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RECOMMENDATIONS FOR FUTURE PROJECT DIRECTION

USAID/GOUV RURAL WATER SUPPLY PROJECT

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RECOMMENDATIONS FOR FUTURE PROJECT DIRECTION

The purpose of the purpose of the following report, as a supplement to my End of Service Report (May '83) is to briefly outline major problems and constraints involved in the implementation of the health component of the USAID/GOUV Rural Water Supply Project and to recommend changes to improve the outcomes of this project.

The health component of this project has progressed relatively well in the past 2½ years in the implementation of some of the activities set forth in the Project Agreement. However, the appropriateness of certain activities to project goals and the potential for effectively implementing all aspects of the project must be re-examined in the light of realities existing in the field and constraints within the project in order that efforts undertaken thus far and to be undertaken for the remainder of the project, result in maximum impact on village health.

I. PROBLEMS

The following are problems 1) with the effective implementation of project activities (as described in the Project Agreement), or 2) with the contribution of these activities to project goals. (For further details, refer to End of Service Report.)

A. Village Health Workers (VHWs)

The recruitment and training of 550 village health workers from villages with a project well during the life of the project is unattainable given 1) the amount of time and resources required for effective recruitment, training, and supervision of VHWs; 2) the limited number of staff to carry out this task; 3) the 18-month delay between the signing of the Project Agreement and the beginning of project activity; and 4) the fact that the health component is necessarily allied with and dependent upon resources and other activities of the Ministry of Health in the project zone. (Of the approximately 400 VHWs currently in the project zone, approximately 1/3 have been recruited and at least partially trained by other individuals and organizations in the region, beginning as early as 1977. There does not yet exist in the project zone a functional and effective system of supervision for VHWs.

B. Itinerant Health Workers (IHWs)

The recruitment and training of 110 itinerant health workers during the life of the project is unattainable due to delays in project start-up and the organization of this new program. A maximum of 52 IHWs will have completed the one year training program by July '84.

The first class of IHWs received minimal practical training in the construction of latrines and waste water soak holes and in well maintenance and improvement.

C. Analysis of Well Water

The periodic analysis of water quality in project wells called for in the Project Agreement has not occurred as planned for reasons given in the End of Service Report. However, this activity is not an immediate priority in terms of village health (except in isolated cases of obvious well contamination), given that 1) with few exceptions, properly covered project wells provide clear water in contrast to most unprotected traditional wells; 2) project wells often do not meet the needs of the majority of the village population, the remainder being forced to continue to use other sources of water, generally ponds and unprotected and polluted traditional wells; and 3) most project wells have significant waste water problems which project staff have not had the time to address. (Other wells projects in Upper Volta do not periodically test their wells.)

D. Demonstration Latrines

Demonstration latrines built with cement slabs and foundations (as proposed in the Project Agreement by the fact that "materials are to be provided by the project") are probably not appropriate technology nor useful models in the project zone, given 1) the unavailability of cement and iron outside of major towns; 2) that latrines are virtually nonexistent in rural areas of the project zone; and 3) that cement is a luxury by the standards of most villagers in the project zone.

E. National Center for Health Education (CNES)

The anticipated audio-visual support from the National Center for Health Education (CNES) is impractical, given 1) the distance between

the CNES office (Ouagadougou) and the project base in Bobo Dioulasso; 2) the repair problems encountered with the Jeep cinebus based at CNES and additional problems likely to be encountered with film projectors were they to be transported frequently over rural roads; 3) the lack of appropriate films; and 4) the small CNES staff which is responsible for health education requests throughout the country.

The lack of technical support by CNES has not been crucial to the implementation of project activities. Films, which were to be used as part of the health education effort in villages, are not necessarily the most appropriate technology in this situation. Suitable visual aides (i.e. flanelographs) are available in Bobo Dioulasso. Project staff have begun negotiating with CNES concerning the development of certain visual aides for use in the primary health care program.

The fact that more collaboration between the project and CNES was not possible does not mean, however, that project support of CNES was not productive. The continuing development of CNES is important to Upper Volta's public health program. The project cinebus has been more appropriately used for in-service training for health personnel (for whom there are appropriate films) than it might have been for project purposes.

F. Other

1. A continuing problem has to do with the design of the health component, that is with the fact that it was originally designed to complement the wells of the project and later modified to serve as a model primary health care program. The health component has attempted rather unsuccessfully to fulfill both these roles.

There are advantages and disadvantages to either focus. A close link with the wells component theoretically could maximize the benefits to be gained from a clean water supply. However, the value to be gained from this linkage is somewhat reduced by problems encountered with project wells (see End of Service Report, pp. 6-7 and 9). Secondly, the pace of activity of the two components of the project is such that it would be difficult to collaborate effectively on all aspects of water supply. Such a linkage would necessitate limiting the health component's broader

focus on primary health care since, as can be seen by activities to date, the health component does not have the staff to respond effectively to both foci.

An orientation of the health component toward primary health care allows the MOH to try out its primary health care program on a fairly large scale and to thereby use it as a model for primary health care planning throughout the country. The health component has essentially taken this approach with an emphasis on choice of villages with project wells. (For valid reasons, this emphasis has not always been maintained by other health department personnel in the project zone.) In taking this approach, staff have not had time to adequately address water supply problems.

2. In general, health component activities have been hampered by transportation problems both in terms of 1) the initial miscalculation of the transportation needs of project sanitarians, and 2) repair problems of Jeep vehicles (despite a very responsive project garage).

Some of the above problems are complicated by a lack of critical on-going planning and evaluation of effort by project staff and by a general reluctance to question project activities set forth in the Project Agreement in the light of realities encountered in the field.

II. RECOMMENDATIONS

The options available for improving and maximizing the impact of the project are few. Staff cannot be increased before the summer of '84 when the second class of IHWs will have completed their training. The project (variously described in project documents as improving the health of rural villagers in the project zone and providing an effective health education program to maximize the potential health benefits inherent in an improved water supply) will require 1) an extension of the health component for one to two more years, 2) a modification of some project activities, and 3) a re-ordering of some priorities.

An extension of the health component for one year would allow an assessment of progress and problems (as proposed later in this report) and some project modifications. It would also allow the recruitment and training of an additional 50-75 VHws and 30 IHws. A two-year extension,

or phase two, is necessary for the recruitment and training of the full 550 VHWs and 110 IWHs called for in the Project Agreement. It would further allow the MOH and USAID to do a more valid evaluation of this model program following two to three years of 1) concentrated effort with the same VHWs and villages, and 2) practical water supply and sanitation interventions in the same villages.

I can only recommend such an extension, however, if the following immediate priorities outlined below are adopted. Their adoption will require the temporary postponement of new VHW recruitment and training (perhaps for the entire '83-84 campaign). To continue the past pace of recruitment and training of VHWs during the next campaign is to continue to neglect the existing problems of VHW supervision and of attention to village water and sanitation problems. And it does not allow time for an overall assessment of the outcomes of past recruitment practices and quality of training and supervision.

A. Village Health Workers (VHW)

1. Assessment of the skills and productivity of existing VHWs, especially as concerns their role in preventive health.

Guidelines for this assessment should be developed by central project staff (technical director, health educators and sanitarians) in collaboration with central MOH staff responsible for primary health care. Today the staff of this project (aside from the technical director) have had minimal to no contact with central MOH staff responsible for primary health care. VHW recruitment criteria and training strategies (including the development of a guide for the training of VHWs in curative treatment and disease prevention) have been developed by project staff. Staff of this project and of another project in the region have proposed different reporting systems for VHWs activities. Based on their experience, project staff can go one step further and develop guidelines for the assessment of these activities. However, without collaboration with MOH staff, such guidelines (and subsequent program development) may be incongruent with MOH goals and resources.

2. Determination and implementation of ways to improve the effectiveness of VHWs.

Probably the most important contribution to improve effectiveness of VHWs will be the establishment of a system of regular and supportive supervision. VHWs should be visited at least twice monthly until they are capable of conducting causeries in their villages, have the confidence fo the villagers and until the villagers begin to take an active role in identifying and carrying out preventive health measures. This supervision will entail a) the supervisor's participation in village health committee meetings as necessary to help them define their role and begin to organize selected activities; b) assisting the VHW with causeries until he becomes confident and capable of doing them alone; c) advising VHWs and villagers on disease transmission and on practical means of prevention in the village and d) reviewing the records of the VHW. As this form of supervision has not been widely practiced to date by supervisors of VHWs in the project zone, it may initially require assistance by project staff.

3. Establishment of a long term structure, independent of project personnel, for the renewal of VHW pharmacy supplies in the Bobo Dioulasso department.

4. Development of uniform procedures for the reporting of activities of VHWs and supervisors of VHWs.

B. Itinerant Health Workers (IHWs)

1. Organize the practical sanitation training for IHW trainees so that each individual participates directly, at least once, in each of the following tasks: latrine slab and foundation construction, using mud and wood and using cement; waste water soak hole construction; and well maintenance and improvement (including the construction of protective walls, slabs and trenches for wells). If IHWs are to be committed to and effective at promoting preventive health measures in the villages, they need more practical training in the above tasks than the first class received.)

C. Well Water Analysis

1. Assessment of existing water supplies in villages with a VHW and project well to determine: a) the general quality of the water at the source and obvious causes of pollution; b) the extent to which each source is used for domestic purposes (especially drinking); and 3) the

importance and feasibility of improving the source (especially in the case of modern or traditional wells). Such assessment would be done by project sanitarians in collaboration with IHWs and nurses. This task could be extended to villages with a VHW but no project well and to villages with a project well but no VHW. However, given staff and time constraints, villages in these latter two categories would need to be screened perhaps more carefully in terms of the potential for improvement of water supply as each is missing an important component: either a modern well or a VHW.

2. Where it is feasible to improve a water source, work to encourage the responsible individuals to take the indicated action and assist them as necessary.

D. Latrine construction

1. Assess the effect of demonstration latrines 1) with cement slabs, and 2) with mud and wood slabs in terms of use, maintenance, and number of villagers having subsequently built either model. If the cement slab model has seldom been adopted, the project should seriously consider eliminating this model.

E. Other

1. Collaboration between the two components of the project (in choice of project villages, site selection in villages and village animation/sensitization, etc.) has not been as productive as originally planned for reasons noted earlier in this report and in the consultant's End of Service Report. The idea of this close collaboration, essential to achieve project objectives, must be redefined and more appropriate strategies developed to reflect project realities.

Most important in developing appropriate strategies for collaboration between the two components would be the creation of a working technical committee composed of project officials and staff as well as a USAID representative which would have the responsibility to plan joint actions, and address problems common to the progress of both components.

The development of strategies for the achievement of a collaborative effort among the two components should be addressed as soon as possible, so that, if the project is extended to preferably a two-year period, there would be ample time to have well-defined strategies and actions which would be implemented in that period, evaluated at the end of the two-year extension, and serve as a basis, if need be, in the design of a potential phase II.

III. CONCLUSION

In conclusion, the health component has worked hard to accomplish the activities outlined in the Project Agreement. However, it is time these activities be seriously examined in terms of their long-term effect on rural health; and that subsequent project activity be modified accordingly. If this project is to serve as a model, every effort must be made to develop it in ways that are relevant to the needs of Upper Volta and particularly to the needs of its rural target population.

Feasibility and Potential Value of Possible Strategies for Health Component Direction:

1. Complete all project activities as outlined in the Project Agreement by the project termination date, July '84, and terminate the project.

It is physically impossible to complete all project activities within the next year.

2. Terminate the project in July '84 and use this final year of the project to evaluate activities undertaken to date.

While this option is feasible, it does not promote application of lessons learned from previous experience in subsequent project modification. Nor does it allow for completion of all project activity.

3. Extend the project for one year and:

a) Attempt to complete all project activities during this two-year period.

While this option might be feasible, it does not allow for assessment of project effectiveness and subsequent modification which is crucial to project success at this point.

b) Evaluate project activities and make necessary modifications during the first year and continue with this modified program during the second year.

This option is feasible. However, it is not likely that all project activities would be successfully completed during this time and a terminal project evaluation would be based on rather minimal experience with the chosen program modifications.

4. Extend the project for two years, or establish a phase two, and:
 - a) Complete all project activities during this three-year period.
This option is feasible; however, it does not allow for assessment of project effectiveness and subsequent modification which is crucial to project success.
 - b) Evaluate project activities and make the necessary modifications during the first year, and continue with this modified program during the two following years.

This is the option recommended earlier in the report. It is necessary for the recruitment and training of the full 550 VHWs and 110 IHWs called for in the Project Agreement. It would further allow the MOH and USAID to do a reasonable evaluation of this model program following two to three years of 1) concentrated effort with the same VHWs and villages, and 2) practical water supply and sanitation interventions in the same villages.