Santénet2: Training and Supporting Community Health Workers in Challenging Conditions in Madagascar

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Background

Santénet2, known locally as *KM Salama*, comprises the fourth phase of a USAID-funded community health project running from 2008-2013. Santénet2, led by RTI International, contributes to the achievement of the USAID Strategic Objective 5 (SO 5): "Increased use of specific health services and products and improvement of practices." IntraHealth's role on the SantéNet2 project focuses on quality improvement, training, supervision, and strategic results.

The scale of the project is vast, covering 800 communes throughout Madagascar and involving nearly 11,000 community health workers (CHWs) known locally as *agents communautaires* (ACs). Chosen by the *fokontany* or village council, the CHWs are usually people who are respected in the community and who can read and write. There are two types of CHWs: CHWs who focus on mothers and work to improve reproductive health, family planning, and safe motherhood (referred to as "mother CHWs" in this document); and CHWs who focus on children and carry out integrated management of childhood illness (IMCI) and nutritional monitoring (referred to as "child CHWs" in this document).

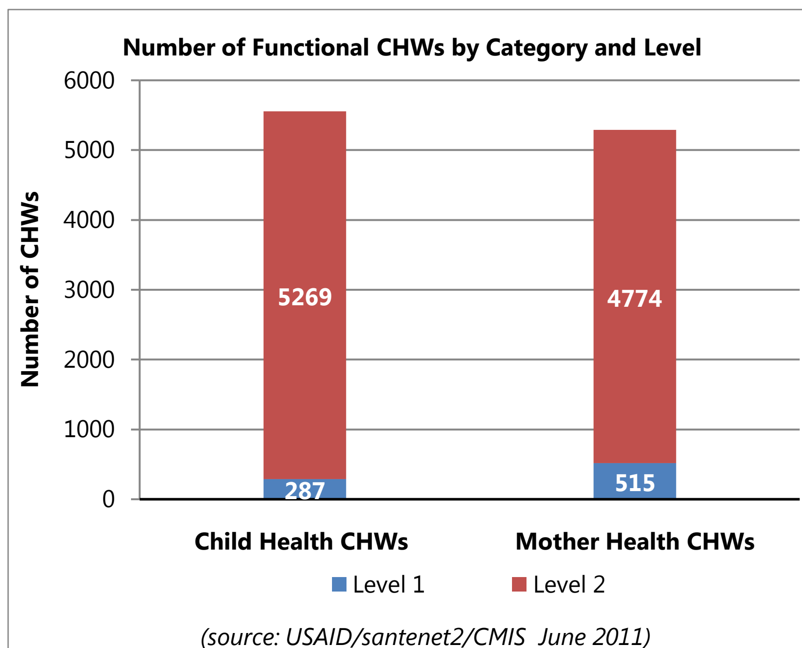
KM Salama Community Health System Strengthening Strategy

- Rapid scale-up of CHWs
- Empower community leadership
- Meet unmet need and generate new demand through multiple communication channels
- Institute high-quality, integrated package of health service and expand access to remote communities
- Pilot test innovations (services and systems) and integrate new best practices
- Sustain quality of community systems

Both groups of CHWs work on issues relating to hygiene and Community Led Total Sanitation (CLTS). Each type of CHW has two levels that allow the CHWs to take on their full roles in stages as described in the table below.

CHW	Level 1 community based services	Level 2
Child health	• Nutrition: Essential actions in nutrition, growth monitoring, malnutrition screening and referral. • IEC/BCC: vaccinations, seeking early treatment, insecticide-treated bed net (ITN) use, safe water, intermittent preventive treatment of malaria during pregnancy (IPTp) promotion • Micronutrient supplementation, including deworming, vitamin A, and iodized salt	All level 1 tasks + • Treatment of malaria, pneumonia, diarrhea
Mother health	• Quality antenatal care, including referrals and distribution of iron folic acid (IFA) • Promotion of good nutrition for women and children, including immediate and exclusive breastfeeding for a duration of 24 months, access to products during mother and child health week • FP: counseling, oral contraceptives, condom distribution and post-partum obstetric care, SDM, and LAM • IEC/BCC: vaccinations, seeking early treatment, ITN use, safe water, IPTp promotion	All level 1 tasks + • FP—depot-medroxy-progesterone acetate (DMPA)

Most level 1 CHWs for both maternal and child health have been upgraded to level 2.



The CHWs are supported by a technical assistant from one of the project's 16 nongovernmental organization (NGO) implementing partners and by the health center manager of the local basic health center. In addition, each commune has a social development committee which orients the CHWs and mobilizes the community to support their work.

Throughout a large part of Madagascar, hilly and mountainous terrain abounds, and villagers live in small, widely scattered hamlets often just comprising a few houses. Hamlets making up the *fokontany* may be many kilometers apart; and to travel from the *fokontany* itself to the basic health center may require walking hours or even days. This makes health care provision, and direct supervision of the CHWs, very challenging. Most villagers practice the Christian religion (both Protestant and Catholic) but combine it with very strong local animist beliefs which can influence beliefs about illness causation and health care decision-making.

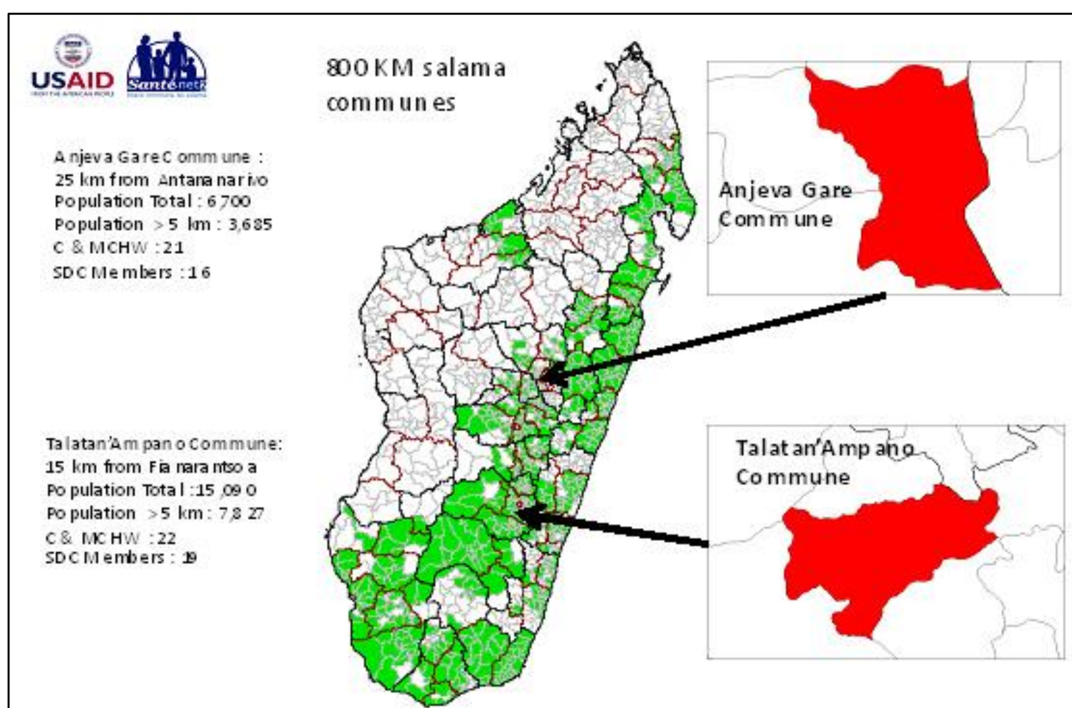
Source: Sarah Castle, Consultant, IntraHealth

METHODOLOGY

In June 2011, qualitative research was carried out to look at the following issues:

- Strengths and weaknesses of the CHW training program
- Client satisfaction
- Effectiveness of current and suggested supervision systems
- Capacity building among community stakeholders and local NGO partners
- Issues relating to sustainability.

Villages in communes of Anjeva Gare (just half an hour from Antananarivo, Madagascar's capital, were involved in the research as well as villages in the commune of Talata Ampano in the region of Fianarantsoa, a mountainous area over eight hours drive from Antananarivo.



Source: RTI/ USAID Santénet2/CMIS

The methodology involved focus group discussions with two sets of mother CHWs and two sets of child CHWs, male and female clients, as well as an additional discussion with the social development committee members. In addition, in-depth individual interviews were carried out with four trainers (who also act as supervisors), one NGO technical assistant, a representative leader of a partner NGO, two community leaders, the director of health at the district level and a representative from Santénet2. Informed consent was obtained for all interviews which were recorded in Malagasy and transcribed in French.

TRAINING

Strengths of the Training

Before the CHW training, Santénet2 revised all training curricula (training of trainers, training for CHW levels 1 and 2) in line with national service guidelines using the Learning for Performance methodology. The Learning for Performance methodology tailors the training materials to trainees' specific needs. A training/supervision strategy was also developed at this time. The training and supervision strategy is woven into the overall KM Salama approach that aims to help communities increase ownership and build capacity to address their health needs.

The project identified 410 trainers to strengthen the capacity of CHWs in KM Salama. Among the 410 trainers, 398 have been trained in adult education, 233 in IMCI and/or Depocom, and 262 in supervision skills. The trainers trained:

- 5,289 mother CHWs in integrated family planning/reproductive health (level 1)
- 4,774 mother CHWs in injectable contraceptive delivery (level 2)
- 5,556 child CHWs in child health/nutrition (level 1)
- 5,269 child CHWs in IMCI (level 2).

The CHWs undergo five days of intensive training during which they are taught basic preventive and curative health care skills and record keeping. In addition, the level 2 mother CHWs are taught how to give the injectable contraceptive Depo Provera. The level 2 child CHWs are taught to treat child illnesses, including malaria, after diagnosing it with the rapid diagnostic test. Both groups are taught the importance of respectfully welcoming their clients and of maintaining confidentiality.

Source: Sarah Castle, Consultant, IntraHealth

The interviews revealed that the CHWs had gained considerable technical skills and were familiar with simple medical equipment such as the timers used to monitor infant breathing. The CHWs were able to successfully record consultations and referrals and had learned when to treat patients and when to refer them to the local basic health center. They were able to clearly articulate the knowledge and skills they brought away from the training.

For me, what was very important was that I became able to treat children. After having received the training, I know if I have to send them to the health center or treat them on the spot.
—Male child CHW, 40 years old, secondary education, Anjeva Gare

For me the strong point [of the training] was that we were shown how to give Depo Provera injections because normally women have to wait in line at the hospital, and they are all employed and in a hurry to get to work. It is very good that we know how to give this injection. It is a strong point.
—Female mother CHW, 51 years old, secondary education, Anjeva Gare

For me, after having received the training, the community then trusted me, and I would say that, for them, my house has become a little hospital. Parents don't go to the real hospital unless I refer them, and that only happens if I can't help them here. The community has confidence in me, and they come if the child is sick, even at night.
—Male child CHW, 49 years old, secondary education, Talata Ampano

Weaknesses of the Training

Despite the strengths of the training, the CHWs also expressed some concerns about the training; principally that it was too short.

The training is really short. Because if you compare us with doctors, they have had a longer training. We are asking for it to be prolonged so that we can better convince people—because they say, 'You've only been trained for a short time, and you're already doing that?!' The duration is short. It should be longer.
—Female mother CHW, 52 years old, secondary education, Anjeva Gare

They also complained that the quality of the paper on which the materials was printed was poor and often ripped.

The training manuals we were given get torn easily because we have to have them with us at all times—for example, when we visit people at home. The cover is very delicate and when it gets torn, we have to repair it with Scotch tape because most of the time it rips easily.
—Female child CHW, 40 years old, secondary education, Anjeva Gare

However, most of the trainers themselves were convinced that training length was appropriate. In their view, the perception of the short duration was because, in some cases, villagers appeared to confuse the CHWs with doctors and were skeptical that they could have learned enough to treat people in just five days.

The community will think as follows: 'You've only studied for this short time, and you are going to be a doctor to treat our children?' It is an issue, but it's not really a barrier as they are pleased that the CHW is so nearby.
—Male trainer, 49 years old, university education, Fianarantsoa

By contrast, the trainers were concerned about other issues such as the fact that the curriculum used to give CHWs skills to address rumors about family planning (such as that it makes you infertile or that it gives you cancer), but now these sessions have been removed.

> *There was a section called 'Rumors about family planning' in the previous curriculum, but it has been taken out. But when we do the training, we address this subject so that the CHW can challenge the rumors because they do exist, and we can't ignore them.*
> —Female trainer, 67 years old, high school education, Fianarantsoa

The trainers nearly all complained that there is a widespread problem with the CHWs' lack of schooling. In some cases nepotism means that a CHW is nominated who might not have the required level of education. In other cases, the lack of schooling is so widespread that there are simply no potential CHWs who can read and write properly.

> *For example, if they cannot read or write, they can't follow along as there are a lot of exercises to do during the training. If they can't read or write, then we lose time because the others have to wait for them.*
> —Female trainer, 50 years old, university education, Antananarivo

Programmatic Challenges

This research showed that there are four main programmatic challenges. First, child CHWs do not have enough scales for baby weighing—an activity that mothers like and which brings them into contact with the health workers on a regular basis. CHWs had to collaborate with community nutrition workers from SEECALINE (a community based nutrition program funded by the World Bank) to borrow scales, but this was unsatisfactory and frequently meant that infants could not be weighed. This, in turn, discouraged the mothers who had often trekked long distances for a consultation.

> *We have to give our scales to the CHWs who live farthest away, and then we have a problem because for us to look after children we need the scales. Some women go and get weighed at SEECALINE, but when their agent is absent the women just go back home because they can't be seen, and it bothers them.*
> —Female child CHW, 44 years old, secondary education, Talata Ampano

The second problem concerned stockouts of essential medicines which not only meant that clients could not be treated but it also undermined the credibility of the project in the eyes of the community.

> *There are also times when there are stockouts of medicines, and this has given us great problems with the people we look after. They are not happy because we referred them to the health center. We are asking you not to interrupt the supply of medicines but rather to ensure that it is continuous.*
> —Female mother CHW, 37 years old, high school education, Anjeva Gare

The third problem was that in many villages there was no locale for the CHWs to see their clients, and many received them in their own homes. This was unsatisfactory in terms of clients' confidentiality and privacy as well as potentially exposing CHWs' family members to infectious disease.

Source: Sarah Castle, Consultant, IntraHealth

Because we don't have a center, we receive people in our own homes. For example, because we only have one room which serves as both a kitchen and a bedroom, it is really not suitable to receive patients. It can bother those who come to see us—they say, 'Oh we're being seen in someone's house.' We would like a proper office where we can see our clients.
—Female mother CHW, 37 years old, high school education, Anjeva Gare

In some other villages throughout Madagascar, social development committees have encouraged villagers to build a separate health hut where consultations take place discreetly. This was considered an in-kind contribution to the project and reflected local commitment to supporting the CHWs and their work.

The fourth problem was that the current set-up creates a division between maternal and child health when in fact there should be a holistic approach. Mother CHWs have even requested to receive the training of the child CHWs. Not only would a holistic approach allow for maximum use of services (for example, women coming for baby weighing could be sensitized about family planning) but would also increase the value of the CHWs in the eyes of the community. Some villagers have doubted the CHW's competence if, for example, a mother CHW was not able to address an issue relating to child health and vice versa.

> *Learning how to manage childbirth is our wish, and we would like to be trained in this. Once, in my village, my sister-in-law was about to give birth, and they called me but when I arrived she had already delivered. I was afraid and asked myself, 'What am I supposed to do?' I was ashamed because I am a health worker, and I didn't even know how to deal with the umbilical cord.*
> —Female child CHW, 42 years old, secondary education, Anjeva Gare

Project's Impact

The program appeared to have had an impact in three main areas. First, there was a direct impact on maternal and child health. Villagers perceived that the following health-related phenomena were a direct result of the program:

- Fewer births
- Fewer closely spaced births
- Fewer abortions
- Better management of the umbilical cord

- More exclusive breastfeeding
- Fewer childhood illnesses
- Better management of childhood illnesses
- Fewer child deaths.

At the time of the harvest in April-May, fevers are very widespread among children. Before, the child would die after two days. Now the fever may last up to four days, but then the child gets better. You see, even if we don't have the statistics, we can see 'echoes' of the project. Diarrhea was also very frequent among children during the rainy season, but we see that it is now less frequent. There still is some, but it is less than before. Now if someone is ill, when mothers and fathers go and see the CHW, they get help. They either get advice as to how to treat the child or the recommendation to go to the health center.
—Male client, 48 years old, primary education, Talata Ampano

[The impact has been] on maternal and child health. It is in these areas that I have noticed the biggest impact. The number of children hospitalized has decreased, and the number of women using family planning has increased. . . . When I have discussions with the doctor, this is what we remark on.
—Deputy mayor, Anjeva Gare

Further epidemiological evidence is needed to support these claims, but the table below shows data that illustrates an increased use of services for malaria treatment and family planning in KM Salama communes and a decrease in cases of diarrhea. The fact that the project beneficiaries perceive these changes indicates that the project is indeed likely to be addressing morbidity and diminishing mortality in the communities it serves.

Indicator	2008			2010			
	NATIONAL (A)	800 KMs (B)	(B)/(A) 100%	NATIONAL (A)	800 KMs (B)	(B)/(A) 100%	CHWs
Number of cases of malaria in children <5 years treated by the health center	117,030	21,789	19%	97,940	25,946	26%	**25,747**
Number of cases of diarrhea in children <5 years supported by the health center	306,255	150,706	49%	299,991	110,650	37%	**17,584**
Number of family planning users of all methods	1,076,642	685,848	64%	1,300,915	831,754	64%	**27,912**
Contraceptive coverage rate	23%	21%	N/A	26%	25%	N/A	**28%**

A second main impact, as referenced by the male client cited above, is that the time to seek treatment has been greatly reduced. Before the arrival of KM Salama, mothers tended to delay seeking treatment for sick children because of the long walk to get services.

> *With regard to illnesses, we no longer wait until the illness gets serious, but as soon as the illness starts, for example a fever or headache, we immediately go and consult the CHW.*
> —Female client, 32 years old, primary schooling, Fianarantsoa

Third, there appeared to have been an improvement in general well-being, economic production, and community development. CHWs saw this directly related to the use of family planning, which left both spouses able to work without being encumbered by children.

> *For example, a mother who uses injectable contraceptives does not fall ill. She is in good health, and she can look after her children properly as well as her husband. There is no sickness. They are all in better health.*
> —Mother CHW, 37 years old, high school education, Anjeva Gare

> *Since we started working as CHWs, I have noticed that there has been a reduction in poverty as both the mother and the father can earn money because the woman uses family planning.*
> —Mother CHW, 43 years old, primary schooling, Talata Ampano

Program's Effect on CHWs' Behavior and Status

The fact that the CHWs had been recruited as health workers appeared to increase their respect and influence, improve their community status and communication skills, and increase the likelihood of villagers' imitating the CHWs' behavior and/or living arrangements—for example, by constructing latrines.

> *We occupy an important place in the village—being a CHW is really something special! It is as if we are among the VIPs. It's really wonderful! We are distinguished people in the community. For me personally, whenever anyone has even a little health problem they say, 'Mrs. CHW, here is what's wrong!' The fact I was trained is really satisfying. I get great pleasure from being respected in the community.*
> —Female child CHW, 42 years old, secondary education, Anjeva Gare

> *We are happy because the mothers are able to ask us everything. People have called me 'little doctor.' They really trust me!*
> —Female mother CHW, 41 years old, secondary education, Talata Ampano

> *Before I wasn't able to tell the mothers to take their children to the health center . . . but now I can talk to them openly.*
> —Female mother CHW, 42 years old, secondary education, Talata Ampano

ISSUE OF CHW REMUNERATION

The CHWs are not paid for their work although they do receive small financial benefits from the products they sell (family planning, water purifying solution, anti-malaria treatment etc.), but some perceived the lack of payment as a problem.

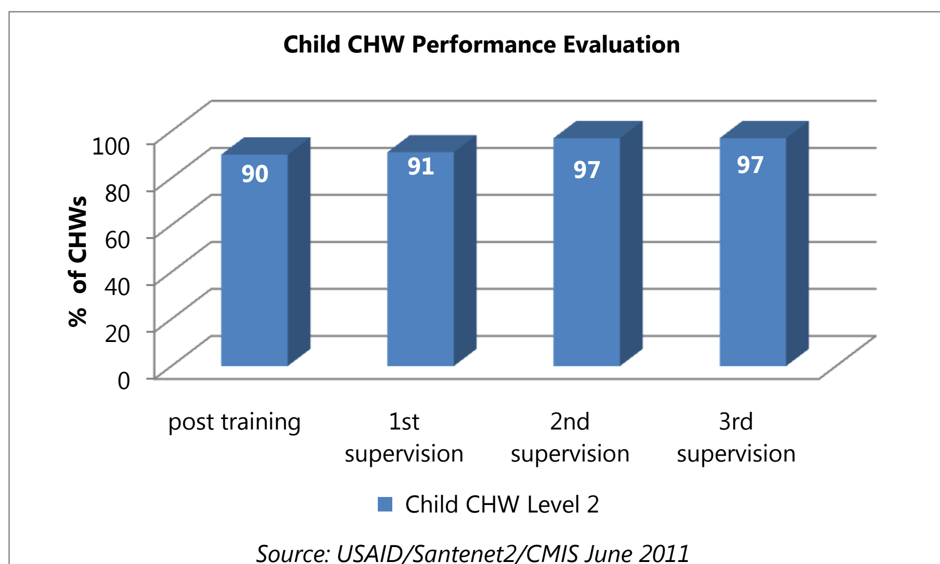
> *The obstacle is the lack of money because if we go out to sensitize, as mothers, with life being so difficult right now you have to help your husband earn money. But sometimes doing the sensitization is not enough, and earning a living takes priority. We want to be paid for our work, and in this way we can include it in the way we plan out time.*
> —Female mother CHW, 51 years old, secondary education, Anjeva Gare

This was particularly an issue in Fianarantsoa where agents from SEECALINE, community program addressing nutritional problems in the same area, are paid monthly salaries. Nevertheless, there was a general feeling that the CHWs could be recompensed in other ways by the community, and to initiate a payment system would be a barrier to sustainability. Compensation might instead take the form of the village cultivating the CHWs' fields for them and helping CHWs' out with other types of agricultural labor. Alternatively, they could be enrolled for free in the local health insurance system and thus receive free health care at the health center.

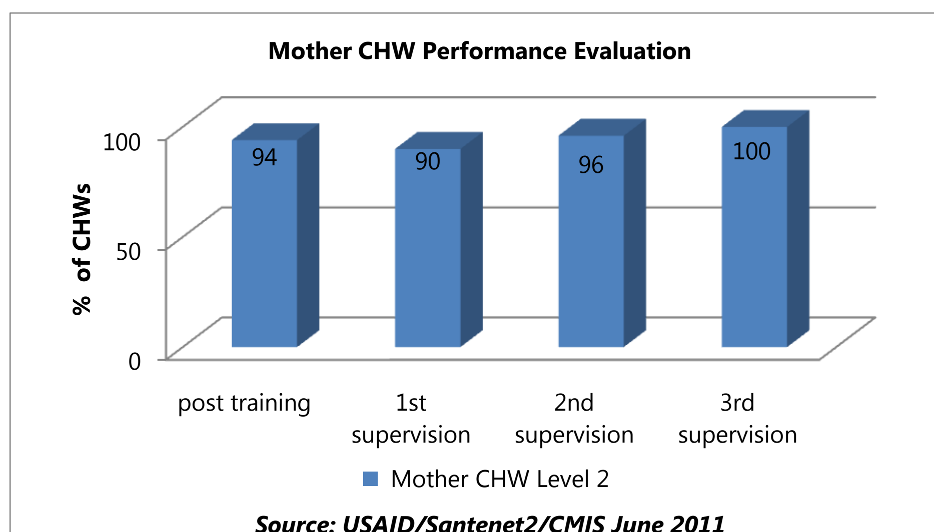
> CHW: *We don't want to pay when we get sick.*
> Interviewer: What? Receive free treatment?
> CHW: *Yes, as a favor.*
> —Female mother CHW, 51 years old, secondary education, Anjeva Gare

SUPERVISION OF CHWS

Regular supervision of the CHWs is integral to ensuring the ongoing quality of service delivery. The graphs below show that for both the child CHWs (N=5,556) and the mother CHWs (N=5,289) evaluated, there appear to be very high standards of performance.



Source: USAID/Santenet2/CMIS June 2011



As noted above, the immense geographical scale of the project and the distances involved between the isolated hamlets which make up many *fokontany* present great challenges in terms of project operations and supervision. Initially, the project held quarterly review meetings to provide comprehensive supervision to the CHWs every three months, but, given the logistical challenges, these supervision meetings will now occur at six-month intervals. This change also responds to the increasing need for local capacity building and ownership to assist with sustainability.

This move towards less frequent comprehensive supervision by Santénet2 project supervisors—and more frequent local, regular supervision by the health center and local NGO partners—reflects the core aims of the project which are to transmit skills to stakeholders in the field. Increasing the involvement of the health center manager is facilitated by the fact that, in most cases, the CHWs have excellent relations with the health center manager.

> *We have a good relationship [with the health center] and a good collaboration if there is a problem. We ask, 'Did such-and-such a child come to the health center because his form has not been returned to us?' In this case, there are complementarities between us.*
> —Female Child CHW, 40 years old, secondary education, Anjeva Gare

> *Our relationship with the health center is excellent! If there is something that escapes us, then they advise us. Whether it be the doctor or the midwife, they can talk to us, and we have a great relationship!*
> —Female mother CHW, 52 years old, secondary education, Anjeva Gare

The health center manager, thus, frequently provides on-the-spot supervision, answers questions about complex cases, and provides other information when the CHWs submit their monthly reports. In turn, the CHWs provide the health center with assistance regarding sensitization for immunization and help with routine baby weighing at the health center.

> A: *We have a good relationship with the health center. We help them with baby weighing every Thursday.*
> B: *We weigh the children and immunize them at the same time.*

Interviewer: You both come every Thursday?
A and B: *No. We take turns!*
—A: Child CHW, 49 years old, high school education, Talata Ampano
—B: Child CHW, 42 years old, secondary education, Talata Ampano

The NGO representative interviewed also saw the benefits of a system whereby the submission of the CHWs' monthly reports can also be used as a time for supervision by the health center manager himself (or herself) or by the partner NGO.

> *We supervise monthly in collaboration with the health center manager. For example, we draw up a monthly calendar which tells us when we will go into each commune. At this time, the CHWs come to the health center and turn in their monthly reports. We use this moment to give supervision as well as to collect their reports.*
> —Director of a local NGO, 42 years old, university education, Fianarantsoa

The NGO director perceived it to be important that supervision skills were consolidated and strengthened at the level of the health center to ensure the sustainability of the project.

> *To improve the quality of the supervision, there needs to be more of a transfer of skills to the health center manager because it is an activity which falls within the framework of public health in Madagascar. Then you also need to reinforce the capacity of the social development committee [members] so that they can resolve any problems that may exist with the health center manager.*
> —Director of local NGO, 42 years old, university education, Fianarantsoa

The health center manager in Talata Ampano emphasized that her work was carried out in an integrated manner with the local social development committee and the mayor's office.

> *Concerning health, the mayor's office and the health center manager always work together for the development of health care in the community... it would be good if we didn't have to wait for Santénet [for the supervision] but were able to do it ourselves.*
> —Health center manager, 50 years old, university education, Talata Ampano

In a discussion with members of the social development committee (the health center manager and a representative from the mayor's office are usually members), they themselves saw the importance of being involved in the supervision in order to aid the long-term duration of the project.

> *What I would like to talk about is the sustainability of the project. The follow-up and the supervision could come to a halt if there are not enough funds. It is clear that the project has its limits, and so what I would like to ask for is a training at the commune level so that we can help the CHWs when the budget allocated to this project is finished. If the funds stop, so that the activities don't stop but rather continue, there needs to be training at the commune level...*
> —Assistant mayor, 50 years old, high school education, Talata Ampano

The NGO's technical assistant was of the same opinion that the supervisory sessions should be carried out by local personnel to increase ownership and to ensure that the local cultural, economic, and logistical environment was properly understood.

> *We shouldn't recruit people from outside the community for the follow-up—it must be done by someone competent from inside the community. There's always a leader in each community, and s/he knows how to manage his area. Because what used to happen was that the supervisor would come from Antananarivo and do the follow-up in a community he didn't even know. The local technicians should have been alerted. These [outside] supervisors do not know the local history and environment of the village.*
> —Local NGO technician, 36 years old, university education, Fianarantsoa

He was mindful that the logistics of the project—given the vast, mountainous terrain—make it difficult to copy community projects which have been developed elsewhere in the world where there is easier geographic access. Local adaptations in terms of operations and supervision for the Madagascan context are therefore necessary.

> *The history of this project can be found in a project from overseas—Bangladesh, so the research for it in the first instance was done by foreign researchers, and then the project arrives in Madagascar, and it is implanted just like that when in fact we need to harmonize it with the culture and the social and economic environment of people here.*
> —Local NGO technician, 36 years old, university education, Fianarantsoa

Likewise the director for heath (although not directly invoked in the project since the beginning of the political turmoil in Madagascar) also saw the logistics difficulties as a major barrier to service delivery and supervision.

> *For us, the main problem is the distance . . . if the health center manager is alone in the post, then if s/he does supervision [on site], s/he needs someone to take his/her place. Either someone keeps the health center open, or this person does the supervision in the field. Or, to avoid the health center closing [during periods of supervision], the health center manager can treat sick people for half the day and go and supervise in the community during the other half, provided s/he has a means of transport. We are short of vehicles from the district health service to the health center level.*
> —District health officer, 52 years old, university education, Fianarantsoa

Although there had been much reflection about supervision among the higher echelons of the KM Salama structure, this had not been successfully communicated to the CHWs themselves. In reality, if the health center manager takes over supervision and can integrate aspects of the comprehensive review meetings (i.e. role playing sessions) and carries it out monthly when the CHWs present their reports, then the frequency of the supervision will, in fact, have increased, not decreased. However, the CHWs feared that they were being abandoned due to the supervision moving to six-month intervals.

> *There is a monthly review and supervision. The monthly review will not change, but the supervision was every three months, and now we are surprised to learn that it is going to be every six months!*
> —Female mother CHW, 37 years old, high school education, Talata Ampano

We need supervision. It is good that the supervisors come because they help us—they shake us up a bit and wake our brains up! It is better to do the supervision every three months rather than every six months. If not, our brains will go to sleep!
—Female child CHW, 45 years old, secondary schooling, Talata Ampano

Thus, sensitization of the CHWs needs to take place rapidly to reassure them that it is in their own interests, and that of the project, for the comprehensive supervision meetings to decrease in frequency but have local supervision improved by making it more comprehensive. In this way, the health center manager will better support them in collaboration with the local NGO and the social development committee. This is likely to be a successful strategy given that the majority of CHWs has extremely good relations with the health center manager. One time management system that could be used has a classification system so the health center manager can grade or classify the CHW. Then s/he could focus on providing more comprehensive supervision to those most in need.

CONCLUSIONS

The scale of Santénet2 project is enormous and its rate of scale-up rapid. Thus, the ambitious goals in terms of coverage and service provision are challenging to achieve, but the program appears to be on track to accomplishing its mandate in terms of the process indicators examined in this study. Madagascar presents specific idiosyncrasies in terms of its terrain and culture, and the project cannot be based upon a 'cookie-cutter' template drawn from other community health care programs elsewhere in the world nor can one model fit all of Madagascar. Thus, the project response needs to be innovative and flexible, and the current debates about supervision show that it is well-equipped to respond to local needs, particularly those relating to sustainability.

Training has improved CHWs' knowledge and health practices and facilitated behavior change (by information transmission, application, and imitation) in their communities. CHWs' status in the community is high and their social skills well-developed. CHWs placed particular emphasis on welcoming clients, discretion, and confidentiality. However the CHWs' effectiveness is inhibited by stockouts which need to be better managed in collaboration with project partners. The CHWs are also hampered by the lack of a locale for consultation. This could be rectified with increased community collaboration and the collective construction of a suitable venue for consultation and treatment. The impact of the program on family planning use, maternal health, and childhood morbidity and mortality is

Source: Sarah Castle, Consultant, IntraHealth

perceived to be high as is its impact on overall social and economic development.

CHWs appear to have extremely good relations with the health center manager who provides them with routine supervision and advice. This will be increased and capacity strengthened at this level so that the health center manager takes increasing responsibility for the supervision in collaboration with the local partner NGO. Supervision meetings every six months by Santénet2, in conjunction with improved monthly supervision by the health center and the local NGO, will improve sustainability. This has yet to be communicated effectively to the CHWs who have a sense of feeling abandoned with regard to supervision, although they derive great satisfaction from the rest of their work. The reality is that by improving the quality of the supervision given monthly, CHW supervisions will become more frequent, not less, and create greater local ownership by engaging the health center and also by increasing stakeholder participation. The latter is illustrated by the willingness of the social development committee to also play a more active role in the supervision.

The project has made great strides in rolling out service provision in areas that are extremely logistically challenging. Community engagement appears to be high, and the CHWs provide an important link between the villagers and their local health center. In addition, they intervene quickly and effectively on the ground to ensure that waiting time to treatment is minimal, and appropriate referrals are made. The perceived impact appears not only to be in the health sector but also in terms of overall community development and family well-being.

RECOMMENDATIONS

1. There is an urgent need to carefully explain to all actors and partners (CHWs, health center, social development committees, NGOs) the reasoning behind the move to six-month formal supervision meetings. The new strategy is focused on relying on local supervisors to conduct supervisory sessions with CHWs on a monthly basis. The Santénet2 independent supervisors will then conduct joint, in-depth supervisory sessions with CHWs and local supervisors once each semester. This mechanism will ensure the quality of the supervision provided by these local supervisors. This is the most appropriate, cost-effective, and sustainable means by which the project can influence the quality of supervision provided by local public employees.
2. The project should continue to support the role of health center manager in continuing to provide monthly supervisions and ensure quality of supervisions, and encourage integration of role-playing and provision of technical advice to the CHWs in collaboration with the local partner NGO and the social development committee.
3. There is an urgent need to work closely with partners, such as PSI, to minimize stockouts and to draw up contingency plans with the health center for when stockouts occur (for example, on the advice of the health center manager, replace one unavailable medicine with another appropriate available one).
4. Similarly, there is an urgent need to resolve the problem of the lack of scales for baby weighing. This could be done via a better collaboration with local partners such as SEECALINE.

5. There should be increased emphasis on community commitment and support for the program—for example, by encouraging communities to construct a locale for consultations and by encouraging them to 'reimburse' the CHW in time or kind, for example, by cultivating their field.
6. The future development of the project should enable mother CHWs to receive child CHW training, and vice versa. As it stands, the two domains are separated, and it creates a false division in the conceptualization of the mother-child dyad. For example, if CHWs receive both trainings, infant malnutrition could be identified during family planning consultations, and, likewise, women bringing children for baby weighing could be counseled about family planning. Until this cross-training becomes feasible, CHWs should be encouraged to work in pairs and/or refer to their CHW counterpart.
7. More attention needs to be given to the cultural and religious context of the project, in particular addressing negative rumors about family planning. Similarly, positive aspects of cultural behavior around health, such as breastfeeding, should be encouraged.