From the Region to the Community: Spreading Community Approaches in Child Survival through Regional Best Practices in AWARE-RH

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Background and Introduction

According to the Lancet's seminal series of papers on Child Survival (Lancet, 2003), approximately 10.8 million children still die unnecessarily each year in the world. Forty-one percent (41%) of these deaths occur in sub-Saharan Africa. In several African countries, mortality rates among poor children actually rose during the 1990s, even though they fell among better-off children. In 2000, 90% of global under-five deaths occur in 42 countries, of which 25 (59.5%) were countries in Africa. The great majority of these deaths are from preventable diseases.

Often what is lacking in a community's response to its child illness can be found in other communities with similar experiences, if not locally, then in other countries in the region facing the same kinds of problems. Many approaches and tools for increasing access and improving quality of FP/RH and CS services exist in West Africa. Program managers often lack knowledge of successful programs in the region, of tested and proven approaches and tools, and other best practices. Furthermore, they are often unaware of those programs, tools and approaches that are ineffective, impractical, or non-sustainable. The sharing of knowledge across programs about successes and failures is poor. Thus, programs often spend significant time and resources developing new tools and approaches when there are appropriate best practices or program models that already exist.

Finance by USAID and managed by Engenderhealth, Management Sciences for Health, the Academy for Educational Development and Abt Associates, the AWARE-RH project is a regional project that seeks to expand best practices in family planning, reproductive health, child survival, health policy development and health reform and finance in 21 countries in West and Central Africa. The AWARE-RH program has pioneered the replication of best practices in Community Case Management of Malaria and IMCI from one successful program to other programs in the region in need of strategies. This paper describes the process by which the program has identified successful community-based programs in one country and transferred them to other countries, using regional organizations as mechanisms for spreading best practices. The program initiated a region-wide search for the best ways of dealing with key child survival issues, documented them, and disseminated these practices in regional forums to spark interest in replication by regional organizations. This program has resulted in important expansion of key regional child health strategies, with organizations trained and equipped to continue their regional scale-up.

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Strategy

USAID has committed to an 8-year strategy to help West Africa[2] achieve political stability and economic prosperity under its West Africa Regional Program (WARP). One of USAID's Strategic Objectives (SO5) is to "increase adoption of sustainable family planning (FP), reproductive health (RH), HIV/AIDS, sexually transmitted infections (STIs) and child survival (CS) policies and approaches" in the region. This strategic objective is expressed in four Intermediate Result Goals (IRs), one of which -- "Improve Approaches to FP/RH, CS, ID, STIs and HIV/AIDS Service Delivery" -- forms the center of the Best Practices approach adopted by the project.

The project has sought to champion the dissemination of Best Practices in child health through an innovative strategy that leverages the region's own proven best practices and socioeconomic homogeneity that permits these best practices to be spread easily.

The project has chosen to improve child health from the regional level is to identify a selected set of best practices (e.g. standards, curricula, tools, approaches, program models, etc.) in services, training and quality improvement that are suitable for the West African environment. In fact, experience has shown that many best practices exist in the region, but are restricted to communities in one country. The project sought to become a vector of widespread knowledge of already proven West African best practices, to avoid "reinventing the wheel". These best practices would be harmonized with existing activities and approaches, so as to add value to ongoing work. To implement the expansion of best practices, the project would identify regional organizations where knowledge of these best practices could sit, working with them to integrate the best practices into their "product line" of technical assistance expertise.

With regional organizations firmly in control of key best practices at the project's end, as well as the methodology for identification, documentation, dissemination and replication of best practices, the project will have created a cadre of regional staff to research and channel best and promising practices around the region for the better health of all countries. This breaks through the traditional barriers to the communication of best practices between countries in ways that would be difficult for individual countries to champion themselves.

This approach is identical for the Reproductive Health/Family Planning, Policy Advocacy and Health Reform and Finance activities also targeted by the project.

Adapting the design to the context

The above Best Practices approach was designed as part of the proposal development process. With the award, the design of this aspect of the project had to be adapted to the

[2] AWARE-RH's West Africa includes the 15 ECOWAS countries (Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Nigeria, Niger, Senegal, Sierra Leone, Togo) plus Chad, Mauritania, Cameroon, Equitorial Guinea, São Tomé & Principe, and Gabon.

realities of the field. Working both internally and with the West African Health Organization (WAHO), the project staff built a Best Practice integration process that operationalized the strategy at the project level. The staff adopted, as well, the key working principle of limiting the number of interventions, and concentrating on those that would have the greatest impact on regional health, if replicated in many countries.

While initially it was thought that much of the work of spreading Best Practices could be done from within the project, the project soon decided to involve partners, and look for opportunities where partners could implement much of the replication work, and the project could provide catalytic inputs to make connections and make activities happen. This then became the *modus operandi* of the project: to seek out partners, and create connections.

The Design Elements

As with all the best practice exchange activities in the project, the strategy for expanding Child Survival best practices in West Africa followed a standard template, conceived in the proposal design stage, and completed as part of the project design process once the project started up.

The strategy implements four distinct stages for each Best Practice, as follows:

1) ***Identify***: The process starts with the identification of best or promising practices in the region. The project collected up to two hundred experiences from several regional and international workshops on Child Health. In some cases, there are best practices that are known by the project or best practices that are known by project counterparts, like the World Health Organization (WHO), the United Nations Children's Fund (Unicef), non-governmental organizations and the West African Health Organization (WAHO). In other cases, the project's technical staff may interview national health programs in various countries, wherein Best Practices are suggested and discussed. The result is a short list of Best Practices that become targets for further investigation. This list is refined by passing each Best Practice through a series of criteria. These criteria may involve feasibility questions, like "Does this Best Practice have the potential of creating significant health impact?" or "Can this Best Practice be replicated in other settings?" They may be questions around impact, like "Is this Best Practice likely to be scalable to larger populations?" or "Is this Best Practice cost effective in other settings?". The resulting list then becomes the list upon which the project component will focus for the balance of the project.
2) ***Document***: The project then ensured that each Best Practice selected has technical documentation, showing the structure of the intervention, the cost in monetary and human resource terms, the proven results in the area from where the Best Practice originates and the expected results in any replication.
3) ***Disseminate***: With the documentation of the Best Practices in hand, the project personnel charged with expanding the usage of these Best Practices schedules meetings with representatives of national health programs, attends regional

conferences, makes networking contacts, all with the purpose of informing decision makers in countries of the region about these Best Practices, and the services of the project in assisting the countries in replicating the Best Practices in additional countries. The project technical advisor generates interest in these activities in the hope of creating opportunities for replication.

4) ***Replicate***: Once interest is generated, then the technical advisor arranges a series of visits where s/he works with organizations and offices of the government that will set up the replication of the Best Practice in the focus country. This requires visits for assessment, planning, training and evaluation, as well as abundant contact with those responsible in-country for the replication to provide problem solving and mentoring on the replication of the technique. In some cases, study groups are planned with the third country, to give the prospective replicators a chance to see how the Best Practice works on the ground, and discuss it with the originators of the Best Practice.

The final step in the process is the documentation of the replication. This shows how the replication was done in the new setting, discusses the problems encountered and solutions found, and adds to the literature on the Best Practice itself.

The body of Best Practices then becomes a part of the legacy of the project, "owned" in a sense by the West African Health Organization, and the organizations that have participated in the replications like UNICEF, WHO and non-governmental organizations.

Assumptions

The project built its strategy on a few important assumptions:

- There are best practices specific to the region – this assumes that regional practices do exist in the West African region that is more culturally suited to West Africa, and easily replicatable within the West African context.

- National health programs are willing to share their best practices – this assumes that there are no territoriality issues or barriers to sharing Best Practices in Child Health within the region. The corollary to this assumption is that health programs in one country are willing to learn from the experience of other countries in the region, as well as share its experience with others.

- There are venues for the dissemination of best practices – the strategy assumes that there are existing vehicles for regional exchange in health. Without these vehicles – such as conferences, meetings and networks, it would be difficult to convene health authorities to discuss exchange.

- West Africa is culturally homogeneous enough to enable smooth transfer of practices from one country to the next – it is important to consider the homogeneity of the culture and economy in which the project is expanding Best Practices. In other regions, the cultural differences from country to country might

create impediments to a regional approach. Fortunately, the economic and cultural integration already alive in West Africa makes this regional Best Practices approach very appropriate.

Implementation

Community Case Management of Childhood Illness – A Case Study

To illustrate how the strategy has played out, it is instructive to look at a particular Best Practice in Child Survival and to note how it was implemented in the region. For this case, we will look at Community Case Management of Childhood Illness, an adaptation of Integrated Management of Childhood Illness at the community level.

Early in the project AWARE-RH joined efforts with the WHO and WAHO to document the variety of best practices in Integrated Management of Childhood Illness (IMCI) that have been developed in four countries in West Africa. IMCI consists of 3 major components: a) Improvement of health workers' case management skills through locally adapted guidelines and training; b) Improvement in health systems in delivery of case management of childhood illness, especially in the supply of essential drugs; and c) Improvement in family and community child health behaviors. The first two of these components are known as clinical IMCI. The last one is known as Community IMCI (C-IMCI). All three components need to be functioning well to fully benefit the child.

The project noted in its research that where clinical IMCI was the central focus of the country's national health program, the implementation of C-IMCI was generally weak. The project participated in regional workshops to seek out best practices in supporting C-IMCI to complement the clinical work that had been done in these countries.

Through visits and meetings with health officials in Senegal, the project identified a practice of Community Case Management (CCM) of Pneumonia as a Best Practice. The Senegalese Ministry of Health, the Senegalese non-governmental organization Canah, Unicef, and USAID (US Agency for International Development), through the Basic Support for Institutionalizing Child Survival (BASICS 2) and Rational Pharmaceutical Management-Plus (RPM-Plus) projects, initiated a pilot program of community management of pneumonia in four districts in Senegal. The strategy includes provision of cotrimoxazole for acute respiratory illness among children under 5, where the cotrimoxazole is prescribed by community-based non-medical health workers. The approach is predicated on the existence of a strong training, supervision, and referral system to support the community workers. Results have shown that 97% of pneumonia cases were seen by the community health workers and severe cases were referred to the next level. In April 2005, AWARE-RH sponsored a regional consultative meeting in collaboration with WHO, WAHO, Unicef, and several USAID projects to discuss the Senegal experience and develop a regional strategy to integrate community management of pneumonia into a broader C-IMCI approach in the region. In meetings with USAID, WHO, Unicef, and WAHO it was recommended that the practice could be adapted to focus on main killer diseases like malaria, diarrhea and malnutrition, depending on a country's disease priority. Community Case Management is, therefore, a part of, and an extension of the standard C-IMCI protocol as developed in Senegal.

AWARE-RH then took the opportunity of various regional workshops organized by partners (including the IMCI Focal Persons meeting, annual Unicef Administrators' meetings, annual WAHO countries ministers' meeting) to disseminate the CCM strategy and advocate for its replication. AWARE-RH has sponsored additional participants in selected country to attend a series of dissemination workshops (Ghana, Niger, Burkina Faso at the IMCI focal persons meeting).

The networking meetings bore fruit as indicated by the interest displayed from several countries. The project organized a joint team composed of AWARE-RH, WHO regional office, WHO and Unicef country offices to visit Niger, Burkina Faso and Togo – all of which had shown interest in the dissemination meetings - to assess the feasibility of replicating the approach, as well as to orient decision makers at the national level, get their support, and encourage ownership of the initiative.

A field visit was organized to enable interested parties to observe and understand the Senegal experience. The participants interacted with community leaders and village health committees on health hut management, the benefit of the introduction of antibiotics at the community level, and community health worker motivation.

In each country, the project worked with the National Health Ministry to select pilot districts in which to replicate the CCM approach. Convincing local partners took time, as this was a new direction. The project conducted more detailed orientation and planning at the district level to convince local stakeholders of the importance of the new approach. In Niger, for example, the adherence of 14 administrative, traditional and religious leaders was essential to supporting the strategy. One of the important issues they raised was that some people regarded CCM as a new program. During preliminary visits, the project emphasized the fact that it is indeed part of C-IMCI, which was already adopted by the MOH in Niger as a national strategy. After detailed discussions and answering their questions, the project gained their commitment to the pilot.

To implement the replication, AWARE-RH led the development of training material and management tools based on the existing materials of clinical IMCI and other management tools (supervision, drug management tools etc.) Key to the success of the initiative was the inclusion of a consultant who was the principal investigator in the implementation and documentation of the Senegal CCM experience. The consultant assisted with the trainings of trainers (TOTs) for 75 Heads of Integrated Health Centers and Community Health Workers (CHWs). The project revised training materials based on the first experience from the TOTs. Using the revised materials, Unicef then expanded the training in 5 additional districts and trained 135 CHWs in CCM.

After the initial training, the project implemented follow-up visits, assessing the performance of the CHWs trained. An outside team composed of the consultant, representatives of the WHO regional and country office and Unicef worked with authorities in the target districts to understand the impact the training made and the gaps that still remained. As a result of the visits, the training materials were updated to include new treatment protocols for malaria and malnutrition.

The project worked to make connections in-country for the adoption of the approach by other groups in other areas. In Niger, the project identified 4 non-governmental

organizations (Mercy Corps, Plan Niger, Helen Keller International and Save the Children UK) working in health on community based activities to replicate interventions beyond the initial demonstration site.

These results were then shared in regional workshops where several countries including Chad, Guinea, Togo, Rwanda, and Mali requested AWARE-RH support.

WHO has praised the studies in its reporting, saying, *"The experience in the studies indicates that community health workers can be trained to responsibly dispense antimicrobials for pneumonia according to a simple classification of ARI."*(WHO, ARI Control Programme, Report WHO/ARI/88.2, 1988)

Partnership

AWARE-RH has built up a strong partnership with Unicef, WHO and the Ministry of Health supported by the exchange of Memos of Understanding. The partners appreciated the project's support and frequent visits to the field. Moreover, the project played a catalytic role between the MOH and partners in the target countries, and supplied complementary funding as appropriate. The project initiated telephone and e-mail communications with the Ministry and partners for better coordination.

Unicef received funding to accelerate child health interventions and development in four countries, however it has not had a sufficient budget to document, disseminate and replicate best practices . The project thus assisted by providing documentation and replication services, adding value to Unicef's role in these countries. Unicef is now providing drugs (antibiotic-Cotrimoxazole, CoArtem for malaria, Oral rehydration Salts, and zinc tablets). It plans expansion of the best practice in 5 additional districts, planning to expand to 7 more districts in a second round of scale-up activities. Unicef's support in the project activities is valued at about $250,000.00

WHO's Africa Regional Office (WHO/AFRO) has documented the IMCI strategy in 8 countries since the strategy's inception. However, it had not planned on replicating. WHO has a mandate in developing policies and strategies and providing technical assistance to countries. Working with the project, WHO/AFRO's technical assistance has been focused on replication of best practices promoted by the project. The AFRO and the country office individuals in charge in each of the target countries have been involved in all the steps of replication. They have provided valuable technical input, as well, in assessing the feasibility of the strategy, the orientation and planning, and the TOTs. WHO/AFRO has not had, however, sustainable funding for activity costs. It did provide key funding for printing and logistics in Niger.

Results

Community Case Management

In Niger, the project trained 15 trainers in February 2006 -- including 10 Chiefs of integrated health centers --, 5 technical staff of District Health Team and 75 CHW in Madarounfa District from March to June 2006. Following AWARE-RH experience,

Unicef replicated the training, adding 135 CHWs in 5 additional districts in January 2007. WHO, Unicef and AWARE-RH assessed CHW performance in 2 of the districts. Two evaluation teams visited 25 health post CHWs (13 at Madarounfa and 12 at Matameye), and made direct observation of them managing cases when possible. They interviewed 110 caretakers (62 at Madarounfa and 48 at Matameye) using the questionnaires and checklists developed by the project. 100% of the health posts were found to be equipped with timers, scales and essentials drugs (cotrimoxazole, ORS and Zinc). Sixty-nine percent (69%) of the CHWs in Madarounfa and about 85% in Matameye performed a correct assessment, including classification and treatment of the case in the prescribed manner. 73% of caretakers in Madarounfa and 54% in Matameye know about at least 2 danger signs in sick children. In addition 98% of caretakers in Madarounfa and 88% in Matameye know how to administer the prescribed drug courses indicated in the CCM materials; 89% of caretakers in Madarounfa and 68% in Matameye attended return visits to the health post. In 6 months, 5 supervision visits were completed in Madarounfa (about one a month, the recommended periodicity). In addition to the health post built by the government, the community has added rooms for the CHW residence, guest, fence and latrines.

Community Health Workers Performance in 2 Districts

Performance level	Madarounfa	Matameye	Observations
Number of health Post visited	13	12	
Proportion of CHW with correct cases assessed and treated	69%	83%	
Availability of timers, scale and essential drug at HP	100%	100%	
Number of caretakers interviewed	62	48	
Proportion of caretaker knowledge about at least two danger signs	73%	54%	
Correct administration of prescribed drugs by caretakers	98%	88%	
Return visits done by caretakers	89%	88%	
Number of Supervision visits by district health team in 6 months	5	0	Training was completed one month prior to assessment in Matameye

Peer Health Education Program on Malaria Control and Prevention

Based on a request from Sierra Leone in replicating a Peer Health Education best practice from The Gambia, the project organized a study tour for 5 participants from Sierra Leone and is supporting replication activities in both countries. The Peer Education project

applies peer education strategy from HIV/AIDS behavior change projects to the problem of malaria prevention. School children are trained as peer educators in malaria prevention, and dissemination healthy behavior messages about malaria in the community.

Targeting 45 schools and their communities linked with the Nova Scotia – Gambia Association (NSGA), the project trained 889 persons as Peer Educators in effective youth response to malaria. These include students as Peer Health Educators, teacher coordinators, opinion leaders, Parents Teachers' Associations (PTAs), women's groups and Drama groups on malaria in The Gambia and Sierra Leone. It is estimated that in Sierra Leone and the Gambia, with an estimated population covered by 45 schools and their communities 280,939 under-5 children will sleep under bednets as a result of this program.[3] The project developed training materials and educational tools (flip charts, T-shirts) to support this activity. The trained students, women groups and the drama troops will be intensively spreading messages on malaria prevention and treatment in communities and schools in the 2 countries through outreach activities using skits and video films.

Strong partnerships at regional and country level replicate Best Practices

Before the project's inception, the exchange of regional best practices happened, at best, by chance. Through the eventual informal networks of government ministers and the vehicles of regional conferences, there was the possibility of exchange. But exchange and dissemination of best practices as a reason for maintaining relationships was not a motivating factor for these international connections. The project has successfully used the international exchanges as opportunities for dissemination. There are signed that this is catching on in regional encounters, as evidenced by Best Practices presentations given at the WAHO Annual Assembly of Health Ministers in November 2005, WHO/AFRO Annual IMCI Focal persons Meeting September 2005, and the Unicef's West and Central Africa Regional Office (WCARO) workshop on CCM March 2006.

Beneficiaries assume Ownership

The project spent a great amount of time garnering the understanding and support of community leaders in the areas affected by the replications. Without the communities' active participation and ownership, the replications would not find the kind of support necessary to survive and grow in new environments. The project's clear success in not only implanting the best practices in the replication sites, but in spurring the scale-up by local organizations, host governments and multilateral organizations is evidence of not only ownership, but the ability of the replicated activities to produce results for the target communities.

[3] The schools selected in Sierra Leone are mostly in the peri-urban area of Freetown with an estimated population of 950,924 including 237,731 <5 as 25%. In the Gambia the population covered is 172,835 including 43,208 <5 as 25%)

UNICEF is implementing its Accelerating Child Survival and Development (ACSD) using the CCM model developed by the project in 7 districts in Niger. After the TOT and the training of CHWs in Madarounfa, UNICEF used the training materials and management tools to expand the training in 5 additional districts. 4 non-governmental organizations (Mercy Corps, Helen Keller International, Plan International Niger and Save the Children UK) are being technically and financially supported by the project to initiate the replication through local groups in 14 additional districts.

In Sierra Leone and The Gambia, the malaria program has organized, sensitized and trained opinion leaders, women, youths groups, traditional communicators and students Peer Health Educators to spread messages on the control and prevention of malaria. Opinions leaders took the ownership of the program and mobilized the community for outreach activities on the fight against malaria including environmental cleaning, skits and night film shows on malaria where opportunity is given to the community to discuss on all aspect of malaria control and prevention. Another example of program impact can be seen at Albreda, in The Gambia. The opinion leader representative said that the AWARE-RH/NSGA initiative on malaria sparked the initiative of Opinion leaders to borrow money from the bank to buy bednets for poor people in need.

Capacity building at the peripheral level (training of CHWs) to assess and treat life threatening conditions (Pneumonia, Malaria, Diarrhea and Malnutrition) in the community in Niger

The project trained over 300 (total of 492 will be trained by Dec 07) Community Health Workers to carry on the practice of Community Case Management of Malaria, Pneumonia and other life threatening diseases like diarrheal disease. The training here represents a permanent achievement in increasing the skills base of health workers at the community level. These health workers can now treat diseases at a lower level than the health center or post, opening up access to health services and solutions to a wider range of clients.

Capacity building at school and community level to raise awareness about malaria using self assessment tool, and conducting outreach activities to prevent and control malaria in The Gambia and Sierra Leone.

889 Peer Educators were trained through the Peer Health Education program in the Gambia and Sierra Leone. Working in schools across Sierra Leone, these peer educators will continue to practice the Peer Health Education program elements long after the project is over, through the established projects in both countries. The Ministry of Health and Sanitation of Sierra Leone has built the Peer Health Education program into its multiyear health strategy at the national level.

Discussion

Why the results are important

It might be easy to ask, "Why a regional approach to health development?" When speaking of the spreading of best practices, often the region is the best place to start for finding context-appropriate solutions to local problems. Each national health program has its set of strengths and weaknesses. Often these weaknesses are perpetuated by continuing to look within country for solutions, instead of looking outward. The regional approach offers a structured way forward in creating solutions to seemingly insoluble problems.

The results above are only important in their potential for scale-up. Surely, the funded demonstration of a best practice from one country to another is not the sign of success for the uptake of a best practice. The "proof of the pudding" is in the demonstration's potential to be spontaneously replicated by those in a position to observe, learn and replicate the practice because a) it has impact; b) it is affordable; and c) it is appropriate. These three criteria are all present in the experiences of the AWARE-RH project's Child Survival best practices. They are the reason that the government, local communities, and interested third party organizations have elected to expand the replication of CCM at the district level. AWARE-RH plays an important role as a catalyst in leveraging funds and donor support for expansion of best practices. Relatively small investments in one country can eventually lead to larger health impacts region-wide.

Key to success is the community's ownership of the process. Built into the project's design are orientation meetings and planning sessions at national and district levels that become opportunities for the country and the local authorities to take ownership of the best practice and truly make it their own. This is then passed down to the communities through the health workers. Community leaders monitor the implementation of the process and report back to the public health system through their individual clinics. One good example is the signed commitment statement by the districts leaders in Madarounfa district. The Prefect of the district, after an orientation, led the discussion ensuring that all community leaders present (including mayors, community elected leaders, and religious leaders) have the same understanding and commit themselves to supporting the implementation of the strategy.

Appropriateness is an essential element, as well. It was also essential to demonstrate that the replication of selected best practice is in accordance with the country's decennial planning process, particularly in the context of C-IMCI in Niger and Togo. The documentation of agreement is an important step, starting with the memorandum of understanding. An memorandum of understanding is always signed with the Ministry of Health and partners where the Ministry of Health commits to supporting replication activities through coordination, availability of key technicians and logistics.

The final element that makes the results above important is that they show that coordinated effort at the regional level can have an impact on the community level. AWARE-RH has built strong partnerships with WHO, Unicef, WAHO and other non-governmental organizations around the idea of expanding Best Practices. The coordination among partners and the ministry of health was crucial not only for better planning and implementation of the replication activities, but also ensuring funding. No

one organization could have implemented the replication activities to such an extent. Thus, the project has showed the way for other regional efforts to gain impact in health at the local level across national boundaries, ethnicities, and language groups.

Lessons Learned

While the project was a success in expanding best practices, it is not without its difficult lessons learned. The following are just a few of the lessons drawn from project setbacks:

All CHWs trained demonstrated a very good performance when observed, or in simulated cases, suggesting some bias in the results due to reactivity of the trainees. In Madarounfa District in Niger, the absence of records made it difficult to tell which cases had been managed by CHWs trained by the project, and which had not. The project learned from this that data collection sheets should be provided to CHWs as soon as possible after the training, so that they can collect data on their performance from the very beginning.

Drugs and equipment were available, but there is some concern that some CHWs may be using drugs beyond their competency level . The project and partners have drawn MOH attention on this matter and will need to assist the MOH in monitoring their activities more closely to prevent consequences arising from false diagnosis and prescription errors. The use of drug stocking tool is still a problem with most CHWs. The cost recovery system has been nationally adopted, but more formative supervision is needed for its effective application. Drug management is essential to the sustainability and demand creation for the health centers.

Common understanding of the profile of the community health worker is central to making C-IMCI work. The fact that 38 Mères Educatrices (Educator-Mothers) were trained, but are yet not providing services was a concern in Niger. The issue was reported to UNICEF health team leader and the DGSP for immediate decision whether to provide them with drugs (cotrimoxazole) or stop or limit their training to only preventive and educational activities. During one workshop on Harmonization of community based practices (June 2007), co-facilitated by the project, a common name for the community workers was proposed. The name of "Relais Communautaire" (Community Liaison) was adopted during the workshop. The Mères Educatrices will fall into that category and will receive appropriate training for community based practices. This shows that the development of the profile for workers in C-IMCI can resolve other problems.

Working with and through partners, it is important to realize that partners' planning and programming may be different from that of the project. When AWARE-RH tries to bring its own agenda to the fore without consideration of competing priorities on the partner side, this can lead to delay in implementation. For the purposes of keeping momentum, and also of ensuring the flow of partner funding to the activities, it is important to always respect the scheduling priorities of partners when planning activities.

Means of communication are often a limiting factor with national Ministries of Health. Partners operate according to their own agendas and priorities, as do national health programs. Often the MoH offices have little or no internet infrastructure, and no access to long distance phone lines, delaying regional activities that must be coordinated from a distance. The project has confronted this limitation by concentrating its efforts on a limited number of countries, and a limited number of best practices which yield the greatest health benefits.

A challenge has been the lack of organizations that are willing to "house" the best practices, outside of the government. The project is predicated on the idea of establishing Technical Leadership Institutions that will serve as sustainable homes for technical assistance in replication of the best practices championed by the project. To date, the project has not been able to find a home for the Best Practices of Child Survival. In the case of the Peer Health Education best practice, the NSGA can serve as a long-term home for the best practice. But for the Senegal experience of CCM, there is no regional organization that has been found willing or competent to embrace it as a Best Practice to replicate through technical assistance. Organizations have been identified on national bases, like the NGOs participating in Niger, or CREDOS in Mali, but no regional presence has taken up the promulgation of these practices. This is a concern for the project.

To address this problem, the project and WAHO have been collaborating in child health efforts at the regional level. WAHO itself appears to be moving towards supporting the replication of best practices in selected countries. WAHO could in fact house the replication of best practices in Child Survival.

The ownership of Best Practices by the Ministries of Health and Education, as well as by the implementing NGOs is crucial to the success of replication activities. In those areas where the MoH and MoE worked together to support replication activities, the project had success in implanting the best practices, as adapted to the local context.

Working through local implementers is the key to implanting best practices in any context. Because of budget constraints, AWARE-RH has not had staff on the ground and has to rely on Ministry of Health personnel in each of its target countries to implement selected activities. The project has played the role of advocate, disseminator and technical assistant for each country level program. Coordination of all activities at country level is crucial. There should be a partner initiator who can ensure the lead in coordinating all stakeholders in country or assist Ministry of Health in doing so. Otherwise, stakeholder agendas often have other priorities.

Management of country activities from the regional level is complicated and logistically difficult, but ultimately feasible. In West Africa, with its inherent problems of air connections between countries, banking differences, security concerns and language barriers, the region has proved difficult to work in. However, with imaginative and flexible work scheduling, use of informal ways to transfer funds when necessary, and a functionally bi-lingual staff, the project has been able to surmount many of the problems that the region offers.

Non-governmental organizations receiving support to replicate best practice, need, themselves, to have their capacity reinforced. The project found that many non-governmental organizations did not have adequate knowledge of donor requirements and monitoring strategies. When preparing a replication of a best practice, it is important to assess the organizational capacity of the entity responsible for replication, before the implementation itself.

Conclusion – Next Steps

The end of the AWARE-RH project has given the staff time to reflect on the project's activities, and where further work is needed. The following are some issues that remain for the next project to tackle.

- **The development of a regional strategy for Best Practices in Child Health.** At the regional level it is possible to see the outlines of larger shared health problems in the region's countries, and transnational solutions to these problems. While the project has focused on constructing a mechanism for transferring Best Practices, the mechanism has not yet becoming a modus operandi for the region to improve its health. Working at the level of the Economic Community of West African States (ECOWAS), and WAHO, it is now feasible to take the model pioneered by the project, and adopt it as a working policy for all states in the region.

- **Creation of a regional technical leadership institution for Child Health.** While there are organizations in the region that are recognized as regional hubs for malaria, HIV/AIDS, health worker training, etc., the project has not been able to identify an existing organization whose function in is to spread best practices in Child Health across the region. In the future, a priority should be to create an organization that can offer technical assistance regionally in Child Health. In countries where there are fewer technical experts (such as Sierra Leone), a regional organization can sometimes play a crucial role in keeping the child health interventions in the country current.

- **Linkage of regional best practice replication and regional policy development.** The AWARE-RH project has demonstrated that a regional organization can be a great advantage in helping countries comply with regionally set standards and policy guidelines. A coordinated effort between best practice organizations and policy advocacy organizations is key to ensuring the relevance of best practices and policies in the region, and the feedback to the regional level on the effectiveness of the policy guidelines they produce.

- **The creation of strong links between the regional-level activities, through national and district level, to health outcomes at the community level.** Because a regional project does not work directly with the people who ultimately derive health benefits from the project's activities, the legitimacy of regional health programming has been called into question. In the future, there should be a more robust effort to make the linkages clear between regional activities and health outcomes "on the ground".

The Lancet series on Child Survival and the Millenium Development Goals make it abundantly clear that child survival programming is essential to any health program that hopes to reach tangible health outcomes. The project's devotion to identifying, compiling and selecting best practices in child survival, as well as its building of

partnerships at regional and national levels has laid a good framework for future development of consistent and high quality child survival activities across a large region of the developing world. It is hoped that future projects in West Africa, or other regions, can learn from the experiences of this project to create similar successful frameworks to make child deaths from treatable illness an artifact of the past.