

**REPORT ON THE EVALUATION OF NSGA IMPLEMENTED
PROGRAMS IN THE GAMBIA AND SIERRA LEONE**

SUBMITTED BY

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EVALUATOR**

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The Nova Scotia – Gambia Association (NSGA)

EXECUTIVE SUMMARY (Final Report)

CIDA Innovation Fund Project # S-063385

Achieving Community Health through Youth Development and Leadership

December 2005 – October 2007

Report prepared by: Joan Baxter, Executive Director, NSGA

I. PROJECT PRIORITIES . . . MEETING THE TARGETS

This two-year project aimed to develop targeted *seven* priority development sectors in The Gambia: (1) Health; (2) Governance; (3) Youth empowerment & development; (4) Women in development; (5) Basic Education; (6) Infrastructure support and capacity building; (7) Human rights

We believe the project was effective in meeting the priorities in the following ways:

- **Health/Basic Education** – developed an effective Peer Health Education (PHE) manual used in 120 schools with more than 240 Teacher Coordinators and 3,600 student Peer Health Educators, increasing exponentially the awareness among these youth (and their peers and their communities) of reproductive health, prevention of HIV/AIDS, other STIs, malaria and other diseases in The Gambia.
- **Governance/ Youth empowerment & development** – identifying youth with leadership potential and fostering this leadership potential through PHE, increasing health knowledge base and confidence to lead among their peers and in their communities
- **Women in development/Human rights** – training more than 3600 PHEs, of whom 54% are female, in healthy relationships, reproductive health and rights, gender equity, spreading these messages to peers in schools with a total population of close to 100,000, and in communities in a traditionally male-dominated society.
- **Infrastructure support and capacity building** – trained more than 100 Teacher Coordinators and collaborated with 120 school principals in developing PHE program activities within school curriculum and routine, with impact up to the ministerial level where PHE is now considered a key component of national education and youth development.

II. CAPACITY-BUILDING: VARYING DEGREES OF SUCCESS

The intention was to develop capacity and achieve results with three main areas: (1) Education Ministry & Schools throughout Gambia; (2) Community-based Organizations (CBOs); (3) Youth groups and women's groups

As can be seen from the following discussion, and in more detail on the RBM table [NSGA RBM CH Final Report.doc] that accompanies this final report, achievements in each of these three capacity-building areas were considerable, but in varying degrees:

- **Education Ministry & Schools throughout The Gambia** – surpassed expectations by developing more than 3600 PHEs in 120 schools throughout the country, and more than 100 Teacher Coordinators, including more than 400 highly-trained student trainers of PHEs, through NSGA’s summer school, fostering sustainability of the PHE process and positive impacts.
- **Community-based Organizations (CBOs)** – While NSGA was able in the final six months of the project to make some inroads in this area, largely through interactive community video shows (produced by NSGA using original skits and NSGA drama troupes, designed to provoke discussion and understanding of health and social issues such as gender equity), this was one area where we were unable to meet our original target, or offer the depth and level of training of CBO leaders in health issues, governance and leadership. (To complete this work, NSGA is currently submitting a proposal to the UN to reach out to vulnerable groups such as long-haul drivers and transient workers, as well as female market vendors to help foster CBO development and training for HIV/AIDS prevention and gender equity).
- **Youth groups and women’s groups** –Community outreach with Drama Troupes and Trainers reached 40 CBOs, most of them youth and women’s groups, while Community Video Shows in collaboration with CBOs numbered close to 100 and may have reached close to 100,000 people. While NSGA does not have the capacity to ascertain the exact size of audiences at these shows (done after dark and in informal settings in neighbourhoods and villages), we estimate an average of between 500 and 1000 people per show, and in urban areas the numbers can reach 1500 – 2000.

III. PURPOSES – PROGRESS AND BUILDING SUSTAINABILITY

The two main purposes of the project were:

1. To improve community health and community governance in The Gambia through youth development and leadership.
2. To demonstrate to Canadians a “template” for effective development work in health, education and governance, through public engagement in Canada.

Both of these purposes drove the project activities in The Gambia and complementary Public Engagement activities in Canada, and progress was achieved in both. There is still much to be done, however, in community governance and health education in the country, as noted above. Progress will continue on Purpose 2 as this project ends, as NSGA has undertaken a Stand-Alone Public Engagement Fund project designed to illuminate positive Canadian (CIDA – supported) international development efforts in West Africa, which will focus on the importance and positive impact of health, education and governance activities.

IV. GOALS – SPECIFIC ACHIEVEMENTS

The nine specific goals of the project were to:

Goal 1. Develop informed, responsible community-minded youth leadership in schools and communities. **Achieved:** *more than 3600 PHEs trained in 120 schools, more than 400 PHEs intensively trained in PHE knowledge and presentation/communication skills for spreading knowledge to peers and communities. The PHE program develops informed, responsible and community-minded youth leaders (see PHE quotes, Annex F)*

Goal 2. Develop community-based governance skills. **Achieved:** *Basic governance skills introduced in 40 community-based development organizations (CBOs), a total of 91 reached through community video shows; trained PHEs continue to share their knowledge and leadership skills with their own communities but more should be done in this area in future.*

Goal 3. Develop proactive communities with knowledge, skills and behavioural models to prevent and manage serious infections and diseases, e.g. sexually transmitted infections (including HIV/AIDS), malaria, tuberculosis. and tobacco and drug related illnesses. **Achieved:** *PHE program involving over 3600 PHEs and 240 Teacher Coordinators inculcates the knowledge, skills and behaviour to prevent and manage serious infections and diseases, and communication skills (drama skits, presentations with posters, games) to transmit these to peers and communities, including elders and traditional leaders. A recent scientific evaluation of NSGA PHE program shows PHE brings positive behaviour changes (see Annex H, password: malaria).*

Goal 4. Develop communication & parenting skills in children & youth, and **Goal 5.** Create an environment in Gambian communities and schools supportive of healthful behaviour on the part of youth in particular and the general population
Achieved: *438 PHEs given intensive training in communication and PHE healthy relationships messages; 64,000 people with community video shows & over 17,000 with live performances by NSGA Drama Troupes bringing messages on parenting, sexual abuse and harassment of girls, teenage pregnancy, health relationships and gender equity, importance of schooling for girls.*

Goal 6. Enable Canadian health professionals and teachers to contribute their expertise and experience in health information and training programs for Gambian students and teachers with an emphasis on health knowledge, communication skills, interactive learning strategies and teamwork, and **Goal 7.** Enable Canadian teachers and health professionals to participate in development work in Gambia and, on their return to Canada, engage the Canadian public with the value and efficacy of overseas development work and **Goal 8.** Enable Canadian teachers and health professionals to stimulate support within their own professions for Canada's ODA programs.
Achieved: *20 Canadian health personnel and teachers (rather than the targeted 8) took part in this project, as follows: 1 medical resident; 1 graduate doctor; 1 professor of medicine, 2 graduates of Health & Human Performance, 6 nursing students, 2 nurses, 7 teachers participated as trainers developing health knowledge,*

communication skills and interactive learning strategies, to build capacity among PHEs, Teacher Coordinators, and CBOs in this project. These volunteers and Dalhousie medical residents engaged the public in presentations in both academic and public venues throughout the duration of the project, and continue to do so.

Goal 9. Enable Gambians to speak directly to Canadians and present dramas on health issues (e.g. healthy and unhealthy relationships), through video productions made in Gambia by NSGA's Media Unit. **Achieved:** 3 CBC documentaries featuring NSGA's project activities and Gambian partners aired on Atlantic Canada CBC supper hour show in March 2006, and one 12-minute CBC documentary on this project work aired on CBC's The National in August 2006. Multi-media presentations using photos of Gambian students at summer schools and in PHE groups in schools continue to be shown in Canadian presentations.

V. OUTPUTS, OUTCOMES AND REACH

In many areas, NSGA was able to exceed its own stated goals in both outputs and reach of the project, while in others, the organization fell a little short of the stated targets (see RBM for details) of actual reach. In general, however, the focus on the stated goals allowed NSGA to achieve a great deal of what it had intended to with this ambitious and multi-faceted project.

VI. IMPACTS

While it would be presumptuous of NSGA to assume that a two-year project could claim to have a large impact on any nation, we believe we are not overstating the case when we say that the cumulative effect of this project that reached so many students in so many schools and so many communities, picking up where previous CIDA-funded and other NSGA projects have left off in developing health education through Peer Education models in The Gambia, has indeed had a lasting impact.

Of note: in 2006, the National HIV/AIDS Secretariat (NAS) in The Gambia showed that HIV/AIDS prevalence rates had dropped in the country (to 1.1% on average, and to .5% among 15-24 year-olds, the target age for NSGA's PHE work), and HIV/AIDS awareness levels had risen significantly.

Through NSGA's long experience in The Gambia, much of it with the support of CIDA, the organization has become a household name in the small West African nation, as has the Canadian International Development Agency, which is credited on all training materials, publicity materials and banners in all the project activities.

There is a snowball effect of the PHE learning model, whereby thousands of trained PHEs then spread their knowledge – particularly reproductive health and methods of prevention of diseases such as HIV/AIDS, other STIs, malaria, typhoid, etc – with their peers and their entire communities, making the true reach – the number of indirect beneficiaries of such a project – impossible to gauge in exact numbers. However, we estimate the numbers to be in the hundreds of thousands.

In addition, the full engagement of government education officials – as shown by their attendance at the major public events that were part of this project, such as summer school graduation ceremonies - assures that there is official impetus and support for such community health and youth leadership initiatives that involve schools.

The profoundly positive impact of the CIDA-funded PHE work of NSGA in The Gambia has revealed itself in recent months, in the refusal by many students, teachers and others who have been part of the Community Health Project and understood its messages, to succumb to powerful messages from the president who has been claiming to have found a “cure” for HIV/AIDS. NSGA trainers have discovered that despite these claims, those who have been exposed to the messages of the Community Health project and PHE work – both in schools and communities – understand that there is no scientifically proven cure and that prevention is the best option when it comes to HIV and other STIs.

VII. LESSONS LEARNED

- Budgeting for future projects must take into account the unforeseen costs of moving students and teachers and NSGA staff around the country without the benefit of public transport, which has been reduced to extremely poor and unsafe vans that ply poor and unsafe roads.
- Summer schools that involve Canadian volunteer professionals (health, teaching, etc) and large numbers of promising Gambian students (Peer Health Educators) and teachers (PHE Coordinators) are highly successful and a cost-effective way of promoting health knowledge in The Gambia and elsewhere in West Africa, building capacity among the PHEs and students, and engaging Canadians in international development efforts, thereby increasing awareness – and appreciation - of CIDA.
- PHE messages needs to be constantly updated and refined, with input from both Gambian (local) and Canadian professionals, who can develop modules that are culturally appropriate and scientifically accurate to promote gender equity and human rights, while informing on controversial and sensitive topics including female circumcision, contraception, and abortion, as these subjects usually arise in open discussions with PHEs and teachers.



IN CLOSING . . .

Summer school student, Ramatoulie Colley, had this to say about her experience at the CIDA-funded school in 2007: “The classes give us the power, knowledge and foundation to challenge and empower the young and old. The classes help us to cooperate with different types of people, no matter who you are, where you are from or what you can do. It is the place where students can exchange their experiences. It really helps me to take care of myself. I learned how to protect myself from deadly diseases like HIV/AIDS, STI’s and diabetes etc. With the

information that I learned here, I believe I can save so many people's lives.”

*Report prepared by Joan Baxter, Executive Director, NSGA
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Mission Implementation Completion Report Outline:

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1. Terms of Reference and Objectives of Assignment

The Consultant was hired by NSGA as an internal evaluator of NSGA implemented programmes focusing mainly on the World Food Programme (WFP) funded Community Health Programme and the CIDA funded “Improving Community Health through Youth Education and Governance”. Specifically the Consultant was required to establish the relevance of the programme, achievements and implementation challenges. The consultant was also required to identify and note any attitudinal and or behaviour change that can be attributed to the NSGA interventions. The terms of reference of the consultants also required him to review the performance of the summer school with the view to noting key lessons learnt in order to improve subsequent summer schools to be organised by NSGA.

The terms of reference of the consultant also required him to review the internal operations of NSGA and NSSLP with the view to making recommendations on key areas for improvement. This was deemed necessary in view of the fact that NSGA as an organisation continues to grow both in terms of size and scope.

At the end of the consultancy, the consultant is expected to submit a detailed report on key findings and recommendations for the overall improvement of the NSGA interventions in the Gambia and Sierra Leone.

2. Evaluation Methodology:

The Consultants conducted extensive literature review with the view to understanding NSGA’s programmes, objectives, strategies and targets. Questionnaires were also prepared to collect data from the summer school. In regards to the community perspectives discussions were held with beneficiaries of the programmes and questionnaires targeting key informants including NSGA staff directly involved with programme implementation were administered. Discussions were also held with NSGA/ NSSLP staff in the Gambia and Sierra Leone respectively. The consultant also sat in the classroom to observe the conduct of the summer school.

3. Limitation of the Evaluation Methodology:

The consultant could not validate some of the data collected by NSGA by conducting independent reviews and verifications of such data. The consultant could also not visit the direct beneficiaries of some of the NSGA programs to get an impression of their own perspectives on the outcome of the programs targeted at them.

4. Preamble: NSGA in Perspectives, Mandate, Mission Statement, Core Programmes

Nova Scotia –Gambia Association (NSGA) is an international charitable organisation that has been operating in The Gambia since 1992 implementing mainly school based Peer Health Education programmes. The main themes of NSGA PHE programmes focus on healthy relationships, the prevention of HIV/AIDS and other sexually transmitted infections, malaria, and tuberculosis. The organisation was registered in Canada as a charity in December 1989. It attained full status as a charity in the Gambia on August 24th 1992. In Sierra Leone however Nova Scotia-Sierra Leone programme was registered and attained full NGO status on 20th January 2004. NSGA has an existing MOU with the Department of State for Education clearly stating out its mandate to implement a peer health education program within the school system. The scope of the NSGA program covers almost all the senior secondary

schools, except four. All the upper basic schools have been covered. A pilot programme through funding from the WFP is currently being implemented targeting the grades 5 and 6 in 27 lower basic schools in three divisions across the country.

4.1 Mission Statement:

The Nova Scotia-Gambia Association is a non-profit volunteer organisation based in Canada which works through partnership with Gambians, Sierra Leoneans and other West Africans in pursuit of initiatives for equitable and sustainable futures for youth.

4.2 Vision of Sustainable Development:

Sustainability is a primary concern of the NSGA. Therefore NSGA concentrates on human resource development (and in particular the acquisitions and development-by Gambians and Canadians working with NSGA) of knowledge, skills and other human resources, through activities and processes which also help develop cooperation and trust between partners , confidence, self reliance, self-esteem and motivation.

NSGA has to-date implemented over 30 projects most of them in the Gambia. However since 2004, its areas of operation have been expanding to other West African countries, Sierra Leone in particular. The main strategies of NSGA interventions are in-school Peer Health Education and community out reach programmes including community video shows and out of school youth programmes.

The Peer Health Educators and drama troupes perform skits in the schools and or communities respectively. The main thematic areas are prevention of HIV/AIDS among youth, prevention, treatment and control of malaria, and tuberculosis, and ensuring that youth understand and live by the basic principles of healthy relationships.

The implementing partners of NSGA are Government especially the education sector, community organisations, youth and other civil society organisations. As part of its core programmes NSGA also collaborates with the Department of State for the Interior particularly the Police and the Mount Saint Mary's University, Halifax, Nova Scotia in Canada as consultant to implement a community-based policing programme. The objective of this programme is to improve healthy relationships between the police and community they serve in the Gambia. NSGA provides the services of the drama troupe, office space, transportation and other logistical support. However NSGA is not an implementing partner of the community police program.

5. The 2006 Summer School

NSGA has pioneered the running of summer schools in The Gambia since 1992 by recruiting competent and highly qualified Canadian volunteers who work with Gambian counterparts teaching various subjects with more emphasis on reproductive health, communication skills and healthy relationships. The summer school programme has now been emulated by many other institutions in the Gambia such as NGOs, government schools and many other development partners in the education sector. The Department of State for Education also runs summer schools now not only for the teachers but also for the students in both primary and secondary schools.

The 2006 summer school organised by NSGA and started from July 31st through to 30th September 2006, brought together 243 students from 58 schools from all the administrative divisions in the Gambia. NSGA recruited eight volunteers from Canada who worked with their Gambian counterparts. The total number of students enrolled dropped to 223 by the end of the summer school representing only **8.2%** drop out rate as against **91.77%** turnout. This very high turnout indicated that the students did not only like the summer school but found it useful and interesting.

The Gambian counterparts are full time NSGA staff. The drama troupe members also participated in the summer school. In order to ensure that the teacher coordinators have the required knowledge and information to enhance their coordination of the Peer Health Education programme, special sessions were also organised for them as well.

More than 60 Teacher Coordinators across all the administrative divisions were gathered together for a period of 4 days. The Teacher Coordinators, like the students also benefited from this intensive training programme on HIV/AIDS, malaria, tuberculosis, diabetes and the wider issues of reproductive and sexual health.

5.1 Main Findings:

In order to establish the impact of the summer school on the students gathered, NSGA in collaboration with the Canadian teachers conducted both pre and post tests. This was deemed necessary by providing documented evidence on the relevance and impact of the summer school. The pre-test results provided the baseline data on the overall performance and standards of the students. The consultant also developed tools to collect information from both the students, Canadian teachers and NSGA staff working on the summer school.

The importance, relevance and impact of the summer school on the students were well established. Both the students, teachers and NSGA team involved with the summer school indicated that the quality of the teaching and the information provided had adequately prepared the Peer Health Educators to effectively embark on implementing their educational campaigns.

The 2006 summer created an opportunity for students from the rural areas to participate in a summer school for the first time in their lives. Asked whether this was the first ever summer school they attended **60%** (134 respondents) out of 223 respondents said yes whilst only **39%** (87 respondents) said they had ever participated in a summer school.

Asked whether they would like to be involved in a summer school next year, **97%** (216) respondents said yes and only **1.7%** (7 respondents) said no. This is an indication of how the students valued and appreciated the summer school.

On the rating of the summer school, **86%** (194 respondents) said the summer school was good, **7.17%** (16 respondents) rated the summer school as average whilst only **4.03%** (9 respondents) rated the summer school as below average. On the performance of the teachers **89.24%** (199 respondents) rated the performance of the summer school teachers as good, **7.17%** (16 respondents) rated the performance of the summer school teachers as average, and only **1.79%** (4 respondents) rated the performance of the summer school teachers as below average.

As can be seen from **Table 1** below there has always been marked improvement on the performance of the students from the pre to the post summer school sessions. In the pre tests administered for Grades 7A the average score was **45%** whilst in the post summer school tests the average score was **78%**.

For Grade 10A the average score for the pre-test was **52%** whilst the average score for the post-test was **67%**. The low mark during the pre-test was **20%** and **40%** for the post-test respectively. For Grade 8B however the lower mark was **50%** whilst the higher mark was **40%**. It can only be stated that Grade 8B did better in the pre-test than the post test. This is an exception from the norm and cannot be used to draw any conclusion.

As can be seen in **Table 2** below, the low marks for Grade 8A is **13%** during the pre-test whilst the low mark for the post-test was **47%**. A similar trend is noticed for the Grade 7B where the low mark during the pre-test was **6%**. However during the post test the low mark was **60%**. This clearly indicates how the knowledge level of the students has improved as a result of the quality of the teaching and the adequacy of the information provided to them during the summer school.

5.2 The Drama Troupes:

NSGA experimented the participation of the drama troupe members in the 2006 summer as students in order to improve their knowledge and skills. The drama troupe members were therefore selected and spread amongst all the classes with the view to enhancing the effective participation of the peer health educators. However it became apparent that the drama troupe members were dominating most of the discussions thereby sidelining and intimidating the Peer Health Educators. To most of the drama troupe members, they should have been in separate classes instead of joining the Peer Health Educators they have been teaching and supervising prior to the summer school. They felt that joining the same classrooms with the Peer Health Educators is tantamount to “down grading their profiles”.

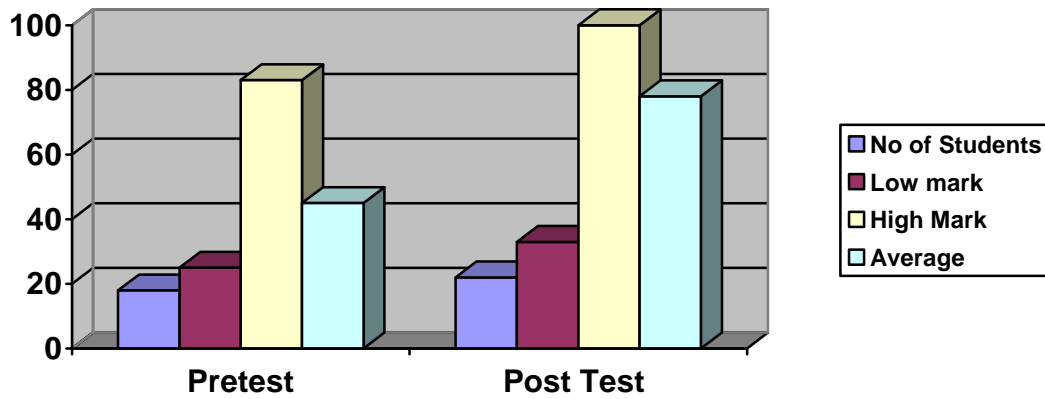
The teachers and the NSGA facilitators in the summer school therefore had to spend time managing the drama troupe members in order to ensure the free flow of the lessons and the effective participation of all the students. The participation of the drama troupe members in the summer school was also considered very expensive and perhaps not the least cost effective. In future therefore due consideration should be given to the participation of the drama troupe members in the summer school. Whilst their participation is well intended, its cost effectiveness should be the driving force.

**Table 1: NSGA Summer School Marks for Pre and Post Tests)
Topics: Immune System, Tuberculosis, Malaria, and Drugs**

Grade 7A

Pre-test	Score	Post-Test	Score
Number of Tests	18	Number of Tests	22
Low Mark	25%	Low Mark	33%
High Mark	83%	High Mark	100%
Average	45%	Average	78%

Figure 1: NSGA Pre and Post Test Grade 7A



Grade 7 B

Pre-test	Score	Post-Test	Score
Number of Tests	19	Number of Tests	27
Low Mark	16%	Low Mark	42%
High Mark	75%	High Mark	100%
Average	52%	Average	73%

Grade 8A

Pre-test	Score	Post-Test	Score
Number of Tests	26	Number of Tests	23
Low Mark	40%	Low Mark	50%
High Mark	90%	High Mark	90%
Average	79%	Average	83%

Grade 8B

Pre-test	Score	Post-Test	Score
Number of Tests	27	Number of Tests	26
Low Mark	50%	Low Mark	40%
High Mark	90%	High Mark	100%
Average	77%	Average	82%

Grade 10A

Pre-test	Score	Post-Test	Score
Number of Tests	33	Number of Tests	25
Low Mark	20%	Low Mark	40%
High Mark	90%	High Mark	95%
Average	52%	Average	67%

Grade 10B

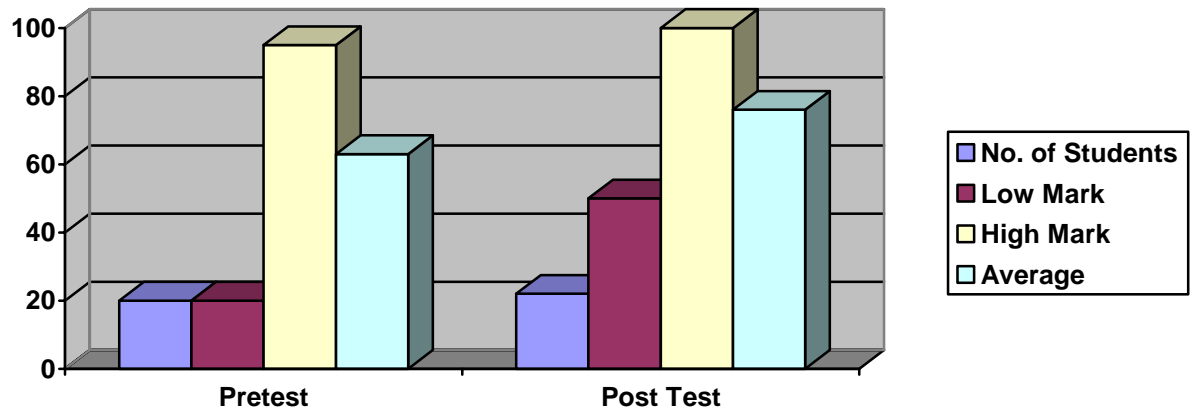
Pre-test	Score	Post-Test	Score
Number of Tests	26	Number of Tests	25
Low Mark	35%	Low Mark	40%
High Mark	90%	High Mark	95%
Average	58%	Average	67%

Grade 11A

Pre-test	Score	Post-Test	Score
Number of Tests	13	Number of Tests	21
Low Mark	20%	Low Mark	30%
High Mark	90%	High Mark	95%
Average	60%	Average	76%

Grade 11B

Pre-test	Score	Post-Test	Score
Number of Tests	20	Number of Tests	22
Low Mark	20%	Low Mark	50%
High Mark	95%	High Mark	100%
Average	63%	Average	76%



Summer School Pre and Post Test Results Grade 11 B

Table 2: NSGA Summer School Marks for Pre and Post Tests (Vanessa Donnelly)
 Topics: Diabetes, Prevention, Nutrition and Exercise

Grade 7A

Pre-test	Score	Post-Test	Score
Number of Tests	26	Number of Tests	28
Low Mark	13%	Low Mark	27%
High Mark	73%	High Mark	100%
Average	38%	Average	76%

Grade 7 B

Pre-test	Score	Post-Test	Score
Number of Tests	31	Number of Tests	31
Low Mark	6%	Low Mark	60%
High Mark	93%	High Mark	100%
Average	54%	Average	86%

Grade 8A

Pre-test	Score	Post-Test	Score
Number of Tests	33	Number of Tests	31
Low Mark	13%	Low Mark	47%
High Mark	80%	High Mark	100%
Average	53%	Average	81%

Grade 8B

Pre-test	Score	Post-Test	Score
Number of Tests	30	Number of Tests	29
Low Mark	40%	Low Mark	66%
High Mark	87%	High Mark	100%
Average	65%	Average	87%

Grade 10A

Pre-test	Score	Post-Test	Score
Number of Tests	28	Number of Tests	28
Low Mark	40%	Low Mark	60%
High Mark	75%	High Mark	100%
Average	59%	Average	82%

Grade 10B

Pre-test	Score	Post-Test	Score
Number of Tests	21	Number of Tests	22
Low Mark	50%	Low Mark	70%
High Mark	95%	High Mark	95%
Average	?	Average	85%

Grade 11A

Pre-test	Score	Post-Test	Score
Number of Tests	23	Number of Tests	22
Low Mark	15%	Low Mark	45%
High Mark	90%	High Mark	100%
Average	59%	Average	80%

Grade 11B

Pre-test	Score	Post-Test	Score
Number of Tests	23	Number of Tests	20
Low Mark	10%	Low Mark	50%
High Mark	95%	High Mark	100%
Average	61%	Average	77%

5.3 Conclusion

The analysis of the data collected on the summer school revealed that the summer school has impacted positively on the lives of the students, NSGA staff and the Canadian teachers. These were what some of the student participants at the summer school had to say:

*“I have upgraded myself especially with regards to diabetes and communication skills”
(Kaddy Suso – Glory Baptist SSS)*

“What I learned here, I will go and teach to my colleagues who were not here as I have gained a lot (Knowledge and Skills)” (Kaddijatou Jallow – Brikama Methodist SSS)

“Even if it means me paying for myself, I will come back next year”

“Thank you for asking me these questions. I like the summer school. Please could I come back next year in my grade 9? Please! Please! Please! I beg you people”

During the planning stage of the summer school the consent of the parents and guardians of the students (Peer Health Educators) invited to participate in the summer school were sought. For most of these parents their exposure to the NSGA programmes was based on the active role played by their children in their capacities as Peer Health Educators in their various schools. These were some of the remarks made by the parents”

“The skills that she (my ward) will gain from the workshop will gain her a lifetime and the community she lives in” Wally Jallow (Guardian)

“I appreciate my child being part of this noble summer training session. My sister died of T.B two years ago due to ignorance. Therefore I am happy that my child is contributing a lot by spreading health messages in our community” Mrs. Fatou Jatta (Parent)

“I particularly take interest in this program as I know its importance for my son. Since he joined this program, he sensitized me and my friends a lot of things (health) that I don’t know about. When he told me about the training program I had to close my shop (at North Bank) to accompany him because I know the value of the Program” Momodou Chernou Jallow (Parent)

“Since my daughter started the program, she is more responsible sexually. Her understanding of the sex education component is very important to me. In our communities parents don’t talk about sex in the open and it is important for our kids to know” Buba Buwaro (Parent)

“As a former PHE, I know my brother will learn a lot from this workshop. He will capacitate himself and our community” Ousman Dem (Guardian)

In deed the spirit of the summer school was based on the principle of learning and experience sharing. This is evident from the remarks made by the teachers/resource persons during the summer school. These were some of the remarks made by the teachers and resource persons.

“I came here to teach, but I ended up learning” (Vanessa Donnelly, Canadian Teacher in the summer school)

“This important training should be something continuous, maybe once every year as it is a move towards sustainability” (Mr. Simon Barba Gibba – St. Martin’s Basic Cycle)

“The training has exposed me to a different teaching technique” (Cyril Agbeh – Teacher Coordinator Glory Baptist SSS)

“This training session encourages learning and sharing with other teacher coordinators from other schools” (Maimuna Drammeh –Teacher Coordinator Madinah Basic Cycle)

Overall, the summer school was a major success .It has brought together students from diverse backgrounds to work together with the view to enhancing their performance as Peer Health Educators. The summer school also created a forum for openness, experience sharing for the NSGA staff, Peer Health Educators and the Canadian teachers. In conclusion therefore the impact of the summer school can be summed up as follows:

- The students demonstrated their liking and interest in the summer school as evident in the evaluation report.
- The summer school has increased the knowledge base of the Peer Health Educators by exposing them to additional information on HIV/AIDS, Malaria, Tuberculosis Nutrition, Diabetes etc.
- The summer school boosted the confidence level of the Peer Health Educators by adequately preparing them especially on communication and presentation skills.
- The Teacher Coordinators were provided with up-to-date information on HIV/AIDS, Tuberculosis, Malaria, Diabetes and Nutrition as well as being exposed to different methods of teaching and presentation skills
- The drama troupe members have equally been exposed to additional information and more important they have enhanced their presentation and communications skills

6. World Food Programme (WFP)

The World Food Programme (WFP) provided supported to NSGA to implement a 12-month Health Education programme in 27 lower basic schools and their communities in three administrative divisions in the Gambia. The three divisions are Lower River, Upper River, and Central River Divisions respectively. The project which was approved in January 2006 became effective on 27th February 2006. The targeted intervention areas were pre-selected by WFP. Some of the schools are located in very remote areas and access to these schools is constrained by the difficult terrains especially during the rainy seasons.

The program targets students in grades five and six in the 27 selected schools, and also the teaching staff of all of these schools, the parent-teachers associations and the rural communities in which the schools are located.

The main strategies of the interventions are not peer health education because of the age of the children. Instead NSGA resource persons directly conduct interactive information sharing programs with students in the classrooms and with teachers through in-service programs. The NSGA drama troupes also provide health education to parents, out-of-school youths and village elders. Thus the learning that takes place in school is being reinforced by what is learned in the community-at-large. The objective of this approach is to demonstrate that it is possible to have continuity of health education among students and parents, schools and communities thereby promoting improved levels of nutrition, hygiene, and health-related behaviour within the communities.

To achieve this objective, a **“Health and Information Handbook for Primary Schools”** was reviewed and revised to the standards of the targeted audiences especially the children in the primary schools. The main topics covered are Human reproductive Health, Healthy and Harmful relationships, Drugs and Addiction, Malaria, Tuberculosis and HIV/AIDS. In keeping with the WFP concerns about basic food and environmental sanitation among young children in the rural areas, the revised manual also included a new topic, “Nutrition, Health and Hygiene”. In order to establish the effectiveness of the program, NSGA conducted baseline pre and post tests in all the 27 target schools.

The results of the pre and post tests facilitated NSGA to monitor the level of understanding of the content of the program amongst the target audience. **Table 4** below is a summary of the pre and post tests questions administered in the schools. In the case of CRD pre-tests were conducted in two schools for the Grade 5 (Jahally and Kayai) with an average score of 64.0% and 71.1% respectively.

Similarly pre-tests were conducted for three schools for the Grade 6 (Jahally, Jessadi and Kayai) with an average score of 66.6%, 54.2% and 77% respectively. Comparing the schools, Kayai had the highest average score of 71.1% and 77.0% for both the Grades 5 and 6 respectively.

The post test conducted for Grade 5 schools in LRD indicated that Jali had the highest score of 90% whilst Batelling had the lowest average score of 42%. For the Grades 6 however Janneh Kunda had the highest average score of 63.3% whilst Jouli had the lowest average score of 45.7%.

In CRD the post test conducted for the Grades 5 showed that Mabally Kuta had the highest average score of 79.6% whilst Jessadi had the lowest average score of 48%. In a similar test conducted for the Grade 6 schools in CRD, Kunting had the highest average score of 86% whilst

Jahanka had the lowest average score of 62.9%. However data on all the other Grade 6 schools is not available to make a direct comparison between the schools.

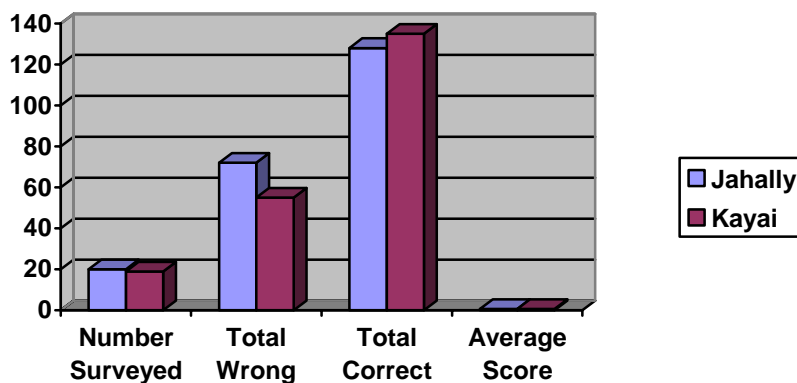
In the URD post test results for the Grades 5 showed that Julangel had the highest average score of 68.3% whilst Sare Demba Toro had the lowest average score of 61.3%. For the Grades 6 however Kulari had the highest average score of 75% whilst Sare Njobo had the lowest average score of 50%.

Although the pre and post test results provided baseline data on the performance of the schools and the program, there is no clear pattern when compared to the observations during the field monitoring visits. However the monitoring team observed that the schools in CRD demonstrated a better understanding of the program compared to the schools in URD and LRD respectively. This statement however should be qualified because not all the schools in the intervention areas have been visited to draw any conclusion. It is therefore important to continue the collection of data throughout the project implementation phase in order to determine a trend in the performance of the schools and or the regions.

Table 4: Pre and Post Test Results of the WFP Project

Pre-Tests: Survey of Health Knowledge CRD Schools Grade 5

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Jahally	20	72	128	64.0%
Kayai	19	55	135	71.1%



Pre-Tests: Survey of Health Knowledge CRD Schools Grade 6

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Jahally	38	127	253	66.6
Jessadi	12	55	65	54.2%
Kayai	20	46	154	77.0%

Post Test: Survey of Health Knowledge I URD Schools: Grade 5

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Julangel	12	38	82	68.3%
Kulari	12	42	78	65.0%
Madina Samako	12	44	78	63.3%
Sare Njobo	12	44	76	63.3%
Sare Demba Toro	15	58	92	61.3%

Post Test: Survey of Health Knowledge I CRD Schools Grade 5

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Faraba	19	49	141	74.2%
Galleh Manda	6	16	44	73.3%
Jahanka	30	82	218	72.7%
Jessadi	30	156	144	48.0%
Kunting	27	64	206	76.3%
Mabally Kuta	47	96	374	79.6%
Sarengai	17	40	130	76.5%

Post Test: Survey of Health Knowledge I LRD Schools Grade 5

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Batelling	8	46	34	42.5%
Jali	14	14	126	90.0%
Janneh Kunda	14	71	69	49.3%
Jouli	4	22	18	45.0%
Karantaba	17	79	91	53.5%
Kwinella	29	147	143	49.3%
Manduar	15	84	66	44.0%
Sare-Sarjo	17	47	123	72.4%

Post Test: Survey of Health Knowledge I URD Schools Grade 6

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Julangel	8	26	54	67.5%
Kulari	6	15	45	75.0%
Madina Samako	11	33	77	70.0%
Sare Njobo	8	40	40	50.0%
Sare Bojo	14	58	82	58.6%
Sare Demba Toro	15	53	97	64.7%

Post Test: Survey of Health Knowledge I CRD Schools Grade 6

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Galleh Manda	11	34		69.1%
Jahanka	14	52		62.9%
Kunting	15	21		86%

Post Test: Survey of Health Knowledge I LRD Schools Grade 6

Name of School	Number Surveyed	Total Wrong	Total Correct	Average Score
Batelling	18	72	103	60.0%
Jali	19	80	110	57.9%
Janneh Kunda	9	33	57	63.3%
Jouli	14	76	64	45.7%
Karantaba	20	79	121	60.5%
Kwinella	45	206	244	54.2%
Manduar	10	49	51	51.0%

6.1 Field Monitoring Visit:

A joint program monitoring mission was also undertaken by representatives of the World Food Program (WFP), the Department of State for Education and Novo Scotia-Gambia Association from 5th to 8th November 2006.

The objective of the mission was to assess the outcome of the health Education program in selected schools in URD, CRD and LRD. Three schools out of the nine schools were selected in each division. In URD the schools selected were Madina Samako, Perai Tenda and Sare Bojo.

In CRD the schools selected were Kunting, Faraba, and Sare Ngai, whilst in LRD the schools visited were Kwinella, Manduar and Karantaba. At each of these schools the team held discussions with the school administration and also observed the NSGA staff during their classroom presentations.

The mission however did not have any meeting with the Parents-Teacher Association (PTA) and or direct beneficiaries of the program at community level. The findings of the mission are as follows:

- The health education program has the full support of all the school administrators (heads of the schools) in all the sites visits. They indicated that the health education is very relevant as it compliments by adequately preparing children at an early stage in their lives to understand reproductive health issues, hygiene and nutrition thereby making them responsible for their own health.
- The communities have been sensitized and they have embraced the health education program in the schools. No community has confronted the school for introducing sex education to children in the primary schools;
- The school feeding program is a major contributing factor to higher enrolment rates in the schools. All the school administrators noted that without the school feeding program, the drop out rates for children will be high;
- The schools have school garden programs which provides some of the vegetables for the meals cooked in the school in order to give the children a balance diet;
- Early and or forced marriage and teenage pregnancy are issues confronting schools in some of the project sites visited. However the problem is more acute in URD and CRD than in the LRD. The mission also noted early marriage seems to be more of a problem in Fula, Jahanka and Sarahule communities than in Mandinka communities;

- The children in most of the schools visited have difficulties in speaking English language. The participation of the children is higher when discussions are facilitated in English and the local languages than in English alone.
- The enrolment rate for girls is higher in almost all schools compared to boys;
- In some of the classroom presentations observed, the messages especially on nutrition and hygiene tilt more towards foreign practice than what is known and available locally.
- Inadequate water supply affects some of the schools thereby causing major constraint in their school gardening programs
- The teachers have also been reached with messages as they all attend classroom presentations by the drama troupe and the teaching session conducted by NSGA staff.

6.2 Achievement

One of the major achievements of this project is the establishment of the health education programme in all the 27 lower basic schools and their communities. All in all about 1606 students were trained in all the schools in the target areas. More than 50% of the students trained are females. In addition to the school based interventions, the drama troupes have performed in all the 27 schools reaching an estimated number of 7000 students and 80 teachers.

However the drama troupes performed in 22 communities of the 27 targeted intervention areas reaching an estimated number of 1890 people. The main topics discussed during the health education sessions were on hygiene, nutrition and reproductive health including the prevention and control of HIV/AIDS and STIs.

Table 3: WFP Program Selected Schools

Name of School	Division	School Population	No. of Grades 5	No. of Grades 6	Total Grades 5& 6	% Reached
Batelling	LRD	80	12	15	27	33.75
Jali	LRD	175	25	18	43	24.57
Janneh Kunda	LRD	101	17	16	33	32.67
Jouli	LRD	92	18	10	28	30.43
Karantaba	LRD	316	16	19	35	11.08
Kwinella	LRD	346	33	33	66	19.08
Manduar	LRD	192	28	14	42	21.88
Toniataba	LRD	414	61	80	141	34.06
Sare Sarjo	LRD	128	21	25	46	35.94
Total		1844	231	231	461	25.00
Mabali Kuta	CRD	216	42	68	110	50.93
Madina Jahanka	CRD	324	40	42	82	25.31
Galleh Manda	CRD	100	13	7	20	20.00
Faraba	CRD	460	53	51	104	22.61
Jahally	CRD	326	33	28	61	18.71
Sare Ngai	CRD	271	40	38	78	28.78
Jessadi	CRD	344	42	24	66	19.19
Kayai	CRD	201	22	23	45	22.39
Kunting	CRD	371	54	58	112	30.19
Total		2613	339	339	678	25.95
Julangel	URD	200	20	20	40	20.00
Sare Njobo	URD	170	27	18	45	26.47
Kulari	URD	187	18	13	31	16.58
Sare Bojo	URD	221	36	24	60	27.15
Medina Samako	URD	206	25	28	53	25.73
Sare Demba Toro	URD	139	23	21	44	31.65
Perai Tenda	URD	187	26	30	56	29.95
Demba Kunda	URD	274	25	35	60	21.90
Darsilime	URD	213	47	31	78	36.62
Total	URD	1797	247	220	467	25.99
Grand Total	All	6254	817	790	1606	25.68

The NSGA has also plans to conduct large screen video shows in all the selected communities within the next couple of months. The achievements of the project surpass all expectations. To date more than 7000 direct beneficiaries in school and 2000 within the communities have been reached.

Although the implementation of the project cycle is yet to be completed, preliminary results have proven beyond any doubts that the project has created an indelible impact on the lives of the beneficiaries. The students were reached for the first time with information on HIV/AIDS, sexual and reproductive health, nutrition, malaria and

tuberculosis control as well as environmental sanitation and hygiene. The major challenge is therefore to scale up and sustain the gains made thus far.

The in-school direct beneficiaries (young children) are very important in early childhood development interventions. The children will at an early stage have been exposed to reliable and important information on HIV/AIDS, malaria, tuberculosis, nutrition, hygiene, diabetes, healthy and harmful relationships to enable them make informed decisions.

These are some of the remarks made by the head teachers:

“The program will help to prevent children from disease and when they are empowered, society will be protected as” (Mr. Sanyang, Toniataba Lower Basic School)

“The program is important as it teaches nutritional values and health issues to the students” (Mr. Jallow, Jahanka Lower Basic School)

“The school is benefiting through the information they receive. The community is also benefiting through the parents-teachers association. They (the parents) are changing” (Mr.Sanneh, Julangel Lower Basic School)

Despite the good indicative results there is still room for improvements. Some of the recommendations are as follows:

- NSGA staff should use both English and the local languages when teaching the children in order to enable them better understand the messages and disseminate those messages to their families and peers;
- The messages presented to the children should take the local context into consideration in order to ensure relevance and applicability;
- The pace of the program should be slowed down and a lot of emphasis placed on outcome rather than output;
- NSGA should continue the training of staff especially those working in the field with the view to building their capacity for effective program implementation;
- There is a need to recruit (or where possible deploy an existing staff) a female field worker in URD who would act as a role model for girls;
- NSGA should further review the training manual to make it more relevant and appropriate to children in the lower basic schools;

- There is a need to continue the collection of data for both the school based health education program and the community outreach in order to establish the outcome and possible impact of the program.

7. Community Health and Governance Project

The Innovation Fund of the Canadian International Development Agency (CIDA) has awarded NSGA \$200,000 to assist school-based peer education teams take their health education program to villages and towns throughout the country. NSGA raised \$100,000 making a total of \$300,000.

The rationale behind the interventions and the chosen strategy is based on the fact that community health in The Gambia, especially in rural areas, can be substantially improved through youth development and leadership in providing communities with the requisite knowledge, skills and behavioural models to prevent and manage serious infections and diseases including HIV/AIDS.

The project integrates and built on two previous innovative program models developed by NSGA in the past:

- Comprehensive, national school-based peer health education programme with a significant community outreach component, including the development and deployment of full-time community-based youth drama troupes (2001-05);
- Summer school intensive skill-upgrading programs for junior and senior school students combined with a focused upgrading of teachers' skills (1992-94).

The project which became effective in December 2005 and will be implemented over a period of two years targeting 60 schools and 100 communities is due to close on 28th February 2006.

The main thrust of the programme is to substantially improve youth community health especially in the rural areas through youth development and leadership in providing communities with the requisite knowledge, skills and behavioural models to prevent and manage serious infections and diseases, e.g. sexually transmitted infections (including HIV/AIDS), malaria, tuberculosis, tobacco and drug related illnesses.

The Goal of the programme is **“To improve community health and governance in the Gambia through youth leadership and development”**

The objectives of the project are:

- To provide 240 students and 60 teachers each year with the health information, communication skills and motivation to enable them to take effective leadership roles in their school PHE teams and in their communities.
- To equip 2,000 Gambian youths each year (2006 and 2007) with the knowledge, communication skills, and leadership ability to help their peers and their communities to achieve better health, while preventing the spread of HIV/AIDS, STIs, TB and malaria.

- To train community-based organizations (CBOs) in 100 villages with the knowledge, presentation skills and ability to enable their communities to take responsibility for, and control of, their own health.
- To enable Canadian health professionals and teachers to contribute their expertise and experience in health information and training programs for Gambians, and to inform the Canadian public about the efficacy of such development work..

The intended direct beneficiaries of the project are:

- 480 secondary school students (peer health educators) and 120 teachers in the summer school programs
- 60 Peer Health Education teams (about 2,000 students) in the participating schools
- 100 community-based organizations in The Gambia
- 40,000 students per year in the 60 participating Gambian secondary schools (grades 7 - 12; ages 12 to 22)
- 140,000 residents of 100 Gambian villages (all ages): 10% of the country's population

7.1 Achievements

One of the major achievements of the community health programme is the successful completion of the 2006 summer school. The summer school brought together about 243 students, 60 teacher coordinators, 8 Canadian resources persons, and about 8 NSGA staff.

On the community outreach programme, an estimated number of 50 communities out of the 100 targeted communities have been reached with an estimated number of 20,000 direct beneficiaries. More than 50 % of the direct beneficiaries are women and about 10% fall within the age bracket of 15—24 years. An estimated number of 50,000 indirect beneficiaries have been reached making a total of 70,000 beneficiaries.

The large screen community video shows were conducted in 21 communities out of the 100 targeted for the period reaching an estimated number of **113,320** people. The topics shown during the community video shows center on HIV/AIDS prevention, malaria, tuberculosis and diabetes.

8. Nova Scotia-Sierra Leone Programme (NSSLP)

In August 2004 NSGA signed an agreement with the Canadian International Development Agency (CIDA) and the Ministry of Education of Sierra Leone to develop a nation-wide peer health education program in that country, where the long civil war has made young people especially vulnerable to HIV/AIDS and other sexually transmitted infections. CIDA provided the Nova Scotia - Sierra Leone Program (NSSLP) with \$424,000 for a period of three years, whilst NSSLP/NSGA provided matching funds to the tune of \$212,000. The matching funds were raised through public donations in Canada. The total funding for the project is \$636,000.00

The intended target beneficiaries of the programme are children and youths, male and female, between the ages of 12 and 24.

The in-school and community outreach work by the PHE teams was reinforced by parallel programs among other groups whose members are considered vulnerable to HIV infection. The vulnerable groups targeted by the project are:

- the 23 teams of the Premier and First Division Football League, their families, associates and fans;
- long-distance truck drivers and other members of the national union of drivers and general transport workers;
- Sierra Leone Teachers Union.

8.1 HIV Education for Drivers in Sierra Leone

The Nova Scotia – Sierra Leone Program (NSSLP) collaborated with the members of the Sierra Leone Motor Drivers’ and General Transport Workers’ Union and initiated an HIV/AIDS prevention program targeting commercial drivers including long distance truck drivers. The program conducted several training sessions on sex and sexuality, reproductive health, prevention of sexually transmitted infections including HIV/AIDS, tuberculosis prevention, drugs, and presentation skills.

The program was able to train **129** drivers. Out of this **65** female drivers representing **50.39%** of the total drivers were trained during the period. The topics covered during the training were reproductive health, sexually transmitted infections including HIV/AIDS, tuberculosis, drug, tobacco and alcohol addiction, healthy and unhealthy relationships, and presentation skills.

In Makeni, the Northern Provincial headquarters, in collaboration with the National AIDS Secretariat of Sierra Leone, a joint HIV/AIDS testing program targeting drivers was initiated. The test kits were provided by MEDMIRA, a Canadian company that donated free HIV testing kits. All the forty-two drivers who volunteered during the pilot phase tested negative. This pilot testing programme will now be extended to the diamond mining area town of Koidu, in the Kono District.

8.2 Community Health Outreach Work in Kono and Kailahun Districts, Sierra Leone

In June 2006 NSSLP accepted an invitation from GTZ (German Technical Cooperation) to work together to implement the model Peer Health Education in the Districts of Kono and Kailahun in Sierra Leone. The goal of the project was *“To inform, train and develop youth drama troupes to take information on hygiene, nutrition, reproductive health and other issues to residents of 100 villages or communities in each district”*. Program implementation started on July 1st 2006 and is due to be completed in July 2007.

Although NSSLP operation started very recently, the program is now a household name in Sierra Leone. The program trained 1600 peer health educators in 80 high schools reaching an estimated number of **XXXX** students in all the 13 districts in Sierra Leone. NSSLP has employed 28 fulltime staff who work at different levels in order to ensure the smooth running of the planned interventions.

Despite having its office located in Bo outside Freetown, NSSLP has been actively involved at national level program planning. Recently NSSLP participated in the preparation of a national program on HIV/AIDS for the Global Fund Round 6. NSSLP will continue to raise funds with the view to sustaining and scaling up the response. It effectively participate in forging partnership with key stakeholders, NSSLP will move its headquarters to Freetown and still maintain a field office in Bo.

Despite the huge success that had been registered since becoming operational in Sierra Leone, the program encountered some implementation challenges. Some of these challenges are:

The program did not have sufficient and reliable transport fleet to facilitate the implementation and monitoring of planned activities.

The location of the head office in Bo instead of Freetown had created an island between NSSLP and its partners.

The cash flow affects timely implementation of planned activities.

There is a need to have written management procedures and guidelines to enhance the efficient and systematic running of the programs.

9. Observations on Achievements, Administration and Management Procedures, Implementation Challenges and the Way Forward

NSGA has expanded its operations in recent years both in terms of scope and scale. Presently NSGA has employed 73 fulltime staff in Banjul whilst the Sierra Leone programme has employed 25 full time staff. The total numbers of projects currently under implementation are 4 in the Gambia and 2 in Sierra Leone.

Currently trained teams of Peer Health Educators were active in almost every secondary school in The Gambia, including:

- 36 senior secondary schools
- 80 junior secondary (upper basic) schools
- 35 basic cycle schools
- 7 vocation schools
- Gambia College.

Only four secondary schools in the country – both of them private schools are yet to participate in the Peer Health Education program. One can therefore conclude that the PHE program has been a genuine national program and a key component of accelerating the Education Sector's response to fighting the threat of HIV/AIDS especially among the young people. National institutions such as the National AIDS Secretariat have recognised the potential of the NSGA peer health program and supported the scaling up of the intervention. NSGA was a major implementing partner of the Community and Civil Society Initiatives (CCSI) of the HIV/AIDS Rapid Response Project (HARRP) coordinated by the National AIDS Secretariat.

During each of the past two school years, 2003-04 and 2004-05, the PHEs reached about **80%** of the students in secondary school (grades seven to 12) throughout the country representing about **80,000** students altogether. The main strategies have been presentation of short drama skits in the classrooms, at the assemblies and during other social functions in the schools.

In addition, NSGA had employed over the past three years **36** graduate Peer Health Educators as community-based drama troupes. Their primary job has been to take the health information directly to the community through street theatre in urban centres and presentations in rural villages in all divisions of the country.

The Peer Health Educators made presentations in more than **1,000** villages reaching a total audience in excess of **400,000** representing about **30%** of the total population of the Gambia. These young professionals also made regular presentations in schools and helped to train the schools' PHE teams improve their presentation and communication skills.

In its efforts to scale up the response at community level, large screen video shows were conducted in rural villages, reaching approximately 74,000 people in 92 villages as at the end of December 2005.

The NSGA nation-wide school-based Peer Health Education Program has specifically targeted the age-group 15 to 24 reaching between 70,000 and 80,000 of them in their schools during each of the past three years. As can be seen in **Table 5** below in 2001 NSGA trained 776 Peer health Educators and 68 Teacher Coordinators in 44 schools reaching a total of 11, 500 students. Ten 30 minutes radio programs were also aired to an estimated audience of **XXX**.

In 2002 1992 Peer Health Educators and 140 Teacher Coordinators were trained in 105 participating schools reaching a total of 45,000 students. Fifty-two 30 minutes radio programs were aired reaching an estimated number of 400,000 people in the Greater Banjul Area. During the same year twelve community video shows were conducted reaching an estimated number of 8000 people.

By 2005 NSGA has successfully trained 4306 Peer Health Educators and 350 Teacher Coordinators reaching an estimated number in excess of 80,000 students. Forty-nine 30-minutes radio programs were aired reaching an estimated number of between 200, 000 to 300,000 people. During the same year 21 large screen community video shows were conducted reaching an estimated number of 13, 000. Six fulltime drama troupes were appointed with about 36 actors. The NSGA drama troupes have performed in about 1000 villages across the country.

Table 5: NSGA Achievements in five years (2001-2005)

Achievement Indicators	Achieved in Year One 2001	Achieved in Year Two 2002	Achieved in Year Three 2003	Achieved in Year Four 2004	Achieved in Year Five 2005
# Peer Health Educators Trained & Retrained	776	1,992	3,100	4,096	4,306
# Teachers Trained to Coordinate Program in School	68	140	208	327	350
# Schools Participating	44	105	124	149	159
# Students Reached (Informed)	11,500	45,000	68,000	80,000	80,000
# 30-Minute Radio Programs on Health Issues	10	52	50	50	49
# Community Cinema Programs	0	12	46	29	21
Attendance	0	8,000	32,000	21,000	13,000
# Full-time Community Drama Troupes	0	2 Troupes	7 Troupes	7 Troupes	6 Troupes
# Members (Actors)	0	16 Actors	43 Actors	43 Actors	36 Actors
# Community Drama Performances	0	NSGA's drama troupes have performed in more than 1,000 villages across the country			
Audience	0				

9.1 Implementation of the Malaria Component of the Global Fund for Health

In collaboration with the Department of State for Health and Social Welfare, Catholic Relief Services (CRS) has subcontracted NSGA to jointly support the implementation of the Global Fund Programme. To date NSGA has about 91 nets to distribute. Twenty five of these nets will be distributed in each of the three “ITN Friendly Communities” and 25 through the scheduled radio programs as prizes to winners of the quiz competitions. The program also identified and trained 1970 peer health educators in 82 schools.

The Peer Health Educators have reached an estimated number of 54,588 students in all the 82 schools in the intervention area, that is, the Western Health region. The drama troupe members have also sensitised over 200 communities reaching directly over 109,969 people. The program also conducted 72-one hour radio programs reaching an estimated number of between 175,000 to 200, 000 people. This number is considered a modest estimate as the audience for Kids with Talent (KWT).

The program conducted large screen community video shows in 56 communities reaching an estimated number of 18,490 people.

These major achievements made by NSGA have contributed to meeting the targets set by the Global Fund. The Gambia’s malaria Global Fund programme has been reviewed and given an extension for the second phase. This extension was only possible as a result of meeting the program performance targets set and mutually agreed between the Gambia government and the Global Fund. The commitment and contribution of NSGA in ensuring the malaria program meeting its target was remarkable.

11. Implementation Challenges:

Although NSGA has made tremendous progress in instituting the PHE program in the schools and communities, there are implementation challenges which need to be addressed. The consultant therefore proposes the following recommendations for consideration:

1. NSGA should develop guidelines and procedures to enhance effective personnel, financial and procurement management functions. This is very crucial in improving efficiency and the overall effectiveness of interventions.
2. There is a need to strengthen the program monitoring and evaluation system by creating a unit with core staff to take charge of overall program monitoring and evaluation. The unit should equally develop tools and guidelines for data collection, recording, analysis and dissemination to enhance decision making.
3. NSGA should create a personnel office to be responsible for personnel management functions. This unit should work on creating personal files for staff, documentation of all personnel management issues, human resources, promotion development and capacity building.
4. NSGA should introduce a staff appraisal and performance evaluation system based on milestones agreed with staff at the beginning of the year. The results of the performance evaluation should be the determining factor for contract renewal, salary increment and other incentives such as bonus payment.
5. The programme planning and implementation systems should be further improved to improve implementation schedules and enhance efficient utilization of resources especially transport, forecasting expenditure, budget control.
6. There is a need to improve the financial management and accounting functions with the view to ensuring efficiency in cash flow management.
7. NSGA should work on a clear organisation structure clearly defining the functions of the staff and the authority relationships.
8. NSGA should set up “Management Committee that should meet at least once every fortnight to review progress on program implementation as well as serve as a forum to address operational issues affecting program implementation.
9. There is a need to have regular internal reviews and progress reporting by staff on the activities they implement. Such reviews should allow staff to identify their implementation challenges and the proposed interventions they envisaged to address the challenges.

10. In view of the expansion of the NSGA program particular attention should be paid to the capacity building, training and motivation of staff.
11. In order to enhance effective implementation, operational policy and procedures for transport and logistic system should be developed. A transport requisition form should be developed to be completed by staff and submitted to a central point for scheduling of the movement of the transport fleet.
12. NSGA should create a local area network with internet facility to facilitate internal communication and information sharing as well as enable staff have access to information related to their work.
13. NSGA should work on regularising its legal status as a registered NGO in the Gambia.
14. The collaboration and experience sharing with the Sierra Leone programme should be strengthened. To this effect annual joint programme reviews should be encouraged.
15. In a bid develop financial management and accounting standards, NSGA should move the accounts office from the front office and be allocated a separate office with limited access to the rest of the staff.

10. Conclusion:

The expansion of NSGA means that the level of informality in the running of the organisations should be reduced and procedures, rules and regulations prepared and institutionalised to guide its operations. More importantly programme planning, implementation; monitoring and evaluation should be strengthened to focus more on sharpening NSGA interventions.

The NSGA staff are highly committed and dedicated to their work. They have developed a natural passion for the work. However there is need to improve internal communication, devolve responsibility and decision making powers to the staff. This will allow the staff to grow and take responsibility for their actions. It will also create room for innovation and practical ways of identifying and resolving bottlenecks to programme implementation. The spirit of ownership of the programmes will also be enhanced.

The need to improve the financial management, accounting and procurement cannot be over emphasised. Therefore NSGA should develop financial management and procurement guidelines and procedures to strengthen its operations and compliance with donor requirements.