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SAVE THE CHILDREN/US

**CHILD SURVIVAL 8 ANNUAL REPORT FY 1993
BURKINA FASO FIELD OFFICE
SAPONE**

Cooperative Agreement No. FA0-0500-A-00-2034

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I. OVERVIEW OF YEAR ONE

A great deal of activity characterized the first year of Save the Children's Child Survival project in Burkina Faso: hiring and training of staff, expanding the office, carrying out a baseline survey and family registration, laying the ground-work for village health committees, and supporting the vaccination program. This report describes these activities based on the guidelines provided.

A. Accomplishments Compared With Goals and Objectives

The project is now fully staffed, and all major equipment and materials have been procured and delivered. The DIP was developed, with the technical assistance of Dr. Ahmed Zayan, Acting Director of the SC/US Health Unit in Westport, Conn. Office space has been provided for project staff, and project activities have been proceeding as planned. The following table presents the objectives established for the year, and the achievements to date.

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Register families in HIS	100 %	app. 3,000	9/93	100 %
Conduct base-line study	100 %	1	12/92	100 %
Women 10-45 yrs trained in treatment of diarrheal diseases	100 %	1300	9/93	127.5 %
Women of CBA trained in proper feeding and weaning of young children	100 %	800	9/93	99 %
Growth monitoring of children 0-36 mos. through quarterly weighings	100 %	1500	9/93	95 %
Children 6-59 mos. receive semi-annual dosages of Vit A capsules supplements.	80 %	2205	9/93	91 %
Women who have given birth within last two months receive semi-annual dosages of Vitamin A capsule supplements.	60 %	220	9/93	48 %

OBJECTIVES	PERCENT	TARGET NUMBER	TARGET DATE	ACHIEVED TO DATE
Families trained in the importance of consuming locally available foods rich in Vitamin A	100%	800	9/93	99%
TBAs trained in birth-spacing	100%	26	9/93	100%
Married couples trained in birth-spacing	100%	100	9/93	0%
Prenatal consultations provided pregnant women.	100%	200	9/93	166%
Postnatal consultations provided recently delivered women.	100%	200	9/93	22%
Children 0-11 mos. completely vaccinated.	65%		3/93	52.3%
Women of CBA receiving TC 3.	60%		3/93	65.3%
Mobile vaccination team receiving fuel, kerosene and gas for vehicles and cold chain.	100%		9/93	100%
Training of village health agents in malaria prophylaxis and treatment and in procurement of chloroquine.	100%	36	9/93	100%
Pregnant women trained in importance of avoiding malaria during pregnancy.	70%	237	9/93	140%
Construction of latrines	100%	24	9/93	79%
Training of families in hygiene, hand washing, clean water, cleaning of latrines.	100%	800	9/93	0%

The five major components of this child survival project are Control of Diarrheal Diseases (CDD), Nutrition/Vitamin A, High Risk Births, EPI, and Malaria Control. All interventions in these components were carried out in basically the same way, with project staff first

receiving foundational training in the particular intervention. The next step was for Village Health Committee members and Health Promoters to organize educational sessions in villages, usually with groups of women.

Control of Diarrheal Diseases: Once project staff were trained in CDD, the Health Promoters organized training sessions in each of their villages through the Village Health Committees. During these sessions, the Health Promoters trained Village leaders for three days in messages regarding hygiene, cleanliness, and the treatment of diarrhea. They stressed the particular importance of correctly treating diarrhea in young children through the continuation of breast feeding, and provision of ORS. The training sessions consisted of two days of theory and one of practice. Each neighborhood leader received a measuring bowl to facilitate training in preparation of ORS.

Nutrition/ Vitamin A: Health promoters held regular quarterly sessions with village groups to discuss nutritional themes during growth monitoring visits. They described how good nutritional practices, including the consumption of local foods rich in Vitamin A, were important in ensuring the health and survival of young children and pregnant and lactating women. They also distributed Vitamin A capsules twice annually to target groups. When a child was identified during weighing as being seriously malnourished, his/her mother received additional monthly home visits during which the Health Monitor and/or a nurse midwife demonstrated ways to enrich local foods.

High Risk Births: Once high-risk pregnancies were identified during the family registration and then during subsequent regular update of the HIS, these pregnancies were brought to the attention of the project nurse/mid-wife in charge of consultations. She would then visit the woman in question, and refer her to the nearest Health Center for follow up/delivery. An attempt was made to make at least two prenatal visits to women identified as being at risk. Traditional midwives participate in these prenatal visits, and follow the evolution of the pregnancies.

EPI: The role of Save the Children staff in the EPI through this project has been limited to the organization of information sessions for families regarding immunization, the preparation of villages for the visit of the mobile vaccination team, and the provision of fuel to the team. These sessions were carried out in the weeks before the mobile team arrived in a village.

Malaria Control: Health Promoters trained 36 community health workers in malaria prophylaxis and treatment, and in procurement of chloroquine. They also trained pregnant women in the importance of avoiding malaria during pregnancy. Activities planned for promoting general village hygiene as a way of limiting malarial mosquito breeding have been postponed until the coming year.

The scheduled baseline study was carried out during the first week of December 1992, during which 10 surveyors interviewed 240 mothers of children less than 24 months old using a questionnaire of about 50 questions. Field staff carried out the family registration in 18 villages as planned during January and February 1993. The data from these field surveys are

available on family registration charts, and the HIS coordinator is entering them into the project computer's health information software (ProMIS).

1657 families received training in diarrheal disease control, more than the 1300 families targeted in the objectives. 15 latrines were constructed, fewer than the 24 planned for because of a late start and the onset of the rainy season. The remaining latrines will be built this year. SC provided support to the MOH-run vaccination program in the area in the form of fuel for the mobile team's vehicle and kerosene for the cold chain, and by organizing awareness sessions in project villages.

Village health committees -- whose core members include traditional birth attendants, neighborhood leaders, and community health workers -- were established in all 18 villages, and trained in a variety of interventions. Because the Provincial MOH authorities are in the process of adapting the Bamako Initiative to local needs before implementing it, they asked that we postpone officially establishing committees until they determine the appropriate makeup of the committees. Nevertheless, informal committees, consisting of at least the members named above, exist in all project villages, and meet regularly with field staff (see I D below).

36 CHWs -- including 20 from outside the project area -- were trained in antimalarial activities, family planning techniques, nutrition, and STD/AIDS prevention. With support from WHO, a KAP survey on AIDS was carried out in June in the project area. Staff are developing an AIDS prevention strategy based on the results of this survey.

Certain planned-for activities were not carried out during this reporting period. Staff had planned to provide training to village-based water source management committees in hygiene and maintenance of a clean source of water. However, the group initially identified to carry out the training proved to be more expensive than had been budgeted for. During the coming months, this training will be carried out using in-house and local expertise. Project staff had also planned to provide supplemental training to MOH staff working on the EPI, using EPI funds for the training.

B. Project Staff Training

The eight Health Promoters were trained in November and December 1992 in diarrheal disease control, immunization, growth monitoring, malaria control, family planning, AIDS/STD prevention, pre- and post-natal consultations, nutrition interventions and Vitamin A distribution, and the health information system. These training sessions involved communicating of basic knowledge about the various themes to the health promoters, a presentation of the messages they in turn should communicate to villagers, and certain training techniques. A more complete Training of Trainers session for the Health Promoters was carried out by a consultant from Helen Keller International, in September 1992 (just before the official project start date).

Training of Health Promoters in each intervention lasted two days, with the first day involving mostly theoretical presentations and the second day involving hands-on practice. The Health Monitors were also trained in training techniques, such as how to lead a meaningful discussion, how to involve participants actively in session, how to use local resources, and how to prepare objectives and goals for session. The main topics of the training sessions were as follows:

CDD: the need for hygienic practices and clean water to avoid diarrheal diseases; the importance of continuing breast feeding children during diarrheal episodes; proper weaning practices; the preparation of ORS, and the correct use of rehydration packets.

Nutrition/Vitamin A: Training of Health Promoters in Nutrition/Vitamin A included sessions explaining that Vitamin A is a vitamin for the eyes which also helps the body to fight against certain illnesses. Its absence from one's diet and in one's body can lead to vision problems, especially night blindness (*yuu zondo* in Moore, the local language). Vitamin A deficiency also leads to slow growth and weakness. By working together as a community, villagers can promote the acceptance of Vitamin A capsules, thereby reducing the incidence of the conditions described above. There are many locally available and accepted foods that are rich in Vitamin A. They are: liver, whole milk, eggs, butter (from milk), *nere* powder, baobab leaves, beans, carrots, cabbage, spinach, squash, papayas, mangoes and other yellow fruits, tomatoes, etc. By producing and consuming such food, villagers will help to avoid Vitamin A deficiency. Planting small vegetable gardens and consuming the products is one way of increasing the availability of nutritious vegetables.

High Risk Births: Health Monitors participated in two-day training sessions regarding high-risk births. During these sessions, part of which were held at the Medical Center in Sapone with MOH staff, the following themes were addressed: the definition of high risk as pregnant women who have previously delivered by Cesarean, experienced still-birth, had more than two miscarriages, been sterile for more than five years, are under 18 or over 35, have had more than eight children, are less than 150 cm tall, or have a history of hypertension, diabetes, or sickle-cell anemia. The Health Promoters and Nurse-Midwives observed prenatal consultation at the health center in Sapone during the training. The training also instructed that women identified as being at high risk should be receiving at least two prenatal visits by the project nurse-midwife.

EPI: During the training of SC staff in EPI the role of Save the Children in the EPI through this project was discussed, as described above. Health Promoters were trained in the delivery of messages regarding information sessions for families about immunization, the preparation of villages for the visit of the mobile vaccination team, and the provision of fuel to the team.

Malaria Control: Health Promoters were trained in malaria prophylaxis and treatment, and in procurement of chloroquine. They also were trained pregnant in the importance of instructing women to avoid malaria during pregnancy.

Gaston Sobgo, Health Information System coordinator, traveled to Save the Children headquarters in August for training in the HIS software, PROMIS. This training was carried out by Ken Herman, coordinator of SC's Personal Computer Group, and Dr. Katherine Kaye, an epidemiologist at SC's headquarters.

C. Technical Support Visits

The following technical support visits took place during the reporting period:

- 21-25 September 1992:** Marlene Gay, HKI consultant, conducted a training of trainers session for health promoters from Child Survival programs being undertaken by Save the Children and Africare in Burkina Faso.
- 1-12 December 1992:** Dr. Fodé Doumbia, director of SC's health program in Mali, led the baseline survey.
- 7-18 December 1992:** Dr. Ahmed Zayan, Acting Director of SC's Health Unit in Westport, led the project team in putting together the DIP.
- 1-2 April 1993:** Mr. Roger Tondé, Co-Coordinator of Africare's health activities in Burkina Faso, conducted a training of SC health staff in the use of neighborhood health leaders.

D. Community Health Committees

As mentioned above, health committees exist in all 18 villages targeted for year-one activities. These committees are informal in nature for the time being, since MOH officials in the area want to postpone officially recognizing them until the details of the implementation of the Bamako Initiative are worked out. We expect this official recognition to take place within the first quarter of FY 94.

The committee members have been actively involved in all project related activities at the community level since the project's start. They assisted in organizing and mobilizing their respective communities for the Family Registration, helping to ensure the 100 per cent coverage. They helped arrange interviews during the base-line study. The TBAs and CHWs are the primary community-level contacts for maintaining the HIS. They track vital events and report them to the Health Monitors during their visits; they serve as liaisons between the monitors and their respective communities to program and coordinate family-level visits and other interventions.

Over the past 90 days, each committee has met as a group at least three times. These meetings were held in the presence of the Health Promoter covering the village, and on some occasions a project Nurse/Midwife or the Health Promoter Supervisor also participated.

E. Ministry of Health and Other Linkages

An agreement has existed between Save the Children and the MOH since 14 February 1990. We plan to sign a more detailed agreement, based in part on the DIP, with local health officials during the first part of fiscal year 1994.

In Ouagadougou, SC's Field Office Director meets as necessary with MOH officials, and sends the appropriate authorities copies of relevant documents. Provincial MOH officials hold annual and quarterly planning meetings which are attended by SC Health personnel. The project staff also attend monthly "Zone Meetings" at the Medical Center in Saponé with local health agents. At these meetings the various partners coordinate plans for the coming month, and review the previous months' accomplishments. They also discuss difficulties encountered and share reports.

The two local NGOs with which SC is collaborating in the field -- l'Association Burkinabè de l'Action Communautaire (ABAC) and l'Association Vive le Paysan (AVLP) -- also participate in the local level coordinating and planning meetings. One health monitor from each of these NGOs has been seconded to the Child Survival project, and will return to AVLP and ABAC after the end of the project. This will permit to transfer the skills and knowledge to the corresponding local NGOs.

Some project materials -- including the Mother/Child Health Cards, and Vitamin A capsules -- are obtained from the MOH's Department of Family Health. Messages presented by the SC health staff in family and other trainings is based on information made available by the appropriate MOH departments. A qualitative study on AIDS awareness carried out in the project area relied on inputs from the National AIDS Control Committee (Comité National de Lutte Contre le SIDA). Local administrative and traditional authorities have been supportive of activities, and are kept up to date on the project's progress through meetings and reports.

A series of irregular and informal meetings between NGOs active in health activities in Burkina Faso has been ongoing for the past year or so. Africare, Plan International, Save the Children Fund-UK, SC-US, and other groups meet to discuss themes chosen at the previous meeting and of interest to us all. The most recent meeting dealt with collaboration with government health personnel, and incorporating such personnel into NGO activities.

NGOs in Burkina have been discussing the coordination of AIDS related issues and activities on a national level. The second of a series of meetings on the topic is scheduled for 8 October, and SC-US staff will present the findings of their qualitative study in Saponé.

A project midwife, Fadima Maiga, has been invited to participate in a national commission to define a country-wide policy on nutrition.

F. Staff Changes

No changes in professional staff have been made since the DIP was submitted. The organizational chart is included in appendix A.

II. CHANGES MADE IN PROJECT DESIGN

No changes have been made from the DIP in terms of objectives, type or scope of interventions, location or number of beneficiaries, or budget.

III. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

A & B. Constraints and Strategies Used to Overcome Them

Local MOH authorities' decision not to officially recognize Community Health Committees has to some extent limited the committees' effectiveness. Additional members need to be selected and trained for all committees, and a more formal structure needs to be put in place to ensure that regular meetings continue and that the committees be recognized as legitimate, long-term institutions.

SC/US health staff and the Field Office Director will place the highest priority in the next quarter on working with local MOH officials to recognize the committees already in place, and to formalize their training. They will continue to reinforce the effectiveness of the existing committees through regular meetings and additional training.

The delay in the installation of an electrical power source has caused the input of health information data into the system's software to take longer than planned. With the computer now up and running on solar power, the data entry clerk and HIS coordinator will make special efforts to bring the system up to speed.

Due to the US embargo on Haiti, a follow-up Training of Trainers session to be carried out by HKI's Marlene Gay (a Haitian national), was canceled at the last minute. The field office will follow on this issue to ensure that this follow up training is conducted.

C. Circumstances Leading to Unexpected Benefits

The collaboration with Africare's health staff provided some valuable innovations for the Saponé project, especially the introduction of the strategy of Neighborhood Leaders. This has enhanced community participation in the project, and improved the timeliness and thoroughness with which the HIS data are collected. It has also reinforced the likelihood that benefits of the project will last beyond its funding period, since the neighborhood leaders are

long-term community residents who can continue to undertake the activities for which they have been trained.

While the glitch in formalizing the community health committees has been mainly a constraint in the first year, we believe that the implementation of Bamako Initiative strategies in the area -- which will reinforce community management and financing of health activities -- will ultimately further strengthen the sustainability of the project.

The recent approval to allow community health workers to dispense contraceptive pills, rather than requiring more highly trained professionals to do so, has increased the availability of this modern family planning method. It will likely lead to increased adoption of its use.

D. Lessons Learned

The above mentioned unexpected benefits serve in our minds as significant lessons learned. In addition, project staff learned early on from experience in previous health and other sectoral activities that active and meaningful community participation in all phases of project planning and implementation is crucial to its short- and long-term success. Therefore, from the base-line study, to the family registration, to family training activities, community members have worked side-by-side with project staff in planning and implementation. These lessons have started to be institutionalized through the neighborhood leaders and community health committees.

Project staff have also learned that the involvement of the local NGOs, ABAC and AVLPL, has also strengthened the potential of project sustainability, as well as providing a certain amount of additional legitimacy to the project since these groups (like SC) have solid local reputations.

IV. PROGRESS IN THE COLLECTION OF HEALTH INFORMATION

A. HIS Characteristics and Effectiveness

The HIS works on two levels: the community level and the central, or office level. At the community level each family has an enrollment card; basic health information from the enrollment is used to create women's and children's rosters kept and used by the health promoters. Rosters contain data on immunization, growth monitoring, ORT training, pregnancy, etc. Demographic and health information is updated on an ongoing basis through home visits assisted by members of the community health committees.

The HIS is used to ensure that each member of the community receives appropriate health services. Data are also used for planning and decision making. While the HIS employs manual methods at the village level, reporting at the central level is being incorporated into a computerized system which aggregates and analyzes the detailed village data and prepares reports to suit the needs of the users.

B. HIS Data Collection and Utilization

Census data, services statistics, and data on project interventions are being collected. Except for service statistics, data is collected on a daily or weekly basis by village health committee members, and added to the computerized data base every two months for every health promoter. The HIS coordinator is responsible for tabulation and analysis, and for the generation of reports. The health promoters receive regular visits and support from their supervisor, the HIS coordinator, and the project manager. They verify the health promoters' records, and also conduct home visits to check the rosters' data on home records. The computerized HIS has a cross checking capability that allows the user to reduce entry of incorrect data.

Promoters compile the data into monthly reports which they discuss with their respective VHCs for decision making at the community level. They then pass the data to the HIS Coordinator in Saponé, who checks data validity and supervises its entry in the computer. The HIS Coordinator's reports to Promoters provide the latter with timely, actionable feedback for further discussion with VHCs. The project manager uses the data to design the project's workplans. The MOH staff participate with SC in the process to monitor and target its activities. The advantage of this HIS is three-fold: it is effective, in that it allows for the thorough and verifiable collection of data; it is simple enough for all involved parties to understand and carry out their tasks; and it is timely, enabling information to reach the office for verification and tabulation at least monthly.

C. Needs for Refining the HIS

As mentioned above, the late installation of the computer in the project area has slowed this aspect of the HIS. A great deal of effort will have to be made by project staff to make up for this slow start. Additional training is necessary for all parties in the HIS, especially the community-level participants and the data entry clerk. A more active discussion between the various links in the HIS needs to be systematized so that feedback on information leads to results in the field.

V. BUDGET AND EXPENDITURES

A. Major Budget Revisions

No major budget revisions have been made since the Cooperative Agreement was signed.

B. Pipeline Analysis

The project's pipeline analysis is appendix B.

C. Cost/service Correlations and Explanation

Because the project began 12 months ago, and most of the effort and expenditures were start-up costs, the staff was not able to accurately quantify the cost of the outputs. There is not, however, any budget overruns.

VI. FOLLOW-UP OF DIP REVIEW

The following is the FO comments on the DIP technical review. The single most important recommendation of the technical review was to obtain additional technical assistance for the project. The field office is in the process of obtaining this technical assistance through negotiations with SC Headquarters, USAID/PVC office, and the John's Hopkins Child Survival Support Project.

SAVE THE CHILDREN BURKINA FASO FIELD OFFICE RESPONSES TO TECHNICAL REVIEW COMMENTS OF CS8 DIP

Concerns and Recommendations

The proposal reviewers noted that "Especially commendable are such activities as small scale credit system development, literacy training... well digging... establishment of cereal banks." It is possible that those activities are described in adequate detail in the proposal itself, but if that is the case, it is unfortunately not reflected in the DIP. If for example the cereal bank is to play the important role that is assigned to it as a way of dealing with seasonal deficits in the food supply, the who, where, when and how need to be clear in the detailed plan. In the absence of that kind of information, one might reasonably question whether the cereal banks are actually important to the nutrition component.

Response 1: The credit, literacy, wells and cereal banks aspects of the proposal are mainly funded through complementary funding, much of which is not even included in the match of the CS 8 project budget. Because of this, we did not describe these activities in any detail in the DIP. Attachment A is a description of the Sapone's program other sectors. It could be added as an appendix to the DIP.

More detail is needed on how SC plans to establish village health committees, since there were none functioning in the project area at the time the DIP was written.

Response 2: Village health committees will be formed with the help of SC health promoters. Core VHCs members will include Community Health Workers, TBAs, and the neighborhood women's leaders. Other influential community members may also be invited to participate. A typical committee will have a CHW, a TBA, five neighborhood leaders, and two other influential villagers. Groundwork has already been done to form these committees, and their official organization will be completed during the second year of the project.

More information is also needed on the role of women's groups and family representatives, and on how the project will assess the effectiveness of all these community projects.

Response 3: Neighborhood women's leaders will be trained by the SC health promoters so that the leaders can pass on the project's major health messages to their peers in their own neighborhoods. The midterm and final evaluations will both assess the degree to which these messages have been understood and adopted by individual mothers at the neighborhood and household levels.

There are inconsistencies in Table A.

Response 4: Could you provide us with the details of the inconsistencies.

It would be helpful if the DIP could include a list of abbreviations at the beginning.

Response 5: A list of abbreviations is attachment B. It could be added to the grant document as an appendix. Most abbreviations are spelled out when first used in the text.

The guideline request for messages has been ignored. SC states that there would be a "... Focus on helping mothers recognize and treat most prevalent illnesses.. , " but this does not describe the messages. Technical assistance is recommended to develop appropriate, simple and focused messages to mothers.

Response 6: Messages have been developed for project interventions based on national MOH guidelines. An example is in appendix 2 which list the messages for the diarrhea component. Messages for the other components have been developed by the MOH. They were not available during developing the DIP. SC is planning to acquire them from the MOH during the implementation of the project. The FO, however, would welcome technical assistance to ensure that the messages are as appropriate as possible.

Immunization

On page five SC states that, "5000 children less than five years old will be fully immunized," and on page 4, "80% of children aged 12-23 months will be completely immunized." SC needs to justify vaccinating these older children. The focus should be placed on infants less than one year old. This was a recommendation from the proposal review that was apparently not heeded.

Response 7: SC follows the host country MOH policies/guidelines for its interventions. In the event that such policies are absent, SC follows the following guidelines: (1) The focus of immunization activities will be on children under one year old. (2) Incompletely immunized children will be immunized regardless of their age, and (3) The age group used to measure project progress in immunization will be 12-23 months old. In Burkina, the national EPI program does not exclude children over one

year of age from vaccination, even though the emphasis is on full vaccination before the first birthday.

Point 5.a3 explains in details the project immunization policies. Because Sapone villages are remote, we can expect that a large number of children over one year of age are not fully immunized. I do not believe that the reviewer is expecting the project to deny immunization service to those children, especially when mobile teams will already be in the villages to vaccinate children under one. Project's strategy is well explained in point 5a.5.

SC states on page eight that "The MOH is responsible for maintaining the cold chain. The project will work closely with the MOH personnel to ensure its reliability." However, it is not stated who will work with the MOH or how they will "ensure" cold chain monitoring. A written monitoring protocol needs to be developed.

Response 8: The EPI in the project area is funded by UNICEF and the national government. Only a level of effort corresponding to 2% of CS8 resources will be devoted for immunization. It will focus on mobilizing the communities for vaccination and contributes to smooth functioning of the EPI through assistance with fuel needs when such needs are indicated by Provincial Health staff. All will be the responsibility of the project manager who will supervise the work of the VHWs to mobilize the communities, and will maintain the dialogue with the provincial health staff to assess their needs. Roles and responsibilities of participating SC and MOH staff are well explained in point 5a.6 and 5a.7. SC appreciates the suggestion to develop a written monitoring protocol for the cold chain, and will follow up with the MOH as described in point 5a.11.

Nutrition

The hours allocated to training for the different interventions do not make sense. The project proposes 21 hours of training for EPI which is supposed to have 2% of project effort, while training for nutrition (25% of project effort) is not mentioned. Vitamin A (10% of effort) is given six hours, and growth monitoring is allocated 12 hours of training.

Response 9: The hours of training mentioned in the DIP refer to training of SC health promoters and some training of MOH staff. The number of hours of training reflects the technical training needs of SC and MOH staff in the various interventions. The length of the training curriculum per intervention depends on the amount of information and practicum needed to be passed on to the workers in order to properly carry out the activities. It does not depend on the amount of project's resources allocated for the implementation of each component.

Because there was not any question in CS VIII DIP guidelines asking for the number of training hours for the nutritional improvement section, the group that worked on that

section did not include it in their text. After discussion with project staff, it is estimated that health promoters will receive at least 16 hours each in training in Nutritional Improvement. This will be in addition to the 12 hours for growth monitoring, and 6 hours for vitamin A.

The objectives for nutrition and Vitamin A are of concern, since they do not correspond to the many activities described under D.5c. Means of measuring these activities should be described in detail.

Response 10: This is a strange comment that we would like to challenge. We are also puzzled by the technical review comments that ask us to describe in detail the means of measuring these activities, and the DIP guideline (D.4) that ask for a one paragraph summary.

The objectives for nutritional improvement and vitamin A are listed in points 5c.5, 5c.15 respectively. As for the growth monitoring component, point 5c.24 lists the number of eligible population. The objectives are simple and straight forward. They are stated in terms of competence (for nutrition) and in terms of effective Vitamin A capsule distribution, and number of children to be monitored for growth. Strategies and activities are listed for each objective. Please refer to points 5c.6, 5c.7, 5c.8, 5c.9, 5c.14, 5c.16, 5c.19, 5c.22, 5c.24, 5c.25, 5c.26, 5c.29, and 5c.30. We believe that most of the strategies and the activities are clearly stated and reflect the achievement of the objectives.

A summary of the indicators that will be used to measure success of the nutrition interventions are listed in section D.2 (page 5). Section D.4 summarizes in one paragraph, the project monitoring system. Also, the level of achievement of the objectives (as well as project outputs) will be assessed through sample surveys at the midterm and final evaluations.

A three to four month interval for growth monitoring is of doubtful value. It needs to be done monthly if faltering is to be recognized in a timely fashion. If it is not done that often, some explanation is needed. SC needs to explain how the project will identify moderately or severely malnourished children and what is expected to happen when such children are "follow(ed) through home visits." What is to be taught about what steps to take if the child's weight is faltering? - which is the main point of monitoring. It appears that the weighing itself is an end in this project, and that is not enough.

Response 11: Growth monitoring is done by the SC health promoters, assisted by CHWs and neighborhood leaders. Using this strategy, **and with only 8 promoters**, growth monitoring at more than a quarterly rhythm is not feasible. Children found to be malnourished during the quarterly weighing session are then weighed on a monthly basis during the regular growth monitoring sessions and during home visits mentioned in point 5c.22. Growth monitoring sessions will also be used as opportunities to

educate all mothers on how to prevent infant and child malnutrition. Home visits for moderately malnourished children will be used to reinforce these messages. Severely malnourished children will be referred for treatment and nutritional counseling. As mentioned above, SC would welcome technical assistance to ensure that appropriate messages are used during both weighing and counseling sessions.

If children are to be weighed quarterly, it is not clear how the number of contacts per mother per year average to "six contacts" nor how the children are to be contacted (home visits? rally points?), nor who is to contact the child.

Response 12: Point 5c.4 stated that children will be weighed quarterly. Mothers of moderately malnourished children (20%) will be asked to attend at least two nutrition education and demonstration sessions. Point 5c.22 states that moderately and severely malnourished children (30%) will be identified and followed through home visits. It missed saying that this will be done on a monthly basis, and the child will be weighed during this visit using the Salter scale. Also, severely malnourished children will be referred. Therefore, we can assume that mothers of 70% of the children (normal) will be contacted 4 times a year, and 30% (moderate and severe malnutrition) will be contacted 12 times per year. Computing the average number of visits per mother per year will equal to $(70 \times 4) + (30 \times 12) : 100 = 6.4$. Children and mothers will be contacted by the SC health promoters, CHWs and neighborhood leaders, using lists generated by the family registration-based health information system. Follow up will be mostly done during home visits and during nutrition education and demonstration sessions; both are mentioned in points 5c.4 and 5c.22 of the DIP.

The statement that "four visits per child per year will be required to reach full coverage" misses the point. Full coverage of the individual child may be provided, but that is different from coverage of all eligible children. Defining "high risk" as children below the 80th percentile of weight for age raises serious doubts about technical knowledge concerning growth monitoring on the part of DIP authors. Technical assistance is needed.

Response 13: As described in section E.2, the Health Information System (HIS) will contain health data on all members of the target population. In order to ensure universal coverage with nutrition interventions, lists of all eligible children will be generated for each village, and neighborhood. These lists will be used by health promoters, CHWs and neighborhood leaders to reach mothers and children with the different interventions. It is in this context that the DIP is using the phrase "All eligible children". In other word, the DIP defines full coverage as reaching each eligible child four times a year with growth monitoring and promotion activities.

The DIP defines high risk for malnutrition as those children who are below the 80 percent of the reference weight for age. The field office uses the government of Burkina guidelines which are based on WHO recommendations. Please refer to section

3 and appendix 1 of the "Manual on feeding Infants and Young Children" published by Oxford University Press, New York in 1991. We apologize if the word percentile confused the reviewer.

Please clarify how the health information system will provide the information on the number of children who lost weight in the last three months.

Response 14: The weight of each child will be recorded on the Growth Monitoring Card and in the children roster. Each weight will be marked based on the GM/P curve if it is an increase, decrease, or the same as the previous weigh. Therefore, the promoter will be able to count, at any point in time, the number of children in his corresponding village that increased, decreased, and/or remained the same weight. The promoter will be expected to report these figures to her supervisor on the monthly report. Also, growth monitoring data will be promptly entered into the computerized HIS (ProMIS) by the HIS Coordinator, who will then generate lists of children who are malnourished or growth faltering.

Thought needs to be given as to whether monthly visits to villages by a mobile team might be integrated with nutrition activities - namely growth monitoring.

Response 15: Thank you for sharing this notion with us. This idea was discussed during the workshop held to develop the DIP. Unfortunately, it was not favored because of the following reason. The mobile teams component of the immunization campaign will be conducted by MOH staff. The project health promoters who will be responsible to carry out the GM/P activities will be busy before, during, and after the mobile team visit. Please refer to point 5a.c for a clear description of the role of SC animators (also called promoters) and VHWs. Given this wide range of activities that the animators need to carry out, it would be unrealistic to expect them to also conduct growth monitoring and promotion activities. Also, because the animators and the VHWs live in the villages, there will be no cost savings in integrating both interventions.

Why are 350 mothers "trained" in year one, 800 in the second year and 1200 in the third? How will this phasing take place?

Response 16: Training of mothers will be limited in Year One due to project start-up constraints (baseline survey, family registration, etc.). In Year Two, expansion to eight more villages will necessitate further family registration. In addition, activities are not expected to be in full force in the first year of contact with any village. In Year Three, no new family registration or other start-up will be required, and all activities will proceed at their maximum rate.

More clarification is needed about the plans for grain banks and gardens. Who will do the work and how will activities take place? What messages will be communicated about the grain banks and gardens? Specific messages are needed for pregnant women about iron rich foods, Vitamin A rich foods, and increasing calorie intake by increasing grain consumption.

Response 17: Please refer to response 1 for information on integrated activities, and response 6 for questions about messages.

Maternal Care and Family Planning

The investigation of maternal mortality and morbidity by the community nurse midwives would be a useful addition to their duties and would help them in their supervision and education of the traditional birth attendants.

Response: The suggestion of maternal mortality and morbidity investigations by the nurse midwives is a good one, and will be discussed with field staff to assess its feasibility.

The DIP does not address the problem of the cost of fuel to the family for high risk obstetric referral. Could savings funds be set up by women's group activities to offset this disincentive to needed care?

Response: The idea of savings funds to help pay for obstetric referral is under discussion with villagers. Results of the discussion will be included in the annual report.

Is there any evidence that villagers will be willing or able to pay village health workers and traditional birth attendants for contraceptives? An additional survey might be useful before adopting the present plan.

The project DIP does not address the concerns expressed by the project reviewers over whether sales of contraceptives, etc. will be a viable option for attainment of revenue, or whether the village health worker will be competing for these funds.

Response: National contraceptive promotion projects have had good results with sales of contraceptives. On a relatively small scale, this has worked even within the project area. There is no reason to believe that it will not work on a larger scale. Also village based health workers and TBAs currently sell chloroquine and other products for a small profit, with success. Modest competition among sellers of contraceptives is expected to be helpful in contraceptive promotion.

The survey idea of integrating vaccination activities with prenatal care is an interesting one that was not addressed in the DIP. It might avoid duplication of effort in bringing all services to the village level.

Response: The activities of the nurse midwives represent training tools to promote local demand and capacity for pre-and post-natal services. However, these nurse midwives will only be active during the life of the project. Therefore, integration of vaccination into their activities would not be sustainable after the end of the project. Also, immunization activities require cold chain logistics, and will reduce the nurse midwives time devoted to the implementation of the maternal health component. Given the high coverage rate for Tetanus Toxoid among women, and for the above mentioned reasons, the DIP authors decided not to included the integration of vaccination activities in the maternal health component. (Baseline data shows that 80.8% of interviewed mothers had received 3 or more Tetanus Toxoid vaccines)

SC did not address the suggestion of the proposal reviewers to add education in reproductive health issues to the school training curriculum. It still seems a good idea to increase the number of adolescents that the program could reach. In the Annual Report, SC should address why they decided to adopt this suggestion.

Response: Education in reproductive health issues is being introduced to schools in the project area through the creation of adolescent youth groups focusing on family planning and AIDS prevention. This will be implemented by the nurse-midwives, and will increase the number of adolescent that the program will reach. Adding education in reproductive health requires that SC negotiate changing the national school curriculum. This is beyond the scope and objectives of this project.

Malaria Control

The only malaria objective for the project is the percentage of community health workers able to inform and refer families. Reviewers suggest that SC set targets for the percentage of individuals to be informed or appropriately referred for treatment, and the percent of pregnant women expected to receive weekly chloroquine prophylaxis.

Response: We appreciate the suggestion to have malaria control output objectives. Percentage of individual referred, however, will be hard to compute because the denominator (number of cases with Malaria) will be impossible to determine. As stated in point 5.f8, it is illegal to dispense Chloroquine outside the formal health system in Burkina. Therefore providing a prophylactic dose for pregnant women has to be through that system. Consequently, the following objectives will be added to the Malaria component: 1. 60% of families will adopt measures of proper malaria prevention, and 2. 50% of pregnant women who receive prenatal care from the formal health system will receive a weekly dose of 300 mg of chloroquine for Malaria prophylaxis.

HIV/AIDS/STDS

A DIP for AIDS was not included. There is mention of AIDS and STD prevention messages being promoted via health education sessions, women's group discussions and home visits, but no details were given.

SC mentions increasing condom availability and accessibility, but no details are offered on costs, feasibility, logistics, and on how this fits in with the Ministry of Health strategies, etc. SC needs to develop a detailed plan for the AIDS prevention component.

Response: Scaling down the AIDS/HIV/STDs to just education through the High risk birth component of the project was made based on the recommendations of the USAID mission in Burkina. This was documented in the revised objectives presented to the PVC office in April 1992, and was consequently included in the Grant agreement. Since the DIP was developed based on the revised proposal objectives, the AIDS/HIV/STDs intervention was designed as such. The objectives, strategies, outputs and activities for AIDS/HIV/STDs are described in point 5d.7 and point 5d.8. Because AIDS/HIV/STDs activities are a part of the maternal health care strategy, there is no reason to develop a special DIP for them. The issue of condom accessibility and availability is partially addressed in point 5d.8, and 5d.9. The reviewer is correct that there is no detail offered on costs, feasibility, logistics, and on how this fits in with the Ministry of Health strategies. This however, is not an oversight. Because of the limit put on the number of pages for the DIP, the authors refrained from describing the details of the subcomponent. There is a mention however, that a Community Based Distribution system for contraceptives, including condom, will be set, and the supply systems will be discussed with the MOH. the social marketing project took a marketing approach to make condoms available at the village level. The idea is to create a national depot, and a number of wholesalers across the country. VHWs, after training, supply and re-supply themselves through the area wholesaler. In Saponé the pharmacy of one of the local NGO (AVLP) is acting as a the region's wholesaler. This role was promoted and encouraged by SC. The project will consider supporting each VHW for his/her first condom supply. Resources for re-supplying will come from sale proceeds.

The field office is currently involved in conducting studies under other funding (WHO) to help identify the knowledge and attitude towards AIDS risk factors. This will determine the exact plans for HIV/AIDS/STD prevention activities outside the Child Survival program. A more detailed plan is under development for this intervention.

Health Information System

The 100% family registration proposed is clearly intended to be an essential element of much of the monitoring, but (1) how exactly the registration will be done, or (2) what it will include, is not clear. It would be helpful if an example of the family registration form were included in the DIP.

Response: Section E of the DIP provides a broad description of the Health Information. The FO, during the development of the DIP, assumed that a full description of the system is beyond its scope. This is particularly true because of the limitation on the number of page allowed. A full report on the 1993 family registration in the first 18 project villages is attached to this memo. It includes examples of all the family registration forms as requested by the reviewers. This document will be considered an appendix to the DIP.

Sustainability

This project is comprehensive and complicated and one must wonder whether, at the end of another two and a half years, the "knowledge and skills" will have been passed on to enough people for the project to survive. Mention is made of MOH people participating, but who they are, how many there are, and just what they do, is lacking. A better description of their roles would help - they may be better able to carry on the project than it appears in the DIP.

Response: This project is part of an integrated community development program that has been ongoing since 1986. Because the villages involved have already made progress in their organizational and management abilities, it is expected that they will be able to continue to benefit over the long term from the knowledge and skills passed on by the project.

MOH staff involved in the project include the Provincial Health Director (planning, monitoring and evaluation), and local health center staff (planning, implementation, monitoring, evaluation). The local health center staff in Sapone, Ipelce and Sambin include two doctors and 8 nurses. While MOH staff are not physically present at every session of the project's activities, they participate in supervision and in service delivery (vaccinations, maternal care, family planning, etc.).

Although the acronyms for two PVOs are given, and it seems they are expected to help sustain the project, just what they can contribute is not clear. Clarification might make the sustainability more credible.

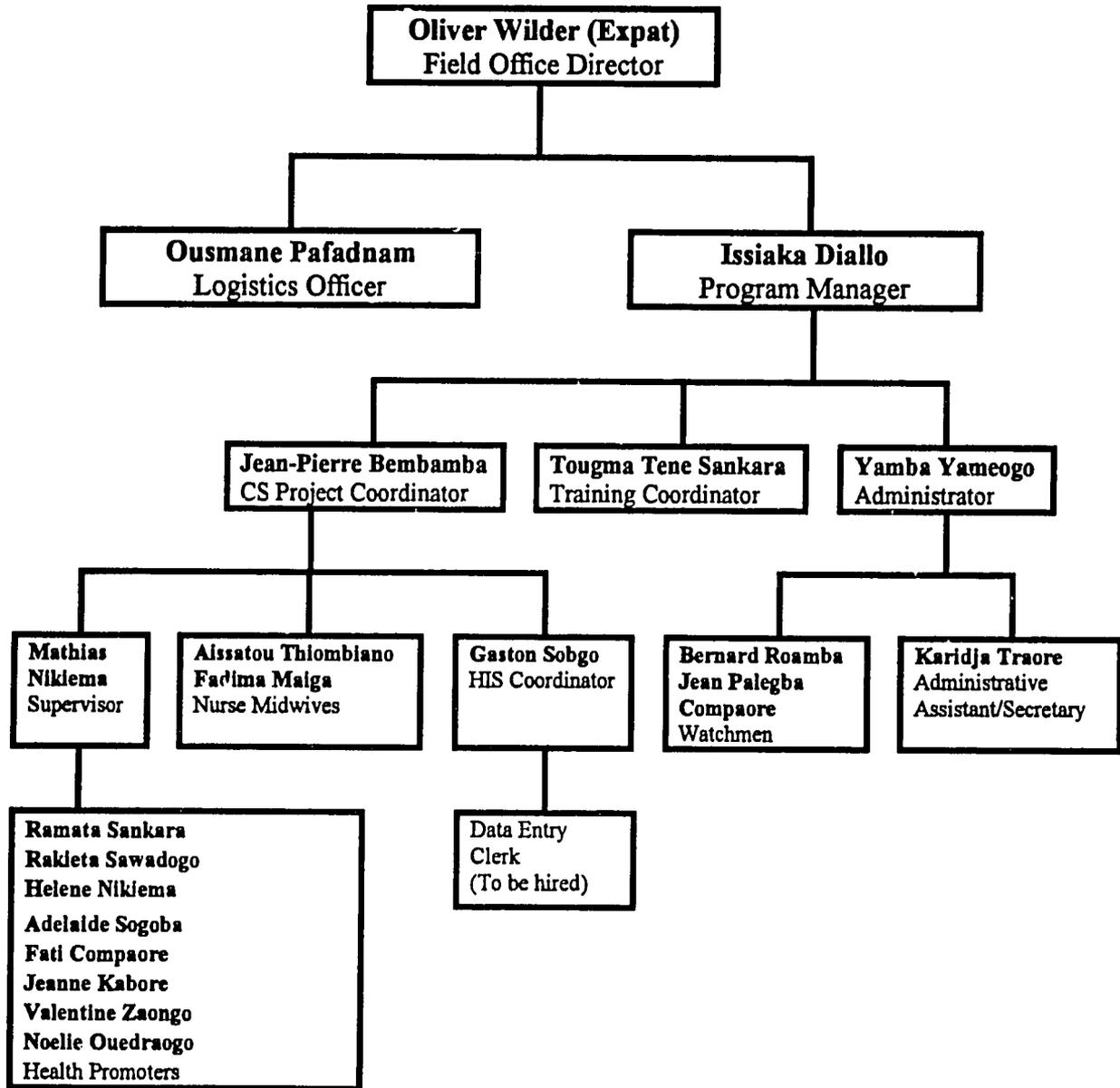
Response: The main purpose of including two local PVOs (Association Vive le Paysan - AVLP - and Association Burkinabe d'Action Communautaire - ABAC) in the project

is to increase their capacity to include a coherent primary health strategy as part of their regular community development activities (which include mainly small enterprise and natural resource management activities). Their participation is also, aimed at encouraging replication of the project approach by these partners on a broader scale, rather than only providing another support system for sustainability in the 26 project villages. Such replication will require financial support, and SC hopes to be able to help these local PVOs to acquire such support from interested funders.

VII. OTHER INFORMATION

The project is fully integrated into all SC development activities in Sapone. This includes agriculture, education, and credit/savings projects in most of the villages. This approach allows for synergy, and will increase the impact of the CS project on the health and survival of the children.

ORGANIZATIONAL CHART



**SAVE THE CHILDREN
Pipeline Analysis**

Appendix B

COOPERATIVE AGREEMENT FAO-0500-A-00-2034

21-Oct-93

CHILD SURVIVAL VIII: BURKINA FASO

YEAR 1: EXPENSES VS. PLANNED BUDGET

LOG: CUMULATIVE EXPENSES VS. TOTAL GRANT

	EXPENSES 07/31/93	PLANNED BUDGET	BALANCE	% SPENT	BUDGET YEAR 2	BUDGET YEAR 3	CUMULATIVE ACTUAL	TOTAL BUDGET	BALANCE	% SPENT
Evaluation	2,248.58	3,550.00	1,303.42	63.3%	15,600.00	4,000.00	2,248.58	23,150.00	20,903.42	9.7%
Personnel	68,563.16	115,042.00	46,478.84	59.6%	120,744.00	126,762.00	68,563.16	362,548.00	293,984.84	18.9%
Travel	8,413.19	13,600.00	5,186.81	61.9%	13,800.00	13,700.00	8,413.19	41,100.00	32,686.81	20.5%
Communications	4,180.81	11,000.00	6,819.39	38.0%	5,000.00	5,000.00	4,180.81	21,000.00	16,819.39	19.9%
Facilities	1,827.99	1,000.00	(827.99)	182.8%	1,000.00	1,000.00	1,827.99	3,000.00	1,172.01	60.9%
Other direct	17,215.04	22,200.00	4,984.96	77.5%	22,700.00	25,200.00	17,215.04	70,100.00	52,884.96	24.6%
Procurement										
Supplies*	7,468.83	14,500.00	7,031.17	51.5%	5,000.00	4,500.00	7,468.83	24,000.00	16,531.17	31.1%
Consultants		1,000.00	1,000.00	0.0%	1,000.00	1,000.00	0.00	3,000.00	3,000.00	0.0%
Services	2,359.70	1,500.00	(859.70)	157.3%	1,500.00	1,500.00	2,359.70	4,500.00	2,140.30	52.4%
sub-total Procurement	9,828.53	17,000.00	7,171.47	57.8%	7,500.00	7,000.00	9,828.53	31,500.00	21,671.47	31.2%
Total Direct	112,275.10	183,392.00	71,116.90	61.2%	186,344.00	182,662.00	112,275.10	552,398.00	440,122.90	20.3%

Year 1 = Sept.30,1992 - Sept. 30, 1993

Year 2 = Oct. 1, 1993 - Sept. 30, 1994

Year 3 = Oct. 1, 1994 - Sept. 30, 1995

Budget revised to Amendment 3

*Supplies are individually under \$500 per item.

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