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MIDTERM EVALUATION

AFRICARE CHILD SURVIVAL PROJECT

GANZOURGOU PROVINCE

BURKINA FASO

Submitted by:

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I.EXECUTIVE SUMMARY

The midterm evaluation for the Africare Child Survival Project in Ganzourgou Province, Burkina Faso was carried out by a team that included two Ministry of Health representatives, the Africare Child Survival Coordinator from Washington D.C., and a child survival consultant who was the team leader. The two project coordinators also participated actively. The outside people were in country from October 11 - 30, 1992, yet the whole team was only available from October 16 - 30. Ten days were spent out in the province. This included 4 days actually spent out in villages, and three days spent in meetings with project staff and government officials. The methodology was qualitative, using structured interviews both in groups and individually at multiple levels, activity observation, and review of documents.

The main project accomplishments are 205 well trained neighborhood "counselors" who are functioning effectively at the household level in oral rehydration interventions and vaccination mobilization. These women are supporting approximately 15 households each and provide education and rehydration support every time a child in her neighborhood gets diarrhea. The project has also achieved a very high participation rate for growth monitoring, but this has been through the direct efforts of health promoters who were hired and trained by the project. Lastly, the project has trained 23 health center nurses and midwives in oral rehydration and nutrition interventions. The nurses in the impact area health centers report changing their practice in the treatment of diarrhea as a result of the training and their subsequent experience.

While it is early to truly determine the success of the model, the model of training neighborhood women to actually carry out the interventions appears very promising - both in terms of achieving behavior change at the household level and in terms of being able to carry out the activities on their own with minimal support. The messages have been kept very simple and a lot of up front training time has been invested in order to make this possible.

Primary recommendations of the evaluation team focus around the need to increase the project's interface with the Ministry of Health. While the emphasis has been on the establishment and training of counselors, the project now needs to work more actively and closely with all levels of the provincial health structure in order to assure maximum impact as well as to achieve some sustainable elements. The project also needs to begin to develop a structure at the village level to support and maintain the health activities currently being carried out by the counselors and village health teams. The project needs to expand the view of its work to one of more integrated development. This is particularly important with Africare's beginning a new water project in the area. Lastly, the team recommended that the nutrition program begin to shift its emphasis away from the weighing activity and to begin to define and emphasize very simple messages around food intake that the counselors could carry out at the household level.

II. PURPOSE OF EVALUATION

Project Background

Africare is an African-American non-governmental organization seeking to improve the quality of life of people in rural Africa. Working in Burkina Faso since 1973, Africare has been involved with natural resource management, water projects and the construction of rural health care facilities. The Ganzourgou Child Survival Project is Africare's first USAID funded Child Survival program in Burkina.

The Child Survival Project is located in the Meguet Department of the Ganzourgou Province of Burkina Faso. Ganzourgou Province has a total population of over 200,000 while the Meguet Department has approximately 48,000 inhabitants. The Project is working in 14 of the 36 villages in the Department with a total of about 30,000 people. This impact area is in the northern part of the province, located about 2 hours drive from Ouagadougou. In spite of its proximity to the capital, it is very rural and the Government prioritized it as an area that was particularly needy of health services.

Goals for the Midterm Evaluation

The scope of work for the midterm evaluation (see appendix) requested a qualitative evaluation particularly looking at the nature of relations between the project, the Ministry of Health, the communities, and the families involved. This was to include an assessment of the model using neighborhood level counselors (neighborhood liaisons) as the primary means for reaching mothers. It also requested an evaluation of behavior change at the household level, particularly related to diarrhea and a review of the effectiveness of the growth monitoring intervention as a mechanism for achieving nutritional behavior change.

With the project only working actively in the villages for one year, it was too early to have any clear assessment of impact. Of more importance was to evaluate the function (process) of the project and to get a sense of whether the project was effectively moving towards the achievement of its objectives. This was to provide information to make changes that would lead to more effective and efficient achievement of its goals. With one year left of funding, it was also important for the evaluation to assess the potential for sustainability and to make recommendations in this regard as well.

III. METHODOLOGY

The evaluation took place in Burkina Faso from Oct. 12 - Oct. 29, 1992. (see schedule in appendix) The first week was spent in Ouagadougou working with project staff and those members of the team who were able to participate in the development of the

evaluation strategy, priorities, design and questionnaires. Meetings were also held with national Ministry of Health officials. Oct. 18 - Oct. 27 were spent with the entire team in Zorgho, the capital of Ganzourgou Province. The evaluation format was finalized, meetings were held with provincial officials and project staff, 4 days were spent gathering data in villages, and initial analysis was done and presented to provincial officials. The final couple of days were spent by the entire team in Ougadougou. Analysis was completed, and the evaluation culminated in a presentation of results to officials from the Ministry of Health, Unicef, Helen Keller International, Save the Children, and United Stated Agency for International Development (USAID).

There was a core team selected to carry out the evaluation. This included: (see appendix for resumes)

- Marcie Rubardt RN, MPH - consultant, team leader
- Ibrango Issouf MD, MPH - representative from the Department of Evaluation and Planning, Ministry of Health, Ouagadougou
- Nebie Bademe DR - Provincial Director of Health, Ministry of Health, Zorgho
- Evelyn Gorsline MPH - Coordinator for Child Survival programs, Africare, Washington D.C.

Because this was a midterm evaluation focusing on process and with the goal of making recommendations to be implemented during the remainder of the project, the team leader felt it was important for the two coordinators of the project to participate as much as possible. In this way they would directly experience and be more likely to own the recommendations that came out of the evaluation. They were also eager to participate in and learn from the process. As a result, they were involved with the development of the methodology and the information collection at most points. They did not participate in the evaluation of the project management, nor in the initial analysis and development of recommendations because of their proximity to the project.

The two coordinators were:

- Claudia Williams MPH - Coordinator, Africare Zorgho Child Survival
- Roger Tonde AST/S - Co-coordinator, Africare Zorgho Child Survival

The methodology chosen for this evaluation was qualitative and process oriented rather than quantitative in nature. This was consistent with the scope of work requested, and with the goal of providing recommendations for changes in the design and management of the project.

Key information categories were selected to provide a framework for data collection. These were drawn from the scope of work priorities as well as from the Midterm Evaluation Guidelines supplied by USAID. The categories chosen were:

- the specific interventions of diarrhea, nutrition, and immunizations
- general project design issues
- program management

For each intervention staff competence, specific message content, progress toward behavior change, and barriers to service were to be looked at. The design issues included community relations and support, the clarity of roles for both staff and volunteers, the level of integration of the project with the Ministry of Health, sustainability possibilities, appropriateness of the project interventions to health and development needs, and possibilities for cost recovery. Under program management the administrative, technical, and financial ability of the project to carry out the work were assessed.

Information for each of these categories was collected at a variety of different points. It was collected through group and individual interviews, focus groups, activity observation, review of documents, and individual case studies. This provided an opportunity to triangulate and verify the consistency of the information gathered.

Specific information points included:

- Individual interviews with mothers at growth monitoring session
- Individual interviews with men who were observing the activities
- Interviews (individual and group) with counselors and the village health teams (village midwife and health worker)
- Group interviews with chiefs and elders
- Individual interviews with health post nurses
- Interviews (individual and group) with the project's 5 village health promoters
- Focus groups on nutrition messages with counselors in 2 villages
- Case studies of non-participators
- Observations of growth monitoring and family planning education sessions
- Observations of role plays of diarrhea counseling between counselor and mother
- Interviews with provincial and central Ministry of Health and government officials

IV. BRIEF PROJECT DESCRIPTION

The specific Ganzourgou Child Survival Project interventions include:

- Diarrheal Disease Control: oral rehydration therapy (ORT) education, appropriate dietary management of diarrhea and promotion of simple preventive measures such as hand washing, use of potable water, and food hygiene.

- Growth Monitoring and Nutrition addressing improved child feeding practices and Vitamin A food promotion through vegetable gardening.
- Immunization promotion through community education and mobilization.
- High Risk Birth Prevention including the promotion of acceptable child spacing methods with both men and women, education regarding the importance of pre-natal care.

The objectives for these interventions, as outlined in the Detailed Implementation Plan include:

Diarrheal Disease

By the end of the project (Sept. 1, 1993) among mothers of children under five in the 14 impact area villages it is expected that:

1. 80% of eligible mothers will be able to describe correctly the preparation and administration of an ORT solution
2. 40% of eligible mothers will report using an ORT solution for diarrheal episodes in their children under five.
3. 50% of eligible mothers with children who have started eating will report an increase in the number of feedings during the last diarrheal episode.
4. 75% of eligible mothers with children who have started eating will report an increase in the number of feedings after the last diarrheal episode.
5. 80% of eligible mothers will state that it is important for a mother to wash her hands before feeding her child.
6. 60% of eligible mothers will state that it is important to wash her hands after defecating or after helping her child to do so.

Growth Monitoring and Nutrition

1. Train at least 75% of women in nutritional improvement behaviors with at least 75% of children under three years participating at least quarterly in growth monitoring.

2. Specifically, 75% of children in the villages will participate in growth monitoring the following number of times before a given age:

6 months	3 times
12 months	7 times
23 months	14 times
35 months	20 times

Immunizations

1. At least 50% of children to be completely vaccinated before their first birthday.
2. At least 80% of children to be completely vaccinated before their second birthday.
3. At least 85% of women aged 15-49 years to be vaccinated with 2 valid doses of tetanus toxoid.

High Risk Births

1. Train 5 health promoters and 14 village health workers in birth spacing promotion. The project plans to promote those services which are available at either the village level (condoms), the health center level (pills and condoms) or the medical center (CM) level (includes foam and IUD's)

A summary of project accomplishments related to the detailed implementation plan and to the objectives is included in the appendix.

A door to door family registration was completed in July for the 14 impact area villages. This was felt to be more accurate than the target population numbers cited in the implementation plan since these were only estimates drawn from the government's 1985 census. The results of this registration led to significant revision of the project's estimated target population in the 14 impact area villages. The changes are as follows:

	population estimates (from 1985 census)	actual pop. (family reg.)
# women aged 15-49	6800	3176
# children 0-59 mos.	5700	2504
# children 0-11 mos.	760	677
# children 12-23 mos.	710	630

While this revision was discouraging, it would be difficult to make up the difference by adding additional villages due to the extremely dispersed population. Villages are as much as 15-20 kilometers apart and neighborhoods within a given village may be as much as 10-12 kilometers apart. This means that small groups of population are widely spread and thus extremely difficult to reach.

V. CONTEXT

The fourteen project villages are located approximately 2 1/2 hours out of the capital in an isolated rural area. The climate is Sahelian with a rainy season and dry season. The villagers' livelihood is subsistence farming with the quantity and timing of the rains being the primary determining factor in food sufficiency. During the dry season there is some migration to the coastal countries (usually Ivory Coast) to look for work.

When village chiefs and elders, as well as the health project counselors, were asked directly about their needs, the lack of both drinking and surface water were most frequently cited. A different, but related need was to build dikes around the fields in order to contain the water that does fall.

Beyond water issues, the formation of economic groups was also mentioned as a need. Ideas for their function included the establishment of funds to provide emergency transport, purchase mills, and develop a system for grain storage and/or marketing in order to improve food security. It seems that these kind of groups have been tried in the past with varying success, and that the concept was something people were familiar with.

While literacy was not specifically mentioned as a need in the village level discussions, it is a need that the project has attempted to address. The government already has a literacy program with certified literacy trainers who are available to go into villages and carry out a 48 day training when a village organizes itself to support them. The project hopes to pursue this by helping villages organize themselves to support these trainings.

Specifically related to health, village people were very conscious that health issues were a priority for them and they were satisfied that the project was helping to address the most acute of these needs: diarrhea and infectious diseases. However, the lack of a reliable drug supply, particularly for aspirin and chloroquine, was consistently mentioned. In 1987, the government had appointed and trained a village health worker and a village midwife (village health team) for each village. The health worker was given a health kit which included some basic supplies and drugs. The idea was that they would "sell" their supplies and services in order to compensate themselves and replace the supplies. Health committees were also appointed at the time consisting of the village health team, a chairman, vice chairman, and treasurer. However, there was essentially no training or follow up in the management of these committees, services, or supplies and they have not been functional in any of the 14 project villages. At this point, most of the elders interviewed were open to the idea of collecting money for another drug stock and felt that it would be very possible to organize a group to manage it.

When general development issues were discussed with the health promoters, they were aware of development related activities going on in their villages and seemed to understand the relationship of health to overall development. In a few instances they were already involved with the support of some economic groups. In addition, Africare intends to use the match money it has raised to implement a water well development project in the impact area villages. While many of these needs were discussed, the project approach has largely been one of running a vertical health program. It has not capitalized on existing efforts nor developed organizations within the community either to support its current health activities or to take a broader view of development solutions in its villages. Between the awareness of the health promoters, the extent to which they have managed to develop the trust of the communities, and the plans already developed for Africare to expand to a water project in the Ganzourgou Province, the project is well situated to take a more integrated development approach to its work in the area. In the immediate future, it is essential for the health staff to take an active role in the implementation of the water project.

VI. STRATEGIES

The main strategies the project chose to achieve their objectives were a very decentralized model using counselors at the neighborhood level to be the primary implementers; extensive training of counselors, village health teams, and health center nurses; and reinforcement of the provincial health structure - both the health teams at the village level and the nurses at the health center level.

Decentralized Neighborhood Model

At the village level, 205 voluntary women "counselors" have been selected in the 14 villages to provide basic health information to families in their neighborhoods and to mobilize them to participate in health activities. This is a ratio of about 1 counselor for every 15 women and means these women are mostly working with their immediate family and relations. The training of this many counselors is the strength of the child survival model this project selected. Because there are so many of them, the work load for each one is such that doing it voluntarily is not a problem. There is an added commitment because they are primarily "responsible" for family and relations. The project has been careful to select only very simple messages for these women to convey. In the case of diarrhea they have been very successful at getting the simple message of oral rehydration into every household the evaluation team had contact with.

The counselors provide an effective network to assure extensive village participation in health activities. Besides the success with household level education and behavior change, counselors were

seen as a community level resource when the guinea worm control program needed a mechanism to distribute water filers. Counselors were able to pick up this task and do it efficiently and effectively even though it wasn't a direct project activity.

The evaluation team was only able to identify 2 non-participators in three villages they visited. One of these was not available and the other was not participating because the family coincidentally associated the death of one of their babies with the participation in a growth monitoring session. This dearth of non-participators was identified by the health promoters in conjunction with the counselors, and verified in the family register. It is important to note that regular participation is still difficult to attain and requires considerable mobilization effort on the part of the health promoters, but it is difficult to find anyone that doesn't participate at all.

Training

The project has taken the training of all levels of participants from the counselors to the village health team, health center nurses, health promoters and Co-coordinator very seriously.
It has implemented a strong program including not only content on the child survival interventions, but also training of trainers and communication skills. These latter areas were first covered by sending the Co-coordinator for training. He subsequently included these in the training he did with the health promoters and nurses. All of the participants the evaluation team talked with or observed were able to demonstrate understanding and use of the content they had been trained on regardless of their level of function. Of particular note were the several excellent community education sessions carried out by the health promoters.

Another of the strengths in the training program has been the careful development of messages for use at the village level. For diarrhea, these were developed using focus group information with the active participation of the health promoters. They were then tested and refined. The nutrition messages were not developed in this way and have been less successful. The project is embarking on a similar process for evaluating and refining the nutrition approach at this time. The evaluation team was involved in two initial focus groups to look at community attitudes regarding the relationship of illness, weight loss, and food.

There are a couple of areas where the training program needs further consideration. These include the exploration of other Information, Education, Communication (IEC) methods as additional ways to get messages across, further training for health promoters in AIDS, and training for health promoters and nurses on how to do effective supervision. This latter is particularly important since village level supervision was identified by all concerned as essential to the success of health interventions. In order for this

to happen, both health promoters and health center nurses need to be trained in how to do effective supervision and work together to achieve it. This should include the development of supervision check lists that can provide a guide for supervisory visits.

With regards to IEC, successful village education is occurring now, but the health promoters felt that visual aids would sometimes help. The evaluation team also suggested that other methods such as skits or songs might be helpful. Care will need to be taken that the interactive format which the promoters are currently using so successfully isn't lost by developing dependence on visual aids or other communication methods.

Reinforcement of the Provincial Health Structure

The last strategy for achieving project objectives is the reinforcement of the provincial health structure. This includes providing training and support for the Ministry of Health appointed village health teams as well as providing training in child survival interventions for the health center nurses and midwives.

At the village level, the village health teams have been involved in all the training and activities that the counselors have been, and they both work with the health promoter when she is carrying out growth monitoring and/or community education sessions. At the health center level, the nurses have been well trained in both diarrhea and nutrition. Particularly in diarrhea, the four nurses indicated that they had shifted their treatment emphasis from antibiotics to oral rehydration packets.

A couple of problems were raised regarding the health centers' need for support. The most salient is the difficulty the nurses have in getting out to the villages to carry out supervision or preventive activities. While the lack of gasoline was the most frequently mentioned reason (they all have mobylettes), the team felt that comfort with the role, motivation, lack of its being a consistent expectation from superiors, and lack of supervisory support from superiors were probably all contributing factors. If the health centers are to effectively provide the village-based support the project is hoping for in the future, these factors will need to be considered.

The other problem that was mentioned was the demand creation at the village level for services the health center is unable to provide. Referrals for weight loss were cited as particularly frustrating for the health center nurses. While referrals to rule out other disease processes and/or parasites may be appropriate, everyone needs to understand that the addressing of actual food supply and dietary habit issues needs to occur at the village level. The clarification of the nutrition program and its messages which the project is undertaking at this time will hopefully begin to address this problem. While the health centers were also suffering from an

increased demand for pre-natal services due to the village level mobilization, everyone agreed that the referrals were appropriate, and the excess demand needed to be addressed in other ways.

VI. PROJECT STRUCTURE AND DESIGN

The health project has Coordinator (expatriate), Co-coordinator (national), an Administrative Assistant, a driver, a guard and 5 health promoters. The health promoters have been extensively trained by the Co-coordinator in the child survival interventions, training, and communications skills. They are the pillar of the program. They are each responsible for 2-3 villages, live out in one of their villages, and work closely with the people in those villages to address the health problems. The Co-coordinator supervises each of them in the villages a couple of times per month.

As mentioned under project strategies, 205 voluntary women counselors along with the Ministry of Health appointed health team provide the village level structure for child survival interventions. While the evaluation team expected that there might be some territoriality issues between the health teams and the counselors, they seemed to see themselves working together as a team in all the villages the team visited. The village health teams will eventually also have the role of providing back up and support for the counselors. A small problem that will inhibit this relationship is that counselors are referring their difficult cases directly to the health promoters. This undermines the potential role of the village health teams. In order to reinforce the role of the health teams as the back up for the counselors, the health promoters should work with the health teams to address these referrals.

Another difficult area in this relationship is that the health promoter has been responsible for the supervision of the counselors, while the health center nurses are supposed to supervise the village health teams. This requires a closer working relationship than is currently found between the health promoters and the relevant health center nurses.

Interviews with men and village elders as well as mothers indicated a tremendous amount of appreciation and support for the project. Villagers were involved both with the selection of their health promoter and with the selection of the counselors. Counselors' husbands felt their wives were doing valuable and important work, even though they were not getting paid.

A weakness in the project is that there has not been a lot of emphasis on general community organization beyond the specific work with the counselors. Although they have been informed of project activities, there have not been regular meetings with village elders, nor has there been any kind of development or health

committee formed. There is a wide variation in readiness among the different project villages, but without some effort at this kind of organization the ability of a community to begin to support some of its own health activities will be limited. In addition, such a group can serve as a target for general consciousness raising in the village as a whole to begin to develop a sense of empowerment around their own problem identification and solving. The health promoter should take an active role in this kind of mobilization as well as maintain her health focus. For the villages that are least ready, it is still important to search out a few innovators and at least begin to work with them.

An additional gap the project is beginning to address is the lack of involvement of men in the health activities. The project has sometimes been called the "health project for women and children". Conscious utilization of the village health worker (male) to develop education groups for men in child spacing and AIDS would be one way to start. The project should also capitalize on existing men's organizations such as working through men's clubs or the imams at the mosques. Such approaches would be more appropriate than hiring a whole set of male health promoters.

Health Information System

The health information system is based on the maintaining of a family register by household. All target women and children are tracked on their participation in immunizations and growth monitoring through this register. The health promoter is responsible for maintaining this register. She uses nutrition information from the register to make monthly reports to the Co-coordinator. She also reports monthly on her activities and on attendance at those activities. The Co-coordinator analyzes the health promoters' reports, makes a monthly report to the Coordinator, and uses the information to provide program information back to the health promoters.

The project also has a good information network within the villages. The system of communication between health promoters, counselors, and households is effective in mobilizing people for growth monitoring and immunization sessions.

A excellent baseline survey was completed at the beginning of the project and has been used in the planning process throughout. In addition, the project has done an ad hoc knowledge, attitudes and practice (KAP) survey to assess the diarrheal disease program, and an ad hoc immunization coverage estimate to evaluate the mobilization component. Information from both of these is also being used in planning and program adjustment.

While most of the pieces are in place for an effective information system, it is not being maximally utilized at most levels. At the village level there is no formal system for monitoring the

activities of the counselors or for knowing what is really happening at the household level. This means that there is very little information in the system regarding the diarrhea interventions since most of these happen at the household level. A very simple pictorial reporting mechanism needs to be developed in order to keep track of what is being done and provide feedback on interventions.

Also at the village level, the health registers are not actively used by the health promoters to provide feedback to counselors on who is missing essential services or who needs closer follow up. Village level analysis and feedback need to happen between the health promoters and counselors in the same way it happens on a project wide level between the Co-coordinator and the health promoters. They need to use the information they already have to actively improve their coverage and target the families most at risk. With regards to specifics, the health promoters do a good job of keeping the family register up to date on growth monitoring but the immunization status updates have been limited to times when a team has come out to the villages to carry out sessions. With the shift in emphasis towards encouraging families to seek out immunizations rather than just waiting for sessions to come to them, regular updating of the register for immunizations in order to identify defaulters is also extremely important.

At the health center level, there is no mechanism for the nurses to take advantage of the information maintained in the family registers. Particularly for immunizations, access to this information would be extremely helpful since immunization record cards are often lost, forgotten, or multiple cards with different doses recorded on each one may have been issued.

At the provincial level, the Provincial Health Director has not received monthly activity reports. While he is updated informally on project activities, he has not had access to the information that would make him an active partner in the analysis and planning of project activities.

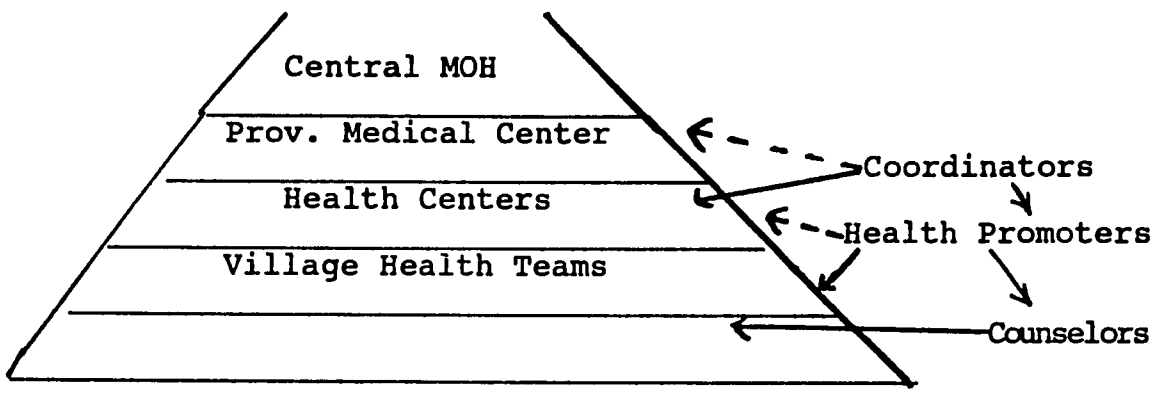
On the national level, an excellent annual report was recently distributed widely. If this is repeated, it would probably be adequate.

Interface with the Ministry of Health

A preventive, child survival approach to health priorities is generally consistent with national health policy and with the Ministry of Health's five year plan. The project seems to have a lot of support from the Ministry. The Provincial Health Director has been very open to and supportive of the project from the beginning, and appears to have spoken well of the project centrally. The coordinators both have an excellent informal

relationship with him. In addition, the participation of two Ministry of Health officials in a midterm evaluation is significant. It was clear in all of the evaluation meetings with officials that they were familiar with the project and often had very constructive thoughts and ideas to offer. This indicated they had read and thought about the information they had received. Lastly, the Ministry of Health has offered the co-coordinator a secondment with a guaranteed position at the termination of the project. This is particularly noteworthy because he did not hold a position within the Ministry at the initiation of the project.

As mentioned under project strategies, reinforcement of the provincial health structure is a key project component. While the training of the nurses seems to have been effectively carried out, the true integration of the health project with the health structure does not seem to have happened. Following is a diagram of the project as it fits in to the provincial health structure. The dotted arrows indicate points of collaboration that the evaluation has proposed be reinforced.



The coordinators' initial vision of the relationships with the Ministry of Health involved the Coordinator working with the Provincial Health Director, the Co-coordinator working with the nurses at the health center level, and the health promoters working with the health teams in the development of the counselors at the village level. While this was a strong model for getting the necessary training and support out to the villages, it does not adequately take into account the need for developing and supporting the Ministry of Health structure or the long term sustainability of the project. The project approach to the provincial system has largely been hands off with the exception of training for fear of infringing upon the responsibilities of the health center nurses. At the provincial level, while the project has tried to work with the medical supervisor to encourage more supervision, there has been frustration that nothing comes of it. The result has been two, nearly parallel systems, both having been well trained in the same interventions, but with very little true collaboration.

Specific areas where this lack of collaboration is noticeable are

in the lack of coordinated activities in the villages, the lack of consistent and coordinated supervision, and an unrealized potential for more efficient use of resources, particularly human resources. Health center nurses and health promoters do not regularly share their activities or plans with one another. While the health promoter is clearly able to carry out more village level activities than the health center nurses, she should at least be available and work with the nurse at those times when s/he is able to get out to the villages. Her experience and knowledge of work at the village level is an asset in developing the effectiveness of the nurses at that level. The only time the health center nurses are predictably able to get out to the villages are to carry out immunizations, yet these occasions have not been utilized to also do supervision or other preventive activities with the health promoter or village health teams.

As previously mentioned, village level supervision was identified by all concerned as essential to the success of the health interventions. Aside from the training and support needs mentioned under that section, the hands off attitude adopted by the project has not helped with the problem. While staff concern about not wanting take over others' responsibilities may be valid, it has not left them in a position to positively influence the supervision situation in the project villages. The project should take a more active role at all levels in the establishment of counterpart type relationships where project staff work side by side with Ministry staff to achieve the implementation and supervision of interventions at the village level.

The last area where closer collaboration could have a positive impact is in the area of motivation, resource management (particularly of human resources), and planning. The Co-coordinator needs to begin to work more as a team with the Provincial Health Director and Medical Director to address the health issues in the province and the ways the project interventions could most effectively be utilized within the constraints of its commitment to the 14 villages and the specific child survival interventions.

While general motivation may be a problem, there are clearly some committed and highly motivated Ministry people working in the project area. These people need to be encouraged and supported. The project needs to look closer at what non-monetary benefits (training, job satisfaction, sense of belonging, informal helping out, etc.) Ministry staff may be able to get out of collaborating with the project and consciously capitalize on those. Secondly, as more intensive coordination happens at the provincial level and as health promoters also begin to work more closely with the health center nurses, activities will be more coordinated and the time spent in villages will be more efficiently utilized. Lastly, during the recent reassignment of staff, two of the four trained nurses in the impact area health centers were transferred. If the project takes the more intensive view of training and developing these

people to be active village health supervisors they will need to be assured of having adequate time to complete the job before transfer. Such planning could be achieved through closer collaboration at the provincial level.

Collaboration with Other Organizations

The American College of Nurse Midwives (ACNM) and the Project of Rural Development of Ganzourgou (PDRG) both have projects working in some or all of the 14 impact area villages. The ACNM did a training for all the village level midwives, and the PDRG has been working on the development of grain banks with some of the project villages for three years. They are interested in working on small animal raising and also have some knowledge of the area's water needs, although they don't have the resources to develop water sources. The project has capitalized on the accomplishments of both of these other projects and people from all projects are familiar with each other's work. However, they currently work in a more parallel but communicating fashion. While actual integration may be difficult due to project differences, maximal collaboration should be a goal in order to make the best use of resources - both project resources and people in the villages who are the innovators and "doers". It is all work towards the goal of development.

On the national level, the project maintains close ties with the USAID mission and has made good use of their expertise. They have also exchanged visits with the Save the Children Child Survival Project in Dori. This has allowed for a constructive exchange of ideas both for coordinating staff and for the more front line staff.

The government has shown considerable receptiveness to ideas and innovation from non-governmental organizations (NGO's) both through their availability for discussion and their willingness to participate in the project evaluation. However, some of the difficulties around distribution of services, motivation, village level activities, and lack of supervision also have origins at the Central level. With the current openness of the Ministry of Health structure, it would seem that more formal ties between the NGO's working in health and a more coordinated effort to collaborate with officials at the Central level would increase the impact of the NGO projects on the national health program.

VIII. SPECIFIC INTERVENTIONS

Diarrhea and Oral Rehydration Therapy

The diarrhea component has received the most emphasis during the first year of the project. It is primarily addressed at the household level through the counselors' training of mothers in the preparation of sugar salt solution (SSS) at the time a child gets diarrhea. All 205 counselors have been trained in the recognition of diarrhea and the preparation of SSS to be administered as soon as diarrhea begins. Women have been alerted to contact their counselor as soon as a child begins to have diarrhea. If there is a problem at the household level, the child can be referred to the village health team who has a supply of oral rehydration packets. If there is still a problem, the child is referred to the health center where there is an oral rehydration corner. The diarrhea messages are also reinforced by the health promoter at village education sessions in conjunction with growth monitoring. Hygiene messages and the importance of continued feeding have also been covered in both arenas, but these have not reached the household practice level as successfully.

The real strength in this intervention is the coverage. The utilization of the counselors, and the knowledge of SSS preparation and utilization were universal among the people the team encountered at all levels of the project. During a recent KAP survey carried out by the project, they found 81% (42/52 cases) reporting use of SSS during an episode of diarrhea occurring in the past two weeks.

The training that occurred at multiple levels of the health system has considerably helped the consistency of messages and treatment throughout. Province trainers, health center nurses, village health teams, and counselors all recommend SSS and/or oral rehydration packets for treatment of diarrhea. Nurses report using less antibiotics for diarrhea treatment or at least combining antibiotic treatment with use of the oral rehydration packets. They also report that women come in requesting the packets and that they are seeing fewer cases of severe dehydration. (These reports were not directly verified by the team.)

While this is a very strong and apparently successful intervention, there are several things that bear further consideration. At the time the project was begun, the use of SSS was consistent with national policy and was selected based on availability of the contents in the villages. Even though world opinion is moving away from this as a preferred solution, it is still consistent with national policy. The project may be in a position to experiment with the use of cereal-based solutions to treat dehydration and may be able to help with the development of a national policy in this regard. However, even if successful cereal-based solutions are discovered, the decision of whether and how to implement such a

change after all the credibility and effort the project has invested in the training of counselors in the use of SSS will be difficult.

The messages around hygiene, continued feeding, and danger signs indicating the need to seek additional help have not been learned as clearly as those around the use of SSS. The evaluation team felt these messages were appropriate, but that their implementation was weak. They were not emphasized by the health promoters, and without this emphasis the counselors had not picked them up. This may have been appropriate because the simplicity of the SSS message led to such universal knowledge, but these additional messages need to be covered now.

The current program has assumed that a free supply of Unicef oral rehydration packets for the village health teams is available through the health centers. The evaluation team was concerned that there is a move in the Ministry of Health towards charging for all medicines and that a continued free supply of packets is not sustainable. The project needs to plan for the time when a free supply is no longer available both in terms of its education messages and in terms of its supply mechanisms.

Immunizations

The primary responsibility of the project in the immunizations intervention is the education and mobilization of villagers. The Ministry of Health is responsible for all the administration of the vaccines, including the maintenance of personnel, supplies, and cold chain to make this possible. The health promoter is notified when the health center or mobile team staff plans to do a vaccination session in one of the project villages. She then notifies the counselors who notify and mobilize the eligible women and children in her neighborhood. Town criers have also been used on market day to make the same announcement. The counselors have been trained in the importance of vaccinations, the vaccine preventable diseases, and the schedule for administration.

The strength of the immunization program is that it is supporting an existing system for vaccinating people that will continue after the project funding is gone. There is good communication in place for mobilization of eligible participants, and community sensitization to the need is well under way.

The team felt that a lack of clarity and simplicity in the specific vaccination messages was a weakness. The essential message in line with the national campaign are 5 contacts before one year of age. This got tangled up when the project tried to account for late starters who then may be able to double up doses and complete the series in fewer than 5 contacts. It also gets confused when the schedule by antigen is included. Likewise, the tetanus message needs to be simplified to the need for 5 vaccinations in order to

be completely vaccinated and the need to verify vaccination status with the nurse if a woman is pregnant.

The other issue around immunization mobilization is the extent to which such activities depend on vaccination sessions in the immediate village. Ministry of Health staff felt that the ability of vaccination teams to continue to reach remote villages was dubious. As a result, an additional message regarding the importance of seeking out immunizations at the health center for children at an eligible age even if the vaccination teams don't arrive needs to be added. To support this effort, the Provincial Health Director made a commitment to make vaccines available daily at the health centers and to remind his nurses of the importance of opening a vial even if only one child needed immunizing.

Coverage estimates were reviewed during the July session of growth monitoring. Women were asked to bring their immunization cards and coverage rates were calculated based on that information. These estimates are low because the denominator was all eligible children according to the family register while the numerator included only those eligible children brought to the weighing session and who had their cards with them. With this caveat, estimates were:

	July estimate	Baseline
BCG	69%	75%
DPT3	27%	50.6%
measles	47%	65%
TT2	42%	17-30%

These numbers are generally lower than indicated in the baseline, except for TT2. This may be due to the manner in which these estimates were concluded, but may also be due to a decreasing frequency with which the immunization team is able to arrive in some of the project villages. The increase in tetanus toxoid coverage could be attributable to the project sensitization effort since many women hadn't been aware that they were also eligible to be immunized.

These numbers raise a question about the appropriateness of the project objectives. Coverage objectives only minimally measure the project efforts in this intervention since most of the variables impacting coverage depend on the Ministry of Health activities. In the implementation plan, the project strategy deliberately did not address those activities carried out by the Ministry of Health. Team members in discussion with project staff came up with the following recommendations for revised immunization objectives:

1. 80% of mothers will know that 5 immunization contacts before one year of age are necessary to complete the series. They will also be able to list measles and two others of the vaccine preventable diseases.
2. When a vaccine session occurs in one of the project villages, 90% of the eligible children still needing vaccinations will participate.
3. 10% of mothers will seek out vaccinations other than in their own village for their babies during the first six months of life.

Nutrition

The focus of the nutrition program has been the regular growth monitoring of all children under three years old. This provides a forum for teaching mothers the importance of adequate weight gain and offers education intervention when a child does not gain weight. A group education session on a health topic is always associated with a growth monitoring session. Of significance was that village people saw growth monitoring as having a positive impact on the health of their children and they valued it.

The growth monitoring sessions were very well implemented. The health promoters were competent in the weighing, the record keeping, and the information content necessary for counselling. The village health team and the neighborhood counselors were all present at the sessions and participated actively in the activities. The one shortcoming was that in one of the sessions observed there was enough crowding and a large enough number of children that it wasn't possible to devote the necessary focus and attention to counselling growth falterers. It may be possible to set aside time at the end of the session and or to make follow up visits on these children rather than trying to determine the cause and counsel at the time of weighing. In addition, this would provide an opportunity to begin to involve the related counselor in the nutrition process and to begin to make her responsible for household level nutrition program support.

While the implementation of growth monitoring seemed excellent, the success in getting women to understand the connection between growth monitoring and food intake was more dubious. Women seemed clear that weight gain was related to health, but did not make the connection to food intake. Some initial work on the development of these messages was done during the evaluation through two focus groups held with counselors. Further refinement still needs to be done. Specifically, it seems messages need to focus on food as the first treatment for weight loss, and on food quantity - both frequency and quantity per feeding. Women in the discussions did seem to have a reasonable understanding of food quality.

The other concern is that it appears that the actual weighing is seen by the villagers as an end in itself - that it brings health to their children. Because growth monitoring as an activity is not likely to be sustainable in the long run at the village level, it will be a challenge to begin to separate nutrition interventions from the weighing activity. Counselors need to be able to provide nutrition counselling using a few simple messages even when there are no longer growth monitoring sessions.

It appears from reviewing the family register and spot checks of growth monitoring cards that the project has more than achieved its objective of 75% of children participating quarterly in weighing - at least for the last six months. However, in order to achieve this level of participation, the health promoters are spending a majority of their time carrying out weighing sessions - sometimes several days in a row in a given neighborhood.

With the lack of actual behavior change and seeming dependence on growth monitoring as an end in itself; maintaining the current rate of growth monitoring coverage may not be an appropriate emphasis for the nutrition intervention even though it is consistent with the project objective. Having essentially achieved the objective without achieving the hoped for behavior change at the household level, the evaluation team felt that a shift in program emphasis should occur. Eventually, it will be the village health team and the counselors who will be carrying out the village level nutrition program. Towards this end interventions emphasizing food as treatment to achieve health, as contrasted to baby weighing, need to become the focus of the program. In addition, the counselors and village health team need to be trained in these messages and included in the counselling the health promoter does so that they can learn the skill. Other means to assess growth such as arm circumference, or training the village health team to do growth monitoring may be considered. However, both of these have difficulties and limitations to overcome such that they may not be feasible It is more likely that actual growth monitoring will have to be limited to the health centers.

Given the shift towards health centers as primary service providers in pre-natal care, child spacing, immunizations, and growth monitoring; and given the distance people have to travel to avail themselves of these services; it is important to work towards the integration of these services at the health centers. Currently, services are provided in a more vertical manner with specific days for specific services. This needs to move towards making all services available during a single visit in order to maximize the rare visit a mother may be able to make to the health center. Families also need to be sensitized to take advantage of their rare trips into town to get health needs taken care of - even when no one is sick. These are changes the project will need to work closely with the provincial health structure to achieve.

Other Interventions: Prevention of High Risk Births / Malaria / Literacy

Community education is the main project intervention to decrease high risk births. The health promoters have been trained in and carried out group education sessions in the importance of getting pre-natal health consultations and in child spacing. They had not yet been trained in AIDS prevention, although this was expected to happen in November, 1992.

Since there had not been much effort expended on this intervention during the first year of the project, the evaluation team did not set out to directly evaluate it. However, several members of the team had the opportunity to observe an outstanding education session on child spacing held by one of the health promoters with a group of village men and elders. All the important points were concisely covered in a way that the men were comfortable enough to ask questions. Feedback indicated they had understand the content. While sexually transmitted diseases were mentioned briefly, AIDS prevention information was not included within the context of the session and could easily have been.

Malaria has not been addressed by the project at all. However, in the context of the community development discussions held with the village elders, a reliable chloroquine and aspirin supply was consistently brought up as a need. It may be that some kind of a revolving fund with these very limited drugs could become an intervention in the context of the formation and training of a health or development committee.

The detailed implementation plan called for providing literacy training to at least one member of the village health teams in each of the 14 impact area villages. Some initial training has been provided to several of the village health workers and was enthusiastically received. It is too early to assess the impact of such training on the health program, but completion of the program with health specific training for health workers in the rest of the villages is anticipated during the coming year. The impact of this program should be evaluated and if it is positive, the project should consider the training of a counselor in every neighborhood if there is a second phase to the project.

IX. PROJECT MANAGEMENT

The project is managed by an expatriate coordinator and a national co-coordinator who are based in Zorgho, the provincial capital. The expatriate position turned over almost one year into the project. The transition was handled smoothly with the Co-coordinator acting as coordinator in the interim. The Zorgho team receives logistical and administrative support from the Africare office in Ouagadougou. Staff in Ouagadougou include accountants, and logistical and program support people. There is an expatriate country director

managing the overall program.

The Africare Washington D.C. office provides personnel and financial management support, as well as a full time child survival health coordinator. She provides technical and grant management support to the Zorgho child survival program.

Technical assistance was sought in the development of the survey. Otherwise, the approach has been to seek out training for the Co-coordinator (in project management and inter-personal communications) and then to encourage him to use what he learned in implementing the program. There do not seem to be areas where additional outside technical assistance is needed at this time.

Child survival staff indicated they felt they had the logistical and material support they needed to do the job. The car, motorcycle and five mobylettes provide adequate transportation coverage. Living situations were adequate and people were generally satisfied.

Supervision in the project happens regularly at all levels. However, several people mentioned some dissatisfaction with these relationships. The establishment and use of supervision guides and/or clear expectations against which peoples' performance will be measured might help the effectiveness of these interactions. The health promoters felt they needed more supervision even though they receive supervisory visits twice monthly. Encouragement of more independent problem solving and decision making may help their confidence.

None of the health staff had received an evaluation since the beginning of the project. This has led to some frustration. The Africare policy of approving all salary increases worldwide from Washington has hindered the evaluation process because staff is not free to associate monetary compensation with positive evaluations. However, some kind of regular evaluation process would be positive for staff morale and provide another forum for staff training and feedback.

At the village level, a couple of changes would involve the health promoters more in their own program management. These include the completion of a simple time and motion study to analyze where the promoters are actually spending their time and if this allocation is consistent with the project goals and objectives. While the Co-coordinator uses his observations of needs in the development of training content, the health promoters don't feel they have direct input into the planning of their training. Lastly, while health promoters meet together in Zorgho on a semi-regular basis, they have not had the chance to visit each others' villages. This would provide an additional opportunity for them to evaluate and change their programs based on their own observations.

The team was concerned that the approach to management across all levels seemed to be hierarchical rather than team oriented. If the goals is increased nationalization of the work, a team approach would likely be more successful in getting people to begin to own the work and to develop it and carry it out themselves. It also raised questions as to the management values of the organization as a whole since these attitudes often spread beyond an individual or country.

The other key area needing management attention is the relationship between the two coordinators. With a competent Co-coordinator and the project well under way, it would be difficult to justify the replacement of the Coordinator with another expatriate when her contract is finished. However, in order for the Co-coordinator to begin to take over more of the management and administrative responsibility, job descriptions and the relationship of the two coordinators will need to change. As already mentioned under project design, the Co-coordinator needs to take a stronger lead in coordinating and integrating the project activities with the provincial health structure. In addition, he needs more authority both in the supervision and management of the field component as well as in the administration, management and decision making of the overall program. This should be feasible since most of the training for the health promoters has been accomplished and they should be able to begin to function more independently. Further development of English skills, orientation to Africare management systems, and some technical support in planning are areas in which the Co-coordinator will need additional support in order to be successful in this transition.

As the Co-coordinator takes on more project management, the Coordinator will also need to shift her focus. Her relationship with the Co-coordinator should be more one of a counterpart, even though she will still be his immediate supervisor. She needs to provide the necessary program, planning, and technical support he needs, but move towards an advisory role gradually letting him take on the leadership function. As this transition happens, there are two areas the team felt she could effectively expand her role. These are more involvement at the Central level - both directly and by developing more coordination among other NGO's working in health; and in exploring ways to introduce a health component into some of the other Africare projects in the country.

There appears to be enough money left in the budget to complete the project as planned. However, a couple of adjustments have been made. First, there are significant expenditures that the USAID grant did not cover - either because the grant was so much less than the originally proposed amount or by policy. As a result the match money, which was raised to carry out a much needed water project, has been skimmed to support the health project. These expenses include the car and mobylettes, housing for the health promoters and Coordinator, the office generator, and the opening of

the office in Zorgho.

Within the USAID budget itself, it seems the final budget was designed in Washington and submitted before the field had a chance to approve it. This budget included money allocated to supplies and materials that should have been allocated to training costs. The necessary adjustments are being made to keep total category expenses within the acceptable limits and the training program does not seem to have been compromised.

X. SUSTAINABILITY

The strength of this project with regards to sustainability is the change that has occurred at the neighborhood level. There are 205 well trained counselors functioning on a voluntary basis to support health interventions in their neighborhoods. The messages being implemented were developed with village input and encourage sustainable behaviors such as rehydration practice or the importance of regular feeding. These behaviors will hopefully continue even if the community education sessions carried out by the project stop.

On a broader level, some of the communities in which the project is working are very open and ready to work with the project towards taking responsibility for their own programs. Among these are two of the four villages visited by the evaluation team. Also on a broader level, the Co-coordinator has been seconded by the Ministry of Health and has a guaranteed job at the end of the project. His skills and the training he receives in the implementation and management of a child survival program will be carried back to the Ministry at that time.

More work needs to be done on the village level to assure other elements of sustainability. The project has done pretty well at raising the profile of health issues in the villages and at increasing people's perception of its importance. It can now capitalize on this established demand to begin to move the community towards taking some responsibility for its health. As already mentioned, the formation of some kind of health or development committee would provide a community level organization to begin to do this. Such a committee is also consistent with national policy. It is essential that project staff begin to discuss the eventual departure of the health promoter and Co-coordinator with this committee and with the village chiefs and elders. In this way, the project can work with the villagers to determine what activities they want to sustain and to look together for ways to make that possible. Specifically, such an organization could begin to work more with the nurses from the health centers to support an advanced strategy for getting some primary health services out into the villages.

The other area where sustainability issues need to be constantly considered is in the planning and decisions taken by the project from now on. Even as the health promoters become more involved with the health centers, as the Co-coordinator becomes more involved at the provincial level, and as new village committees are formed, the reality of what will happen to that work when the project no longer has the resources to support it needs to be considered. It would be helpful for the project to define some sustainability objectives in order to keep on track. These might include objectives around the independent function of counselors, village health teams, and/or health center nurses. They might also include the function of a village process (committee) for problem solving and managing health interventions.

XI. RECOMMENDATIONS

Context

- Project health staff needs to be actively involved in the planning and implementation of the Ganzourgou water project.
- The project needs to begin to take a broader, development approach to health problems.

Strategies

- The project should explore other IEC methods (role plays, visual aids, songs, stories, etc.) to transmit messages. However, it should take care not to lose the interactive teaching mode it is currently using.
- Health promoters need training in effective supervision.
- Health promoters need to train counselors and village health teams in communication skills.
- Health promoters need to begin working with the village health teams to train them in child spacing and AIDS; and to work with them to sensitize and mobilize men in child spacing interventions.

Project Design and Structure

- Since village health teams will eventually be the primary resource people for counselors they need to be included in the referral process (e.g. for seriously dehydrated children). The health promoter needs to encourage the counselors to refer to the village health team and she can serve as the advisor, rather than receiving the referral directly from the counselor herself.
- The project should begin to establish village level committees to begin to take responsibility for health activities. These committees can start with very specific tasks such as the management of a supply of chloroquine and aspirin.

- Health promoters should be used for consciousness raising in the village as well as for specific health education activities.
- The project needs to begin to plan with the villagers for the eventual depart of the health promoters.
- For villages in which unified community organization is difficult, the project should begin on a small scale with a few motivated people. Success with these people can then begin to influence others.

Health Information System

- A pictorial reporting system needs to be developed to record and monitor counselors' activities.
- Health promoters need to regularly keep up the vaccination status in the family register by discussing it with the mother during every growth monitoring session - regardless of whether there was an immunization session during that month.
- Health promoters need to use the register to develop a list of eligible children who have not been completely vaccinated. They then need to use that list in collaboration with the counselors to assure the children's participation.
- The health promoter should discuss her monthly report with the counselor before sending it in to the Co-coordinator.
- Ways need to be explored for the health centers to be able to utilize the information (particularly for immunizations) the health promoters maintain in their family register.
- The Co-coordinator needs to send a monthly activity report to the Provincial Health Director. They need to go over it together to use it for planning.

Interface with the Ministry of Health

- Project staff needs to actively coordinate and plan activities with Ministry of Health staff at all levels. At the village level, the health promoter needs to plan her activities to coincide with those of the health center nurse so that she can serve as a "guide" and facilitator for interaction between the nurse, the village health teams, and the counselors.
- The model for Ministry of Health collaboration needs to be modified such that the Co-coordinator will work more at the provincial level, the health promoters will work more at the health center level, and the health promoters will work more with the nurses at the village level.
- Ministry of Health staff need to be strongly encouraged and motivated to participate in project activities and to fulfill supervision responsibilities. The Co-coordinator needs to work with the Medical Director and the Provincial Health Director to help assure this happens at that level. At the village level, the health promoter needs to work with the health center nurses to make sure the village health teams get the supervision they need.

- The project needs to provide training to the nurses at the health center level in supervision and interpersonal communication.
- The project needs to look for non-monetary ways to encourage and motivate Ministry of Health staff at all levels. They need to see a personal benefit out of the presence of the project. This might include computer training, other professional training, social benefits, transportation benefits, etc.
- The Co-coordinator, Medical Director, and Provincial Health Director should work together to best take advantage of the resources (particularly human resources) of the project within the constraints of the commitment to child survival interventions in the 14 active villages and within the constraints of not putting something in place that will later have a negative impact on sustainability.
- The project needs to work with Provincial Health Director to encourage nurse stability in the health centers for at least one year. This will allow for the project to train the nurses to a point where they would be able to take advantage of the skills outside the project area.
- There needs to be more real integration of efforts with other sectors and with other non-governmental organizations in the province.
- There needs to be more involvement with planning and sharing information at Central level. The project should consider working on the establishment of a child survival team in Ouagadougou made up of representatives from the Ministry of Health non-governmental organizations working in health in the country.

Diarrhea Disease Program

- The project should explore possible recipes for cereal-based oral rehydration solution. However, implications for any message change in this regard will need to be seriously considered.
- The project needs to increase emphasis on and work on improvement of feeding and hygiene messages associated with diarrhea. The message content is appropriate, but the implementation is weak.
- Since a free supply of oral rehydration packets from the health center is not likely to be permanently available, the project needs to begin to think about the time when packets will be sold.

Immunization Program

- The project should review its messages regarding frequency of contacts and age with immunization team. These messages need to agree with the national policy and should remain with the emphasis of 5 contacts before 1 yr old.

- Tetanus messages for women aged 15-49 need to be that 5 vaccinations are necessary in order to be completely immunized, and that she should verify her vaccination status with the nurse if she is pregnant.
- The project needs to develop vaccination messages that encourage women to search out vaccinations even if the mobile team is not available. No effort is too much to get a child immunized.
- The project should support the State commitment to making the fixed centers work through information and sensitization.
- The project objectives should be changed to more accurately reflect the project's actual activities.

Nutrition Program

- Use of real food as visual aids and/or food demonstrations should be explored as an education strategy.
- The growth monitoring sessions need to be reorganized in order to allow enough time and space for women to receive counselling regarding their child's progress.
- Nutrition messages need to be clarified and limited to :
  - food is the first treatment for weight loss
  - quantity of food - frequency and quantity per sitting
  - quality of food
- The project needs to explore ways to disassociate the nutritional education from the activity of growth monitoring. Understanding the importance of adequate nutrition for the health and growth of the child is the goal while growth monitoring is only a means to this awareness. In the shorter term, health promoters could begin to occasionally do a nutrition session without actually doing weighing.
- Health promoters should begin to work with the counselors on giving appropriate advice with the goal that counselors will also give nutritional counselling at the household level.
- The project should explore the use of arm circumference or other means of assessing growth in order to provide additional support to a nutrition education program at the counselor level.
- The project should explore the feasibility of maintaining growth monitoring at the village level sponsored by the village health teams.
- As an intermediate step, the health promoters can attach growth monitoring to the immunization sessions as way to still reach families while limiting the time they put into growth monitoring in the coming months.
- The project should explore ways to further integrate primary health activities at the health center level: growth monitoring, FP, and immunizations should all be available when women come for consultation.

Other Interventions

- Health promoters need training in AIDS.
- The project should consider the establishment of a revolving drug fund to provide a consistent supply of chloroquine and aspirin at the village level.
- The project should evaluate its program of literacy training for village health teams. If it has a positive impact on the health program it should consider expansion of the program to include counselors in the future.

Project Management

- The project needs to develop and use supervision guides at health promoter and counselor levels.
- Staff evaluations need to be done.
- The project should do a time and motion study of the health promoters in order to evaluate whether priorities per time spent are appropriate.
- Health promoters need direct input into the content of their training.
- Adopt more of a team approach to management
- Coordinators' roles and tasks need to be evaluated and redefined.

Sustainability

- The project needs to discuss and plan regularly with the villagers for the departure of the health promoter.
- The project should explore the possibility of organizing villages to help support the advanced strategy of the provincial health structure. This could enable the nurse to get further out to villages.
- Even as the project becomes more involved with the provincial health structure, the temporary nature of this involvement has to be kept in mind when choices and decisions are made.
- The project needs to identify sustainability objectives.

XII. LESSONS LEARNED

Upon completion of the evaluation process, the Ministry of Health team members both felt they had learned two significant lessons from the project. These were: 1/ that a successful health intervention model has to include a mechanism for really reaching the household level and 2/ that messages regarding the general importance and relevance of health to the villagers' lives need to be conveyed initially before specific interventions will be successful. Villagers need to feel the interventions really touch their needs. The team as a whole concurred that these were significant lessons.

The model using neighborhood counselors as the primary mobilizers and implementers requires a large up-front input of resources for training and support. However, it provides a solid means for reaching households. These women are taking care of their own extended families and don't have a work load beyond that which can reasonably be expected to be carried voluntarily. The expectation is that their interventions are simple and successful enough that they will continue even when there is less health promoter support.

Additional lessons the team felt have been learned from this project were the importance of having a national health policy and a provincial level health system that support village level primary health care; and the importance of very simple intervention messages. The successful project messages were consistent at all levels, very simple, and developed out of village input.

XIII. REFLECTIONS ON A SECOND PHASE

It seems clear that in planning a second phase the project needs to expand its population coverage and to begin to think about replicability. In addition, several specific recommendations come out of this evaluation.

- The project needs to consider moving into more integrated development rather than remain an isolated health program. The match project for water will help significantly since that is the primary need mentioned by most people. However, malnutrition in the project villages is often truly due to lack of means to feed a child. Therefore, there appears to be a significant need to improve the economic situation and/or food availability in the villages. This might include further work to develop economic groups (particularly for women) and/or support for small animal raising. This would help get money into women's hands. Some of these activities are already in progress sporadically, and the PDRG is ready to work closer with the project in these areas.
- In considering the expansion of intervention for prevention of high risk births to maternal mortality prevention, it is important to survey the cause of recent maternal deaths to better understand the problem. It is likely that the availability of transportation during labor will be a key problem that will need to be taken into account even though there is an ambulance in Zorgho.
- In considering the expansion of interventions into AIDS, education at the neighborhood level should be the key. The structure is already in place for easy implementation. Counselors need to be trained in several key messages, and village health workers need to be trained to sensitize men.

APPENDIX I

Africare Ganzourgou Child Survival Project
Mid-Term Evaluation
Evaluation Framework

prepared by Claudia Williams, Coordinator

I. Diarrheal Disease Activities Anticipated in DIP

Activity Anticipated	Activity Occurred	Input Anticipated	Input Occurred
Improve Health Worker diarrheal disease management through day training of health workers in 5 health centers - August 1991	Training took place in March 1992	16 health center staff from project zone trained for 10 days	20 health center staff from throughout Province trained for 5 days
Improve community management of diarrheal disease through training of ASV and AV in 14 project villages - November 1991	Training Occurred in May-June 1992	28 VHW's from 14 project villages trained for 8 days - each received stock of SRO packets	33 VHW's from 14 villages trained for 3 days in group and 2 additional days with the NL's by HP's - total of 5 days training
Observational Study of health center case management before training - August 1991	Study occurred in February 1992	1 medical center and 4 health centers visited for observation	1 medical center and 6 health centers visited
Observational study of health center case managment after training - Three months after training	Study has not yet occurred	I CM and 4 health center visited for observation	
Improving mothers' knowledge of DDC through training of counselors and mothers	counse-lors and mothers trained	70 counselorse and 2800 mothers to participate	205 counselors and 2896 participants (men and women-may be duplicated)

Diarrheal Disease - Activities anticipated in DIP cont.

Activity Anticipated	Activity which Occurred	Input Anticipated	Input which Occurred
Mothers' ORT knowledge assessed in growth monitoring sessions and home visits - activity anticipated on a monthly basis	Activity underway in Sep 1992 - not considered feasible to complete monthly	Home visits made on a sample of mothers whose children have had diarrhea - each HP to sample 20 mothers per month	KAP quest to be completed on a sample of at least 8 mothers per village whose children have had diarrhea in last 2 weeks
Conduct focus groups to explore attitudes towards treatment and message blocks	Focus groups to explore attitudes towards treatment conducted in January 1992, not focus groups conducted on message blocks	not identified	Project HP's conducted focus groups in all 14 project villages with the NL's to
Introduction of National monitoring forms for diarrhea case management in health centers	These forms were discussed during training but are not being used in health center - copies have not been distrib.	Provision or reproduction of forms by the Project	No national diarrhea forms are appropriate to reduced symptom list for dehytration. Anticipate development of pictorial system used by counselors

II. Vaccination Program - Activities anticipated in DIP

Anticipated Activity	Activity which Occurred	Input Anticipated	Input which Occurred
Community Meetings to inform mothers of vaccination sessions and train mothers in basic PEV knowledge	HP's have generally broken activity into two pieces. They pass through the neighborhoods before the sessions to inform and then deliver a "health talk" on vaccines the day of the vaccination at the site	Community meetings before each vaccination session	For 30 out of 34 of the vaccination sessions to date the HP was informed, informed the village and conducted an animation session before the vaccinations
Needs assessment and retraining of members of village health teams on basic vaccine knowledge and community organization skills - December 1991	No specialized training targeted to village healt team has occurred. Teams have participated in general information and education sessions on vaccines conducted by HPs.	Training during 4.5 days of 28 members of the village health teams	Through participatio n in community meetings and discussions on mobilization estimate that health teams have received 1.5 days of training
Registration of vaccinations received by mothers and children in family registration notebooks during vaccination sessions	Vaccinations received are recorded by HP during the trimestrial baby weighing sessions rather than at the vaccination session	Quarterly monitoring of vaccination coverage using family registration notebooks	To date project has calculated vaccination coverage twice, in October 91 and in June 1992, it will be calculated again in January 1992

Vaccination Program - Activities anticipated in DIP cont.

Anticipated Activities	Activities which occurred	Inputs Anticipated	Inputs which Occurred
Participation of Health Promoters in village vaccination sessions	Health promoters have participated in 89% of the village vaccination sesssiions	Health promoter records the vaccinations received by child in neighborhood notebooks	Health promoter assists the nurse to fill out the vacc. cards and organize session
Experimental develop. of alternative vaccination card	Project has not yet engaged in this activity	Revised vaccination card for illiterate mothers	not anticipated

III. Nutritional Improvement - Activities anticipated in DIP

Activities Anticipated	Activities which Occurred	Inputs Anticipated	Inputs which Occurred
Monthly Growth Monitoring sessions in all project villages	Starting in Feb/March 1992 HP's conducted trimestrial growth monitoring for all children 0-36 months and monthly sessions for high risk children (under 12 months and those who lose weight)	HP organizes monthly baby weighing sessions in each village	Project strategy has been to organize GM by nieghborhood, although sometimes two or more neighborhoods are regrouped for one session.
Pilot testing of nutrition education and nutritional demonstration activities in one or two villages April 1992	In reality project could not carry out GM activities without nutrition education. Activities consist of individual nutritional counselling with mother at GM session, some home visits and introduction of PMI bouillies	all GM participants receive nutritional education	nutrition education carried out

Needs assessment and Training of 8 CSPS workers from project zone in growth monitoring and promotion. Sep 1992	Training of 7 health center workers from 5 health centers which cover project villages in nutrition communication (counselling) in June 1992. Training on nutrition animation using AED flip-charts planned for Nov/Dec 1992. Did not complete a formal needs assessment or post training analysis	10 days of training for health centers level health workers. After training and purchase of scales health centers will conduct GM at least weekly	3 days of training in June and 4 days antic. in Nov/Dec on flip charts = 7. Two of the four health centers (Meguet and Kabouda) conducting GM sessions regularly

Nutritional Improvement - Activities anticipated in DIP cont.

Activities Anticipated	Activities which occurred	Inputs Anticip	Inputs which occurred
Training of village health workers in GM activities - Nov 1992	While traditional midwives and village health workers have regularly participated in GM sessions the project has not organized or conducted GM or nutritional training focused on the village health teams	Training of 28 village health workers for 8 days in growth monitoring and promotion with focus on interpretati on of Growth chart and follow-up counselling	Has not yet occurred
Home visiting for growth faltering children completed by the Neighborhood liaison	Home visits completed somewhat sporadically for children considered at high risk by the health promoter. To date home visits conducted by the health promoter.	project will consider home visits by counselors	

Project will purchase baby scales for the health centers that are not equipped and for the use of health promoters in villages	Project has purchased baby scales for the use of health promoters but has not yet purchased scales for the use of health centers	purchase five hanging Salter scales for HP's and two beam scales for health centers	Project has purchase d Five hanging Salter scales
Project will introduce the regular MOH GM card in the fourteen villages and experiment with a bubble chart starting in 1992	With the beginning of regular GM in Feb 1992 HP's have been selling the GM card for 65CFA to all particiapting mothers	Project purchase of GM cards and free distrib to mothers	Project supports Nat'l policy by selling cards for 65CFA

Nutritional Improvement - Activities Anticipated in DIP (Cont)

Activities Anticipated	Activities which Occurred	Inputs Anticipated	Inputs which Occurred
With assistance of Vitamin A experts and results from baseline survey, develop Vitamin A strategy - Oct 1991	Have not yet elaborated a strategy to focus on Vitamin A. Nutritional messages include promotion of consumption of greens for children and pregnant mothers		

IV. Prevention High Risk Births - Activities Anticipated in DIP

Anticipated Activities	Activities which Occurred	Input Anticipated	Input which Occurred

Support activities of the ACMN project which plans to train TBA's in birth spacing methods and use TBA's to distribute condoms	Project coordinators participated in parts of the refresher training for the CSPS accoucheuses organized by the ACMN. In October, 1992 the Population Council conducting an evaluation of ACMN project	No defined inputs	The Health promoters provide supervision and support to the TBA's in practicing animation on topics covered in the ACMN training
Train the male community health workers in birth spacing methods and techniques	No specific activities yet undertaken to train male health workers in birth spacing	Form village health workers in child spacing	
Providing information on types of contraceptive methods vailable and where they can be obtained	The project health promoters conduct animation sessions targeted to men and women to promote family planning		Between January and July project had 2887 p articipants in 105 child spacing sessions

Prevention of High Risk Births - DIP continued

Activities anticipated	Activities which occurred	Inputs anticipated	Inputs which occurred
Promotion of prenatal sessions available at health center	Educational sessions with pregnant mothers to encourage them to attend prenatal sessions at health center		

V. Project HIS System - Activities anticipated in DIP

Activities anticipated	Activities which occurred	Inputs anticipate d	Inputs which occurred

Initial Census of target populations - September 1991	Family Registration occurred between October and December 1991	Fill out family registrati on forms for all women 15-49 and all children under five. Weigh children and check vaccinatio n records	Same as anticipated
Continual updates of family registration	same		The counselor informs the HP when a child is born. The HP accompanied by the counselor makes a home visit to register and weigh the child. Deaths of children and women (associated with chilbirth) are registered on family registration forms

Project HIS System - Activities Anticipated in DIP (Cont)

Activities anticipated in DIP	Activities which Occurred	Inputs Anticipated in DIP	Inputs which Occurred

Regular monitoring of data for consistency and quality		Weekly field visits to each HP by coordinator initially to verify data collection, subsequently field visits every two weeks	Specific site visits are not made to cover HIS. The coordinator makes three to five site visits a month to the project villages. During these visits HP's data are reviewed

APPENDIX 2

EVALUATION SCHEDULE

APPENDIX 2

EVALUATION SCHEDULE

October 12-16	Development of evaluation plan, preparation of evaluation tools, and meetings with people in Ouagadougou
Mon. Oct. 12	Met with Claudia Williams, Roger Tonde, Dellaphine Rauch-Houekpon, Suleiman Drave and Evelyn Gorsline to discuss evaluation goals, plan, strategy, etc.
Tues. Oct. 13	Met with Jatinder Cheema and Neen Alrutz from USAID
Wed. Oct. 14	Met with Dr. Ibrango Issouf: team member representing the Department of Evaluation and Planning, MOH Met with Dellaphine Rauch-Houekpon, Country Director
Thurs. Oct. 15	Spent the day in Zorgho: observed KAP survey for diarrhea and reviewed evaluation tool with Claudia Williams, Roger Tonde, Nebie Bademe, and Evelyn Gorsline
Fri. Oct. 16	Met with Dr. Leonard Tapsoba: Director of the Department for Planning and Evaluation, MOH Met with Dr. Bekouan Didier, Director of the Department of Family Health, MOH First meeting of full evaluation team
Sun. Oct. 18	Travelled to Zorgho
Mon. Oct. 19	Team meeting to finalize evaluation tools Met with Tapsouba Gomkuliga, High Secretary and Yonli Cristof, Secretary General of Ganzourgou Province Met with Ahmed Kouama, Mayor and Department Head for Zorgho
Tues. Oct. 20	Met with and interviewed health promoters Met with Head Nurse from the hospital Met with Seni Blandine from the nutrition recuperation program Met with Pulcherie and Amadeau, nurses who had been in health centers last year and had been trained by the project Met with Nebie Bademe, Provincial Health Director

Wed. Oct. 21	Visited Gnegnogo - observed growth monitoring, interviewed mothers, met with chiefs and elders
Thurs. Oct. 22	Visited Vagma - observed growth monitoring and diarrhea counselling, interviewed mothers, met with neighborhood chief and elders
Fri. Oct. 23	Visited health center at Zamce Visited Yembtenga - observed session on child spacing, interviewed chiefs and elders, interviewed counselors, nutrition focus group, interviewed health promoter
Sat. Oct. 24	Visited health center at Salogo Visited Nahoube - interviewed chiefs and elders, interviewed counselors, interviewed health promoter Visited Gnegnogo - interviewed counselors nutrition focus group, interviewed health promoter
Mon. Oct. 26	Reviewed documents, analyzed results and recommendations
Tues. Oct. 27	Met with Dr. Traore Celestin, Provincial Medical Director Gave report to Medical Director and High Secretary Finalized analysis Travelled to Ouagadougou
Wed. Oct. 28	Met with Dellaphine Rauch-Houekpon and Suleiman Drave to discuss results Prepared presentation
Thurs. Oct. 29	Presentation to interested officials from MOH, NGO's, USAID, and Unicef
Fri. Oct. 30	Depart for USA

APPENDIX 3

INTERVIEW GUIDE QUESTIONS

Africare Burkina Faso
Projet Survie de l'Enfant Ganzourgou
Evaluation Mi-Parcours
Questionnaire

I Entretien Avec ASC/Conseilleres

I(a) Maladie Diarrhéïque

1. Selon vous, Qu'est-ce que la Diarrhée ?

2. Quels sont les conseils que vous donnez aux mères pour s'occuper de leurs enfants qui font la diarrhée ?

3. La Diarrhée, peut-elle être dangereuse ? Pourquoi ?

4. Quel est le conseil qui vous semble le plus important ?

5. Comment savez-vous que cet conseil est mis en pratique par la mère ?

6. Est-ce que vous avez déjà vu un enfant gravement malade de la diarrhée ?

a) Si oui, quels étaient ses signes/symptomes ?
b) Si non, pouviez-vous m'expliquer les signes ?
7. Qu'est ce que vous avez fait ?
Qu'est ce qu'on doit faire ?

8. Aux ASCS : Est ce que vous avez de sachets? Si non - pourquoi? Si vous n'avez pas de sachets, que diriez-vous a la mère.

I(b) Observations/Maladie Diarrheique

Dans la maison ou se trouve un enfant qui a eu la diarrhée, et qui a été suivi par la conseillère.
1. Qui vous a informé que cet enfant avait la diarrhée ?

2. Le rapport que la conseillère a avec la mère.

3. Quels sont les messages qu'elle donne à la mère. Sont-ils claires ces messages ? Sont-ils appropries et précises ?

4. A-t-elle essayé de vérifier que la mère a bien compris ?

5. Laisse t-elle des consignes pour assurer que l'enfant sera bien soigné.

I(c) PEV

1. Combien de contacts faut-il pour qu'un enfant soit complètment vacciné ?

2. A quel âge un enfant doit commencer à recevoir les vaccinations ?

3. Pour la dernière séance de vaccination comment avez vous été informée ? Qu'avez vous fait par la suite ?

4. Pour les enfants qui ne sont pas venus à la vaccination la dernière fois, Qu'est ce que vous allez faire pour assurer qu'ils viennent à la vaccination la prochaine fois ?

5. Les vaccinations protègent l'enfant contre quelles maladies ?

6. Pourquoi la vaccination contre le tétanos est important ?

7. Combien de fois une femme doit se faire vacciner contre le tétanos.

8. Y-a-t-il des femmes enceintes dans votre quartier qui n'ont pas été vaccinées contre le tétanos ?

9. Qu'est ce que vous pouvez faire pour qu'elles soient vaccinées contre le tétanos ?

I(d) Générales

1. Est- ce que le travail que vous faites avec les animatrices est utile ?

2. Quelles sont les difficultés les plus importantes que vous rencontrez dans l'exécution de votre travail ?

3. Comment voyiez vous votre travail (avec les animatrices) par rapport aux problèmes de santé dans ce village ?

4. Est-ce que ce travail vous intéresse ? Pourquoi ?

5. Comment votre travail est-il complémentaire à celui des autres

II Entretien avec Animatrices

II(a) Discussion après pesée

1. Comment s'est passé la séance.
2. Qu'est-ce-vous que vous pensez avoir bienfait ? Pourquoi ?
3. Ou avez vous rencontré des difficultés ? Pourquoi ?
4. Nous avons vu que(nom de l'enfant) a perdu de poids entre les pesées. Quelle était votre évaluation des causes de cette situation ?
5. Quel était le problème majeur pour cet enfant ?
6. Quels conseils avez -vous donné à cette mère, et pourquoi ?

II(b) Observation faite pendant l'activité de Pesée.

A. Technique de Pesée

1. L'Animatrice ou fait les vêtements de l'enfant : Toujours, parfois, jamais.
2. Le balance à zéro avant chaque pesée
3. La carte de Croissance :
   a) Date correctement enregistére
   b) La courbe rempli
   c) Le point correctement placé.
   d) Age par rapport à la date de naissance bien calculé
4. Enfant suspendu avec sécurité ? Si le poids était bien pris.

5. Vaccination enregistrée au fiche d'enregistrement familial
6. Poids enregistré sur aussi au fiche d'enregistrement.

B. Communication avec la mère

1. Le poids de l'enfant communique à la mère.
2. L'animatrice communique si l'enfant a gagné ou perdu le poids.
3. Animatrice pose des questions à la mère.
4. Messages appropries au problème relevé par la Mère.
5. Est-ce que l'Animatrice cherche à évaluer la compréhension de la mère et comment.

II(c) Mobilisation/Intégration de l'activité

1. Est-ce que les ASCS étaient présents ?
2. Quel rôle ont-ils joué ?

II(d) PEV

1. Il faut combien de contacts pour qu'un enfant soit complètement vacciné ?

2. A quel âge un enfant doit commencer ses vaccinations?
3. Pour les enfants qui ne sont pas venus à la vaccination la dernière fois, Qu'est ce qu'on peut faire pour assurer

qu'ils viendront à la prochaine séance de vaccination ?

4. Les vaccinations protègent l'enfant contre quelles maladies?

5. Pourquoi la vaccination contre le tétanos est importante pour les femmes en âge de procréer ?

6. Combien de fois une femme doit se faire vacciner contre le tétanos ?

7. Montrez-nous comment vous collecter les données sur les activités de vaccination, et comment vous les analyser et comment vous les supporter ?

8. Comment vous contribuez aux activités de vaccination dans les villages ?

II(e) Diarrheée

1. Selon vous, Qu'est-ce que c'est que la Diarrhée ?

2. Quels sont les conseils qu'on doit donner aux mères pour s'occuper de leurs enfants qui font la diarrhée ?

3. Pourquoi la diarrhée peut être dangereuse ?

4. Quel est la conseil qui vous semble le plus important sur la diarrhée ?

5. Comment savez-vous que cet conseil est pratique par les mère ?

6. Est-ce que vous avez déjà vu un enfant gravement malade avec de diarrhée ?

a) Si oui, quels étaient les signes/symptomes ?
b) Si non, est-ce que vous pouvez me dire les signes ?

7. Qu'est ce que vou avez fait ? Où ?
Qu'est ce qu'on doit faire ?

8. Montrez-nous comment vous collectez l'information sur les activités de cet volet, et comment vous l'analyser et rapporter.

9. Qu'est ce que vous faites pour suivre le travail des conseillères sur la diarrhée ? Comment vous évaluer leur travail dans ce volet ?

II(f) Nutrition

1. Comment pouvez vous savoir si un enfant est bien nourris ou pas ?

2. Selon votre expérience quelles sont les raisons de la enfants malnutrition ?

3. Selon votre expérience quelles sont les raisons pour enfants lesquelles les enfants perdent du poids entre deux (2) pesées ?

4. Si vous êtes en train de conseiller une femme sur la perte de poids de son enfant, qu'allez-vous faire en premier lieu.

5. Si vous apprenez qu'un enfant a perdu du poids parce qu'il a déjà 6 mois et la mère n'a pas encore commencer a lui donner des aliments, qu'est ce que vous devez lui dire ?

6. Qu'est-ce qu'il faut dire à la mère d'un enfant qui est gravement malnourri et ne gagne pas de poids ? Quels sont vos critères pour référer un enfant malnutri ?

7. Quelles sont les précautions nutritionnelles que doit prendre une femme allaitante ?

8. Quand vous visitez a une femme qui vient d'accoucher, de quoi parler vous ?

9. Montrez-nous comment vous collectez les informations sur les activités de cet volet, et comment vous les analiser et rapporter.

II(g) Questions pour les Animatrices en Groupe

(A) les Issues Générales

1. Est ce que le travail que vous faites au village est utile ? Quelle est la partie qui semble le plus bénéfique pour le village ?

2. Quelles sont les atteintes dont vous êtes le plus satisfait ?

3. Quelles sont les difficultés les plus importantes que vous rencontrez en faisant votre travail ?

4. Qu'est ce vous pensez du support que reçoit le projet au niveau du village ? Est-ce suffisant ? y a-t-il des actions de la part de la communauté qu'on pourrait voir ?

5. Dans une communauté, on ne peut pas développer un projet de santé sans se rendre compte des autres besoins qui existent aussi dans la communauté. Quels sont ces volets, ou même d'autres préoccupations que nous d'Africare pouvons considérer si nous nous pensons à l'extension du projet.

6. Est ce qu'il serait faisable d'inclure plus de villages dans la deuxième phase ? Comment choisir ces villages ? Est ce qu'il y a des villages qu'on pourrait abandonner ?

7. Pensez-vous que les activités que vous faites bien au village

répondent aux problèmes les plus pressants de la santé ?
Y a t-il d'autres problèmes plus pressants ?

8. Quand le projet prendra fin, comment voyez- vous un meilleur soutien aux ASCS et conseillères.

9. Quels sont les tâches des conseillères vis a vis les ASCS ? Font-elles le même travail ? En quoi c'est différent ?

10. Les villages sont-ils prêts pour payer les services ou les produits de santé tels les capotes, les médicments de base, les consultations etc...
Quels sont les services que les gens peuvent mieux prendre en charge. C'est à dire payer ? Et comment cela pourra se réaliser ?

(B) Le Gerance du Programme

1. Quelle est la formation qui vous a le plus aidé pour faire votre travail ?

2. Quelle est la formation dont vous souhaiteriez avoir encore pour mieux faire votre travail ?

3. Avez-vous des exemples de situations dans lesquelles vous pu exécuter vos propres idées quand le besoin s'est fait sentir ?

4. Avez vous le support nécessaire pour bien faire votre travail? Logistique ? Tecnique ? Social ? etc.

5. Quels sont les tâches clé du technique dans le travail d'une animatrice ?

6. Est-ce que le volume de travail que vous avez concorde t-il avec le temps que vous avez pour le faire ?

7. Empowerment ??

8. Qui est responsable pour superviser les conseillères ? Les ASCS ?
Avez vous eu une formation sur la supervision. Quels sont les activités qu'on doit faire comme une bonne superviseuse.

9. Quelles sont les techniques plus bénéfiques que fait Roger pour vous aider avec le travail.

III Entretien pour les Infirmiers/Accoucheuses aux CSPS

1. Quelle sont les formations que vous avez eu avec le projet de Africare ? Ces formations ont duré combien de temps ? Qu'est ce que vous avez apris ? Avez vous reçu quelque renforcement ou supervision sur ce que vous avez apris pendant la formation ?

2. Comment est-ce que le projet vous a aidé avec votre travail. Est-ce qu'il y a des problèmes que le projet a créé pour vous dans votre travail ?

3. Connaisez vous le travail que font les conseillères au village ? Comment l'avez vous su ? Comment voyez-vous leur ce travail ? Comment peut-on améliorer leur travail ?

4. Quel rôle pouvez vous jouer pour aider le travail de la santé préventive dans les villages ?

5. Si vous voyez un enfant avec diarrhée et déshydratation à la consultation, comment déterminez-vous comment vous le traitement, et que dites vous à sa mère ?

Observations aux CSPS

1. Pour les volets de nutrition, PEV, et LCMD il faut utiliser les mêmes observations que pour les animatrices.

2. Pour l'observation des autres consultations : remarquez sur l'intégration qu'ils ont fait des messages preventifs dans la consultation curative.

Competence - Utiliser les memes questions que pour les animatrices

IV: Entretien Pour les Femmes (Exit Interview)

IV(a) PEV

1. Regardez la carte du plus jeune enfant. L'enfant a quel âge (en mois) ? Est-ce qu'il a eu les vaccins appropriés par rapport à son âge ?
2. Combien de fois vous devez revenir pour que l'enfant soit complètment vacciné ?
3. Quand vous devez le ramener pour sa prochaine vaccination. Ou peut-il recevoir cette vaccination ?
4. A quel âge un enfant doit commencer a recevoir ses vaccinations ?
5. A quel âge doit- il terminer ses vaccinations ?
6. La dernière fois qu'il était vacciné avez vous été informé combien de jour à l'avance et comment avez-vous été informé
7. Si vous avez une amie avec un nouveau né, que pouvez vous lui conseiller sur la vaccination de son enfant ?
8. Les vaccins protègent contre quelles maladies ? Comment vous l'avez appris ?

Tétanos

1. Regarde la carte de la femme. Est-elle vaccinée de façon approprié ?
2. Pourquoi la vaccination contre le tétanos est-elle importante?
3. Il vous faut encore combien de vaccinations ? Quand devez vous repartir pour la prochaine vaccination ?
4. Qui vous a dit que vous devez être vaccinée ?

IV(b) Nutrition (En sortant d'activité de pesée)

1. Pourquoi vous avez ammener (nom de l'enfant) à la pesée aujourd'hui ?
2. Montrez moi la carte de Croissance. Dites moi ce qu'elle vous dit sur la croissance de (nom de l'enfant).
3. Qu'est ce que vous avez discuté avec l'animatrice aujourd'hui ?
4. Quel a été le message le plus important pour vous.
5. Comment savez vous si (nom de l'enfant) grandi bien ?

6a. Est-ce que votre enfant a pris de poids depuis la dernière pesée ? Pourquoi ?

6b. Si non, Qu'est ce que vous allez faire pour qu'il gagne de poids à la prochaine pesée ?

6c. Si oui, qu'est ce qu'on peut faire pour assurer que les enfants gagnent de poids ?

7. Qu'est ce que vous avez appris aujourd'hui ? En quoi cela peut être utile pour vous/votre enfant ?

8. Connaissez vous une femme qui n'amène jamais son enfant à la pesée ?

9. Qu'est ce qu'on peut faire dans l'avenir pour encourager sa participation ?

IV(c) Maladie Diarrheique

1. Selon vous, qu'est -ce que c'est que la Diarrhée ?
2. Est-ce que vous avez asisté aux séances, ou aux causeries sur la diarrhée. Quand ? Avec Qui ?
3. Qu'est ce que vous avez entendu ?
4. Est-ce que(nom de l'enfant) a déjà fait la diarhée ?
5. Qu'avez-vous fait ?
6. Pourquoi il faut éviter qu'un enfant atrappe la diarrhée ?
7. Qu'est ce qu'il faut faire pour prévenir la diarrhée ?
8. Quels sont les signes/symptomes de la maladie diarrhéïque ? Devant quels signes de diarrhée il faut chercher une assistance ? Et de qui ?
9. Connaissez-vous ceci ? (montrez sachet de SRO)
10. Est-ce que vous l'avez déjà utilisé ? Si oui, comment ? Est-ce que vous avez utilisé autres choses. Quelles sont ces choses ? Comment les avez-vous utilisé ?

V. Entretien avec les Chefs et/ou personnes influents aux villages (ceux-ci n'ont pas encore été discutés par l'équipe) Les mêmes questions au niveau de la province.

1. Est ce que le travail que les conseillères font avec les animatrices est uitile ?

2. Quelle est la partie du travail qui est le plus bénéfique pour le village.

3. Quelles sont les dificultés les plus importantes que vous rencontrez dans l'exécution du projet ?

4. Comment le projet répond t-il aux problèmes de santé prioritaires rencontrés ici ?

5. A votre avis, quel est le travail que les conseillères peuvent/doivent faire ?

6. A votre avis, quel est le travail que l'AV/ASV peuvent/doivent faire ?

7. Quand le projet de santé prendra fin dans ce village, quelles seront les activités que vous voudriez voir se poursuivre et comment vous allez faire pour poursuivre ces activités ?
   Par exemple :
   Y aura t-il un rôle pour un comité de santé ?
   Y aura t-il un moyen de cotiser/payer pour certains
   Y aura t-il des services ou bien des matériaux comme des médicaments
   Y aura t-il à la fin de supporter des activités ?

8. Pourquoi le comité de santé n'a pas fonctionné en soutance ?

9. Comment voyez-vous un meilleur développement de cette communauté dans les 3 prochaines années ?

VI. Entretien avec les hommes

VI(a) Connaissance du projet

1. Connaissez-vous le projet santé Africare qui se déroule dans votre village ?

2. Quelles sont les activités du projet que vous connaissez ?

3. Ces activités sont-elles utiles pour vous ? Pourquoi ?

4. Etes-vous prêts dès aujourd'hui pour participer aux activités du projet ?

VI(b) Soutenabilité

1. Que feriez-vous pour soutenir la continuité des activités à la fin du projet ?

Terms of Reference
Mid-Term Evaluation
Africare Burkina Faso Child Survival Project

Africare Burkina Faso is seeking to identify an external evaluator to design and carry out the mid-term evaluation for the USAID funded Ganzourgou Child Survival Project.

The mid-term evaluation will provide the project staff with an external perspective on the progress the project has made since its inception in September 1990 and frame guidelines for suggested program changes to guarantee maximum effectiveness in remaining period of program life (until August 31, 1993).

The mid-term should be a process evaluation focusing on the nature of relationships developed between the project, communities and families. This is a time to assess how effectively the project works through these relationships to promote positive behavior change at the household level with regard to the selected child survival priorities and community mobilization at the village and neighborhood level around the most pressing issues affecting families' health.

I. Evaluation Guidelines: General guidelines for mid-term evaluations on centrally funded USAID child survival projects are provided by USAID and summarized on the attached sheet.

There are several issues, amongst those listed, which the Africare team believes to be of highest priority for the mid- term evaluation. These are issues for which the team is in the most need of feedback, analysis and the chance to work together with the evaluation team and field partners, including communities, to generate recommendations for program change:

1. Assessment of the Project's Community Health Support Network. The project has selected and trained community volunteers in every neighborhood who participate in basic child survival activities such as organization of SSS demonstrations. What was the process by which this system was introduced? How are the volunteers viewed by neighborhood women? How do the volunteers view their own role? what are the actual activities carried out by these volunteers? How could the project expand the capacity of the network? What is the potential for this group to play a leadership role in community health problem solving and development? What other activities could these women undertake? What are the training and support needs of the volunteers?

2. Evaluation of ORT Activities: of all of child survival interventions, the Ganzourgou Project has placed the most emphasis to date on community training in management of diarrheal disease. The project would greatly benefit from an assessment of the impact of these activities on actual household behavioral change and the effectiveness of the specific educational messages.

3. Assessment Nutrition Counselling and Growth Promotion: Is the project effectively using growth monitoring and home follow-up as a tool for growth promotion and positive behavioral change infant feeding? Are the behavioral objectives outlined in the Detailed Implementation Plan appropriate? Are the nutrition messages used in counselling targeted to these behavioral change objectives? How can the project deal with issues of food security? what community level mobilizing activities could the Project use to get child nutrition on the village agenda? How could the project better identify and gear activities to the most appropriate target audiences i.e. grandmothers, fathers, traditional healers etc.

4. Analysis of Collaboration with Formal Health sector and communities: What progress has the project make to link project activities with activities in the formal health sector? How has the project engaged communities in project activities and design? What specific strategies would guarantee the sustainability of the neighborhood volunteer network and other project initiatives at the end of project?

II. Evaluation Methodology

The mid-term evaluation represents the assessment of a project in process. Final outcomes and objectives cannot be evaluated at this time. The project needs an objective qualitative nd quantitative assessment of the progress made to date.

A central aspect of the Africare Ganzourgou child survival project, and one which sets it apart from many similar projects, is its use of neighborhood level volunteers who are trained by the projects' five health promoters in basic child survival interventions and who share this information formally and informally with their friends, relatives and neighbors.

To assess the effectiveness of this approach the external evaluator will need to design a participatory framework to find out what communities and the volunteer really think about the project, what they have learned and what are their suggestions for future project development. To assess, in other words what has been the genuine impact of the project in the beneficiary communities.

The evaluation period should also provide the project staff ample opportunity for group learning and auto-assessment. The evaluator will not only serve as evaluation team leader but will also be responsible for guiding and managing the process of discovery and

idea generation amongst the project staff and partners.

The evaluation framework will be designed by the external consultant and submitted in advance of the evaluation period to Africare headquarters and field staff for comment. Evaluation methodology should include:

- Individual and group interviews. with staff, local partners and community members
- Review of project reports, financial records and project documentation.

Summary of USAID Child Survival
Mid-Term Evaluation Guidelines

1. Assessment of Accomplishment
Where does the project stand in terms of measurable inputs; training sessions, number of persons trained etc.

2. Assessment of Relevance to Child Survival
Are the child survival interventions appropriate to address the key child survival problems in project area.

3. Assessment of Effectiveness
Assess the achievement to date of each project objective and, for each objective, evaluate implementation strategy and key lessons learned.

4. Assessment of Project Design
Is the project design appropriate for key child survival problems and adapted to the particular location and environment in which the project operates. Are project strategies consistent with Government of Burkina Faso policy.

5. Assessment of Use of Data
Examine effectiveness of project's information system and assess the project's use of data for decision making. Has the information collected been shared with provincial health systems, project staff, counterparts, community members.

6. Assessment of Community Education and Social Promotion
Has the project developed an educational strategy based on existing knowledge and practices and using appropriate messages.

7. Assessment of Project Administration and Management
Issues to be covered include evaluation of human resources, supervision and monitoring, budget and project management.

8. Sustainability
What steps has the project undertaken to promote sustainability.

9. Recurrent Cost and Cost Recovery
Evaluate financial efficiency of project, level of recurrent costs and strategies to promote cost recovery.

10. Assessment of Partner Relationships
What collaborative activities with counterparts, PVO/NGO's and government agencies have taken place and what have been the results of these contacts.

11. Assessment of Training Programs
Examine the strategy, methodology and approach used in the training of staff and communities and identify priority areas for retraining.

12. Recommendations
What step should be taken by the project staff to achieve its output and outcome objectives. What input can the evaluator give to improve the delivery of services to communities.

* RAPID assessment procedures include:
  - focus groups
  - key informant interviews
  - observation

* Limited household KAP survey on project interventions

Wherever possible staff, partners and community members should be included in the evaluation process itself.

III. Evaluator Scope of Work

Period of Work:	The in-country evaluation will take place between 19 October and 6 November 1992.
Location:	The evaluation will take place principally in the Ganzourgou Province one or two days planned for interviews and meetings in Ouagadougou.
Major Tasks:	1. Design evaluation framework for submission by October 1, 1992. 2. Review all available project documentation before arrival in Burkina Faso. 3. Manage the in-country development, working with evaluation team, of questionnaires, focus-group guides and any other necessary evaluation supports.

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OBJECTIVE: Long term health program management position and/or short term consulting in public health in the developing world

LANGUAGES — Fluent in Spanish, French, and Swahili. Familiarity with Portuguese and Arabic.

WORK EXPERIENCE

4/91-present — **Seattle-King County Department of Public Health**

Public Health Nurse - Maternal Child Health Administration: Provide technical support, community and intra-departmental liaisons, and systems analysis for department districts. Special projects include maternity case management, teen life skills training and a family support project.

10/88-2/91 — **SAVE THE CHILDREN FEDERATION - SUDAN**

Health Coordinator: Managed child survival development program in two rural areas serving 480,000 people. Responsible for program planning and evaluation including use of an health information system, reporting, proposal writing, budget management, Ministry of Health and USAID relations, and staff development.
Refugee Program Manager: Managed program of 100 staff and $450,000 in two settlements in Eastern Sudan. Responsible for proposals, budget, staff development, and program planning.

7/86-6/87 — **COUNTRY DOCTOR COMMUNITY CLINIC - Seattle, WA**

Community Health Nurse: Practiced outreach community nursing including WIC, home visits, and training and supervising volunteers in a peri-natal child abuse prevention program.

9/83-12/85 — **KING COUNTY HIGH BLOOD PRESSURE CONTROL PROGRAM - Seattle, WA**

Community Health Nurse: Worked on planning, implementing, and evaluating community blood pressure control program. Included volunteer management and maintaining community and organizational liaisons.

6/81-1/82 **PEACE CORPS TRAINING CENTER - Bukavu, Zaire**

Technical Coordinator, Public Health Training Program: Developed and executed technical orientation for new public health volunteers including specific skills in immunization, well-child, and pre-natal programs. Provided philosophical orientation to community development.

Special Services Contract: Studied Training Center/community relations concluding with proposals for increased Center contribution to local community development.

3/79-6/81 **PEACE CORPS VOLUNTEER - ZAIRE**

Public Health Nurse: Organized communities for the development and implementation of a rural preventive health program: coordinated with government and funding sources; collected statistical data; trained village health workers; and established and supervised immunization, well-child, pre-natal, and health education programs.

1972-1974 Health worker in Peru and Brazil: Worked in pre-school nutritional recuperation in Peru and Brazil. Opened nutritional recuperation center in northeast Brazil.

EDUCATION

7/87-5/88 Master's of Public Health in International Health - Johns Hopkins University - Baltimore, MD 21218

1974-1977 B.S. in Nursing - University of Washington Seattle, WA. Emphasis in public health.

1971-1972 University of California - Santa Cruz, CA Emphasis in anthropology/Latin American studies.

VOLUNTEER WORK

1983-1987 PUBLIC HEALTH CARE COALITION - working politically on health care issues for low income people.

11/84 member, U.S. nursing delegation to Pan-American Nursing Congress in Managua, Nicaragua.

References Available Upon Request.

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CURRICULUM VITAE

NAME: IBRANGO ISSOUF MANADJI
Docteur en Medecine
Diplome en Sante Publique.

ADDRESSE COURANTE:
DIRECTION DES ETUDES ET DE LA PLANIFICATION
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BURKINA FASO.
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Education (cont'd):

- December 1990: San Diego, California, Management Communication, Development Seminar - Conducted by M.T.D.I.

Computer work skills: possess basic skills in microcomputer programs applicable in the health sciences.

DOS - Lotus (1-2-3) - dBase III - Computer Packages for Statistical Analysis - BMDP - Minitab - SPSS-X-SAS

Professional and Work Experience:

NOVEMBER 1991 – Chief of the Planning Bureau, D.E.P/MOH BURKINA FASO

January 1987-September 1989 Clinical and medical counsellor for the Burkina National Society Security Council, Guagadougou, Burkina Faso.

October 1983-December 1986 Regional Health Director, Burkina Ministry of Health

- 1985-1986: Organized and implemented a regional primary health care facility with a funding from the "OXFAM", a British private voluntary organization operating in Burkina Faso.
- 1986: Medical consultant for "Les Geuvres du Sahel" a french private voluntary organization operating in Burkina Faso. Job related field training/seminar.
- May 1985. Health System Management in developing country seminar conducted by W.H.O. Professional Education and Training Network, Guagadougore.
- September 1986: Bamako, Mali. Methodes de Planification Socio-economique four les regiòn du Sahel seminar conducted by the joint program. UNESCO/Institut du Sahel.

Publication:

1983, Dakar: Dissertation on "2 Hospital d'Enfant Albert Royer de Fann: Bilan d'une annee de fonctionnement et perspectives d'avenir." (Ibrango, I. Dakar: These, 1983, 101).

CURRICULUM VITAE

Name: *Ibrango, Issouf Manddji*

Address: Tulane University, School of Public Health and Tropical Medicine, Box 143, 1501 Canal Street, New Orleans, Louisiana 70112 (504) 523-5794

Birth:

Citizenship:

Languages: Read: French, English
Speak: French, English
Samogo, Bambara, Moore

Present Position: Student, Tulane University School of Public Health and Tropical Medicine.

Education:

- 1974 (Baccalaureate Serie): General Certificate of Education, high level in mathematics and science section. School: Lycee Zinda Kaure, Guagadougou

- 1975-1983: Medical School, Dakar University, Dakar Senegal

- 1982: Medical Doctor

- 1982-1983: Medicine residency in the pediatrics department at the Hospital d'Enfant Albert Royer de Fann, Dakar University

- 1991: Master of Public Health (anticipated), Tulane University, School of Public Health and Tropical Medicine, New Orleans, Louisiana

  Field Training and Seminars: August 1990, Washington, D.C.: Project Management and Evaluation Seminar. Conducted by the "Management Training and Development Institute (M.T.D.I.)."

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CAREER GOALS: Primary Health Care Planning and Evaluation; Development of Rural Maternal and Child Health Programs; Health Policy Development; Training of Public Health Counterparts

EMPLOYMENT:

Program Manager Child Survival Project, Africare, Washington, D.C. Provide logistical, administrative, and technical support to Africare's Child Survival Projects in central and west Africa. Duties include evaluation of all childrens' health programs, monitering village based projects, designing health surveys, and designing and writing health proposals for funding. April 1992 to Present

Child Survival Project Coordinator Africare, Dioro, Mali, West Africa. Managed one million dollar budget child survival program. Coordinated planning and implementation of project activities with Mali's Ministry of Health regional and local officials. Recruited, trained, and supervised seven nurses and thirty village health teams and committees in diarrheal disease management, nutritional surveillance, family planning, and vaccinations. Designed training materials and manuals for use in training illiterate and literate village health teams. Developed information system to monitor project activities. Wrote four project proposals, two received funding and two are pending. January 1989 to March 1992

International Projects Coordinator International Projects, Tulane University School of Public Health and Tropical Medicine. Provided logistical and technical support to three USAID Africa-based health care projects: Niger Health Sector Support Grant, Family Planning Operations Research in Zaire, and the Kenya Information and Planning Systems project. Responsibilities included budget management, technical documents revision, development of information dissemination systems, liaison to field personnel and contracting agencies, coordination and preparation of USAID project proposals, development and logistical support of in-service technical trainings. January 1988 to January 1989

Research and Coordinator's Assistant Health Service Research Division, Tulane University. Organized and implemented Hubert H. Humphrey North-South Fellowship Program for visiting health professionals from developing countries. Responsibilities included development and administration of a cross-cultural program involving special seminars, field trips, identification of local resources, and research into US health occupations. May 1987 to January 1988

Cross-Cultural Training Coordinator Peace Corps, Gabon, Africa. Designed and coordinated a cross-cultural training program for 50 Peace Corps Volunteer trainees. May 1986 to September 1986

Health Education Coordinator Peace Corps, Gabon, Africa. Planning and Evaluation Consultant to Gabon's Ministry of Health. Initiated research and needs assessments, designed and implemented health education programs to train village health workers in primary health care, developed a national primary health care plan as liaison between Peace Corps and Gabonese health officials. August 1985 to August 1986

Program Coordinator/Trainer Non-Formal Education Development Program, Peace Corps, Gabon, Africa. Responsibilities included acting as liaison between Peace Corps volunteers, Peace Corps administration and the Gabon Ministry of Popular Education, provided resources, technical reinforcement and support to filed workers, planned organized and facilitated pre-service training programs in language, cross-cultural skills and health, and conducted in-service conferences. October 1985 to August 1986

Community Health Educator Peace Corps and Ministry of Education, Central African Republic, Africa. Incorporated health education and preventive medicine into a national curriculum, provided in-service training to teachers, collaborated with community development leaders to provide village based health education, served as maternal-child health clinic staff educator at Damara Clinic, and coordinated the Women in Development (WID) program providing maternal and child health education and resources for local health officials and rural populations. August 1984 to August 1985

Health Educator Peace Corps, Central African Republic, Africa. Provided community education, referrals, clinical assessments, and case management at the World Health Organization's Clinic for Sexually Transmitted Diseases. September 1983 to July 1984

Recreational Therapist Leon County Association for Retarded Citizens, Tallahassee, Florida. Designed, implemented, and evaluated recreational programs for 40 impaired adults in a state operated group home. April 1983 to July 1983

Research Assistant Psychology Department, Florida State University, Tallahassee, Florida. Compiled and analyzed data, conducted experiments, and researched effects of sugar of autistic children. January 1980 to August 1982

Nurse's Aide Quality Care, Daytona Beach, Florida. Designed and monitored creative educational program for one autistic child, developed and implemented diet and exercise programs for the elderly. May 1979 to June 1980

EDUCATION

Master of Public Health in International Health/Planning and Evaluation, Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana, 1988

Bachelor of Science in Psychology/Social Work, Florida State University, Tallahassee, Florida, 1982

Associate of Arts in Psychology, Daytona Beach Junior College, Daytona Beach, Florida, 1980

PROFESSIONAL TRAINING

State of the Arts - Population Health and Nutrition course, Washington, D.C., 1990

"Vitamin A" Training of Trainers workshop, Segou, Mali, 1990

"Vitamin A" Communication Strategies, Helen Keller Foundation, Bamako, Mali, 1989

"Training of Trainers", Bangui, Central African Republic. Primary health care education, theory, and application, 1984

Wellcome Museum Training, London, England. Training in african tropical diseases etiology, 1983

Peace Corps Technical Training, Bouca, Central African Republic. Intensive training in health care education techniques (Oral Rehydration Therapy, nutrition, child survival, water catchment, food storage systems), tropical health, cultural studies, and French and Sango, 1983

COMPUTER SKILLS

Wordperfect, Lotus 123, Epiinfo

LANGUAGES

French (FSI 3+) - fluent speaking, reading and writing
Sango (national language of the Central African Republic) - fluent speaking

AWARDS

US Public Health Service General Purpose Traineeship. 1987 to 1988

Outstanding Student Service Award - Tulane University School of Public Health and Tropical Medicine. May 1988

OTHER ACTIVITIES

Vice-President, Student Government Association, Tulane University School of Public Health and Tropical Medicine. 1987-1988

AIDS Health Educator, Louisiana State Department of Health and Human Resources. 1987

Volunteer Coordinator, Florida Association for Handicapped Citizens, Tallahassee, Florida. 1982

PROFESSIONAL ASSOCIATIONS

American Public Health Association

National Council for International Health

National Organization for Returned Peace Corps Volunteers

REFERENCES

Available on request