure that there is equity in coverage between these age groups.

Recommendation:

- Disaggregate coverage results by age group to better assess trends in coverage rates

Lesson learned: Accurate maps (cartography) provide clearly defined health catchment areas and are very useful in determining the route and itineraries for distribution teams. More specific routes and itineraries are equally helpful for supervision teams, helping to pinpoint where exactly to find the team at any given time. Even with accurate maps and improved itineraries there are still some health catchment areas which are expensive, with very long distances to cover

Recommendations

- Allocate number of teams per catchment area taking into consideration not just the target population but also the surface area and the distance to cover
- Ensure that mobilisers and vaccinators follow the same itineraries
- Subdivide the catchment area into zones and assign supervisors while taking into account the number of teams to be supervised

Lesson learned: Organizing the MCHNAW during the weekends is important in order to catch parents at home and increases the chance of reaching younger children

Recommendations

- Advocate at national level for health campaigns to be organized during weekends (this recommendation is already being implemented nationally)

Lesson learned: Distribution schedules should be planned taking into account the realities of the community and target population of the intervention. Specifically, the working hours of parents should be taken into account in order to limit absences when distribution teams are in the area.

Recommendation

- Supervisors should be allowed to take the initiative and organize the work schedule of the distribution teams. (For instance in zones where parents leave for work in the morning and return in the afternoon, distributor can start work in the afternoon instead of starting early in the morning)
- Develop specific strategies to reach those children who are usually absent from the household. This strategy is particularly relevant for very young children, who do not attend school or cannot stay at home without their parents and so are taken to their place of work or business. sensitization and distribution in the market place, railways)

Lesson learned: Simply increasing the number of distribution teams is not enough to maximize the reach of the door to door delivery strategy; effective supervision is needed for maximum impact. Distribution teams need to be closely monitored and their performance evaluated daily to ensure that they are meeting their targets.

Recommendations

- Assign at most 5 teams per supervisor
- Provide training to supervisors. Specific emphasis should be placed on the training of zone supervisors who are usually members of the community.
- Supervisors should communicate on a daily basis the target number of children that teams are expected to reach.
- Short briefings with the teams before and after the working day to identify and rectify difficulties encountered in the field

Lessons learned: Communication and social mobilization are important factors in generating caregivers demand for interventions. Stakeholders cite these two factors as having a direct impact on the results of the MCHNAW

Recommendation

- Effective communication strategies, tools and channels should be identified with respect to the MCHNAW context and used to create and sustain awareness
- Monitor the output of the different communication channels determine efficacy and to decide on the allocation of resources (maximize/minimize resources and efforts)

Lesson learned: Making funds and supplies available in a timely manner and in adequate quantities are good practices. These two key practices allow enough time for distribution of supplies and timely delivery to districts and subsequently to the different health catchment areas

Recommendation

- Funds should be made available to the region at least 2 weeks before the MCHNAW and other supplies at least 1 week prior.
- For health areas where there are problems with over/under-estimation of the target population, health district officials should do a careful review of previous coverage data in order to adjust estimates of the actual population size.
- Supervisors should implement day to day monitoring of the flux of supplies in order to anticipate zones that are most likely to experience shortage and make provisions for that.

Lesson learned: Briefing of the regional level and district level actors 10 days before the start of the MCHNAW allows enough time for cascade training of the other actors and proper planning and coordination.

Recommendation

- As soon as the plan of action has been validated at the central level, initial communication including funding and resources to be allocated should begin with the regional and district levels for micro-planning.
- At the operational level a committee should be delegated to follow-up and evaluate the timeline of activities to be carried out during the implementation of the campaign.

Lesson learned: Training of community level actors is not optimal. Data reveal that training sessions are over populated, participants are not attentive and do not remember what they have been taught, which leads to, poor quality of data entry in tally sheets.

Recommendations

- To ensure that training is effective, standards should be set for the number of persons to train per session and the duration of each training session. It is recommended that trainings include less than 40 participants per session. This

would ensures a training environment suitable for question and answer, plenary discussion and practical exercises

- Participants can be grouped in pools and trained at different venues or at different times under the supervision of district level personnel
- Participants should practice with the data collection tools to ensure that they are familiar with them
- Use job aids to reinforce training and to avoid mixed messages and misinformation given to caregivers

Lesson learned: With the provision of dossards to all actors during the MCHNAW identifying them as coming from the MOH, the distributors were easily accepted in the community and hence minimizing refusal.

Recommendation

- Equip actors with uniforms identifying them as representatives of the MOH during campaigns

Lesson learned: The choice of actors (mobilisers, distributors and supervisors) is a factor that is liable to influence overall performance during the MCHNAW.

Recommendations

- Set criteria for the recruitment of actors should be respected. Disciplinary measures should be put in place to deal with actors that do not respect their responsibilities (they should be replaced if possible with persons who are ready and more willing to work)

VI CONCLUSION

Over the past __ years, HKI has partnered with the Ministry of Health to inform strategies to improve VAS coverage in Douala. So far, significant progress has been made in ensuring that children 6-59 months receive a high dose of VAS twice-yearly during MCHNAWs in Douala, with 80% of children receiving VAS. HKI continues to work with the MoH of Cameroon to test approaches and find solutions to reach the remainder of children who are missed during these mass distribution campaigns.

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ANNEXES

Annex 1: Micro plan of activities for the Communication and Social Mobilization plan 2012

OBJECTIFS	ACTIVITES	INDICATEURS	CONCERNE	RESPONSABLE	PERIODE	COUT
Informer 80 % des autorités religieuses, traditionnelles et politiques plus secteurs apparentes de la tenue de la SASNIM/SMV 1 2012 d'ici Le 25 Avril 2012						
Renforcer les capacités des acteurs						
Informer et sensibiliser les populations						
Mettre en œuvre la SASNIM						
Superviser / monitorer les activités de mobilisation sociale						
Evaluer les activités de mobilisation sociale						

LESSONS LEARNED VAS SURVEY - Regional level actors

Goodday. My name is _____. I come from _____. We are carrying out a study to capture the lessons learned in carrying out the activities concerning the Maternal and Child Health and Nutrition Action Weeks (SASNIM). Your answers will contribute to ameliorate the implementation of the SASNIM. This interview will take just about 20 minutes. Will you like to participate?

Questionnaire # : ☐☐ **Date:** _____ / _____ / _____

1) Sex

☐ Male ☐ Female

2) What is your role in the health system ?

_____

3) In your opinion what do you consider as the best pratices/strategies that can be shared which have been used to attain the present coverage

_____

_____

_____

_____

_____

_____

4) How/What has changed at the level of

4a) Planning

_____

_____

_____

4b) Budgeting/Financing

_____

_____

_____

4c) Allocation/Availability of intrants

_____

_____

_____

4d) Implementation

_____

_____

5) How satisfied are you with the Vit A supply during the SASNIM (is it timely and in the right quantity)

☐ Not satisfied ☐ Satisfied ☐ Very satisfied

6) What explains the shortage of Vit A usually experienced in the field during the SASNIM?

_____

_____

7) Why is there usually no Vit A remaining after the SASNIM for routine supplementation activities?

_____

_____

8) Does a micro planning framework for activities exist?

☐ Yes ☐ No

8a) If yes (provide copy) is it resopected?

☐ Yes ☐ No

8b) If not respected, why?

_____

9) Are the meetings held for the restitution of PECS results useful?

☐ Yes ☐ No

9a) Comment

LESSONS LEARNED VAS SURVEY - HD/HA actors

Goodday. My name is _____. I come from _____. We are carrying out a study to capture the lessons learned in carrying out the activities concerning the Maternal and Child Health and Nutrition Action Weeks (SASNIM). Your answers will contribute to ameliorate the implementation of the SASNIM. This interview will take just about 20 minutes. Will you like to participate?

Questionnaire #: ☐☐ **District:**_____

Date: _____ / _____ / _____ **Health Area:**_____

1) Sex

☐ Male ☐ Female

2) What is your role in the health system ?

3) In your opinion what do you consider as the best pratices/strategies that can be shared which have been used to attain the present coverage

Vit A supply

4) What has changed in the supply of Vit A? Is it timely? Adequate?

5) What explains the shortage of vit A usually experienced in the field during the SASNIM?

Delivery Strategy

6) What explains the fact that door to door is used only at about 65% meanwhile it is the principal delivery strategy

6a) What can be done to improve?

Communication/Social mobilization

7a) What is going well with the mobsoc strategy in place?

7b) What is not going well?

7c) What can be done to improve?

Training of actors

8) How will you rate the training of actors for the SASNIM?

☐ Poor ☐ Satisfactory ☐ Excellent

8a) Comment

9) How was the timing of the training you received with respect to the start of the SASNIM

☐ Timely ☐ Not timely

9a) Comment

10) Are the meetings held for the restitution of PECS results useful?

☐ Yes ☐ No

10a) Comment

11) How effective is the external monitoring by HKI during the SASNIM?

☐ Not effective ☐ Very effective

11a) Comment

LESSONS LEARNED VAS SURVEY - Program team

Goodday. My name is _____. I come from _____. We are carrying out a study to capture the lessons learned in carrying out the activities concerning the Maternal and Child Health and Nutrition Action Weeks (SASNIM). Your answers will contribute to ameliorate the implementation of the SASNIM. This interview will take just about 20 minutes. Will you like to participate?

Questionnaire # : ☐☐ **Date:** _____ / _____ / _____

1) Sex

☐ Male ☐ Female

2) What is your role in the project

_____

3) In your opinion what do you consider as the best pratices/strategies that can be shared which have been used to attain the present coverage

_____

_____

_____

_____

_____

_____

4a) What is going well at the level of planning?

_____

_____

_____

4b) What is not going well?

_____

_____

_____

4c) What can be done to improve?

_____

_____

5a) What is going well at the level of Financing/Budgeting?

_____

_____

_____

5b) What is not going well?

_____

_____

_____

5c) What can be done to improve?

_____

_____

6a) What is going well at the level of Implementation?

_____

_____

_____

6b) What is not going well?

_____

_____

_____

6c) What can be done to improve?

_____

_____

7a) What is going well at the level of Communication?

7b) What is not going well?

7c) What can be done to improve?

8) How have preparatory meetings held at central level impacted performance?