

PD-AAW-615

Best available copy -- pages cut off at bottom

PD-ATAW-615  
ISN-52825

92

9365927

DJIBOUTI TRIP REPORT

A Report Prepared By PRITECH Consultant:  
MARK RASMUSON

During The Period:  
OCTOBER 21 - NOVEMBER 8, 1984

TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT  
Supported By The:  
U.S. Agency For International Development  
AID/DPE-5927-C-00-3083-00

AUTHORIZATION:  
AID/S&T/HEA:  
ASSGN. NO: DC 72

## CONTENTS

	<u>PAGE</u>
Purpose of Trip	1
Summary of Results	1
Next Steps	2
Recommendations to PRITECH	3
Annexes	6
1. Individuals Consulted	
2. Diarrheal Disease in Djibouti	
3. Draft Proposal for Multi-Donor Collaboration in Diarrheal Disease Control	
4. Summary of Findings and Recommendations from CRS Food and Nutrition Evaluation Report	
5. Evaluation/Design Team Scope of Work	

- /  
DJIBOUTI TRIP REPORT  
October 21 - November 8, 1984  
Mark Rasmuson  
PRITECH Operations Officer

PURPOSE OF TRIP

I traveled to Djibouti during the period October 21 - November 8, 1984, to represent PRITECH on a project evaluation/design team requested by the USAID Mission and by the Office of Private and Voluntary Cooperation in the Bureau for Food for Peace and Voluntary Assistance (FVA/PVC), AID/Washington. The purpose of the team visit was to conduct, in cooperation with Catholic Relief Services (CRS), an evaluation of the CRS Food and Nutrition Program in Djibouti and to assist CRS develop an operational program grant (OPG) proposal to submit to AID for the next phase of CRS program activities there. CRS's current OPG expires in April 1985.

PRITECH was asked to participate on the team as a source of expertise in oral rehydration therapy (ORT), one of the program areas CRS had identified for the new OPG, and as a possible source of technical assistance to the new CRS program under PRITECH's disease control component. In addition to myself, the team included Joyce King, team leader for the evaluation, Agma Prins, a consultant who had assisted the USAID Mission develop its primary health care strategy in early 1984, and Ethline Smith-Lloyd, Food and Nutrition supervisor on the local CRS staff. The team's overall scope of work is outlined in Annex 5. I was asked to focus my time and efforts primarily on the design component of the mission, particularly the following:

1. Broad assessment of the diarrheal disease situation in Djibouti, in terms of both disease patterns and disease control activities, and of the overall feasibility of a PRITECH intervention.

2. Development of a conceptual framework and strategy for a CRS ORT program that would build on CRS's existing program structure and staff and be closely coordinated with other planned donor activity in diarrheal disease control.

3. Identification of specific activities within the above framework to which PRITECH could provide technical assistance, particularly in the area of ORT education, communication, and training.

SUMMARY OF RESULTS

By the time of my departure from Djibouti on November 8, the following had been accomplished:

1. A draft of the CRS Food and Nutrition Program evaluation report had been completed and its major findings discussed with

CRS, USAID, and representatives of the Djibouti Government. The report calls for gradual phase-out of CRS's Title II food distribution in Djibouti, based on the program's limited impact and extremely high cost, but recommends that CRS utilize the food program infrastructure to implement an intensive oral rehydration and nutrition education and training project. A copy of the final evaluation report's summary of findings and recommendations is included in Annex 4.

2. A broad, preliminary assessment of the diarrheal disease situation in Djibouti had been performed by the team through review of relevant existing documents, interviews with health staff, and analysis of registry data from 2 MCH centers. A summary of the findings of this assessment are contained in Annex 2. An in-depth assessment, including a national morbidity/mortality survey is planned by WHO as part of its development of a national diarrheal disease control plan. WHO's assessment and plan will obviously be an important element in USAID and PRITECH planning.

3. A series of meetings had been held with the major donors preparing to assist diarrheal disease control activities (WHO, UNICEF, FAC, the French aid program) and those Djiboutian organizations most likely to be involved in such activities (the Health Education, Training, Hygiene, and Primary Health Care units within the Ministry of Health, as well as the non-governmental Women's Union) to discuss areas of mutual interest and possible collaboration.

4. A draft proposal for a "multi-donor collaborative intervention to reduce child mortality in Djibouti" had been prepared by the team in English and French and circulated to the above individuals and organizations for review. A copy of the proposal, which will form the basis for CRS's OPG proposal to AID, is contained in Annex 3. The proposal suggests a strategy for a national program for control of diarrhea and malnutrition, identifies CRS as an important coordinator of training and public education activities, and outlines a first-year plan of technical assistance to be funded jointly by PRITECH, WHO, and UNICEF. The initial response from WHO, UNICEF, and the unit within the Ministry of Health most likely to coordinate such a program, the Primary Health Care office, was extremely favorable. In particular, the WHO representative welcomed the proposal's recommendations for collaboration as important input to the WHO control of diarrheal disease (CDD) planning mission scheduled for late November.

#### NEXT STEPS

The following are the immediate next steps that must be taken to complete the CRS OPG proposal and determine PRITECH's potential role in it:

1. The draft OPG proposal must be completed and submitted for review and preliminary approval by the Government of Djibouti. This work will be done by the remaining members of the evaluation/

design team, Joyce King, Agma Prins, and Ethline Smith-Lloyd. It is essential that this document be developed in continued close consultation with WHO, UNICEF, and FAC and with the WHO CDD planning team (Drs. Madkour and Cooper) which is scheduled to visit Djibouti in late November.

2. The draft OPG must be reviewed by AID/Washington, CRS's regional office in Nairobi and national office in New York, and by PRITECH. Agreement must be reached among CRS, AID/Washington, and the USAID Mission on the process and time frame for submission and review of the proposal. The original mandate of the evaluation/design team was to assist CRS develop a proposal for submission to AID/Washington according to routine OPG procedures. In the course of the team's visit, however, the USAID Representative stated his wish to include the proposal developed by the team in a PID-type document he intends to submit to AID/Washington in December to expedite the review and approval process. CRS, which would be designated as the likely but not necessary recipient of the OPG in this document, has not understood and feels threatened by this proposed review process.

3. PRITECH must assess the draft OPG proposal and the role for PRITECH suggested in it and develop its own intervention strategy for Djibouti. This strategy will be developed from data and recommendations in this document, the CRS OPG proposal, the WHO CDD assessment and national plan, and the USAID Mission's primary health care strategy.

4. The final OPG proposal, with changes from the review process incorporated, must be approved by AID/Washington, the USAID Mission, CRS, PRITECH, and the Government of Djibouti. PRITECH's intervention strategy for Djibouti must be submitted to and approved by S&T/Health.

#### RECOMMENDATIONS TO PRITECH

PRITECH should proceed in developing a country intervention strategy and plan for Djibouti according to the technical assistance needs identified in CRS's OPG proposal. The proposed project and the diarrheal disease situation in Djibouti offer a positive opportunity for PRITECH assistance in the following ways:

1. Diarrheal disease mortality rates are very high--diarrhea is implicated in 60% of under-5 deaths--but very possibly amenable to substantial, measurable reduction in the relatively near term, given Djibouti's small concentrated urban population and effective communication channels, both face-to-face (the MCH network, community health committees) and broadcast (radio and television).

2. The Djiboutian Ministry of Health is in the midst of a promising process of reorienting its health system to the delivery of primary health care services and has appointed a bright, energetic young Djiboutian doctor to a key coordinating role (Coordinator of Primary Health Care). Control of diarrheal

disease, promotion of breastfeeding, and nutrition education are among the top priorities of the Ministry' emerging 5-year plan. The Service d'Hygiene has been involved over the past year in an impressive process of organizing and working with community health committees.

3. There is an excellent spirit of cooperation among the health donors, particularly WHO, UNICEF, CRS and USAID, and a convergence of interest in addressing the diarrheal disease problem in Djibouti. As already noted, WHO is planning a CDD program planning mission in late November and a national morbidity-mortality survey in 1985. UNICEF has already played a major role in diarrheal disease control, having supplied most of the country's ORS packets for the past 5 years, sponsored health worker training that included ORT, etc. UNICEF is planning to assist WHO with funding of the morbidity-mortality survey next year and to sponsor a communication seminar to promote improved collaboration between the Ministry of Health and the country's information services. CRS's existing food and nutrition program offers a solid and essential clinical and interpersonal infrastructure--20 MCH centers, 40-50 field staff, and several thousand regularly attending mothers--through which to implement an ORT training and education effort.

4. The proposed project offers an important opportunity to address diarrhea and malnutrition in a programmatically integrated fashion, including operational research on dietary management of diarrhea.

5. The project affords AID and PRITECH an opportunity to assist CRS move in an innovative direction: away from programs that only distribute food to programs with a more developmental and educational emphasis. This is a major change which both CRS and AID are eager to see happen.

Among the constraint issues PRITECH must address before committing itself to a Djibouti intervention are the following:

1. Complications from CRS's termination of the Title II food distribution program: As already noted, the evaluation/design team found the current CRS food distribution program in Djibouti of limited impact and high cost and recommended its gradual phase-out. There continues to be disagreement between CRS and USAID in Djibouti about the timing and duration of this phaseout and about how and when it should be communicated to the Djiboutian Government. While the team found most Djiboutian officials receptive to the logic of the phaseout, some felt strongly that the food aid should be continued. It is thus still a sensitive issue. Agreement must be reached among CRS, USAID, and the Djiboutian government about how and when the phaseout occurs in order that the planning and implementation of the new OPG project may proceed smoothly.

2. CRS staffing and management issues: CRS is in the midst of staffing changes in Djibouti as well as a regional management reorganization whose consequences for the proposed new OPG project

are not yet clear. CRS's current representative will shortly be reassigned to a regional post in Addis Ababa, and it is unclear whether his replacement will be designated a country representative ~~has just been reassigned to a regional post in Addis Ababa, and it is unclear whether his replacement will be designated a~~ country representative or CRS will downgrade the position to that of a project manager. The assistant country representative has just been reassigned to West Africa and his replacement is yet uncertain. The current food and nutrition supervisor who has assisted with the development of the OPG may also leave Djibouti next year. Added to this uncertainty is the need the OPG design team sees for a full-time, well-qualified technician to manage the new OPG project for CRS. The design team feels CRS should be willing and may have to recruit this position from outside the organization.

While there have been some suggestions that a successful AID-assisted ORT program could be implemented even in the absence of CRS participation, PRITECH should consider CRS's continued involvement as a necessary ingredient of project implementation and success given the importance of the staff and program infrastructure CRS offers.

3. The short project time frame: CRS and the OPG design team were informed by the Africa Bureau in AID/Washington that only 2 years of project funding may be approved for the new CRS OPG, as all AID project funding to Djibouti is being phased out in keeping with the Bureau's current policy regarding development assistance to small countries. The OPG design team is thus planning a project with a 2-year time frame. CRS's willingness and ability to maintain any substantial level of program activity with its own resources after that time is questionable, given the very high costs of maintaining staff and programs in Djibouti.

4. The role of FAC: The role of the French aid program in Djibouti's emerging diarrheal disease control program is still unclear. USAID and WHO have approached FAC with a request to actively participate in the CDD planning process now underway and received an expression of positive interest. There appears to be some resistance to the USAID-WHO initiative from the French, however, both from the institutional self-interest of FAC, which is by far the largest donor to the health sector in Djibouti (primarily the curative services), and because of disagreement within the French community itself between the more conservative military medical corps and the more progressive cadre of cooperants. Winning the support of the French is critical, however, to the establishment of ORT in Djibouti's clinical services.

## ANNEX 1

### INDIVIDUALS CONSULTED

#### USAID

Mr. John Lundgren, USAID Representative

#### WHO

Dr. Butera, WHO Representative

#### UNICEF

Mr. Abdul Hamid Idrissa, Resident Program Officer  
Mr. Edward Martin, Master Driller

#### MINISTRY OF HEALTH

Mr. Mohamed Abado Kako, Minister of Health  
Dr. Claude Gilles, Advisor to Minister  
Dr. Henri Filippi, Chief Medical Officer, Farahad Dispensary  
Dr. Mohammed Maalin, Chief Medical Officer, Balbala Dispensary  
Dr. Abdellahi Ainan, Chief Medical Officer, Enguella Dispensary  
Dr. Jean Renaudet, Director, Hygiene Service  
Dr. Pierre Zannotti, Chief Medical Officer, Pediatrics Unit,  
Peltier Hospital  
Dr. Acina, Pediatrics Unit, Peltier Hospital  
Mr. L. Jan, Director of Central Pharmacy  
Mr. Ismaila Said, Nursing Officer, Balbala Dispensary  
Ms. Marie-Pierre Calderon, French volunteer, Farahad Dispensary  
Mr. Said Hassan, Nursing Officer, Enguella Dispensary  
Ms. Samira Ali Higo, Director, Training Center  
Mrs. Jacqueline Anis, Director, Health Education Unit  
Mrs. Saada Idriss, Nurse, Health Education Unit  
Dr. Abate, Coordinator of Primary Health Care

#### CRS

Mr. Bob Roche, Country Representative  
Mrs. Ethleen Smith-Lloyd, Food and Nutrition Supervisor  
Mr. William Canny, Program Assistant

#### RADIODIFFUSION-TELEVISION DJIBOUTI

Mr. Mohamed Djama Aden, Director

#### FAC (FRENCH AID PROGRAM)

Mr. Dominoni, Director

NATIONAL WOMEN'S UNION

Mrs. Saida Hassan Bogoreh, Secretary General  
Martha Mamozai, Advisor

RED CRESCENT SOCIETY

Mr. Abdi Kireh, Director

PRIVATE MEDICAL COMMUNITY

Dr. N. Georgalis, General Practitioner

## ANNEX 2

### DIARRHEAL DISEASE IN DJIBOUTI

#### Mortality and Morbidity Patterns

Estimates of diarrhea-associated mortality in Djibouti vary widely in the absence of reliable data. Infectious gastroenteritis, bacillary dysentery, and amoebiasis accounted for 9% of all deaths reported by the Ministry of Public Health in 1978, when the leading causes of death were tuberculosis (72%) and measles (17%).

Diarrhea figures much more prominently as a cause of 0-5 year mortality. Estimates of diarrhea-associated mortality in this age group range from 28% (Baudouy, 1980) to 60%. The latter is the Djiboutian government's currently used figure, making diarrhea the leading cause of death in this age group, followed by pulmonary infections (20%), malnutrition (15%), and other transmittable diseases (5%).

Diarrhea and colds are the two most common illnesses among all age groups in Djibouti. Diarrheas accounted for 21% of all illnesses reported by the Ministry of Public Health in 1978, and are estimated to be responsible for 30-40% of all dispensary consultations in the 0-5 year age group.

The CRS evaluation/design team analyzed disease registry data in two Djibouti-ville dispensaries and found the following: In the Farahad dispensary, 32% of all new cases in the 0-4 year age group during the period September 18-October 20, 1984 were diarrhea cases, making it the highest cause of illness followed by colds (23%). In the Balbala dispensary, diarrhea accounted for 24% of new 0-4 cases during the period July 31-September 12, 1984, the second leading cause of illness following "fever with cold" (30%).

These elevated incidence rates are reflected in Cook's interviews with 155 Djiboutian women in early 1984. 43% of all illness episodes reported by the women involved diarrhea, sometimes in combination with other symptoms. Following diarrheal illnesses in the mother's reports were colds (13%), measles (8%), and bronchitis, flu and vomiting, all at 5%.

The incidence of acutely dehydrating diarrhea has been much more difficult to assess. A number of dispensary personnel, including several dispensary medecin-chefs, said that they saw few cases of dehydration. One of these was a young, progressive French doctor who said that dehydration cases were "very rare" now compared to three years ago when he arrived, presumably because he had been actively promoting UNICEF ORS packets. Other medical officials said that dehydration was very common but that most health workers, including physicians, were not adequately

trained to assess it and only recognized the most severe cases of dehydration. Another explanation is that a lot of dehydration is being prevented by Djiboutian mothers' practice of giving soups and other fluids to sick children, which will be discussed further below.

There does not appear to be any marked seasonality to diarrhea patterns in Djibouti. Most physicians interviewed were unaware of any major seasonal variation. Several nursing staff said they saw more diarrhea in the cooler, wetter season but were unsure whether this was due to environmental hygiene factors (more standing water, more flies) or simply to the seasonal increase in their patient loads at this time of the year (many people migrate to cooler weather during the hot summer and return to Djibouti during the cooler months).

### Medical Treatment of Diarrhea

In the public health system dispensaries, the predominant treatment for diarrhea is the prescription of anti-diarrheal and antibiotic medications. Among those stocked and used are the following: Imodium (loperamide), ercefuryl (nifuroxazide), sulfaguanadine, intetrix, lyantil, thiacyl, and arabon.

Oral rehydration salts (UNICEF packets) were visible in most centers visited and occasionally given to a mother, but many health workers, let alone mothers, do not understand the rehydration function of the packets or the importance of mixing and administering it correctly. The chief pharmacist at the Ministry of Health told us that only two dispensary physicians routinely request replenishment of their ORS packet supply.

UNICEF brought the first ORS packets into Djibouti in the late 1970's to serve the refugee camps and has been providing a small supply each year since. In 1984, UNICEF provided 11,000 packets and WHO 20,000 packets. WHO's earliest promotion of ORT in Djibouti occurred in 1979, when a WHO consultant, Dr. R.G. de Bernardi, visited the country on a consultancy to promote vaccination and diarrhea disease programs and other MCH services.

A French ORS product, Adiaril, is available in several pharmacies in Djibouti-ville and is prescribed for diarrhea, along with anti-diarrheals, by several of Djibouti's 5 private physicians. A box containing 3 packets, each of which mixes into a 1-liter solution, is sold for 900-1200 Djiboutian francs (\$5.00-\$7.00), about the same cost as one of the anti-diarrheal products (ercefuryl).

Severely dehydrated children are treated with intravenous therapy in the 23-bed pediatric unit at Peltier Hospital. The medecin-chef of this service, a French pediatrician, endorsed the practice of oral rehydration therapy and said he thought its limited application in recent years had slightly decreased the number of dehydrated cases referred to his unit. He said he is unable to introduce ORT in the pediatric unit on a regular basis

because it is too-consuming for his limited staff, however. He welcomed the idea of increasing national diarrheal disease control activity, including promotion of ORT.

It should be noted here, for national program planning purposes, that a substantial increase in the supply of ORS packets may well be required by a strategy which intensively promotes ORT, particularly if government policy recommends (as it may not) that every case of diarrhea is treated with packets. Using a very conservative estimate of current dispensary coverage of children under 5 years--CRS's monthly coverage average of 5138 under-5's (less than 10% of the national under-5 population)--still produces a yearly ORS packet requirement considerably higher than current levels:

$$5138 \times 30\% \text{ diarrheal morbidity} \times 3 \text{ packets/episode} \times 12 \text{ months} \\ = 54,505 \text{ packet yearly requirement}$$

#### Home Beliefs and Practices Affecting Diarrhea

A number of important beliefs and practices affect the prevalence of diarrheal disease and the way they are treated in Djibouti. Perhaps the most important is the almost universal practice of bottle feeding infants. As Prins noted in 1984:

" The primary cause of childhood diarrhea in Djibouti appears to be the practice of bottle feeding. Over 80% of infants are not breastfed beyond 6 months. At least 20% are breastfed for less than 3 months. Bottle feeding often starts at birth even for partially breastfed infants. While these practices are more common in Djibouti-town than elsewhere in the country, bottle feeding is a widespread practice even among nomadic populations here. Apparently, goat's milk is often substituted for formula in rural areas.

" In Djibouti-town, where an estimated 65% of births occur in medical institutions, the practice of bottle feeding is encouraged by the common practice of separating mother and infant at birth and starting feeding with glucose solutions. Hospitalized children are also often taken off the breast. In addition, many dispensaries, MCH clinics, and maternities distribute "Gallia" brand infant formula and even jars of baby food to mothers free of charge, although in theory this distribution is limited to needy mothers who are unable to breastfeed.

" Faced with the dilemma of a high incidence of diarrhea resulting from incorrect or unhygienic preparation and storage of infant formula and a high percentage of women unwilling to breastfeed exclusively, health education efforts at dispensaries appear to focus rather more heavily on correct preparation of formulas than on the benefits of breast milk. Further, despite an official government policy to the contrary (dating from 1982), prepackaged baby foods are widely advertised and available in even the smallest local stores.

" The popularity of bottle-feeding, apparently of long standing in Djibouti-town, appears to result largely from a widely-held belief in the inadequacy of breast milk as an infant food and that 'impurities' in a mother's milk when she is ill, menstruating, or had sexual intercourse can be transmitted to and harm her nursing baby."

Djiboutian mothers have their own ideas about the causes of diarrhea and about appropriate treatment for it. Cook's 1984 study identified a number of these beliefs and practices and is cited extensively below. One very salutary traditional treatment practice should, however, be highlighted here.

A common practice among Djiboutian women is to give carrot scup or rice water to their child when he or she has diarrhea. This finding of Cook's is supported by a survey conducted by the Health Education Unit in 1981, in which 76% of the 135 mothers interviewed reported giving rice water with crushed carrots when their child had diarrhea. A 1983 study by the Union des Femmes Djiboutiennes found a similarly high percentage of 149 interviewed mothers reporting this practice. This practice should certainly be reinforced in any educational campaign on appropriate home feeding during diarrhea.

Cook's study probably underestimated treatment of diarrhea and other illnesses by local healers. While Cook's respondents reported only five cases of illness seen by a healer--four of which were diarrheal--Baudouy (1980) concluded that recourse to local healers was very common. Baudouy reported that parents often consulted a local healer, either before or after seeing the government health service, and often paid him 2000-3000 francs for a consultation.

One quite common treatment for diarrhea that some of these healers specialize in is called "pointes de feu"--burns are inflicted on the ailing part of the body--and evidence of this treatment was seen on the stomachs of several children in one of the dispensaries we visited.

Summary of Diarrhea-related findings from Jon Cook, "Primary Health Care Sociological Study," USAID, 1984

° 43% of all illness episodes reported by 155 women at PMI's involved diarrhea, sometimes in combination with other symptoms. Following diarrheal illnesses were colds (13%), measles (8%), and bronchitis, flu, and vomiting, all at 5%.

° Diarrhea was assigned causes by about one-half the women. Improper scheduling of food, especially the ignoring of intervals between meals, was a major cause of diarrhea. Milk which was given too cold, or was of the wrong kind was especially implicated in diarrhea. Changing the kind of milk (mother's milk to artificial, one kind of artificial to another) was also an important cause of

diarrhea, as was teething. Improper food scheduling refers to the "heavy-light" dichotomy. Milk, being a "light" food, is often blamed for diarrhea when it is given after a meal containing "heavy" foods. Changes in the season or the "air" also cause diarrhea, as does the mother's ill health.

° Symptoms of diarrhea commonly cited were the obvious changes in stool frequency and composition, but included fever and vomiting at times. (Principal symptom of illness recognized by Djiboutian women was fever. Crying was also important illness symptom).

° Second most popular treatment regimen after dispensaries alone (50% of mothers reported) was a visit to a dispensary followed by diet changes at home. This was used by 40 women for 37 cases of diarrhea and one case each of a cold, measles, and vomiting. Five cases, four of which were diarrhea, were seen at a dispensary, then by a healer, then changes in diet were introduced at home.

° Importance of diet changes in diarrhea treatment: All milk was withheld in 23 cases of diarrhea, artificial milk was stopped in 7 cases and in one case the brand of milk was changed. Milk was replaced by purees of carrots and other vegetables in 15 cases, by rice water in 13 cases (7 mothers said "rice" which may refer to rice water), and by sugar water in 4 cases. Curdled milk and bread porridge were used in two cases each. In some cases, foods and liquids were added to the milk diet. Curdled puree and tea with bread were some of the foods added. Two mothers stopped giving goat's milk and one stopped mother's milk and replaced it with goat's milk.

° Six women whose children had a form of diarrhea indicated that they might have prevented the illness by maintaining the proper cleanliness in the home including, for some, cleanliness of the baby bottles. Six mothers also cited the necessity of correct feeding, by which they meant two things: 1) sufficient foods of the right kinds, and 2) given at the correct intervals (the latter to prevent the mixing problems described above). Four women felt that if they knew more about medicine they could have prevented the illness, and two thought that proper medicines would have avoided the problem. Three cases of malnutrition could have been prevented by correct feeding, or by having sufficient means (apparently meaning enough money to buy proper food). Three cases of diarrhea were not thought possible to have avoided because of bad water, teething of the child, and the fact that "one cannot prevent diarrhea".

° The last question on illness asked mothers what they thought causes diarrhea among children. Of 260 answers to the question, 167 had something to do with feeding practices or the food itself.

Of 134 responses related to feeding practices, 85 mentioned improper food preparation and feeding such as, by order of importance: giving cold milk followed by something hot (23); giving

cold foods (13); improper preparation of milk (probably refers to powdered milk dosages) (11); improper mixing of foods (10); changes in food habits (7); dirty bottles (6); giving too much to eat (5); malnutrition (5); giving left-over milk (3); a poor appetite (1); and weaning (1). The remaining 49 responses related to feeding practices and blamed diarrhea on not following proper meal schedules (48) or giving the bottle to an infant who is very hungry (1).

Of the 33 responses mentioning the food itself, 18 cite foods the child can't tolerate as having caused the diarrhea; 4 answers each refer to lack of nutritional food, artificial milk, and the fact the child ate some earth. Food poisoning, the salty water in Djibouti, and the belief the child drank too much water because of the summertime heat are each mentioned once.

Among the 93 causes given which don't relate directly to food or feeding, 20 respondents cite lack of hygiene as causing diarrhea (if the category "dirty bottles" is shifted from food preparation to hygiene, this cause becomes even more important); 18 blame teething; 13 people mention "catching cold"; 9 cite "guedsare", a Somali illness label referring to diarrhea caused by the flight of a species of bird of prey over the child, or over the child's clothing; 9 believe God causes diarrhea; 8 blame fever; 6 refer to "neglect" as the cause; a sick or sickly child is seen as sufficient cause for a case of diarrhea by 3 respondents; flies and climate change account for 2 causes each, and jaundice was thought by one woman to be a cause of diarrhea.

# A NATIONAL PROGRAM FOR THE CONTROL OF DIARRHEAL DISEASE AND MALNUTRITION

## PROPOSAL FOR A MULTI-DONOR COLLABORATIVE INTERVENTION TO REDUCE CHILD MORTALITY ASSOCIATED WITH DIARRHEA AND MALNUTRITION IN THE REPUBLIC OF DJIBOUTI

### SUMMARY

The following few pages propose a strategy for the planning and implementation of diarrheal disease and malnutrition control activities in Djibouti. The proposal should be seen as a first attempt to suggest a conceptual approach and possible donor agency roles for a control of diarrheal disease (CDD) program, and as one input to the joint OMS/USAID/FAC CDD planning mission scheduled for late November 1984.

#### The key elements of this strategy are as follows:

1. Treats diarrhea and malnutrition as closely related disease entities requiring integrated treatment and prevention measures.
2. Establishes oral rehydration therapy (ORT) and appropriate feeding practices during and after diarrhea as the key therapeutic components of diarrheal disease management.
3. Assigns first priority to the establishment of ORT and appropriate feeding practices as the CDD program elements promising the most immediate impact on child mortality.
4. Assigns highest priority to growth monitoring, nutrition education, and promotion of breastfeeding as activities designed to prevent malnutrition and diarrhea.
5. Includes an intensive training and public education component focusing on a carefully limited set of topics to maximize audience learning and behavior change.
6. Involves extensive close collaboration among donor agencies, government services, and other local organizations to ensure maximum impact and prevent wasteful duplication of effort.

## JUSTIFICATION

The strategy for CDD program planning proposed here is justified on the following grounds:

1. Diarrhea and malnutrition are both extremely serious health problems in Djibouti.

Diarrheal disease is the leading cause of child mortality in Djibouti, accounting for an estimated 60% of deaths in children under 5 years. 30-40% of all dispensary consultations in the 0-5 year age group are for diarrhea.

According to recent CRS data, 35% of all children under 5 years are malnourished (i.e. under 80% of weight for age). 13% of children in the 0-5 year group are under 70% of weight for age.

2. Diarrhea and malnutrition are closely related diseases which it is logical to target together in a treatment and prevention program.

The relationship between diarrhea and malnutrition has been much studied, written about, and discussed. It has frequently been described as a "vicious circle" of malnutrition predisposing to diarrhea and diarrhea in turn aggravating existing malnutrition. While the association between nutritional status and subsequent risk of acute diarrheal morbidity is still not fully understood, there is clear evidence of the deleterious nutritional consequences of diarrhea. It is now well established that a principal cause of malnutrition in the Third World is repeated episodes of acute diarrhea.

This relationship is increasingly being reflected in CDD program planning. While the main focus of CDD programs to date has been on the promotion of oral rehydration therapy, increasing attention is now being given to the dietary management of acute diarrhea. Prevention and/or recuperation of nutrient depletion are being seen as as important as rehydration. Nutritionists especially are recommending an integrated package of oral rehydration and appropriate dietary management for the treatment of diarrhea.

3. Current interests and activities in diarrhea and malnutrition control in the Ministry of Health and among donor agencies are converging in a manner that strongly recommends the establishment of a high-priority, multi-donor national program and promises some very dramatic program results.

a. The Ministry of Health has identified the control of diarrheal disease, the promotion of breastfeeding, and nutrition education as among the top priorities of its emerging 5-year primary health care plan. The Service d'Hygiène has been especially active in organizing and working with community health committees to undertake environmental hygiene and other disease prevention activities.

b. OMS has invited an expert consultant from its regional office to lead a joint CDD program planning mission in late November 1984. OMS is also planning a national morbidity/mortality survey early next year which will establish baseline rates for diarrhea and other diseases.

c. UNICEF has already played a major role in diarrheal disease control and nutrition activities in Djibouti as part of its CSDR program (Child Survival and Development Revolution). It has provided ORS packets, assisted CRS's nutrition education program, sponsored training for traditional birth attendants which included ORT, etc. Currently, UNICEF is planning to assist OMS with the national morbidity/mortality survey and to sponsor a communication seminar early next year to promote improved collaboration between the Ministry of Health and the country's information services. It has also discussed support of a public education campaign by the Union Nationale des Femmes Djiboutiennes on breastfeeding next year.

d. USAID has identified training and community education activities in general, and diarrheal disease control and nutrition education in particular, as its priority intended contributions to Djibouti's primary health care program. USAID has also secured the technical assistance services of a central AID Project, PRITECH, which is specifically designed to assist countries plan, implement, and evaluate diarrheal disease control programs.

e. FAC has expressed keen interest in working collaboratively in diarrheal disease control in Djibouti and hopes to provide a physician expert to work on the joint CDD program planning mission in November. FAC, as the largest supplier of physicians and other medical personnel and the largest overall donor in the health sector, will undoubtedly have a number of major contributions to make to the successful implementation of a diarrhea/malnutrition control strategy in the country's clinical services.

f. CRS has been a leader in maternal and child health in Djibouti since 1979. Since the initiation of food distribution and weight monitoring activities in rural dispensaries in 1979, CRS has expanded its program to encompass school feeding and health education, promotion of fish consumption (with UNICEF), and training of health personnel. CRS is now anxious to significantly strengthen and expand its training and educational activities, with diarrheal disease control being one of its stated priorities.

## PROGRAM COMPONENTS

The experience of national CDD programs in other countries and the current situation in this country recommend the following as essential components of a national diarrhea/malnutrition program in Djibouti.

### 1. Formulation of national policy and plan

Should include treatment norms for home, clinic, and hospital levels; policy statements on infant formula and anti-diarrheal medications; training plans; plans for procurement and distribution of ORS packets and other necessary commodities; evaluation strategy; financial and management plans; etc.

### 2. Research and evaluation

Baseline survey including morbidity, mortality, and KAP data; management information system for program monitoring; media research and other formative evaluation for educational planning; dietetic and feeding program operations research; post-intervention evaluation.

### 3. Health worker training

Should include a national seminar on management of diarrhea and malnutrition targeted primarily at physicians; a national training of trainers on ORT, nutrition education, and training methods; and a series of short, practical training workshops on ORT and appropriate feeding practices for health workers and other community extension agents.

### 4. Community training and education

Broadcast, print, and interpersonal communication channels (such as health committees and women's groups) should be used to educate the public on a carefully limited set of topics: appropriate home management of diarrhea, importance of breastfeeding, and appropriate infant feeding practices.

### 5. Strengthening of surveillance and referral system

Could operate at two levels: (a) growth monitoring and assessment of dehydration in MCH clinics and (b) community surveillance and referral of diarrhea and malnutrition cases by health committees.

### 6. Strengthening of clinical ORT/refeeding services

Should include establishment of oral rehydration unit at Peltier Hospital; establishment of oral rehydration services at all MCH clinics; and experimentation with systems of refeeding for children with serious cases of diarrhea and malnutrition.

The following table breaks down these main components into a number of specific tasks and suggests responsibility for them in terms of (a) execution and (b) finance and technical assistance.

	<u>Execution</u>	<u>Finance and TA</u>
1. <u>Policy and plan formulation</u>	DSP	OMS, FAC, UNICEF, USAID (PRITECH)
2. <u>Research and evaluation</u>		
a) morbidity/mortality survey	OMS, CF, BR, BS	OMS, UNICEF
b) develop management information system	OMS, PMI, SHE	OMS, FAC
c) KAP studies	CE, UNFD	UNICEF, PRITECH
d) media and other formative research	CE, CRS, RTD	PRITECH
e) dietetic and feeding operations research	CRS, UNICEF	PRITECH
3. <u>Health worker training</u>		
a) national diarrhea/malnutrition seminar	OMS, FAC PRITECH	OMS, PRITECH FAC, UNICEF
b) training of trainers		
c) health worker workshops on ORT/nutrition	CF, CE, CRS, UNFD, TBA	OMS, PRITECH FAC, UNICEF
4. <u>Community training/education</u>		
a) message development/communication planning	CE, CF, CRS	PRITECH, UNICEF
b) develop broadcast materials (radio/TV)	RTD, CE	CRS, PRITECH
c) develop print materials	CE, UNFD	UNICEF, UNFD
d) community training (health committees, UNFD annexes)	SHE, UNFD CE, CF, CRS	PRITECH, UNICEF
e) mass media campaign	" + RTD	"

	<u>Execution</u>	<u>Finance and TA</u>
<b>5. <u>Surveillance and referral</u></b>		
a) growth monitoring in PMI's	PMI	CRS, USAID
b) improved diarrhea assessment in PMI's	PMI	CRS, USAID
c) community surveillance of diarrhea/malnutrition	Comités, Annexes, UNFD	SHE, CE, UNICEF
<b>6. <u>ORT/refeeding clinical service</u></b>		
a) ORT unit at Hôpital Peltier	Hôpital	FAC
b) ORT service at PMI s	PMI	CRS, USAID
c) Refeeding program at PMI's	PMI	CRS, USAID

---

Key to abbreviations used for participating services and organizations:

OMS: Organisation Mondiale de la Santé  
 FAC: Fonds d'Assistance et de Cooperation  
 USAID: United States Agency for International Development  
 UNICEF: United Nations Children's Fund  
 PRITECH: Primary Health Care Technologies Project (USAID)  
 DSP: Direction de la Santé Publique  
 CE: Cellule d'Education  
 CF: Centre de Formation  
 SHE: Service d'Hygiène et d'Epidémiologie  
 PMI: Protection Maternelle et Infantile  
 CRS: Catholic Relief Services  
 RTD: Radiodiffusion Télévision Djiboutienne  
 UNFD: Union Nationale des Femmes Djiboutiennes  
 BR: Bureau de Recensement  
 BS: Bureau de Statistiques

## THE CRS ROLE

CRS would be responsible for three major areas of activity:

1. Implementation of an oral rehydration therapy program in all PMI's.

The concept of the program in an individual PMI would be that of a mini-clinical oral rehydration unit for both demonstrating to mothers the correct practice of ORT and actually rehydrating sick children.

The program could be integrated into CRS's existing growth monitoring activity in PMI's as follows:

a. If a child has diarrhea, PMI staff conduct systematic clinical assessment of hydration status.

b. If hydration status is normal, mother is counseled to give appropriate fluids and foods (e.g. breast milk, carrot soup, rice water) to prevent dehydration and educated on signs of dehydration to watch for.

c. If child is moderately dehydrated:

i) child is weighed to determine volume of rehydration solution needed.

ii) rehydration is begun at PMI by staff using UNICEF packet solution.

iii) mother is given ORS packets and instructions for continued ORT at home, appropriate feeding including breastfeeding, and when to return to PMI for refeeding program.

d. If child is severely dehydrated, PMI staff begin ORT immediately and refer child to physician or hospital.

e. Moderately and severely dehydrated children become eligible for follow-up refeeding program along with seriously malnourished children.

2. Coordination of the community training, education, and surveillance components of the project.

CRS will play the central role, with financial support and technical assistance from PRITECH and UNICEF, in planning and implementing a public education campaign focusing on appropriate home treatment of diarrhea, appropriate infant feeding practices, and promotion of breastfeeding.

In this role, CRS will be required to work closely with the following services and organizations:

a. Cellule d'Education: logically CRS's closest counterpart within the Ministry of Health for overall campaign planning, including formative research, message development and prioritization, and development and testing of educational materials.

b. Centre de Formation: excellent local source of assistance for training activities.

c. Service d'Hygiène: provides entrée to comités communautés de la santé, which could serve valuable fonction in both community education and surveillance. For example, comité members could be trained to do assessment of nutritional status using arm circumference measuring tapes and refer malnourished cases to PMI's.

d. Union Nationale des Femmes Djiboutiennes: an important private organization with a large membership which is already engaged in planning research and educational activities for breastfeeding promotion in cooperation with UNICEF.

e. Radiodiffusion Télévision Djiboutienne: the obvious partner in all planning and development of materials for broadcast.

### 3. Dietetic and program operations research.

This project will provide an opportunity for CRS to conduct, with technical assistance provided by USAID, several possible types of small-scale research projects of considerable interest to the larger community of international health and nutrition planners. Among the possible research topics:

a. appropriate local foods for a child during a bout of diarrhea.

b. an appropriate refeeding diet for a child recovering from a bout of diarrhea.

c. the viability and effects of substituting locally available foods for Title II foods in a PMI center or centers.

d. the effect on mothers' attendance and contributions to a PMI center or centers of withdrawing the food distribution.

e. the operational viability and effectiveness of a combined ORT/refeeding program, testing both in-clinic feeding and take-home food distribution.

# IMPLEMENTATION PLAN

	1985				1986				
	OND	JFM	AMJ	JAS	OND	JFM	AMJ	JAS	OND
1. <u>Policy and plan formulation</u>	XXX								
2. <u>Research and evaluation</u>									
a) morbidity/mortality survey		XXXXXX	XXXXXX	XXXXXX					
b) develop management information system		XXXXXX							
c) KAP studies		XXX				XXX			XXX
d) media and other formative research		XXXXXX				XXX			
e) dietetic and feeding operations research		XXXXXX			XXX			XXX	
3. <u>Health worker training</u>									
a) national diarrhea/malnutrition seminar			XXX						
b) training of trainers			XXX						
c) health worker workshops on ORT/nutrition			XXXXX						
4. <u>Community training/education</u>									
a) message development/communication planning			XXXXX						
b) develop broadcast materials (radio/TV)			XXXXX						
c) develop print materials			XXXXX						
d) community training (health committees, UNFD annexes)				XXXXX					
e) mass media campaign					XXXXXXXX	XXXXXXXX	XXXXXXXX	XXXXXXXX	

1985
1985  
 OND JFM AMJ JAS OND JFM AMJ JAS OND

5. Surveillance and referral

a) growth monitoring in PMI's

b) improved diarrhea assessment in PMI's

c) community surveillance of diarrhea/malnutrition

6. ORT/refeeding clinical service

a) ORT unit at Hôpital Peltier

b) ORT service at PMI's

c) Refeeding program at PMI's

	<u>1985</u>				<u>1985</u>				
	OND	JFM	AMJ	JAS	OND	JFM	AMJ	JAS	OND
a) growth monitoring in PMI's	XXXX	XXXXXXXXXXXXXXXXXXXX	XXXX						
b) improved diarrhea assessment in PMI's				XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	
c) community surveillance of diarrhea/malnutrition				XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	
a) ORT unit at Hôpital Peltier				XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	
b) ORT service at PMI's				XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	
c) Refeeding program at PMI's				XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	

1985 Technical Assistance Plan and Budget

ACTIVITIES	COSTS			<u>TOTAL</u>
	<u>Salary</u>	<u>Per Diem</u>	<u>Travel</u>	
<u>National Seminar on Diarrhea and Malnutrition (2nd quarter)</u>				
Includes training of trainers, development of training materials, design of management information system, design of model ORU for hospital and/or PMI's.				
1 PHYSICIAN ORT EXPERT/10 days	\$ 2600	\$ 1820	\$ 2200	\$ 6620
1 ORT TRAINER/ 24 days	\$ 4800	\$ 4368	\$ 2200	\$11368
1 MGT. INFO. SPECIALIST ( <u>WHO</u> ) 10 days				
<u>Communication Planning Seminar (2nd quarter)</u>				
Will provide training in focus group interviews and other formative research methods; message development; materials design and pre-testing; evaluation.				
1 COMMUNICATION PLANNER/ 18 days	\$ 3600	\$ 3276	\$ 2200	\$ 9076
1 MATERIALS DESIGN SPECIALIST 18 days	\$ 3600	\$ 3276	\$ 2200	\$ 9076
1 EVALUATION SPECIALIST 18 days	\$ 3600	\$ 3276	\$ 2200	\$ 9076
1 COMMUNICATION PLANNER ( <u>UNICEF</u> )/ 18 days				
<u>Nutrition Research Consultancy*</u>				
Will assist CRS investigate local feeding practices and determine appropriate dietary recommendations for during and after diarrhea.				
1 NUTRITION PLANNER/ 18 days	\$ 4050	\$ 3276	\$ 2200	\$ 9526

\* 3rd quarter

24

## ACTIVITIES

## COSTS

	<u>Salary</u>	<u>Per Diem</u>	<u>Travel</u>	<u>TOTAL</u>
<u>Media Production Workshop</u>				
<u>(4th quarter)</u>				
Will provide training in planning and scriptwriting for educational broadcast programming through the actual design and production of a series of radio and TV programs for the diarrhea/malnutrition campaign.				
1 BROADCAST PRODUCTION SPECIALIST / 24 days	\$ 5400	\$ 4368	\$ 2200	\$11968
1 PRODUCTION ASSISTANT / 24 days	\$ 4200	\$ 4368	\$ 2200	\$10768
1 PRODUCTION TECHNICIAN (UNICEF) / 24 days				
	-----	-----	-----	-----
<u>TOTAL PROJECT 1985 TA COSTS</u>	\$31850	\$28028	\$17600	<u>\$77478</u>

Local coordination of above technical assistance activities would be responsibility of CRS training/education specialist, with assistance from the Ministry of Health, UNICEF, and WHO.

## 7. SUMMARY OF EVALUATION FINDINGS

### 7.1 Objectives/Indicators for Food and Nutrition Program.

CRS' stated objectives in the OPG were: to improve nutritional status (as assessed from the Growth Surveillance System (GSS)); to attain higher coverage and better attendance on the part of mothers; to establish growth surveillance in the MCH system (through training and supervision); and to facilitate Center operations by establishing separate storage capacity for Title II foods. No health education objectives or indicators were developed. In fact no indicators or quantified targets were stated, except:

- To increase beneficiary coverage from 12,000 (in March 1983) to 17,500 by "FY 1984" presumably the beginning, October 1983.; and
- To train six additional health educators/nurses in Tunisia.

The UNICEF fish promotion activity's stated goal was "to introduce fish into the diet of the Djiboutian family", without specifying the number of families targeted or an evaluation mechanism.

The Evaluation team thought that the lack of clear analysis pertaining to goals, indicators and quantified targets for the Food and Nutrition program, and especially the lack of a plan of operations for how objectives were to be achieved, has contributed to a lopsided emphasis on the food delivery component at the expense of the rest of the program as well as the uneven quality of the other program components-growth surveillance and health education.

### 7.2 The Overall CRS Title II Program in Djibouti.

Only the MCH program is examined in detail by the evaluation team because of its relationship to the continuing OPG. However the MCH food aid has been examined in the context of

the overall CRS Title II program in Djibouti. Over the period studied for MCH cost-effectiveness, July 1983-June 1984, the MCH portion of food distributed in Djibouti was only 24 percent of the food distributed, ~~655 metric tons~~ distributed to an average of a little more than 8,000 mothers and children. The other 2042 metric tons were distributed to 3,500 school children, to 20,000 refugees, and to workers, dependents, and needy families. The refugee program will have been phased out or over to World Food Program by January 1, 1985.\* The school/other child feeding is also expected to be taken on by WFP.

### 7.3 The Special Context of CRS' Contribution in Djibouti.

Djibouti is a very young country located in the drought zone of Africa. Donated foods have come from everywhere, and food is relatively cheap due to controlled prices of staples and to the availability of donor foods in the market. Other programs (refugee and emergency) notably, offer 13.5-15 kilo monthly food rations per person compared with the 5 kilo MCH ration. Thus, the traditional CRS <sup>MCH</sup> Food and Nutrition package fails in the Djiboutian setting; it does not carry the value it normally has for participating families. Further, not unlike the situation in many other developing countries, food distributions are not welcomed within the MCH system.

Djibouti as a new nation in the process of establishing its health system has provided CRS a unique opportunity to participate in the implementation of a primary health care program. CRS began operations with food distributions to refugee camps, and has in four years emerged with a health-oriented program and as a fully accepted partner in the preventive health

---

\* FFW will be phased out by January 1, 1985.

field along with the government and other donors who have shared tasks in developing the MCH program. CRS' particular contribution has been the establishment of a weighing and growth surveillance component and in the provision and training of MCH personnel. However, health colleagues lack enthusiasm for the CRS food distributions being carried out in the health network.

Many of the management problems for which CRS must be partially responsible are attributable in large degree to the youth of Djibouti, especially as reflected in the low skills level of center personnel and the need to teach, train and supervise for the most basic tasks.

#### 7.4 Predominance of Food Management in MCH Program Priorities and Budget.

Food handling and management take 70% of CRS MCH management time and due to the crisis nature of food problems, takes priority over other activities. Costs for food handling and administration amount to two-thirds of the annual Food and Nutrition budget of a little over \$1 million. 655 metric tons of rice, oil and CSM (corn-soya-milk) are brought in and reach a maximum of 6,000 families on an irregular basis. By the time a ration estimated at 3.3 kilograms (reduced from 5 kilograms because of an attendance rate of 65%) a month reaches a beneficiary it costs \$134. For mothers (families) receiving a monthly ration of 8.5 kilograms (5 kilos for mothers plus 1.6 children under five X 65% attendance) the cost per mother/family for the food and minimal education is \$360. For the targeted program child, meaning under five years old, the cost is \$214 a year, several times the cost of similar take-home programs in other countries.

Management of food <sup>plus</sup> and the food <sup>value</sup> cost constitute two-thirds of the MCH budget and staff time. These costs are almost totally the burden of the U.S.G. which not only provides the food and ocean freight but pays port fees and all inland transport which host governments and mothers' fees cover or help to cover in other countries.

Omitting the donated food and ocean freight but including CRS management (labor costs), the total cost of food support and handling paid by the U.S.G. from Outreach and OPG monies over a 12-month period, amounts to \$325,000.

Given that the CRS program and OPG are to be a self-contained two year program, even were the current MCH food component considered priority to the program, the team would have been hard put to find a rationale in support of this continued level of food support cost.

Despite these high costs and priority treatment, control of the foods continues to be unsatisfactory to CRS. The team found that only about one half of the food sent out for MCH beneficiaries is accounted for in the Monthly Distribution Reports received from the Centers. It is suspected that the "lost" foods are handed out to non-MCH families. Yet, just this lack of program control costs the program some \$270,000 more than it would otherwise.

In the MCHs, food distributions are an annoying presence and even those health staff who are fully convinced of the incentive and economic value of the food, think the food should be distributed in a separate location away from the MCH. There is a strong belief in the health and donor community that food aid in the MCH setting undermines their efforts to establish a sense of responsibility among the people with regard to health care.

## 7.5 Value of the ration.

- The nutritional value of the ration theoretically provides enough calories and proteins to feed one family member, but there is no assurance that all of the CSM is accepted and consumed.
- Many health personnel perceive the food to have important incentive value in drawing mothers to the MCH services. Because so many things occurred simultaneously in the development of the MCH system -- recognition by the Government that MCHs should be established, the weighing and growth surveillance introduced by CRS, the vaccination campaigns, radio appeals on the importance of the MCH attendance and the beginnings of pre-natal consultations, it is difficult to separate the influence of the food and decide what role it played in drawing women to the centers. Undoubtedly, it was of significance, at least on a tryout basis. However, when we looked at the indicators of sustained interest, we found a very irregular attendance of about two out of three times and a high dropout rate, 30-40%, after very short periods of participation, which do not argue for successful incentive value.
- The value of the food that an average program mother receives for the family is \$3.92 (based on 2.6 rations per family and a 65% attendance rate) and her estimated monthly food budget (that of a poor family) is \$32. The relatively low economic value of the ration may explain the apparent indifference to regular pickup of the food or giving it up altogether.
- The value is diminished further by the availability of foods at reasonable prices in the market (or in other food distribution programs) making it appear that mothers probably would not come for the food without the drawing power of treatment and use of PMI services.
- Though most agree that food has important incentive value, whether true or not it is perceived that way, and some think it is inhumane to withdraw food that has been received by a truly needy population, all do feel that the food should be distributed in a separate location.
- Since it is generally accepted that there are needy families among the MCH participating mothers, this problem is under discussion between CRS and the Ministry of Health to decide the criteria needed for economic targeting and if deemed desirable by MOH, finding eventual donors to provide food supplements in a continuing basis following CRS phaseout of food activities. CRS will carry out distributions as agreed with the MOH on a phaseover basis.

## **7.6 CRS' Contribution in the Primary Health Care (MCH) System.**

Along with health leaders who pressed to obtain higher vaccination coverage and to improve the very poor maternal health of clients with a pre-natal service, CRS shares honors for helping to develop a meaningful MCH program in Djibouti. Almost everyone agrees that CRS has made a major contribution in introducing weighing and growth surveillance in Djibouti and that it has raised the level of personnel available to the dispensaries, both in numbers and in quality, through the institution of a development fund (mothers' fees) which in part pays for the extra staff, and through the training provided nurses and other health workers, which enable them to be multi-functional in the health centers.

On the other hand, education in the MCHs is sorely missing for the most part. Even one-on-one mother counselling in connection with the growth chart is lacking, inadequate or done in the wrong way. There is not yet enough understanding of the individual card either on the part of the staff or the mothers. When it is understood, the MCH staff do not know how to use the chart well as a teaching tool.\* While it is true that there are no operating guidelines for health education of mothers in the MCHs, one would expect to find some experimental activities with created aids, but any effort observed is the rare exception. There have been no sustained efforts to get an education program launched. What is done is ineffective.

These education inadequacies are directly related to a lack of training at all levels both in content and techniques. The Tunisia training has greatly improved the level of those

---

\* The Master Chart is in fact too complicated to be an appropriate data gathering mechanism.

practical, how-to-teach aspects seem to have been neglected and/or were not applied in their jobs soon enough after return.

Plans for diminishing and eventually phasing out food aid at the MCHs will entail personnel adjustments affecting a cadre of 42 workers in 20 MCHs --responsables, assistant child weighers, counsellors and food distributors --who have been trained to support the growth surveillance and food distribution activities as well as to assist with other clinic activities. If and how mother fees are to be continued with less or no food in the centers must be agreed between CRS and MOH as quickly as possible. Many of these people will be needed to continue growth surveillance and the new activities planned by CRS. Finding the means for their remuneration, which must be self-sustaining, is a primary issue to be resolved before the new OPG can be completed. In the case of food handlers who may not be well equipped for the new MCH activities, CRS will attempt to find job alternatives as food distributions lessen and end.

### 7.7 CRS Management Capability

In studying CRS' resources in Djibouti, the MCH program strengths and weaknesses, fit of CRS strategy with that of the government and international health community, current and potential management capability, the team concluded that the current emphasis on food aid as distributed in the MCHs is inappropriate and not the <sup>most effective use</sup> of human and financial resources. The Ministry of Health is increasingly vocal in its opposition to donor foods playing any part in the nutrition and health activities; it therefore behooves CRS to negotiate Title II withdrawal from MCHs without waiting to be asked to do so. By ~~So~~ doing, the inevitable need to accommodate food handling with the lion's share of management resources, leaving

very little for the other MCH components, is progressively diminished.

While MCH as a type of Title II program is very demanding in administrative time both for food and the other components (growth surveillance, education, and training), taking 70% of CRS' human and financial resources, CRS' role in the preventive health program has the potential for far wider-reaching and lasting objectives on a larger target population.

CRS has the opportunity now to take advantage of the bases established in the MCHs and with health staff, to phase out the food aid in a responsive, ethical manner and to establish the health education and training element for the Government's diarrheal control program which is being elaborated.

In numbers and salary levels, CRS' present staff appears excessive. However, it must be noted that the salary of a professional Djiboutian is likely to be higher than that of a CRS professional; CRS has had in the past to accept personnel judged appropriate by the the Labor Office. All salaries and allowances are relatively high because of the high cost of living in Djibouti. As for the number of personnel, a large percentage of whom now are occupied with food handling activities, the design team will have to analyze current tasks and projected future tasks before deciding on appropriate labor costs in the OPG.

## 8. RECOMMENDATIONS

8.1. CRS/Djibouti should seek to increase program impact on the health of children and their mothers in a more cost-effective manner ("do more for less"), with more lasting benefits. CRS should build on the base of its past activities in the MCHs, reinforcing and broadening the educational and training aspects of its program while reducing the emphasis on food distribution, aiming at a phaseout of its involvement in food distributions in dispensaries. To do so, CRS will need strong and regular technical assistance inputs from PRITECH in the areas of baseline studies and evaluation, operational research, training curricula and techniques, message and materials development, interpersonal and mass media education.

8.2. Any change in orientation should be firmly rooted in on-going activities and future related developments in the Mother and Child Health programs supported by the GROD within the dispensaries. While the GROD does not support food distributions in the MCHs, they do want to develop weaning foods from locally available foods. Since CRS is perceived as a prime mover in the area of nutrition in Djibouti and has in fact concentrated on nutrition-related activities in the past, the development of a stronger educational and demonstrational program should grow out of this area of expertise. Initial expansion of educational activities should concentrate on a limited number of themes related to the nutritional status of children, namely:

- Consolidation, improvement and standardization of a growth surveillance system in the dispensaries with appropriate data analysis for use by the GROD as well as dispensary personnel and mothers. This need not include the Master Chart nor the CRS individual child card.

- Promotion of breastfeeding and discouragement of bottle feeding.
- Control and prevention of childhood diarrhea including the use of oral rehydration and appropriate feeding during and after bouts of diarrhea.
- Operational research in the area of nutrition including development of appropriate dietary messages to mothers for the feeding of infants and children using local foods.
- Operational research on the effects of various systems of interventions by dispensaries on the nutritional status of mothers and children as well as attendance and user satisfaction among the target population.

8.3 Present and future financial resources should be targetted increasingly toward the attainment of the objectives of this new orientation. An initial step in this direction is to develop a plan for phaseout and/or phaseover of food distributions with the MOH, following up on a recent meeting between CRS and the Director of Primary Health Care where basic principles were agreed upon. The team recommends that phasedown start no later than May 1985 when the summer slowdown begins and earlier should the criteria have been established for determining which families should receive continuing food aid. It is envisaged that the distributions would be out of the MCH system by September 1985. However, the details of this plan should be left to CRS and MOH decision. The evaluation team are concerned that staff and task changes be effected to accomodate the new program as early as possible without causing undue hardship to families grown dependent on CRS food. It should be noted that the phaseover period coincides with large planned food inputs by WFP.

In the interest of focussing the maximum number of resources on the inputs necessary to assure the success of this new orientation, the evaluation team recommends that CRS/Djibouti limit its involvement in either presently ongoing or future

strategy. Concerned activities would include school feeding, refugee relief, gardens and educational activities in schools, ~~at least during the first year of the new OPC.~~

8.4. CRS should continue to work with the national PHC Coordinator in determining the appropriate role for MCHs in responding to needy families--i.e., their referral responsibility and criteria for carrying it out. With a larger goal of helping the Government to enunciate a policy on free food distributions, CRS and MOH should continue to address questions relevant to the role of the health services in food distributions:

- Should the dispensary system be the referral point for a target population to receive food aid?
- Who constitutes the targeted population: what are the characteristics of this population; and what are the criteria for selection of mothers into a food distribution program (economic, social, health indicators)?
- What quantity and quality of food ration should be distributed in order to have a significant impact on the nutritional and economic status of targeted families within the context of Djibouti economic realities?
- Which donors would be the most appropriate and cost-effective source for the food rations? WFP, Caritas and other donors should be considered.
- What can the government do to reduce the cost of food distribution: assist with port fees, inland transport?

8.5 CRS should assist the GROD in the initial phases of implementation of any eventual program of nutritional supplementation for needy families <sup>referred from</sup> via the dispensary network. This assistance could be in the following areas: the establishment of a distribution system; training of personnel; and the establishment of a system of control and management of food supplies.

8.6 CRS and the Government must plan for the effects that a  
due to a reduction in food

aid at dispensaries, will have on those dispensary personnel now paid for by these mothers' funds. Of 42 such people, approximately 20 are employed solely to distribute food. These people should be assisted to the extent possible to find other employment in the case that their services are no longer needed in the dispensaries. Among the rest of the personnel paid by mothers' fees, many assist in MCH activities other than growth monitoring, such as vaccinations, pre-natal consultations and health education. Ideally provisions should be made to maintain these partially-trained and fully MCH-oriented people within the new program. CRS should continue to work with the PHC coordinator to develop a source of salaries for these people, preferably from a self-sustaining paying system and preferably before the CRS paying system vanishes from the MCH.

8.7 With PRITECH technical expertise, CRS should work closely with the MOH to develop a health education strategy and approach.

This should include:

- Content: definition of messages to be promoted in the dispensaries.
- A program plan for health education to be incorporated in regular MCH routines including timing and duration of sessions, range of topics to be covered, frequency of transmittal of messages, weekly or monthly schedule, supervision and training of personnel, and motivational strategies for personnel and mothers.
- Development of educational materials and methodology appropriate to the MCH setting as well as to other settings such as UNFD groups, health committees, etc. dialogue, interaction with mothers, use of visual aids and other materials.
- Supervisory strategy (feedback).
- Assisting the MOH to redefine the roles and tasks of PMI personnel so as to make the implementation of health education activities in the PMI's a realistic possibility.

8.9 CRS with technical assistance should assist the MOH to define the objectives of growth surveillance and nutritional data collection in Djibouti and reevaluate the current system in light of these objectives. A more appropriate system should be designed if necessary. If the Government agrees, a fee should be charged for new health cards to cut down losses and ensure better care in the interest of effective growth monitoring. But more important than such vaguely punitive actions as paying for lost cards is the strong promotion of health card merit and a personnel reinforcing its importance. Training and education can make such a change possible.

8.9 CRS should set up the necessary staffing to reflect the qualification needed for this new orientation. As the role of food handling dwindles, staff or tasks should be converted to or replaced by demands of the new program.

*To be most cost-effective,*  
~~It is essential that~~ the Project Manager ~~who~~ would also be the CRS country representative *The Project Manager must* be a senior person, fluent in French, knowledgeable about Africa and most important, technically capable in Third World health training, evaluation and data collection. Since an important qualification will be experience in directing TA activities, it is recommended that CRS recruit outside its own network if necessary.

The evaluation team recommends that two additional expatriates should be: a health technician whose main task would be on-site training and supervision, assistance with health education materials development, growth surveillance and data analysis; a records and statistics person to *account for* ~~manage~~ the different funds--UNICEF, OPG, PRITECH, and to assist the Government in setting up a mothers' fees system and a growth surveillance *statistics compilation system.*

It is recommended that PRITECH technical assistance be available on a nearly continuous basis, though in short terms, throughout the first 12 months of project activity and be regularly available thereafter.

8.10 CRS and the Government should negotiate an official agreement clearly defining mutual responsibilities within the context of a future CRS program proposal. This agreement should spell out any sanctions resulting from a neglect of the agreed upon responsibilities on the part of either party.

Further the GROD should demonstrate its interest in the program by making available core personnel on a regular basis to assist in overall design, training and supervisory activities; by assuring appropriate planning of MCH activities through clear task definition and assignment of responsibilities to appropriate personnel as well as development of a standardized MCH program; and by contributing to a reduction of program costs as possible (e.g. limiting the payment of fees and reimbursements to participating GROD personnel, facilitating importation of any necessary supplies or materials, partially covering housing and maintenance expenses of technical assistance as possible).

UNCLASSIFIED

AID/FVA/PPE:H SUKIN:BEM  
13/04/84 EXT:235-1231  
AID/FVA/PPE:D ATWELL

AID/AFR/EA:F ENEY {PHONE}  
AID/FVA/FFP:K GORDON {INFO}

AID/AFR/PD/I:G RUBLEE {INFO}

PRIORITY

NAIROBI, DJIBOUTI PRIORITY

AIDAC FOR REDSO ATTN B. KIDD, PASS TO P. BERTOLIN, CRS  
E.O. 12356: N/A

DALH  
HS 15

TAGS:

SUBJECT: DJIBOUTI FOOD AND NUTRITION EVALUATION/PROJECT  
DESIGN

REF: STATE 242076

1. PLEASE REVIEW FOLLOWING DRAFT SCOPE OF WORK AND  
ADVISE AID/W OF ANY MODIFICATIONS.

EVALUATION - OBJECTIVES:

1. TO EVALUATE THE CRS FOOD AND NUTRITION PROJECT IN  
ORDER TO IDENTIFY STRENGTHS, WEAKNESSES; EXTENT TO WHICH  
PROJECT OBJECTIVES WERE REACHED; ITS EFFECTIVENESS IN  
REACHING TARGET POPULATIONS, ITS CONTRIBUTION TO HELPING  
THE MOH DEVELOP/INCREASE ITS CAPABILITY TO PROVIDE MCH  
SERVICES, AND HOW IT EFFECTIVELY IT PROMOTED OTHER  
DEVELOPMENT ACTIVITIES.

2. TO RECOMMEND WAYS OF IMPROVING HEALTH AND NUTRITION  
BENEFITS OF THE PROGRAM. THIS WILL INCLUDE IDENTIFICA-  
TION OF OTHER PROGRAM AREAS, I.E., ORT, IMMUNIZATIONS AS  
WELL AS STRENGTHENING CURRENT PROGRAM COMPONENTS. THE  
TEAM WILL ASSSS BOTH CRS AND GOVERNMENT CAPACITY FOR

UNCLASSIFIED

UNCLASSIFIED

| 2

CARRYING OUT RECOMMENDATIONS, INCLUDING MANPOWER, MANAGEMENT AND TECHNICAL REQUIREMENTS AND RECOMMEND SPECIFIC ACTIVITIES NECESSARY TO BRING ABOUT RECOMMENDED CHANGES.

3. TO ASSESS THE ROLE OF FOOD AID IN REACHING PROGRAM OBJECTIVES AND DETERMINING CONSEQUENCES OF PHASING OUT FOOD ON ACHIEVING NUTRITIONAL AND HEALTH BENEFITS.

#### STATEMENT OF WORK

1. TO REVIEW AND SYNTHESIZE EXISTING DOCUMENTATION DESCRIBING THE HEALTH AND NUTRITION PROBLEMS IN DJIBOUTI, CRS PROGRAM, USAID PRIMARY HEALTH CARE STRATEGY, UTILIZATION AND PERCEPTIONS OF HEALTH SERVICES.

2. TO ASSESS CRS F/N PROJECT IN TERMS OF:

##### A. PROGRAM OPERATIONS

- ....1. APPROPRIATE RATION PACKAGE
- ....2. TIMELY DELIVERY OF FOOD
- ....3. TARGETING STRATEGY OF PROGRAM; GEOGRAPHIC COVERAGE OF PROGRAM; ASSESSMENT OF BENEFICIARIES REACHED AND THOSE GROUPS NOT REACHED; OUTREACH ACTIVITIES
- ....4. GRADUATION CRITERIA
- ....5. PROGRAM ATTENDANCE; SEASONAL VARIATION DROPOUTS
- ....6. ADEQUACY OF TRAINING PROGRAM AT ALL STAFF LEVELS
- ....7. EDUCATION PROGRAM, INCLUDING PRIORITY MESSAGES, COMMUNICATION TECHNIQUES, MATERIAL DEVELOPMENT
- ....8. NUTRITIONAL SURVEILLANCE SYSTEM - IS GROWTH SURVEILLANCE SYSTEM FUNCTIONAL; IS RELIABLE DATA BEING COLLECTED AND FED BACK INTO PROGRAM; IS THE GROWTH CHART USED AS AN EDUCATIONAL TOOL
- ....9. SUPERVISION
- ....10. COORDINATION WITH HEALTH SERVICES; DEVELOPMENT OF REFERRAL SYSTEM, ETC.

B. CHANGES EFFECTED IN THE HEALTH SYSTEM INCLUDING: SERVICES OFFERED, STAFFING, SCHEDULING, SALARIES, HEALTH WORKER ATTITUDES, REFERRAL SYSTEMS, PRIORITIZATION OF HEALTH/NUTRITION ACTIVITIES AND IN THE MOH, SUPERVISION, TRAINING, POLICIES

C. CHANGES IN POPULATION REACHED - AS POSSIBLE TO ASSESS EFFECT OF PROGRAM ON PARTICIPANTS I.E., NUTRITIONAL IMPACT, ECONOMIC/CONSUMPTION EFFECT, EDUCATIONAL BENEFITS, INCREASED UTILIZATION OF HEALTH SERVICES.

IF POSSIBLE A COMPARISON SHOULD BE MADE BETWEEN MCH ACTIVITIES IN NON-CRS F/N CLINICS COMPARED TO CLINICS

UNCLASSIFIED

UNCLASSIFIED

3

WITH CRS F/N ACTIVITIES.

3. TO ASSESS PROGRAM'S OVERALL STRENGTHS AND WEAKNESSES AND DOCUMENT EXISTING CONSTRAINTS. DOCUMENT ROLE OF FOOD AID IN CONTRIBUTING TO EFFECTIVENESS OF PROGRAM.

4. RECOMMENDED SPECIFIC ACTIVITIES THAT COULD IMPROVE PROGRAM EFFECTIVENESS BOTH MODIFICATIONS OF ONGOING ACTIVITIES AS WELL AS NEW ACTIVITIES. ASSESS GROD, CRS, OTHER INVOLVED ORGANIZATION'S CAPABILITIES OF CARRYING OUT RECOMMENDED ACTIVITIES.

#### PROJECT DESIGN

1. IN DEVELOPING THE NEW PROGRAM, GUIDANCE FROM HANDBOOK 3 SHOULD BE FOLLOWED.

2. IN ADDITION THE DESIGN TEAM SHOULD ADDRESS THE FOLLOWING SERIES OF ISSUES/QUESTIONS.

....A} PRIORITIZATION OF HEALTH AND NUTRITION PROBLEMS IN DJIBOUTI

....B} DETERMINATION OF WHICH PROBLEMS THIS PROJECT CAN REALISTICALLY ADDRESS

....C} SELECTION OF TARGET POPULATION - BOTH BY AGE, PROBLEM AND LOCATION

....D} IDENTIFICATION OF CAUSES OF PROBLEMS FOR SPECIFIC TARGET GROUPS I.E., DIARRHEA DISEASES CONTRIBUTE BOTH TO MALNUTRITION AND HIGH RATES OF INFANT AND CHILDHOOD DISEASES. BOTTLEFEEDING AT YOUNG AGES, CONTAMINATION OF WEANING FOODS, LACK OF WATER ADEQUATE SANITATION FACILITIES ALL CONTRIBUTE TO THE HIGH INCIDENCE OF DIARRHEA.

....E} IDENTIFY/DEVELOP STRATEGIES FOR ADDRESSING CAUSES OF PROBLEMS, I.E. INCLUDING, NECESSARY CHANGES IN GROD POLICIES.

....F} IDENTIFY SPECIFIC COMPONENTS THAT MAKE UP THE STRATEGIES AND SPECIFY ACTIVITIES THAT NEED TO BE DESIGNED AND IMPLEMENTED IN ORDER TO CARRY OUT STRATEGY.

....G} DETERMINE COSTS {START-UP RECURRENT} FOR IMPLEMENTING PROGRAM, I.E. MANPOWER MATERIALS, TA, ETC.

....H} DISCUSS CONSTRAINTS, ISSUES TO BE RESOLVED.

2. FOR DJIBOUTI: JOYCE KING ARRIVING SUNDAY, 4:30 PM, OCTOBER 14, AIR DJIBOUTI NO 63. WOULD APPRECIATE USAID ARRANGING HOTEL ACCOMODATIONS FOR MS. KING. PLEASE ADVISE FVA, REDSO/EA NAME OF ACCOMODATIONS ASAP. WILL CABLE A. PRINCE AND M. RASMUSSENS ETA AS SOON AS INFORMATION AVAILABLE. THANK YOU. 44

UNCLASSIFIED