

Assessment of the Community Health Club Approach

Koinadugu District, Sierra Leone

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CARE International

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Abbreviations and Acronyms

ANC	Antenatal care
CARE	Cooperative Assistance and Relief Everywhere, Inc.
CHC	Community Health Club
DACO	Development Assistance Coordination Office
DHO	District Health Officer
DRP	Development and Relief Project
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IRC	International Rescue Committee
LINKS	Promoting Linkages for Livelihood Security and Economic Development
MOHS	Ministry of Health and Sanitation
MOSI	Malaria Outreach and Safety Initiative
NGO	Non Governmental Organization
NPRDI	Northern Province Rehabilitation Initiative
PHU	Periphery Health Unit
PM&E	Participatory Monitoring and Evaluation
PPP	Purchasing Power Parity
SAY	Sexuality and Youth
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VS&L	Village Savings & Loan
WB	World Bank
WHO	World Health Organization

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This report assesses the community health club approach to international health promotion. Arising in conjunction with the transition to more participatory and people-centered development, community health clubs (CHCs) are designed to be a means for people to learn more about health and to mobilize to improve the health of their communities. CARE's "For Di Pikin Dem Wel Bodi" (For the Health of the Child) project applies this methodology in rural Koinadugu District, Sierra Leone to increase child and maternal survival rates, while also seeking to improve community cohesion. Sierra Leone and Koinadugu District have among the world's highest rates of child and maternal mortality.

The primary research objective is to assess the CHC approach in terms of its ability to bring about beneficial health and development outcomes as well as to sustain these benefits over time. The research explores the extent of community participation in CHCs; the impacts of CHCs on health outcomes; the impacts of CHC on community development, including community cohesion, leadership, and self-initiated activities; and the relationships between CHCs and other organizations.

Research for this report included literature review as well as just over two weeks of fieldwork. The literature review explored CARE's project documentation, reports of similar health promotion or CHC projects, as well as scholarship on health promotion and community development. In the field, the team of three researchers visited a total of seven CHC communities and five non-CHC communities. The team used a variety of research methods including participant observation, focus groups, interviews and surveys to obtain information from CHC members, non-CHC members, village development committee members, village leadership, CARE staff, and peripheral health unit (PHU) staff. The team observed a range of CHC activities including regular CHC meetings, CHC action plan development, CHC outreach activities within the community as well as to neighboring communities, and CHC member involvement with PHU activities such as antenatal care (ANC) clinics, pregnant women's support groups, child health clinics, and community based growth promotion.

The team was able to identify significant indicators of project success. First, there was widespread participation in CHCs among all strata of society, such that it was difficult to find households that were not represented. The 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.

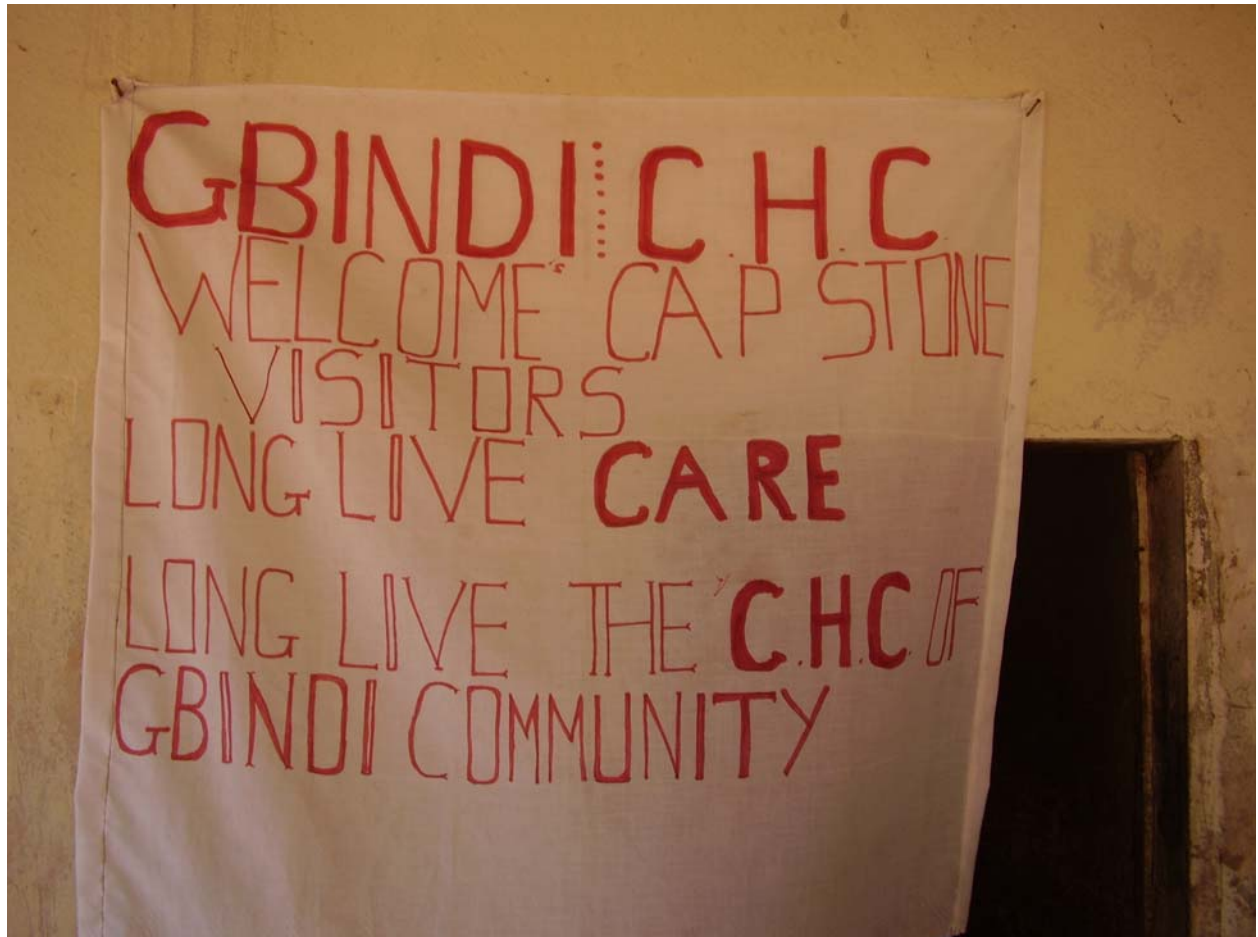
Seeking to understand the success of this project, the team identified four "pillars of success." These pillars represent key reasons for this project's success as well as the foundational elements that the project felt other organizations seeking to implement the CHC approach should include. These pillars are: emphasis on community priorities, integration with existing community structures, staff and organizational commitment to community development, and coordination with the Ministry of Health and Sanitation (MOHS).

The team has prepared several recommendations for the “For Di Pikin Dem Wel Bodi” project, geared toward maximizing sustainability of the health and community development achievements already realized. For the remaining 18 months of this project’s implementation, the team recommends continuing the emphasis on leadership and capacity building, while working with leaders on developing positive motivation and ways to incorporate new members. In addition, leadership training for other community leaders, and opportunities to link CHC leaders with other organizations interested in the CHC approach should be explored.

The team also feels that follow-on projects could help to bolster the sustainability of this project, while bringing additional benefits to community members. Here, the emphasis should be on means to improve organizational capacity and viability through further integrating CHCs within the district-level government structure. In addition, given the high interest from community members in increased opportunities for knowledge, the team proposes several opportunities for meeting this demand, including helping CHC organize literacy training, continued radio programming, and exploring opportunities for institutional collaboration with Sierra Leone’s higher education system.

The project concludes the CHC approach has been instrumental in bringing about widespread and positive changes in the communities in which it has been implemented. With so many of these benefits occurring at the community level and by the community members themselves, the team felt there is strong likelihood that these benefits will be lasting. Given these accomplishments, the team feels that there is great potential for this approach to be adapted and expanded both throughout Sierra Leone and across the globe as a successful model for health promotion.

INTRODUCTION



The purpose of this report is to assess the community health club (CHC) approach to international health promotion. Looking specifically at CARE's "For Di Pikin Dem Wel Bodi" project (For the Health of the Child) in Koinadugu District, Sierra Leone, this research attempts to identify both the strengths and weaknesses of community health clubs. The research addresses issues such as who participates in CHCs, what benefits CHCs have in terms of health and community development, as well as to what extent CHCs are integrating with other community organizations. While some of the lessons learned will be specific to the milieu and implementation of this project and region, by contextualizing our work within the broader experiences of health promotion and community development, we hope to contribute to a more general understanding of best practices within this growing field.

The report begins with background information on the community health club approach, the "For Di Pikin Dem Wel Bodi" project, and the research setting. Here, information is provided on the origins of the CHC approach, how CHCs are being implemented as part of the "For Di Pikin Dem Wel Bodi" project, as well as basic information on Sierra Leone and Koinadugu District. In the research objectives section, each of the four research questions is introduced. A brief rationale for each question is also provided. The subsequent section explains the methodology, including data gathering techniques, communities visited, and research limitations.

The findings section reports the team's main observations and assessment of the CHC approach. The findings center on the four research areas: participation, health benefits, community development, and integration with other community organizations. Complementing the findings, the team has prepared a "pillars of success" section, in which the team outlines what it considers the foundations of this program's success and the elements considered essential for successful expansion of this approach. This section is geared principally towards those seeking to understand the success of this project relative to other health promotion methodologies, or looking to incorporate the CHC approach into their own health promotion projects. The recommendations section is intended for the "For Di Pikin Dem Wel Bodi" project staff and management, although the general lessons may also be of use to other development practitioners seeking to employ this methodology. Recommendations are provided both for the duration of this project, as well as for possible follow-on projects.

BACKGROUND



Health Promotion and Community Health Clubs

For international health, the shift toward more participatory, people-centered and community-based development has meant programs addressing the home and the community are now seen as essential complements to efforts for strengthening national health systems. At the community level, many programs focus on health promotion, which is “a process of enabling people to increase control over, and to improve, their health” (WHO, 1997). Community health clubs (CHCs) are an increasingly popular methodology for health promotion.

Like health education, health promotion seeks to increase health knowledge at the household and individual level. However, health promotion differs from health education in that it works to more actively engage communities, recognizing that didactic health education messages alone (posters, radio campaigns, etc) typically change the behavior of only about one in four people (Campbell, 2000). As result, health promotion considers the cultural determinants of health behavior, taking into account that a lack of information about health is not necessarily the cause of “unhealthy” behavior. Health promotion efforts encourage community members to identify their own problems and needs, and work with communities to develop solutions.

Recently, clubs have been increasingly incorporated into health promotion programs. Since community engagement and community cohesion are correlated with improved health (Gallagher, Easterling & Lodwick, 2003), 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 (Waterkeyn & Cairncross, 2005). Club approaches have been used for a variety of public health goals including tuberculosis control (Getahun & Maher, 2000), promoting insecticide treated bed nets (Tanzania NGO Alliance, 2004), breastfeeding (Volpe & Bear, 2000), promoting the use of health services (Pineda & Lim, 1998), as well as creating demand for sanitation (Waterkeyn & Cairncross, 2005), among others.

As health promotion tools, clubs vary in the scope of their membership and the breadth of their mission. CHCs, which are open to all community members and address a wide array of health issues, are among the most comprehensive health promotion clubs. Developed in Zimbabwe in 1994, the CHC approach seeks to create a “culture of health” within communities. 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 (Waterkeyn, 2003).

Because they exist on the nexus between health improvement and community development, CHCs and other health promotion clubs face the challenges inherent in community empowerment. Many such efforts struggle with capacity building, often increasingly turning toward reaching short-term health indicator targets since community empowerment efforts are inevitably challenging and slow to mobilize and sustain (Campbell, 2003). In addition, in many regions, top-down development and humanitarian assistance have eroded people’s awareness of their own capacity to solve problems, making such efforts particularly challenging. While the CHC approach is one of the most comprehensive approaches to health promotion and community development, there has been little formal study to date on its strengths and weaknesses.

An Overview of the “For Di Pikin Dem Wel Bodi” Project

CARE’s “For Di Pikin Dem Wel Bodi” project is a child survival project working to improve child and maternal survival rates in Koinadugu District, Sierra Leone. CARE’s five-year project began in 2003 and recently reached its midpoint. “For Di Pikin Dem Wel Bodi” has dual goals of improving health and creating capacity that will allow communities to sustain vital health benefits. Adopting a CHC methodology, the project seeks:

- (i) 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;
- (ii) enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms; and,
- (iii) improved quality and accessibility of services provided by Ministry of Health and Sanitation (MOHS) personnel and MOHS extension services (Murima, Kamara, Lindsey, Kukreja & Sinho, 2004:2).

In order to achieve these goals, CARE encourages voluntary participation in CHCs for any adult (age fifteen and over) in the community who wishes to join. The CHCs disseminate health information, promote healthy practices and spearhead community support for the formal health system.

Establishing CHCs

As part of its “For Di Pikin Dem Wel Bodi” project, CARE has organized and trained 56 CHCs in Koinadugu District (Capps, 2006). 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. Proximity to government clinics and presence of other similar projects in the community were also considered. 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. In many communities, VDCs have been re-constituted with the help of NGOs, who see them as important partners in the development process (Tommy & Kasibo, 2003). VDCs spearhead community development efforts, including identifying needs, coordinating with NGOs, and mobilizing communities to undertake development activities. CARE implements all of its projects in Koinadugu in conjunction with VDCs, which CARE insists be elected bodies with at least one female. VDC size varies, but a typical VDC has about seven members. In the “For Di Pikin Dem Wel Bodi” project, VDCs are responsible for overseeing CHCs and undertaking complementary activities.

With the help of local leaders, including the VDC, CARE initiated the CHCs by holding a community meeting to explain the CHC project and process to the community. Interested community members were then invited to attend weekly CHC sessions, held at a time set by the community members. After several weeks, CARE encouraged the community to develop a CHC

leadership structure and identify CHC leaders. Since this process is community-driven, each CHC varies in its structure, but most CHCs elect about six officers to lead their CHC.

CHC Activities

CHCs serve as a venue for community members to learn about health issues and promote health within their communities. For 25 weeks, CHCs meet two hours per week. These first 25 sessions are facilitated by CARE field staff who use a participatory approach 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.

After the completion of the lessons, CARE field staff encourage CHCs to mobilize their communities around health issues through the creation of monthly action plans. While CARE staff helped CHCs identify ideas for action, CHC members themselves determine the procedure for how activities will be decided and which activities will be carried out in a given month. As CHCs become more comfortable in developing their own action plans, CARE field staff contribute less and less to process until it is entirely community-driven. As part of their action plans, CHC members undertake community improvements, review health lessons, conduct outreach sessions to other communities to share health messages, and help non-CHC communities establish their own health clubs. In addition, they work with the government peripheral health units (PHU) to ensure success of formal sector health outreach activities such as antenatal clinics.

Sustainability

CARE is deeply committed to sustaining the benefits of this child survival project. The CHC approach focuses on community capacity, social cohesion, and good governance, as important components in themselves, but also as vitally important to sustaining health outcomes. CARE is working to ensure the persistence of health knowledge and healthy behaviors beyond the end of the project, as well as maximize CHC's abilities to continue their activities even when CARE staff no longer provide support. CARE also hopes that community capacity, especially related to organizational skills, leadership, and community problem solving extend beyond the project - both in terms of scope and duration.

Project Setting

The “For Di Pikin Dem Wel Bodi” child survival project is working in Koinadugu District, Sierra Leone. Sierra Leone has among the poorest health indicators of any country in the world, and Koinadugu District is one of the least developed regions in the country. Additional information on Sierra Leone, Koinadugu District and CARE’s projects in the region is provided below.

Sierra Leone

A West African country with a population of about 6 million, Sierra Leone recently emerged from a notoriously brutal civil war. The 11-year war together with decades of political mismanagement have left Sierra Leone as one of the world’s poorest countries, with a GDP PPP of only \$561 in 2006, despite a wealth of diamonds and other natural resources. In the same year, Sierra Leone ranked 176 out of 177 countries on the human development index, with a literacy rate of only 35 percent (UNDP, 2006).

In terms of health, Sierra Leone has among the poorest indicators of any country in the world (WHO, 2006b; see also Table 2.1). Overall life expectancy is less than 40, with maternal, infant and child health particularly wanting. More than one in four children will die before their fifth birthday - the highest child mortality rate in world (UNICEF, 2007). Major causes of morbidity and mortality include malnutrition, diarrheal disease, malaria, measles, and acute respiratory infections. HIV prevalence rates remain comparatively low, at 1.6 percent.

Figure 1. Sierra Leone's Health Indicators

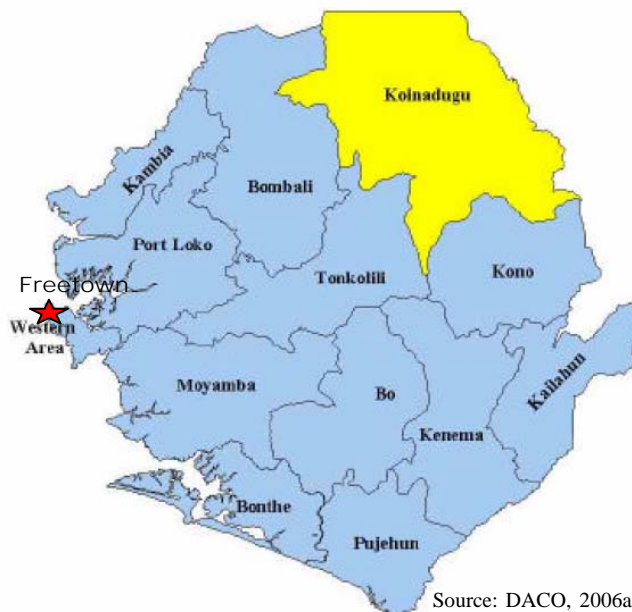
Life Expectancy	37 – Males 40 – Females
Under-five mortality	284 per 1000
Infant mortality	162 per 1,000
Maternal mortality	1,800 per 100,000
Number of physicians	168
Number of nurses	1841
Number of community health workers	1227
Per capita government expenditure on health	\$4
Percent of children underweight	27%
Percent of population without access to clean water	43%
HIV prevalence, adults 15 and older	1.6%

Sources: UNICEF, 2007; WHO 2006a & WHO 2006b. Most indicators reflect 2004 data.

Koinadugu District

Koinadugu district is a remote district in northwestern Sierra Leone. Comprising 11 chiefdoms¹, the district has an estimated population of 234,000 (Development Assistance Coordination Office [DACO], 2006a). Because of its distance from Freetown and its primarily minority ethnic composition, Koinadugu district has historically been one of the most neglected and least developed regions of Sierra Leone. Under rebel control during much of the civil war, Koinadugu received little humanitarian or development aid and suffered widespread destruction. Though now prioritized for development assistance, Koinadugu's poor infrastructure, limited history of development interventions and the large influx of returning refugees and internally displaced people present challenges (DACO, 2006a).

Figure 2. Sierra Leone - Districts

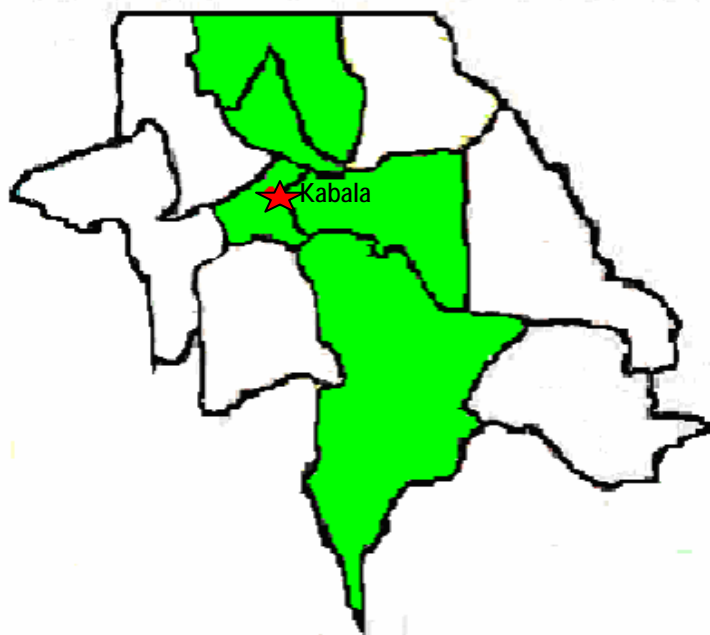


Source: DACO, 2006a

CARE's projects in Koinadugu

Within Koinadugu, CARE operates in Dembelia Sinkunia, Folosaba Dembelia, Wara Wara Yagala, Sengbeh, and Neini chiefdoms. These five chiefdoms (shown in green on the map) are those most easily accessible from CARE's district headquarters in Kabala. Five major ethnic groups and distinct language groups are present in CARE's operational areas including Limba, Koranko, Yalunka, Fula, and Madingo.

Figure 3. Koinadugu District



In addition to the "For Di Pikin Dem Well Bodi" project, CARE has several other projects in Koinadugu, including the Promoting Linkages for Livelihood Security and Economic Development (LINKS) project, the Northern Province Rehabilitation Initiative (NPRDI), the Sexuality and Youth project (SAY), the Malaria Outreach and Safety Initiative (MOSI), and the recently concluded Development Relief Project (DRP). In implementing these projects, CARE uses an integrated approach to build links between these projects and provide comprehensive benefits to communities (see Appendix 1).

¹ Chiefdoms are administrative units within Sierra Leone

RESEARCH OBJECTIVES



While CARE is pleased with the project's achievements to date, additional information regarding the role of CHCs on health improvements and community development would be useful both to improve this project and to expand the knowledge base regarding effective implementation of community-based health promotion projects. This research seeks to assess the CHC approach and its ability to bring about beneficial health and development outcomes as well as to sustain these benefits over time. The research explores four key areas:

1. What is the extent of CHC participation?
2. What are the impacts of CHCs on health outcomes?
3. What are the impacts of CHCs on community development?
4. What is the nature of the relationships between CHCs and other organizations?

In the subsequent section each research question is stated and contextualized.

Extent of CHC participation

Looking at a broad spectrum of community health promotion programs in the United States, Easterling, Gallagher and Lodwick (2003) conclude that composition of membership in community health projects had a significant impact on their success. In particular, greater representation from the different sectors of the community led to broader and more holistic understandings of health and also to greater overall success in project objectives. Additionally, in regard to long-term success, it has proven important that different social groups, particularly those that may have been historically marginalized, feel equally empowered to participate and lead community groups (Edwards, 2004; Campbell, 2003; Healy, 2001). Not fostering this type of inclusive environment limits benefits by denying voice to potential contributors, and can also cause the program to fail since those who feel underrepresented or denied access to leadership positions may impede the project as they lobby for broader social change (Guggenheim, 2006; Uquillas & Nieuwkoop, 2006).

Often, barriers to participation are unintentional. Many community-based health projects have struggled to attract the community's poorest members, even when this is precisely the group the project intends to serve (Preker et al., 2002). The research investigates the composition of CHCs based on several criteria and attempts to assess whether any groups are underrepresented, and if so, determine possible implications of the failure to attract these groups. Additionally, the research will explore who is taking leadership roles within CHCs to determine whether any groups dominate the CHCs at the expense of others – a situation which would be likely to undermine the community cohesion necessary to ensure the project's long term success.

Health Outcomes

Improved health outcomes are a primary goal of the project. Establishing to what extent CHCs are contributing to improved health is essential for understanding the success of this project, and may also provide valuable lessons to other community health projects. Annual data gathering efforts have demonstrated continued improvement in most of the project's targeted health indicators; however, attributing these improvements to the CHC approach, rather than CARE's mobilization of external resources and support for the health system more generally is difficult. By focusing on beneficiary views of the impact of CHCs on health outcomes, the team

hopes to gain insight into whether beneficiaries perceive the effects of the CHCs as the indicators reflect them. In addition, the research explores the mechanisms through which CHCs are bringing about improved health.

Community Development

Important links exist between health promotion and community development, especially in terms of sustainability. Community development helps create an enabling environment (Dongier et al., 2003), where community members can identify needs and work together to solve problems. While community development is hard to assess, community cohesion, leadership, and extent of self-initiated and self-directed activities can provide insight into whether a community has the qualities necessary to sustain benefits.

As recognized in the project literature, community cohesion is important in itself, but is also critical to the ability of the CHCs to effectively carry out their mission. Community cohesion provides networks and other social relationships that facilitate cooperation, help create a shared sense of mission, and encourage collective action. For the CHCs, community cohesion will facilitate their immediate and long-term missions. In the short-term, social networks are a means to spread health knowledge, expanding the projects reach. In the long-term, community cohesion will facilitate and encourage collective action – such as CHC activities - and help community members tackle increasing challenging community problems. Additionally, since the project design relies on community members to improve their own health, and to spread health messages among non-CHC members, strong local leadership is essential.

Finally, it will be vitally important for the long-term success of the project and the overall regional development that community members are encouraged and supported as they identify pressing local needs and novel solutions to address them (Guggenheim, 2006; Uquillas & Nieuwkoop, 2006). As Guggenheim (2006:124) explains, “focusing primarily on the process by which local development projects are planned and managed rather than on what gets built” is vital because enabling participation fosters problem-solving skills, which will be essential after the project period ends. Communities must believe in their own ability to develop and implement worthwhile solutions to break the cycle of dependency. Accordingly, the research will attempt to assess the scope and origin of self-initiated activities.

Linkages

CHCs currently interact with village development committees (VDCs), peripheral health units (PHUs) and other community organizations. As integration and harmonization with other organizations are important for successful development, the research seeks to examine the nature of these relationships and how they enhance or detract from the ability of the CHCs to achieve their stated objectives.

The importance of relationships among different groups in a community is due in part to their impact on building social capital. Fostering crosscutting ties (or bridging social capital) among groups and formal institutions helps create social connectivity between citizens and local institutions that will allow communities to work beyond the CHC's goals. In the long-term, these relationships improve sustainability.

In addition, forging relationships with other community organizations can help address complementary problems. In the case of health promotion, for example, community health groups may need to work with other area groups to address community needs that affect health, such as access to clean water, improved access to health facilities, schooling and income-generating activities.

METHODOLOGY



Literature Review

In order to prepare for and contextualize the field research, CARE project documentation, documentation from similar projects, as well as relevant scholarship related to health promotion and community engagement were reviewed. Key CARE documentation provided for review included, the Project Detailed Implementation Plan (Murima, Kamara, Lindsey, et al., 2004), the 2004 Annual Report (Murima, Kamara, Cunningham & Jennings, 2004), the 2005 Annual Report (Murima, Kamara, Cunningham & Jennings, 2005), the Midterm Evaluation Report (Capps, 2006), and CHC census data. In addition, the midterm evaluation report from the International Rescue Committee (IRC) Child survival project in nearby Kono District was provided for review (Sarriot, 2006). The IRC project is analogous to the “For Di Pikin Dem Wel Bodi,” but does not incorporate CHCs. As the IRC and CARE projects are very similar, the two organizations have been active in exchanging relevant information and learning from each other’s experiences. The team also identified and reviewed relevant literature and reports on health, community engagement and post-conflict reconstruction to draw best practices/success stories from the field as well as to gain insight into potential challenges.

Field Research

The team’s primary research was conducted in Sierra Leone over a period of 15 days in March 2007. Since it was not possible in this short time frame to visit and assess each of the 56 CHCs, the team chose to carry out in-depth analysis of a small sub-set of the CHCs and contextualize these findings through discussions with project staff and project documentation addressing CHCs. In addition, the team visited communities without CHCs to serve as “control groups” and provide valuable insight into the role of CHCs. The team used a variety of qualitative and quantitative research methods to address the research questions, including participant observation, interviews, focus groups, and surveys. Selected interview guides and surveys are included in the Appendices.

Participant observation included the following activities:

- CHC meetings, including meetings at which health lessons were reviewed and action plans were developed;
- CHC outreach sessions to non-CHC communities;
- CHC activities within the community; and,
- PHU activities facilitated by CHCs, including pregnant women support group meetings, antenatal clinics, maternal child health clinics, and community based growth promotion.

Interviews and focus groups were conducted with the following groups:

- CHC members (both, stratified by gender and in mixed groups);
- VDC members;
- Community leadership;
- PHU Staff; and,
- CARE field staff and project management.

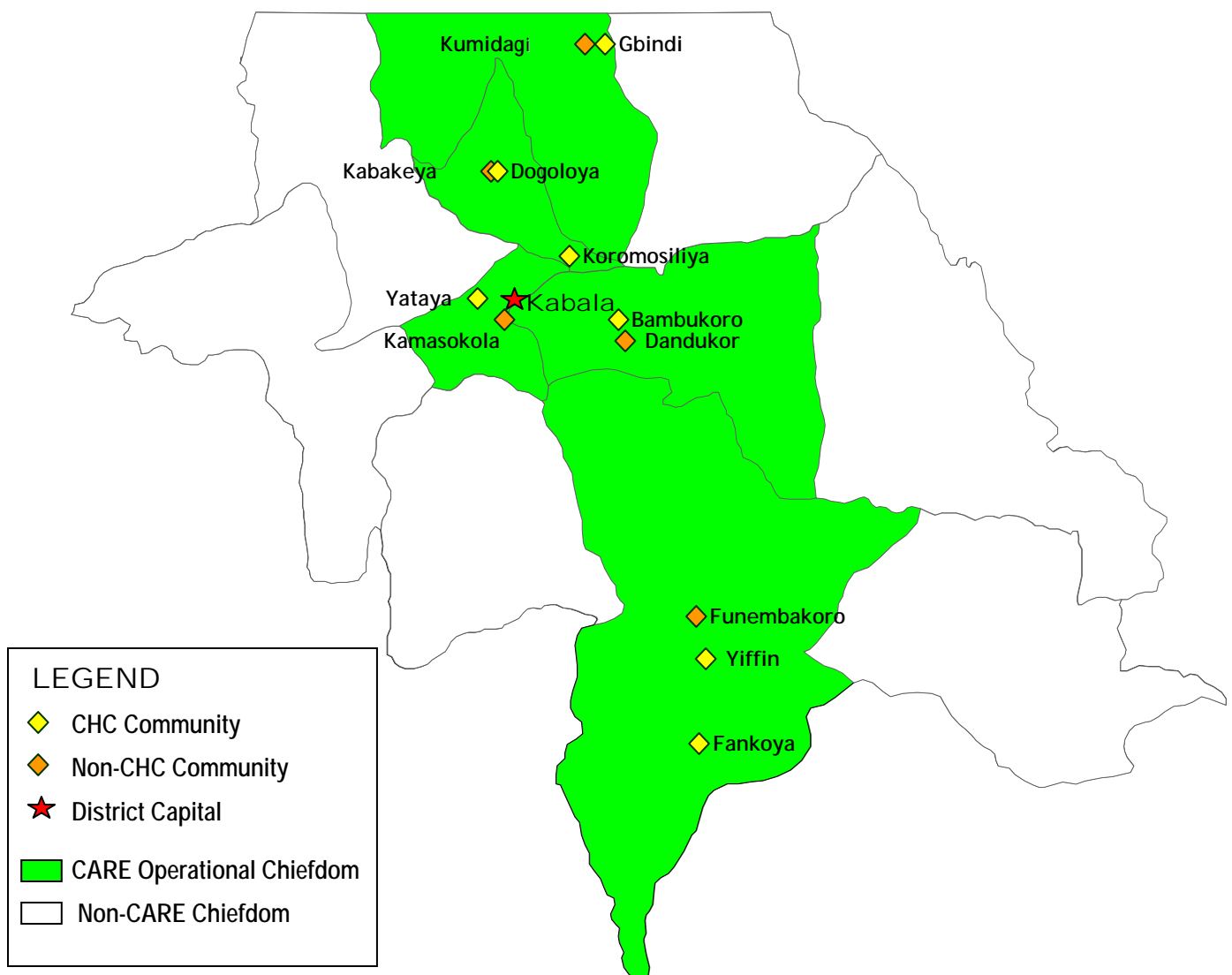
Surveys were conducted with:

- Non-CHC members in Yiffin, Bambukoro, and Fankoya; and,
- Kamasokola, a non-CHC community.

Communities Visited

The team conducted research in seven CHC communities. The CHC communities visited span all five chiefdoms in which CARE is operational and cover the five major ethnic groups with which the project works (see Figure 4). The team spent an average of three days in each community; in five of the seven communities, community members hosted the team overnight, providing additional insight into community life. In addition, the team visited five non-CHC communities, staying an average of about one day.

Figure 4. Communities Visited



CHC Communities visited include (see also Figure 5):

- Yiffin. Yiffin is a large, primarily Koranko community within the Neini chiefdom. It is a PHU community with roads connecting it to a number of larger towns, although transportation is limited during the rainy season. During the war, rebels destroyed the town three times, but each time community members returned to rebuild.
- Fankoya. Fankoya is also in the Neini chiefdom, although it is over 20km past Yiffin and is much less accessible to vehicles. A PHU recently opened in this community.
- Bambukoro. Bambukoro is a Yalunka community in Sengbeh, and home to the chiefdom's paramount chief. Bambukoro is divided into two administrative districts, each with its own CHC and VDC. Research was carried out jointly with both CHCs. The nearest PHU is about 4 km away.
- Yataya. Yataya is a Limba community, near Kabala, in Wara Wara Yagala chiefdom. A PHU is located in this community.
- Gbindi. Gbindi is a large trading community in Dembelia Sinkunia, about 10 kilometers from the Guinean border. The community is primarily Fula, although there is also a large Yalunka minority. The community is divided into five administrative districts, each with its own CHC. Research in Gbindi was carried out jointly with all five CHCs. A PHU had been operating in Gbindi for seven months at the time of the visit.
- Dogoloya. Dogoloya is a primarily Fula community in Folosaba Dembelia. Dogoloya is divided into three administrative districts. Research in Dogoloya was carried out jointly with all three CHCs. There is a recently constructed PHU in Dogoloya.
- Koromosiliya. Koromosiliya is a primarily Madingo community in Folosaba Dembelia chiefdom. Koromosiliya is about 5 km from the nearest PHU.

Figure 5. CHC Communities Visited

Village	Chiefdom	Ethnic Group and Language	PHU Community	Distance (km) from Kabala	Population
Yiffin	Neini	Koranko	Yes	86.4	1,087
Fankoya	Neini	Koranko	Yes	108	668
Gbindi I	Dembelia Sinkunia	Fula/Yalunka	Yes	51.2	421
Gbindi II	Dembelia Sinkunia	Fula/Yalunka	Yes	51.2	510
Gbindi III	Dembelia Sinkunia	Fula/Yalunka	Yes	51.2	683
Gbindi IV	Dembelia Sinkunia	Fula/Yalunka	Yes	51.2	338
Gbindi V	Dembelia Sinkunia	Fula/Yalunka	Yes	51.2	180
Dogoloya I	Folosaba Dembelia	Fula	Yes	17	214
Dogoloya II	Folosaba Dembelia	Fula	Yes	17	544
Dogoloya III	Folosaba Dembelia	Fula	Yes	17	330
Koromosiliya	Folosaba Dembelia	Madingo	No	11	831
Bambukoro I	Sengbeh	Yalunka	No	24	305
Bambukoro II	Sengbeh	Yalunka	No	24	387
Yataya	Wara-Wara Yagala	Limba	Yes	5	407

Non-CHC communities visited include:

- Funumbakoro. Funumbakoro is small Koranko community a few kilometers outside of Yiffin. Research coincided with the first rollout CHC training by Yiffin CHC members. The training was about mapping the village.
- Seduya and Dundukor. Seduya and Dundukor are two Yalunka communities in Sengbeh chiefdom. Research was conducted after observing a PHU vaccination outreach with a health talk held by Bambukoro CHC members. The meeting place was a primary school campus between the two villages. Male and female leaders from both villages participated in the focus group.
- Kumidagi. Kumidagi is a small community near Gbindi, in Dembelia Sinkunia chiefdom. At the time of research, the Gbindi CHC has been conducting monthly outreach sessions in Kumidagi for about six months. Research in Kumidagi coincided with an outreach session by Gbindi CHC members.
- Kabakeya. Kabakeya is a Yalunka community near Dogoloya in Folosaba Dembelia. Dogoloya CHC members have been conducting outreach sessions in Kabakeya and research in Kabakeya coincided with such an outreach. As Kabakeya suffered a devastating fire the day before the visit, extent of research was limited.
- Kamasokola. Kamasokola is a Limba community in Wara Wara Yagala chiefdom. While a CHC has been conducting outreach in Kamasokola for a few months, our research did not coincide with a CHC outreach session.

Research Limitations

The research also faced methodological limitations. The first limitation in the research relates to site selection. The team sought to visit communities that represented a diversity of success. CARE staff selected the sites for research raising the potential for bias, although they claimed the representation was balanced. In personal interviews, the project manager, the assistant project manager, chiefdom supervisors, and field agents were asked to rank the success of each community researched. Each staff person ranked the communities differently, but across a spectrum of success levels, suggesting that the communities visited were in fact representative.

Another limitation of the research was translation. All focus group interviews were subject to double translation: from English to Krio and then from Krio to the local language. Krio is a creole language with limited and variable vocabulary, increasing potential that some information could be lost in translation. In order to overcome potential translator biases, three interns, university students from Freetown, provided most of the English to Krio translation, although CARE staff members also assisted in translations. Members of the local community provided translation from Krio to the local language(s). The team worked to be aware of non-verbal communication and cultural norms, and to factor these into their report.

A third limitation relates to the presence of CARE staff at many of the interviews/surveys. This weakness was partially offset by the team living in the communities for several days, giving them the ability to partially validate community assertions. Additionally, during CARE staff interviews, the team asked if the community responses they heard correlated with what they had seen or heard in past and the consensus was of consistent reporting.

The final limitation is the short duration of field research. The limited number of communities the team visited, as well as the lack of time to interview MOHS staff at district or regional levels, may impact the team's findings. The team worked to overcome this limitation through multiple conversations/interviews with staff who have worked with the project since its conception and with staff who work closely with MOHS staff at district and regional levels.

FINDINGS



CHCs show significant evidence of success and likelihood for sustainability. The project is largely community driven; while initially project staff managed the project, responsibility has been transferred to stakeholders. CHCs now implement health related activities, organize monthly action plans, rollout trainings to neighboring communities, and participate in self-initiated activities, such as building infrastructure.

“For Di Pikin Dem Wel Bodi” addresses both cognitive and structural factors to create sustainable self-initiated collective action. At the cognitive level, the project improved organizational skills and health knowledge which enabled beneficiaries to self identify problems, organize, and come up with solutions. When asked what motivates people, the PHU nurse of Fankoya summed it up in three elements: knowledge transfer, awareness raising, and leadership. Improved health outcomes were predominantly a result of information diffusion and organizational skills training that provided people with the tools necessary to undertake self-initiated activities. Participatory trainings, open election of leaders, and gender inclusion made possible changes in attitudes related to good governance. These cognitive elements were complemented by the structural incentives that facilitate such endeavors. At the structural level, creating institutions such as village savings and loans groups (VS&Ls), and improving relationships with VDCs and PHUs, formed an enabling environment for collective action.

Seeing health from a holistic perspective, project success is as much a consequence of changes in community organization as of direct health related interventions. Success and sustainability will be driven by four key areas: (i) extent of CHC participation, (ii) health outcomes, (iii) community development, and (iv) linkages with other organizations. This section addresses the project’s impacts across these areas.

Participation

Our findings look first at the participation of community members in the CHCs. Across the communities visited, participation in CHCs was widespread and largely representative of the community. The majority of households² within each community had at least one representative among the CHC members. The ratio between male and female members varied from village to village, often with a slight female majority (see figure 6). In addition, there was a diverse representation of ages among CHC members (starting from the late teens), though the oldest members of the community often did not participate due to limited mobility. 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."

Figure 6. CHC Gender Ratios

Village	People/Language	Population ³	No. Males CHC members	No. Female CHC members	Percent Female
Yiffin	Koranko	1,087	21	26	55%
Fankoya	Koranko	668	N/A	N/A	N/A
Gbindi I	Fula/Yalunka	421	20	31	61%
Gbindi II	Fula/Yalunka	510	21	34	62%
Gbindi III	Fula/Yalunka	683	22	31	58%
Gbindi IV	Fula/Yalunka	338	15	25	63%
Gbindi V	Fula/Yalunka	180	20	31	61%
Dogoloya I	Fula	214	19	23	55%
Dogoloya II	Fula	544	6	37	86%
Dogoloya III	Fula	330	18	40	69%
Koromosiliya	Madingo	831	18	30	63%
Bambukoro I	Yalunka	305	19	49	72%
Bambukoro II	Yalunka	387	11	41	79%
Yataya	Limba	407	18	14	44%

Reasons for participating emphasize a desire for improved health, as well as knowledge, especially if it was provided free of cost. For example, women in Gbindi explained that they are "particularly interested in the health of their families and gaining health lessons and health knowledge" and that they joined the CHC to improve the health of their children. Such opinions were echoed across the communities; CHC members in Bambukoro also mentioned the desire to learn about taking care of their "pikin," their children. Community members also emphasized

² Households in Koinadugu are made up of polygamous extended families. In Kamasokola, where a full community survey was undertaken, household size ranged from 4 to 20 with an average household size of 10.9.

³ About half the population in most communities is younger than 15 (unpublished CARE monitoring and evaluation data, 2006).

the opportunity to learn as a reason for joining the CHC. For instance, a CHC member in Fankoya described a sense of living in darkness prior to receiving education through CHC participation. Many of those who had never been to school especially appreciated the opportunity to learn for free: a CHC member in Yiffin stated that he joined because it was voluntary and no payment was required.

In order to understand reasons for non-participation, the team surveyed nineteen non-CHC members in three CHC communities. When asked why they were not members, 42 percent said that they had moved to town after the CHC had begun, while 37 percent cited not enough time as their reason for not participating. One interviewee in Yiffin was a chiefdom co-chairman, who stated that he was out of the village settling disputes too often to attend, but that his wife was a CHC member. Qualitative research echoed these findings: most respondents believed that families who did not participate had not been in the community at the time the CHC began, either because their work required travel (such as traders or village leadership) or they had recently migrated to the area. Nonetheless, CHC members were confident that even those who did not actively participate in the CHC were able to benefit from the CHC through routine outreach and sharing of health information. A CHC member in Koromosiliya explains: “everyone benefits, even if they are not members - we share what we have learned.”

Health Outcomes

Success in health related interventions relies predominantly on generating behavior change by transmitting information and raising awareness. As community members' reflected on the impact of CHCs on their lives, the increases in their health knowledge was evident. In addition, positive changes in health behavior, which other community health programs have found difficult to achieve, were apparent. The CHC approach was also able to increase coordination between communities and the formal health sector. Increased knowledge, behavior change, and improved coordination with the formal health sector have improved health outcomes and created an atmosphere of enthusiasm, empowerment and motivation to continue with positive health behavior. Consequently, there is significant likelihood that these benefits will be lasting.

Increased Knowledge

CHC members were excited to speak of the many things they had learned through the CHC trainings. CHC members mentioned nearly all of the topics covered by their health trainings. Trainings covered topic such as disease case management, nutrition, personal hygiene, and environmental sanitation, among others (CARE International in Sierra Leone, 2005). Community members appreciated the training sessions' atmosphere, where they felt free to seek out the causes of illness and help create solutions.

For example, CHC members in Yataya spoke of learning about malaria prevention, causes, and when to seek care at the PHU. Moreover, many communities spoke of the importance of monthly child weighing to monitor development and identify children with illnesses. Others recounted the importance of vaccinations and how they had seen a dramatic decrease in disease and death of their young children after being vaccinated. Nutrition for children and pregnant women was also frequently mentioned, specifically the importance of exclusive breastfeeding for the first six months. In Fankoya, a CHC member told the story of a child that at five years of age was unable to walk due to poor nutrition, but now the children were healthier as they knew what types of food to give them

Behavior Change

Health education not only increased knowledge, but translated into behavior change. For example, the CHC program taught members to use clotheslines and plate racks, rather than drying these items on the ground. Drying clothes on the ground can lead to contamination from the soil, resulting in skin rashes, while drying dishes on the ground can facilitate the spread of intestinal illnesses such as Typhoid. In this case, behavior change was obvious: each home in the CHC communities had clotheslines and plate racks, which were in use. Not only are these tangible objects visible in CHC communities, but secondary and tertiary beneficiaries in the surrounding communities have also put up clotheslines and plate racks. Here, not only was the behavior change evident, but community members also recognized the positive health impacts: they noticed fewer skin rashes and intestinal diseases. Having experienced these benefits, CHC communities encouraged others to adopt clotheslines and plate racks. Clothesline in particular are becoming a societal norm – in Kamasokola, a non-CHC community, a family indicated they had recently installed a clothesline because they had seen them at most of the houses in the area.

CHC members also describe a number of behavior changes and the positive health impacts that resulted. In Bambukoro, for instance, CHC members described past practices of tying a string on the wrist of a child to monitor their growth, but now they weigh children monthly to measure their growth. As a result, they are now more able to identify when children are ill and need PHU care, leading to noticeable improvements in overall child health. In Fankoya, prior to CHC trainings, community members were less likely to use PHU services, but now that they are able to recognize illness symptoms, they are more likely to take advantage of formal healthcare. Likewise, pregnant women report increased use of PHU ANC services.

Increased environmental sanitation was another element of behavior change that community members often cited. Fankoya CHC members described the newly clean environment within their homes and around their town. Similarly, Yataya VDC members reflected on their sense of pride and accomplishment in the clean environment that was now the norm and expectation within their community.

In some instances, behavior change had even translated into local policy. In Bambukoro, for example, not only do community members no longer drink water from the stream, but they have also implemented regulations such as how far a latrine must be built from a well, in order to protect their drinking water supply. Additionally, most wells in CHC villages had fences to keep the livestock out and the team observed community members taking their shoes off before stepping within these fences to collect water. These positive behavior changes have become the norm and as such create potential for successful sustainability.

There were also areas where education has not translated to behavior change. For example, in some communities with latrines, soap was not apparently available for hand washing. Behaviors like hand washing, which rely on consumable goods, may be constrained by economics, or other barrier to improved health behavior that CHCs have not yet been able to overcome. However, some CHC communities have begun recognizing these limitation and adapting effective strategies. In Yiffin, for example, the PHU staff made and distributed soap, increasing its availability.

Participation in the formal health sector

A third health benefit stems from the increased participation of community members in the formal health sector. 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. For example, the team observed an ANC clinic at the PHU in Yiffin, which the CHC members helped organize and carry out. Pregnant women from surrounding villages came for a nutritious meal together and then were weighed, had their blood pressure checked and inspected for fundus height, and signs of anemia or edema. They were given a dose of Albendazole (intestinal worm treatment) and a month's supply of iron with folic acid to take daily. Simultaneously, CHC members were weighing children just outside the PHU. CHC members actively participated and supported PHU activities while encouraging applicable community members to participate. PHU staff greatly appreciates CHC assistance, which they indicate has helped increase attendance at these prevention-oriented activities, and has made their jobs easier.

Health Outcomes

While final project health indicators are not yet available, there is a consensus among project staff, beneficiaries and other stakeholders that the impact of CHCs on health outcomes has been significant. Most of the project's health indicators, which address knowledge and behavior change, have shown significant improvements, with some areas exceeding program targets by the midterm (Capps, 2006). According to both the PHU staff and CHC members, these improvements are a direct result of CHC training and activities. Community members and PHU staff also indicate that increased knowledge, behavior changes, and increased participation in the formal health sector have been vital in improving overall health outcomes, such as maternal and child mortality. Repeatedly CHC members expressed their appreciation for all the positive changes they had seen in their lives as a result of the training that CARE had brought to them. Likewise, the PHU staff in Dogoloya, for example, enthusiastically reported how few infants had died in the community in recent months. Community enthusiasm for the benefits they have already seen is likely to continue these trends.

Community Development

While keeping health outcomes the focus of the “For Di Pikin Dem Wel Bodi” project, success could not be achieved without also addressing community development. This approach aligns with trends, which see projects not just as forms of resource delivery, but as integrative approaches to help populations build capacities and solve self-identified problems (Guggenheim, 2006). As the project also aims to strengthen community capacity, promoting inclusive and participatory practices while building capacities for future rollout is critical.⁴

Recognizing the importance of organizational skills, the training toolkit “Communicating health – communicating rights” (CARE International in Sierra Leone, 2005) illustrates that project success emphasizes community development as well as health. Sessions address gender inclusion, democratic practices and transparency. Participation – especially by women – has been strongly encouraged, and during the first sessions, CHC members elected leaders from among their peers. Discussing what they had learned, CHC members often mentioned “how to organize,” “leadership,” and “working together.” The extent of CHC impact on community cohesion, leadership, and self-initiated activities is explored below.

Community Cohesion

In the area of community cohesion, the team found that CHCs had helped to bring communities together. Community members indicated that CHCs had 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.

Community members mentioned that after the civil war, villages had difficulties reintegrating. During this time, before CHC involvement, organizing communities was challenging. However, the positive benefits seen from working together for CHC goals have helped many communities. A Funumbakoro VDC member explains they now feel “meeting together is very important.” Similarly, in Gbindi, a CHC member told how “the CHC helped me to come together with my neighbors.” These benefits also expand beyond the CHC, as explained by another Gbindi CHC member: “Coming together improves unity, and it creates ideas, not just improved health.”

Community members indicated that by illuminating the benefits of working together, CHCs had inspired the formation of other groups within the community. For instance, in many communities, traditional birth attendants, motivated by the successful mobilization of CHCs, had formed their own group to improve their ability to work together. CHC success also led to the formation or revitalization of many other community groups, including village savings and loan (VS&L) clubs and farming cooperatives. As a Gbindi CHC member explains, we have learned that “one person does not have much power, but that there is power in the group.”

Increased community cohesion is also seen in the CHC’s efforts to incorporate everyone in CHC activities and benefits. Non-CHC members are aware of CHC activities and benefit from their impacts, which spread across the entire village. CHC activities, such as village cleanings or growth promotion activities, are seen as collective endeavors not limited to CHC

⁴ As stated in the Detail Implementation Plan and at the beginning of this report, as a second objective, the project seeks “enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms” (Murima et al., 2004:2).

members. Community members enforce universal participation in these types of activities. This peer monitoring reveals an increased level of community cohesion, where community members are more likely and willing to work together, and in fact expect this type of cooperation.

Additionally, increased community cohesion is evident in improved gender relations in CHC communities. The project has actively promoted gender equality, which has an important human rights component, but is also vital to improved cohesion. Before CHCs, women were often not active participants in community engagements. CARE field staff encouraged both men and women to become involved. At many CHC meetings, men and women sit interspersed, with women voicing their concerns as much as men; this is in sharp contrast with the previous situation described by women where they either did not attend meetings, or sat in the back but did not speak. In meetings, both men and women are expected to ask questions, participate and take initiative. On this issue, the CHC field staff from Yiffin commented, “Before, men used to say ‘all good things come out of men,’ but now you see more female participation in the CHCs.” CHC communities, such as Dogoloya also indicated that they are now more likely to accept women as valuable contributors to the household- and community-level decision making process.

Women’s involvement in CHCs has led women’s issues to reach the social agenda. Many CHC activities benefit women directly: the construction of weighing huts, birth waiting rooms for pregnant women, as well as the building of wells are all targeted to women’s interests. Men jokingly explain how their influence has been reduced due to women’s empowerment. A group of women indicated that CHCs have taught them: (i) the capacity to ask questions; (ii) the capacity to organize; and (iii) gender equality. CHC communities, regardless of their current levels of gender equality, indicate that gender relations have improved, making it easier for the community to work together to solve community problems.

CHCs created significant changes in the way communities work together and value participation and dialogue in decision making. In many communities, these changes have been integrated into normal life. Unity and working together are not just key benefits of CHCs - they are *the* way decisions are made and activities are carried in CHC communities. As a result, there is little doubt that the CHC approach has provided communities with the increased cohesion that is vital to sustaining improved health outcomes.

Leadership

Leadership is a second vital aspect of community development. When asked about the elements for successful CHC implementation, CARE staff emphasized commitment and leadership as the essential components driving long-term success. The Yiffin field staff gave a compelling picture of the importance of leadership: “Let’s take the example from Soyia,” he said. “No town chief, no leadership. In Tilikoro, an extra effort was made and activities excelled due to local leadership.”

In most CHC communities, leadership is emerging both at the CHC and VDC levels. Particularly enthusiastic CHC members who have gained the respect of their communities have been selected to take the lead in CHC activities. These leaders are very dedicated to the CHCs. In addition, they have many of the skills necessary to maintain CHCs, such as the ability to organize and run meetings, as well as oversee and undertake activities such as outreaches. One area that was not directly noticeable was the ability of CHC members to maintain the motivation

of their constituents. Motivation seemed to come principally from individuals' commitment to CHCs, or from external sources such as CARE staff visits or other special events.

Similarly, VDCs have become more effective leaders in the process of CHC creation. In Kamasokola, a non-CHC community, there was no VDC. Without this leadership, no development activities were underway. Likewise, in Kumidagi, while a VDC existed, community members indicated it was neither strong nor active. In contrast, VDCs in all the CHC communities visited were active participants in leading the community's development. VDCs met regularly, organized action plans to benefit the community and provided valuable oversight to CHCs.

Community leadership has been strengthened from within as well as from without. From without, CARE has been actively involved in working with community leaders to strengthen their leadership skills. For example, CARE has worked with VDC and CHC leaders to recognize their roles and responsibilities as well as to provide them with the training necessary to uphold these duties. Community leaders indicate that this training has enabled them to improve their leadership. For the remaining 18 months of the project, and as part of its exit strategy, CARE will provide VDCs and CHCs with additional leadership training skill workshops on transparency, governance and accountability.

Leadership strengthening has also occurred as a result of internal pressure. As CHC members gained insight into their rights, they came to expect more from their leaders. In addition, the CHC approach promotes peer monitoring, which has allowed village members to supervise the performance of their leaders and exercise social oversight. The high levels of community commitment have generated demand for leaders to perform well.

While leadership is beginning to emerge, much leadership is still in the early stages of development. Many leaders' experience was limited only to their involvement in CARE's project. As a result, leadership remains an area where additional efforts could be beneficial. Recognizing the extreme importance of leadership in maintaining and sustaining CHC benefits, CARE is focusing on expanding leadership training as the project approaches its end date.

Self-initiated activities

Currently CHCs are able to decide upon and implement a variety of activities without field staff supervision. On occasion, CHC monthly planning sessions take place without CARE presence and group leaders report to CARE field staff on the progress of the activities and the agreed upon tasks for the following month. Staff will be attending a diminishing number of activities in the coming months as the project nears its end.

In the end months of the mobilization phase, most monthly activities were CARE-initiated. Thus, village sweeping sessions, construction of plate racks and clotheslines, and digging of wells became standard activities across CHC villages and even in some non-CHC villages where these practices have already diffused. Similarly, most communities have undertaken outreach activities within the community and to neighboring communities that do not have CHCs. CHCs are also active participants in a wide array of other elements of the "For Di Pikin Dem Wel Bodi" project, such as community based growth promotion, pregnant women's support groups, and the use of birth planning cards. Some villages have also begun building

health infrastructure - such as PHUs, weighing huts and birth waiting rooms - inspired by CARE suggestions.

However, as CHC members learned to plan and execute monthly activities, they began to increasingly incorporate their own ideas. 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 Koromosiliya, 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.

CARE also initiated VS&Ls as part of the “For Di Pikin Dem Wel Bodi” project. These common funds are intended to address health needs, although community members have also embraced them as a source of vital capital for productive needs. For example, a common reason women give birth at home is the lack of funds to pay for transport to the nearest PHU. The VS&Ls provide for these ‘emergency funds.’ Similarly, many of the above-mentioned economic projects such as buying a truck, building a secondary school, or repairing bridges, will be funded from the VS&L.

Most villages recognize all types of needs and potential activities, raising the risk that CHCs begin to loose focus on health as they branch out to economic activities. Close relationships between CHCs, PHUs, VDCs and intermediate level MOHS offices such as with the District Health Officer (DHO), should help ensure that health remains a key focus. PHUs, which will have increased responsibility for supporting CHCs, may also help steer CHC activities toward health issues. CHCs can also integrate with other existing organizations to address root causes of poor health. For instance, CARE runs a parallel project (LINKS) that focuses on infrastructure for productive uses. A link with LINKS, as a CARE official put it, is crucial.

Though it is important for CHCs to spearhead health related efforts, this does not preclude them from undertaking other development-related activities. CARE’s integrated project approach looks at health from a holistic perspective in which health issues are addressed within the overall environment. Seeing health promotion as a whole, raising economic and educational standards are important elements in improving health. As Lucas (1988) shows, there is a strong positive correlation between per capita income and social indicators, such as health outcomes. As income per capita increases, social indicators improve. Given this correlation, it makes sense for CHCs to reinforce economic activities, which also lead to better health.

Also, as the community members themselves recognize, infrastructure projects can have direct impacts on health. One of the reasons Koinandugu has such high mortality rates is due to delays in transportation – a fact which highlights the importance of road and bridge construction as “health related” activities. Poor health indicators in the region also stem from malnutrition, since most farmers sell their diverse crops in order to buy enough rice to feed their families. This situation could be offset if farmers have enough of a surplus to be consumed locally. In that

sense, gardening and farming activities become an important element of health interventions. Additionally, after the 11-year civil war, any type of productive activity gives the population an objective to work for and another reason to become organized.

Indeed, these examples show that there is no shortage of self-initiated activities in CHC communities. On the other hand, communities have a host of ideas and are more at risk of over-extending themselves than finding an issue around which to mobilize. This is in stark contrast to the non-CHC community of Kamasokola, where community members were not actively involved in collectively addressing any community needs.

Linkages

CHC success and sustainability is also dependent on their ability to integrate with other community groups. As described above, these linkages help address health in a more comprehensive and holistic manner. Additionally, at the structural level, formalizing the relationships between local organizations such as PHUs and VDCs provides valuable oversight for CHCs. Currently, linkages with formal institutions, which are often CARE-driven, are strong; however, opportunities to engage other community organizations have not been maximized.

Recent literature on community development stresses the importance of institutionalizing or formalizing the practices acquired throughout the project with formal institutions. The linkage between CHCs and village level formal institutions such as PHUs and VDCs is a priority for the project, as these institutions will guide the self-management process once the project ends in 2008. To date, PHUs have built formal relationships with CHCs in which the latter mobilize the communities and support the former's activities. In return, PHUs provide support and guidance to CHCs. Similarly, VDCs have been given increasing responsibilities for monitoring CHCs. Despite CHC initiatives in terms of planning monthly activities and reaching out to neighbor communities, there is still a close link to CARE staff which PHUs and VDCs will need to absorb. For example, monthly health indicators are provided to CARE's Kabala office where monitoring and evaluation takes place. By project close in 2008, VDCs will assume this role at the village level and report to the DHO in Kabala.

While the relationships of CHCs with VDCs and PHUs are relatively strong, CHCs have not yet been able to maximize on the possibility for partnership with other non-formal community groups. There is some level of collaboration with other health related groups that have formed as off-shoots of the CHCs, such as traditional birth attendant groups. There is also some coordination between CARE's other community based projects, most of which include a group element. While this coordination is indicated in CARE Kabala's organizational model (see Appendix 1), community members rarely mentioned working with nutrition clubs, farmer field schools, or other such groups. Community members' lack of emphasis on these linkages suggests that their potential has been under-exploited. Similarly, while most communities have a variety of indigenous groups, CHCs do not seem to be working extensively with them. Community members mentioned that groups such as "Munafa," (profit), which supports group farming activities; "Kankalay" (togetherness), which is in some communities a women's based group; "Sinnicy" (planning for the future), which is engaged in saving activities; and "Wikelena" (unity), a farming cooperative, among others. In many cases, these groups have their origins in historical forms of community cooperation and have been revitalized through CHC emphasis on collective action. However, CHC members did not indicate ways in which these groups and the CHCs work together.

In general, the linkages between CHCs and other community groups are sufficient to ensure that CHCs are integrated within community life and receive supportive oversight. Nonetheless, improved cooperation with a broader base of community groups could benefit CHC goals and sustainability. Likewise, continued integration with formal structures such as VDCs and PHUs for supportive oversight will help ensure progress can be maintained.

PILLARS OF SUCCESS



The preceding section reports that the community health club approach has been largely successful in improving health outcomes and bringing about numerous non-health benefits to the communities and region hosting the “For Di Pikin Dem Wel Bodi” child survival project. Given these strong indicators of success, this section attempts to identify why this project has worked so well when many similar projects have met with significant difficulties and challenges. In particular, since the CHC approach is currently being promoted and expanded both in Sierra Leone and across the globe, this section seeks to provide a basic understanding of what community characteristics and implementation strategies facilitate the establishment of a successful CHC program. Four key “pillars of success” are explored, including emphasis on community priorities, integration with existing community structures, staff and organizational commitments to community development, and coordination with the MOHS. Each of these pillars represents a critical element for project success; together they form the foundation of an effective and sustainable community health club project.

Emphasis on Community Priorities

A key reason that the CHC approach has been successful in Koinadugu District is that health was both a pressing need and a key priority for communities. In order to gain the widespread participation and enthusiasm necessary to make community development efforts successful, projects must address issues of deep importance to communities. As the struggles faced by many groups in gaining and sustaining health club membership attests, it is often not sufficient for health to be a pressing community need, it must also be a top priority.

In Koinadugu, child health was particularly poor, with more than one in four children dying before their fifth birthday. However, more importantly to CHC success, community members were particularly interested in improving children’s health and expressed great enthusiasm in the opportunity to gain health-related knowledge. Since much of the success of community-based health programs depends on the extent of community participation in the process (Easterling, Gallagher & Lodwick, 2003), community prioritization of health enabled success by attracting broad-based and enthusiastic participation. While other community-based projects in Sierra Leone have struggled with participation – some have reported community leaders coercing participation (WB, 2003) or community members participating only to receive access to other services (Bah, 1992) - the emphasis of the “For Di Pikin Dem Wel Bodi” project on a community priority helped to overcome these pitfalls, creating genuine interest, greater success and improved likelihood for sustainability. In addition, by focusing on a broad conception of health, the CHC approach was able to attract greater participation than more narrowly focused health promotion clubs.

While the CHC approach makes clear the importance of beginning community development through a community priority, it also reveals that successfully organizing communities around a particular issue has a vast array of spill-over benefits, leaving communities with stronger leadership, deeper cohesion, and more able to work together. For example, the success of the CHC has led community members to form other health promotion groups (such as groups for traditional birth attendants), to use groups to address other community needs, and to develop a broader understanding of the relationships between health and development more generally. Many communities are now more actively addressing other community development needs such as schools, transportation, and income generation. These experiences underline that once capacity for collective action is created, community members are

able to transfer these skills to address other needs and desires. Therefore, while CHCs may not always be the best entrée into community capacity building, health promotion does not have to be ignored just because a community prioritizes other issues, instead it can be incorporated as projects progress.

Integration with Existing Community Structures

A second pillar of CHC success in Koinadugu District is the integration of CHCs within existing community organizational structures. Relationships between CHCs, local leadership, and other community organizations increase CHC legitimacy, incorporate CHCs into broader development efforts, and provide a vital source of sustainability.

As previously described, CARE actively engaged traditional local leaders when initiating CHCs. Leaders described this as more than a cursory visit but as a genuine consultation. As the project progresses, CARE continues to meet regularly with traditional community leaders to keep them apprised of the project progress and their activities. By engaging traditional local leaders throughout the project, CARE has been able to gain vital leadership support for the project. More importantly however, by regularly reporting to leadership, CARE has conferred that it considers itself accountable to the community, which has contributed to traditional local leaders taking a greater sense of ownership in the project. As a result, local leaders are determined to see the CHCs succeed and involve themselves accordingly.

In addition to reporting to local leaders, CARE integrated the CHCs with other community organizations, most notably the Village Development Committees (VDCs). CARE worked closely with the VDCs, who were engaged not only as partners in the CHC process, but also as a monitoring and oversight body. To this end, CARE negotiated Memoranda of Understanding with VDCs on their roles and responsibilities related to CHCs and provided extensive leadership training to VDC members to ensure they had the capacity to uphold their duties. By transferring monitoring and oversight responsibility to another community organization, CARE was able to ensure a sustainable source of project oversight through peer monitoring. In addition, since VDCs are responsible for coordinating and overseeing all development activities within a community, by working with the VDC, CARE was able to integrate CHC activities more fully with overall community development. As a result, not only have CHCs and VDCs often undertaken complementary activities, but many aspects of the CHC approach – especially communal problem solving and decision making – are now integral across various development activities in many communities.

By integrating with the VDC and other relevant community institutions, CARE's CHC approach also helped to build vital social connectivity between citizens and local institutions. Fostering social capital through community group linkages is essential in addressing poverty, a key barrier to development generally and health specifically. CHCs are but one ingredient in improving community health; their relationship with local institutions will assure that barriers to good health and development are addressed simultaneously across many levels.

Staff and Organizational Commitment to Community Development

A third pillar of CHC success is staff and organizational commitment to community development principles. Many similar efforts have struggled with capacity building, often

increasingly turning toward reaching short-term health indicator targets since community empowerment efforts are inevitably challenging and slow to mobilize and sustain (Campbell, 2003). Indeed, short-term donor targets and the need to demonstrate progress often lead to a drift of program implementation style away from true capacity building toward less significant levels of participation (Edwards, 2004; Edwards & Hulme, 2004). However, CARE was able to maintain its emphasis on empowerment, skill transfer and capacity building, reflecting both an organizational commitment to these goals as well as highly trained staff. By maintaining this focus, CARE has maximized potential for long-term success and sustainability.

As an organization, CARE is committed to empowerment and building local capacity; reflected in their first programming principle: “Promote empowerment: We stand in solidarity with poor and marginalized people, and support their efforts to take control of their own lives and fulfill their rights, responsibilities and aspirations...” (CARE International, 2003:2). In fact, this principle is seen throughout CARE projects, and even within their organizational structure, where a succession plan is working to transfer an increasing number of managerial positions to local staff. Because CARE as an organization is so deeply committed to empowerment and capacity building, it is easier for projects, such as the “For Di Pikin Dem Wel Bodi” project to not lose sight of these goals in the pursuit of other health related indicators.

Indeed, in the “For Di Pikin Dem Wel Bodi” project, all levels of project management express deep commitment to creating sustainability by increasing community capacity. As the project nears its end, the clear focus has been on maximizing capacity building and leadership training. While target health indicators are of course important to the project, they have not been pursued at the expense of a hands-off community development approach.

The commitment to community development and empowerment is also ubiquitous among the field staff and field supervisors who work directly with communities. In all the CHC activities observed over the course of this research, the field personnel took on a supportive, rather than leadership role. Their hands-off approach reveals their genuine trust and faith in communities’ abilities that Alinsky (1971) indicates is critical for successful community development. Both extensive and regular staff training, as well as supportive direction from project management, has helped keep field staff focused on these targets. In addition, the training manual developed from this project (CARE International in Sierra Leone, 2005) helps reinforce this community development emphasis. Finally, for many of the field staff, all of which are Sierra Leonean, their own personal experiences have instilled in them the importance of community development and capacity building.

Together, CARE’s organizational priorities, “For Di Pikin Dem Wel Bodi” management focus, staff training, and field staff experiences have led to a deep focus on community development that has facilitated the project’s success. Through this commitment to community development, CARE has been able to achieve significant health progress, while also creating confidence among community members in their ability to maintain health activities without continued support from CARE.

Coordination with the MOHS

The “For Di Pikin Dem Wel Bodi” project’s coordination with the Ministry of Health and Sanitation (MOHS) at national and local levels is the fourth pillar of project success. Lessons from other community health projects have underlined the importance of the relationships

between the formal health sector and community health projects (see for example Kamchedzera, 2003). With improved relationships between communities and the MOHS a key project objective, CARE's "For Di Pikin Dem Wel Bodi" child survival project has actively engaged the MOHS from the local PHU level to the national level to streamline health promotion messages with available services, ensure availability of complementary resources, and reinforce the importance of CHC activities.

At the national policy level, the "For Di Pikin Dem Wel Bodi" child survival project fits within a national commitment to improve child and maternal health as well as an emphasis within national health policy on "promotion of community participation and involvement" (DACO, 2006b). As a result, while community members are learning through the CHCs that they are important actors in their health and the health of the community, doctors, nurses, and community health workers are also being trained on the value of community participation and community engagement. The "For Di Pikin Dem Wel Bodi" project has also coincided with a push at the national level to expand health services in Koinadugu District, ensuring that as communities became aware of the need for services such as vaccination and antenatal care, these were becoming increasingly available.

At the local level, CARE has helped to build strong relationships between CHCs and PHU staff. Building on the emphasis within the MOHS on community participation, CARE has been able to facilitate the creation of mutually beneficial relationships between the PHU and the CHCs. For the PHU, CHCs represent a cadre of trained outreach workers who are able to assist them by spreading and reinforcing prevention messages, bringing sick patients to the clinic, and ensuring attendance at antenatal and vaccination outreaches. The value of such strong relationships cannot be underestimated: a similar community-based health promotion program in Malawi found that community confidence and capacity were undermined when the community's attempts to assert their values and rights at government clinics were met with negative clinician attitudes toward peasants (Kamchedzera, 2003). In contrast, PHUs provides a continued stream of responsibilities and a valuable source of oversight and leadership to CHCs: regular meetings between CHC leadership and PHU staff provide a point of contact for CHCs to receive information and advice once CARE's project ends.

RECOMMENDATIONS



As reported in the findings section, the “For Di Pikin Dem Wel Bodi” has had significant impacts on community health as well as a variety of non-health benefits including cohesion, leadership, and capacity to undertake other development activities. Because the benefits have been so significant - particularly in terms of health, where many health indicators had already exceeded project targets by 2005 (Capps, 2006) – recommendations for improving this project focus on means to sustain and spread these benefits.

A first set of recommendations addresses issues to be considered or minor adjustments that can be carried out within the scope of the existing project (over the next 18 months). A second set of recommendations proposes other components that we felt could bolster the success of the “For Di Pikin Dem Wel Bodi” project if they were included as part of a potential follow-on project. Because these components are more substantial, we felt that 18 months was insufficient time to implement them sustainably, and that they thus merited consideration only with the additional time available to a subsequent project.

Next 18 Months

The “For Di Pikin Dem Wel Bodi” project management has already identified bolstering sustainability and leadership capacity as key goals in the final months of the project. Focusing primarily on these areas, we suggest four elements related to leadership and sustainability receive consideration and attention in the coming months. These include: working with leaders to develop positive motivation mechanisms, incorporating new members, extending leadership training to other community group leaders, and exploring opportunities to link CHC members with NGOs interested in the methodology.

Positive Motivation

In order for CHCs to continue meeting regularly, developing action plans, and embarking on activities, their leadership will need to motivate members to continue their voluntary involvement. Project field staff, community members, and partners such as PHU staff are confident that CHCs will be able to carry on even without CARE, although some did express concern that the level or extent of activity may decline. Community leaders, for example, mentioned that it can be more challenging to mobilize community members during certain times of the year, such as during the planting and harvesting season. There is also a risk that community members may become less interested in continuing their voluntary role if they reach a point where they feel they have already maximized benefits of their participation. Leaders’ provision of positive sources of motivation is essential to overcome these challenges.

Currently, CARE’s presence plays a key motivational role by providing periodic “special events.” For example, while CARE staff are no longer leading CHC meetings or activities, field staff continue to visit communities and observe CHCs. In addition, CARE occasionally brings outside visitors such as consultants, senior CARE leadership, or NGO partners to visit and observe CHC activities. These visits play an important role in maintaining community motivation – since community members are often eager to please and impress their mentors as well as visitors. For instance, community members delight in being introduced to foreign

visitors and, with great pride, arrive at meetings, certificate in hand, to have their photographs taken. When CARE's active project management ends, such "special events" will be less frequent, placing an added challenge on CHC leaders to keep enthusiasm for CHC participation from receding into the background of every day life.

When asked about how they maintain active participation, CHC leadership most often mentioned negative enforcement - such as fines or the intervention of the chief - rather than positive motivation. Yet, positive motivation can often be more successful in achieving desired results than punishments. Therefore, working with CHC leadership, VDCs, and other local leaders to recognize and implement culturally appropriate positive motivation mechanisms presents an opportunity to improve leadership and maximize project sustainability.

New Members

Another area that is worth addressing before the project ends, is a means to incorporate new members into the CHC. Currently, only those members who attended 80 percent or more of the initial CARE-taught CHC sessions are official CHC members with certificates. In most communities visited, it was difficult to find households without a CHC member. Indeed, community members indicated that just about every household was represented at the CHC. However, a handful of households were not represented, and, lacking a means to incorporate and certify additional CHC members, the proportion of non-CHC households can only increase. Since a key strength of the CHC is the level of representation, opportunities for incoming migrants, youth reaching age eligibility, and others who did not attend the initial sessions to become certified members is vital to maintaining broad-based and enthusiastic CHC participation.

While community members who are not CHC members are eligible to participate in CHC activities, and some communities indicated that such persons would even be able to vote at CHC meetings, these "non certified" participants may feel less engaged in the CHC process. Certificates have important symbolic value to community members. For many community members who have never been to school, CHC certificates are the first recognition of their achievement and knowledge; some CHC member's families traveled from as far as Freetown to attend the ceremony at which certificates were awarded. In addition, community members associate their certificates with a sense of responsibility; the Dogoloya CHC secretary explains: "when we received our certificates we were told the certificates came with a responsibility" to spread health messages and carry out CHC activities. Those without certificates may feel less committed or less responsible. Additionally, those who did not attend the first round of trainings may not have benefited from all the health information.

Since CARE will no longer be providing training or certificates, CHCs will need to develop their own means of training people who wish to become new members, recognize their achievement, and instill in them a sense of responsibility. During this leadership-building phase of the process, CARE should broach this topic with CHC leaders, allowing them to determine their own standards for incorporating new members (likely by establishing criteria for the number of lesson-based sessions that must be attended), and providing them with certificates or other symbols of their achievement and responsibility. CHC leaders will also need to consider how to cover costs of recognition materials - possibly through existing VS&L funds - and whether to use locally available and produced items, or to continue using certificates imported from Kabala.

Extend Leadership Training

CARE may also wish to consider extending opportunities for leadership training to existing community groups with which CARE is not officially affiliated. Though CARE is not working directly with these indigenous organizations, providing opportunities to build the capacity of their leadership is likely to provide spillover benefits to CHCs. First, strengthening overall community leadership will benefit CHCs by contributing to community development through more effective leadership, by creating a culture of strong leadership and good governance, and by providing leadership skills to people who may be the next generation of CHC leaders. In addition, other community groups represent potentially important partners for CHCs: in the future, CHCs may benefit from carrying out projects in conjunction with indigenous community groups, especially traditional farming groups which may be a vital resource in improving nutrition. Strengthening the leadership of these groups will help communities identify additional areas for collaboration and increase the formation of beneficial partnerships. Moreover, even those groups with which the CHCs do not work directly may be contributing to overall development in the community, with important benefits to health such as increased income and improved access to products and services.

Provide Opportunities for CHCs to be a Resource

With interest from other NGOs and the MOHS in the CHC methodology, it makes sense for CHC members themselves to be involved in the process of sharing their experiences. Expanding opportunities such as the one that allowed VDC members to cross-visit with the IRC child survival project in Kono would provide benefits to CHC members as well as other health sector stakeholders. For CHC members, the opportunity to engage with other health sector stakeholders would provide a sense of the importance of their achievements, bolstering their desire to sustain activities. More importantly, such opportunities would help CHCs begin creating a valuable network of contacts and resources for future support. CHCs would also gain important experience in describing their own accomplishments, a skill that would facilitate their organizational viability and capacity. Additionally, if given the opportunity to act as ambassadors for the CHC approach, CHC members could develop useful relationships (social capital) with other communities, allowing them to share experiences and learn from each other.

To this end, CARE should consider working with other health sector stakeholders to recognize the valuable knowledge held by CHC members, and encourage them to engage CHC members as ambassadors for the approach. As community members in Kabakeya explained, it can be a very empowering for people to learn from their peers; having seen progress made by people like them increased their confidence in their ability to create positive changes in their own lives. With this in mind, it makes sense for CHC members to be resources for other NGOs to tap when setting up their own CHCs. CARE can, in the next 18 months, lay the groundwork for such mutually beneficial relationships.

Follow-on projects

This report provides two recommendations for follow-on projects to complement current activities and scale up to higher levels of government. First, emphasizing the importance of linkages with the District Government for long-term sustainability, we suggest ways to link with the DHO while maintaining the current community emphasis. Second, given both the need and the demand for increased health education, we recommend means to make use of existing resources in the district to provide continued education.

Linkages with District Government

At its current stage, one of the key aims of the project is to assure sustainability. Evidence suggests that linking projects with government structures assures continuity of functions as governments assume responsibilities previously held by funders (Uquillas & Nieuwkoop, 2006; World Bank, 2005; Binswanger & Nguyen, 2004). In the case of community development projects, communities' assets in terms of existing social capital need to be complemented with the capacity to centralize management. Poor communities need to generate such ties extending beyond their initial areas, especially with formal organizations that are able to link local efforts with the resources and capacities from outside agencies (Woolcock 1998; Lopez & Stack 2001). Woolcock's (1998, 2001) conception of linking social capital - as the capacity to leverage resources, ideas and information from formal institutions beyond the community - is currently an agreed upon prerequisite for community development project scale-up (Binswanger & Nguyen, 2004; World Bank, 2005). As the transition from funders to government takes place, some elements need to be considered so that the new institution is able to absorb its new responsibilities in an orderly way. These elements are aligning program with district government procedures, maintaining community engagement at the district level, and investing in district level government capacity.

Align program with district government procedures

CARE has already started to pass on functions to VDCs. By project end in 2008, self-management at the village level expects to be fully institutionalized, however, sustainability as well as future scaling up depends more on the relationships with government at the district level than with VDCs. The World Bank gives a categorical example. Looking at the Bank's Africa portfolio during the 1994-1997 period, participatory approaches to development such as community development or integrated rural development projects had sub-optimal results. While 75 percent of the projects that had a community component were rated satisfactory (against 60 percent for all Africa projects); only one fifth passed the sustainability test (World Bank, 2000). One of the reasons was that projects were implemented in a vacuum, without further linkage to government agencies or beneficiary contributions, which made them solely donor dependent (World Bank, 2000; Uquillas and Nieuwkoop, 2006).

For CHCs, improved linkages with the district government will require steps to improve integration with the district health office. As the project transitions to this new phase, aligning procedures and forms of accountability to the current bureaucratic practices will allow a smooth transition. That is, the closer new activities are drawn to current bureaucratic practices, the easier it is to assure district governments will not face problems adapting to the new activities and implementing activities on time. For example, issues related to procurement or reporting

would need to be incorporated under the government's mechanisms. Similarly, timetables should be set according to the DHO's priorities and possibilities.

Maintain community engagement at the district level

As stated in the findings, "For Di Pikin Dem Wel Bodi" has had large impacts on empowerment and participation. As the project scales up, participatory practices should not be lost, especially since communities consider the project to be *theirs* and are eager to keep learning. Working with bureaucracies requires relationships that are more formal than those needed at the community level. Low literacy rates and difficulties arranging travel can present additional obstacles to dealing with district level government. Similarly, the watchdog role usually conferred to civil society may fail to materialize as citizens are not used to monitoring government activities. These limitations suggest that several communities, especially those farthest from Kabala, may not be able to develop relationships with the DHO. Villages closer to Kabala may have a more frequent contact with the DHO, enabling accountability and transparency to take place at the community level.

As mentioned before, informal relations need to become formalized to ensure certainty in the roles and responsibilities of every party. Issues such as transparency and social oversight are not an exception. Given that there is not a strong relationship between state and civil society in Sierra Leone, responsiveness, accountability and transparency must be induced and 'institutionalized' to work efficiently. For example, a formal committee may be established between the DHO and VDC members from nearby villages to start a relationship and formalize practices of accountability. Monthly meetings could take place to develop a formal relationship. Similarly, monitoring and evaluation reports from the DHO could be distributed to VDC leaders to disseminate the improvements in terms of health outcomes. The impact of such meetings would serve a dual purpose for communities: First, it would assure that obligations from the VDCs to the DHO (such as reporting) are permanently monitored. Secondly, it would create a system of downward accountability that could generate practices of citizen engagement with government. Formalizing this relationship would imply sustaining CARE's objective to seek "enhanced community capacity to form groups and institutions that sustain health initiatives, demonstrate social cohesion, and promote good governance mechanisms" (Murima et al., 2004).

One of the mechanisms to allow for a more formal relationship between district government and communities may be through participatory monitoring and evaluation (PM&E). PM&E is a process through which "stakeholders at various levels engage in monitoring or evaluating a particular project, program or policy, share control over the content, the process and the results of the M&E activity and engage in taking or identifying corrective actions. PM&E focuses on the active engagement of primary stakeholders" (World Bank, n.d.). The important element to keep in mind is that stakeholders become participants rather than sources of information. This process builds additional capacities and generates commitments at the local level. Villagers themselves would spot the problems during the progress of specific activities and would feel the incentive to make the necessary corrections.

Invest in capacity building at the district government level

Capacity building also needs to be addressed at the district level. As villagers were trained on participatory processes and transparency, capacity building to the DHO will counterbalance the demand for good governance with supply of public goods. This can be done

either through a follow-on project in which district governments receive additional trainings, or through partnerships with NGOs capable of providing government support. In any case, the current vision of transferring responsibilities to the DHO and slowly backing off should continue.

Given the impact of “For Di Pikin Dem Wel Bodi” and the growing interest of the NGO sector in Sierra Leone to replicate its methodology, linking community needs with NGO supply should also be prioritized. Synergy must not only exist between local communities and district government: relationships between local communities and external and more extensive groups, such as NGOs are also crucial, especially to build capacities among communities and provide a solid network to market the success of this project to the NGO community.

Opportunities for Continued Education

Continuing education is both a community priority and a means to expand upon the widespread success of the “For Di Pikin Dem Wel Bodi” project. During the focus group interview with the VDC in Yiffin, a member asked the team if they had anything to teach or share with the VDC. The VDC Chairman thanked CARE for the knowledge they had been given and the decrease in maternal mortality that has been a result. He went on to say that the community valued opportunities for further knowledge and training. This desire for continued knowledge was consistent across communities; while communities felt they had learned the leadership and organization necessary to undertake health related activities, they wanted more knowledge to increase the scope of their work. Literacy training, radio program and collaboration with Universities could help tap into local resources to meet this demand and enhance existing project benefits.

Literacy

First, a project that focused on adult literacy training could have a dramatic effect on increasing health outcomes. The past decade of war and resulting migration disrupted education and dramatically decreased levels of literacy. Most CHC members are not literate. However, research has shown that improved maternal literacy has a strong positive effect on child health, because parents become more effective users of their health system as their literacy levels improve (Monsen, 2007). Higher levels of schooling for girls and women have been found to correlate with increased obstetric survival (CORE Group, 2004). Given that Sierra Leone has among the highest maternal mortality rates in the world, improved literacy could be a valuable complement to the “For Di Pikin Dem Wel Bodi” project’s health promotion emphasis.

In keeping with the current hands-off community development emphasis of CARE’s work in the region, opportunities for literacy training could be built upon existing resources. For example, CARE could provide a minimal level of support to enable implementation of a literacy program within the CHCs. Literate CHC members, or others in the community, perhaps jointly with the education system, could provide literacy lessons to community members. Many community groups in Latin America have met with great success providing adult literacy using the same participatory methods employed in the CHC training (Healy, 2001). Such resources may be valuable in the design of such a program.

Radio Programming

As the CHCs continue their rollout efforts, they will be faced with the challenge of overcoming potential dilution of health messages inherent in the train-the-trainer process. PHU staff will play an important role in maintaining health information accuracy, but with the large number of communities under their care, outside support is also necessary. One source of support is radio programming. Many CHC members indicated the usefulness of the Radio Bintumani and Talking Drum Studio radio programming currently provided. Extending radio programs would therefore be of value. Providing sources of continuation and expansion of radio programming with new information could meet community desire for increased knowledge.

Institutional Collaboration

Another potential resource for continuing education is through institutional collaboration. Partnerships with local universities could help create internship programs for students interested in providing classes for communities. At present, CARE works with several public health student interns. Working to incorporate other academic fields such as medical residents or nurses would help to familiarize soon-to-graduate medical personnel with the needs and opportunities in outlying districts as well as provide the newest in health information to the communities. By focusing on building partnerships with local universities, CARE could transfer the management of the internship program to the universities themselves.

CONCLUSIONS



The team's assessment of the "For Di Pikim Dem Wel Bodi" project shows that CHCs are an effective method to meet CARE's objectives: people demonstrated substantive knowledge of health issues, and participatory practices were prevalent across the CHCs. Additionally, annual project reports show considerable improvements in health indicators, in some cases surpassing the targets. While other indicators are harder to measure, the team's qualitative interviews showed that CARE's inclusive approach to CHCs is affecting behavior in the areas of health and governance.

The team's research shows that CHCs have an impact across communities due to their inclusivity. Surveys and interviews affirm that most households have a CHC member and, more importantly, CHC impacts benefit communities as a whole. CHCs are currently bringing about a multitude of positive change, as the activities initiated by their members are practiced at the community level. Not only have health indicators changed, but more importantly, village member's *perceptions* of their capacity have increased; they feel more able to control disease and improve their lives. Village members are able to recognize and respond to common diseases. More importantly, they are taking action to prevent disease and sharing what they have learned with other communities.

Good governance elements such as community cohesion and transparency are often seen as separate aspects of projects, but CARE has included them as key priorities and essential elements for improving health. Success in health outcomes has been a product of CARE's inducement of participatory and gender-inclusive practices. Following the learning-by-doing perspective of knowledge transfer, people embraced these lessons, building cohesion and making communities catalysts of improved health. While leadership and linkages with other organizations could be further strengthened, community development as a whole has benefited from this project. Communities now undertake a broad range of self-initiated activities; feel united and more aware of their own capacity to overcome challenges.

This report's 'Pillars for Success' provide an avenue for future design considerations. Four pillars – emphasis on community priorities, integration, organizational commitment and coordination with government – emerged from this research as the project's foundations. While there are several other elements that contributed to the success of this project, they all seemed to stem from these four macro principles, which were mentioned recurrently by beneficiaries and project staff.

As the project implements its exit strategy, certain design elements that were implemented from the start, such as forging good relations with the VDCs and transferring decision-making capacities to the beneficiaries, will provide the necessary basis for sustainability. The current exit strategy builds upon the capacities already created as it seeks to integrate autonomous communities with the district government. In that sense, sustainability was forged from the start of the project and was not seen as a separate component of the project during its final phase.

In the remaining 18 months before the project comes to an end, sustainability should be the project's focus – with an emphasis on opportunities to strengthen leadership. Looking to the future, efficient management will lie in the hands of district and central government, necessitating efforts to integrate CHCs with these formal institutions. Opportunities to expand and continue health promotion activities will also bring benefits to CHC communities.

Overall, the team felt the widespread success of the “For Di Pikin Dem Wel Bodi” project, and the enthusiastic manner in which community members affirmed the role of CHCs in improving their health and their lives more generally, affirms the potential of CHCs as an effective health promotion methodology. While potential for sustainability can be very difficult to measure, the high levels of participation, strong evidence of skills transfer, and support from within the MOHS provide strong indicators that CHCs will continue to be active in many communities well into the future. Efforts to reproduce the success of project should emphasize coordination with government, integration with community structures, and community development. Of course, given that community members themselves form the foundation of this success story, future efforts should ensure that they are addressing true community priorities.

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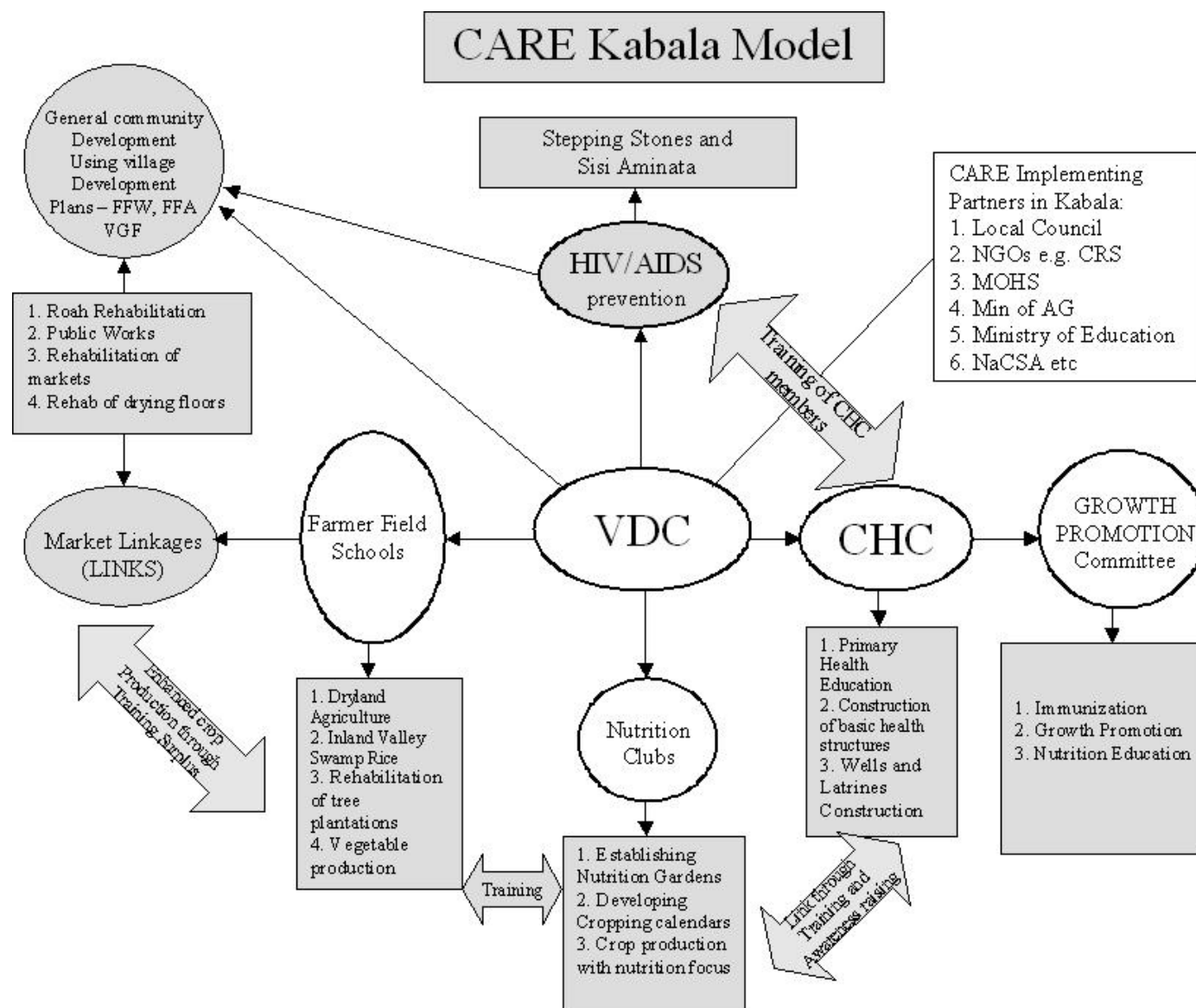
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APPENDICES





Interview Guide for Select CHC Members

1. Why did you decide to participate in the CHC?
2. Does anyone else from your family participate?
3. How did the CHC come to be established in your village?
 - a. How was the idea broached with local leadership? With the community?
 - b. Did the leadership/community make suggestions?
 - c. If so, how were these suggestions received?
4. What kinds of things does the CHC do?
 - a. Who participates?
 - b. Who manages on a day-to-day basis?
5. What have you learned from the CHC?
 - a. Health lessons
 - b. Organizational skills
 - c. Leadership
6. Has participating in the CHC changed the ways you take care of yourself? Your children? How?
7. Do you think the CHC has benefited your family? the village? How?
 - a. Health?
 - b. Access to health services?
 - c. Gender relations?
 - d. Organizational skills?
 - e. Leadership?
8. What happens when someone completes CHC training?
 - a. Tell me about some of the graduates and what they are doing.
 - b. Are there any examples of graduates organizing other activities?
9. Are you happy with the activities of the CHC?
 - a. Do you have any health concerns or notice any health problems in your family or the community that the CHC has not addressed?
 - b. Have you ever made a suggestion to improve the CHC? What about other CHC members?
10. Tell me about the facilitator/leader and project staff.
 - a. What do you think about staff?
 - b. What is your relationship like?
11. Do you think you could continue the activities of the CHC with less help from facilitators and staff?
12. Has the CHC ever decided to take on a new project?
 - a. Who's idea was the project?
 - b. Who implemented it?
 - c. What kind of help did the facilitator or staff provide?
13. Does the CHC ever work with the VDC?
 - a. If so, what types of things have they done recently?
 - b. Whose idea was the project?
 - c. Who implemented the project?
 - d. What types of other things (not related to the CHC) has the VDC done recently?

14. What other community groups work the area
 - a. Name?
 - b. Have you participated in any over the past year?
 - c. Has anyone else in your family participated? Who?
 - d. What do they do?
 - e. How many members?
 - f. How long have they been active?
 - g. Who Participates? Leads?
 - h. Does the CHC ever work with them?
 - i. Does the CHC ever work with a CHC in another village?
 - j. What kinds of things do they do?
15. How does the CHC interact with other groups in the community?
 - a. Which groups does it work with?
 - b. What kinds of things do they do together?
 - c. What are the relationships like?
 - d. Has the CHC impacted the way other groups are organized, for example, by boosting female participation in VDCs?
16. What types of people are leaders in the community?
 - a. Men/Women
 - b. Elders/Youth
 - c. Specific ethnicities, etc
17. Have the types of people that take on leadership roles changed recently? If so, do you think this is because of CHCs?
 - a. Are more women participating in the decisions of the village since the CHCs were established?
 - b. Are more youth participating in the decisions of the village since the CHCs were established?
18. Do you participate in more in community activities since the CHC began? If so, do you think this is because of your CHC participation?
19. Since participating in the CHC, do you feel more confident to (play an active role) be active in community decision-making?
20. Is there anything else you would like to share about the CHC or health in your community?

Interview Guide for VDC or Other Community Group Leaders

1. Tell me a little bit about _____[your organization]
 - a. What is the purpose of the group?
 - b. How many members does _____ have?
 - c. What kinds of people participate?
 - i. Are there membership rules
 - ii. Is it voluntary or elected
 - d. How are decisions made in _____
2. Tell me a little about some of the activities _____ has undertaken in the past or has planned.
 - a. What need does the project address/what problem does it work to change
 - b. Why was the project selected
 - c. How was the project decided on
 - d. What is/was the plan to make this happen
3. Does the _____ ever work with the CHC?
 - a. If so, what types of things have they done recently?
 - i. Whose idea was the project?
 - ii. Who led the project?
 - iii. What was the purpose?
 - iv. How would you describe the nature of the relationship between the _____ and the CHC?
 - v. Are you pleased with the CHC?
 - b. If not, does your group have any interest in working with the CHC? Why or why not?
4. Does the _____ ever work with other groups in the community?
 - a. If so, what types of things have they done recently?
 - b. What was the purpose
 - c. Whose idea was the project?
 - d. Who led the project?
 - e. How would you describe the nature of the relationship between the _____ and the _____?
5. Have you noticed any changes in the community since the CHCs began working?
 - a. Has your organization changed at all?
 - i. Types things they do?
 - ii. Membership rules?
 - iii. Participation of women?
 - b. Have you noticed any changes in the way different community groups interact or work together?
 - c. Have you noticed any changes at the peripheral health unit?
 - d. Have you noticed any changes in community practices or health?
 - e. Do you think the CHC has benefited the community?

Interview Guide for Community Members in non-CHC Communities

1. What kinds of groups work in the community to address community needs?
 - a. What kinds of things do they do?
 - b. Do any address health issues?
 - c. Who participates?
2. Have you ever participated in a community group?
 - a. Organization: _____
 - b. Do you currently participate?
 - c. What kinds of things do they do
3. Have you ever gotten together with other community members to give a solution to a local problem? If not, do you feel able to do something like that?
4. Do you think community groups are taking care of community health needs?
 - a. What kinds of things does the VDC do?
 - b. What other projects are being worked on?
5. Have you noticed any changes in health in the community recently?
 - a. What about gender roles?
 - b. Other areas?
6. Tell me a little bit about your family's health
 - a. How did you learn about caring for yourself/children?
 - b. Do you feel like you know a lot about keeping your family healthy?
 - c. In your family, who makes health decisions?
 - d. Do you use the PHU? What do you think of it?
7. Do you know about the CHC in _____? Tell me a little about what you know about it.
 - a. Do you know anyone who participates in the CHC? Have they ever told you anything about it? If so, what?
 - b. Would you be interesting in joining a CHC if one was formed in this community? Why or why not?
8. Is there anything else you would like to share about your community or family's health?

Survey for non-CHC members

Approximate Age:

Gender:

Marriage status:

Number of children:

- In your family, who makes decisions on health issues?

Husband	Wife	Both
---------	------	------
- (women only) Do you feel that you can make decisions within your family outside of health issues, such as in the handling of expenses or in your children's education?

Yes	No
-----	----
- (men only) Do you feel your wife has participation in the decisions for the health of your child?

Yes	Somewhat	No
-----	----------	----
- (men only) Do you feel that your wife can make decisions within your family outside of health issues, such as in the handling of expenses or in your children's education?

Yes	Somewhat	No
-----	----------	----
- Do your sons go to school?

Yes	No
-----	----
- Do your daughters go to school?

Yes	No
-----	----
- Do you feel confident to play an active role in community decision-making?

Yes	Somewhat	No
-----	----------	----
- Who makes the decisions about the things that happen in your community?

Anyone can participate	Only certain people participate
------------------------	---------------------------------
- Have you ever gotten together with other community members to give a solution to a local problem?

Yes	No
-----	----
- Do you think you could organize a project with other people in the community if you noticed something that could be improved?

No	Yes
----	-----
- How do you feel about the service at the Periphery Health Units?

Poor	Fair	Good	Excellent
------	------	------	-----------
- Have you heard of the CHC?

Yes	No
-----	----

 - Do you know anyone who participates in the CHC

Yes	No
-----	----

- Why don't you participate? (As many as applicable)
 - Not interested
 - Meeting time not convenient
 - Meetings too frequent
 - Too far from home
 - Husband/wife already attends
 - Husband/wife doesn't want me to go
 - No time
 - Don't feel welcome
 - Other _____
- Have you noticed any changes in the community since the CHC became active?
(as many as they mention)
 - Better health
 - More girls in school
 - More community groups
 - Higher levels of community cooperation
 - Better service at PHU
 - Improved confidence
- Have you ever participated in another group/organization?
 - How many? _____
 - Organization: _____
 - Do you currently participate?