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SAVE THE CHILDREN/US

**BURKINA FASO FIELD OFFICE
CHILD SURVIVAL V ANNUAL REPORT FY 1993**

Cooperative Agreement No. OTR-0050-A-00-9149-00

YEAR FOUR

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GLOSSARY

CS	Child Survival Project
DIP	Detailed Implementation Plan
HIS	Health Information System
HKI	Helen Keller International
MOH	Ministry of Health
NGO	Non Governmental Organization
ORT	Oral Rehydration Therapy
SC	Save the Children
VHC	Village Health Committee

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I. OVERVIEW OF YEAR FOUR

This reporting period marked the first full year of activities since the project's mid-term evaluation in June 1992. The evaluation led to significant changes from the DIP in terms of strategy and objectives. However, no further major changes in strategy and objectives have been made since the last annual report, which reflected the changes suggested in the mid-term evaluation.

The primary activities undertaken during this reporting period were: the expansion of the family registration to five more villages, bringing to 40 the number of villages registered; the communication of health education messages, described below, by the health promoters to women of child-bearing age; the establishment and continued training of village health committees; the training of village health volunteers; the distribution of Vitamin A capsules; the carrying out of an AIDS awareness survey; and an evaluation of the educational messages being communicated.

A. Accomplishments Compared With Goals and Objectives

Save the Children's Child Survival V staff in Dori registered 1452 people during this reporting period, bringing the total population of the project area to 24314. This includes 4149 children under five years of age, and 6080 women from 13 to 49 years of age. These numbers are somewhat lower than the target levels, due to logistical difficulties in registering the highly mobile population in the project area. Registers were put in place and maintained for these target groups, and monthly collection of vital events information continued as planned in all villages.

Health education messages which were communicated to target groups included those regarding growth monitoring, proper nutrition for pregnant and lactating women and for young children, the prevention and treatment of diarrheal diseases, hygiene, and the importance of participating in the vaccination program. SC health promoters reached close to the numbers of people they were aiming for: they trained 2382 of the targeted 3011 women (79 %) from 13 to 49 years of age with messages regarding growth monitoring, and between 78 % and 85 % of the targeted group with the other messages mentioned above.

In terms of prenatal consultations, the project confronted a major obstacle when the staff nurse-midwife fell ill half way through the year and was unable to continue her field work. Still, 317 pregnant women received at least one prenatal consultation, and 18 women identified as being at high risk received at least two consultations. Qualified SC or MOH personnel, or trained village midwives, were present at 299 of 670 births.

SC also 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.

B. Training Activities for Project Staff

In late September 1992, just before this reporting period but after last year's report had been written, the project Health Promoters participated in a Training of Trainers session led by Marlene Gay, a Helen Keller International consultant. The training session was also attended by personnel working on Child Survival projects run by Africare and by Save the Children in Saponé.

The CS project coordinator, supervisors, HIS coordinator, and health promoters met at least once monthly to discuss and improve the messages being transmitted. These regular nonformal training sessions served to enhance the ability of participants to carry out their tasks.

Clément Bouyain, CS Project Coordinator, was trained in the management of the HIS software, PROMIS, at SC-US headquarters in early August 1993. This training was carried out by Ken Herman, coordinator of SC's Personal Computer Group, and Katherine Kaye, an epidemiologist at SC's headquarters. Mr. Bouyain in turn trained office personnel in Dori in the program when he returned there in late August.

C. Technical Support

A consultant from the National AIDS Control Committee (Comité National de Lutte Contre le SIDA) visited the program in April to discuss AIDS awareness and how to address the issue at the village level. He met with all senior health staff, and local MOH authorities. The visit was made in preparation for a qualitative study on AIDS awareness carried out in July in Séno Province.

From 21 to 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.

D. Community Health Committees

Sixteen health committees were instituted in April of 1993, so that all 40 villages in the project area have active community health committees. The committee members help collect vital event information which they communicate to the Health Promoters for the HIS; they assist in the planning and organization of family trainings; and they assisted with the family registration in the five new villages. Village Health Volunteers have been trained and integrated into the health committees during this program as one further step towards ensuring sustainability.

Over the last 90 days, each committee has met 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. Linkages to Other Health and Development Activities

An agreement has existed between Save the Children and the MOH since 14 February 1990. Project staff and Provincial Ministry of Health representatives meet monthly to share information and plan activities. They also hold at least biannual meetings with Save the Children Fund-UK and other NGOs active in health projects in the area to plan and coordinate field activities.

In Ouagadougou, SC's Field Office Director meets as necessary with MOH officials, and sends the appropriate authorities copies of relevant documents. 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 July in the project area relied on input 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.

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

The Project Coordinator, Clément Bouyain, was invited to represent SPONG, the NGO umbrella group, in a national commission to define a country-wide policy on nutrition. However, because of Dori's distance from Ouagadougou and because of his other program responsibilities, Mr. Bouyain has asked another SC representative to participate in his place.

F. Staff Changes

As mentioned above, the project Nurse-Midwife has been ill for much of the year, and the project has had to use temporary replacements. No other changes in professional staff have been made. The project Organizational Chart is appendix A.

II. CHANGES MADE IN PROJECT DESIGN

No significant changes have been made from the last annual report in terms of objectives, type or scope of interventions, location or number of beneficiaries, or budget. It should be noted that the changes from the DIP, reflected in last year's report, are quite significant.

III. CONSTRAINTS, UNEXPECTED BENEFITS, AND LESSONS LEARNED

A & B. Constraints and Strategies Used to Overcome Them

The illness of the Nurse-Midwife caused significant delays in pre- and post-natal consultations, and made it impossible to undertake all the consultations planned for. During the final year of the project, a replacement will be hired to carry out the consultations.

Due to cultural restrictions, it was often difficult for health promoters to get all the necessary information to register families. Health promoters often had to visit villages several times to obtain accurate information during family registration, which made it impossible to register all the villages planned for. The population's mobility -- many people are traditional herders who migrate looking for pasture -- makes the regular upkeep of the HIS and other interventions extremely problematic. The project will address this problem by continuing a high frequency of village/home visits made by the promoters.

Some mothers gave home-based sugar-salt-solution to their dehydrated children; however, the mixture was not always properly consumed. Correct usage of the solution will be emphasized so that mothers will understand its importance and use it appropriately.

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.

C. Circumstances Leading to Unexpected Benefits

The collaboration with Africare's health staff led to the introduction of Village Health Volunteers. 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 village volunteers are long-term community residents who can continue to undertake the activities for which they have been trained.

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.

Another lesson we learned this year was to avoid underestimating the amount of time needed to start projects when working with other organizations. This year's vaccination campaign and

AIDS awareness program were to be carried out with Ministry of Health staff. Due to bureaucratic delays, the campaign was late getting started and the AIDS awareness program had to be postponed. In the future, we will make certain that all activities with the MOH are clearly outlined and have definite start and completion dates.

IV. PROGRESS IN COLLECTION OF HEALTH INFORMATION

A & B. HIS Characteristics and Process

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.

Census data, services statistics, and data on project interventions are also 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. They then pass the data to the HIS Coordinator in Dori, 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 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.

The project continued to focus on children from 0-36 months of age for follow up activities, which include quarterly growth monitoring, participation of their parents in nutrition

workshops, home visits to children with identified moderate malnutrition and referral of children with identified severe malnutrition.

Child vaccination was promoted by identification of children not yet completely vaccinated, home visits to these children's families, and distribution of vaccination invitation cards before vaccination sessions.

Pregnant women were identified in each village by promoters and a list was sent to the project midwife. The midwife would then hold meetings with the women and perform training and conduct individual prenatal consultations. High risk women (identified as those with anemia, high blood pressure, swelling, and women who have had previous pregnancy problems, are less than 18 years of age or more than 35 years of age) were identified, recorded in the midwife's roster and referred to a medical center for delivery.

C. Needs for Refining the HIS

Continued effort needs to be made to reach a larger population. The mobility of the population has made this extremely difficult. Project staff need to continue to put emphasis on the active participation of village health committees in collecting and communicating to the Health Monitors all the information relevant to the HIS.

V. BUDGET AND EXPENDITURES

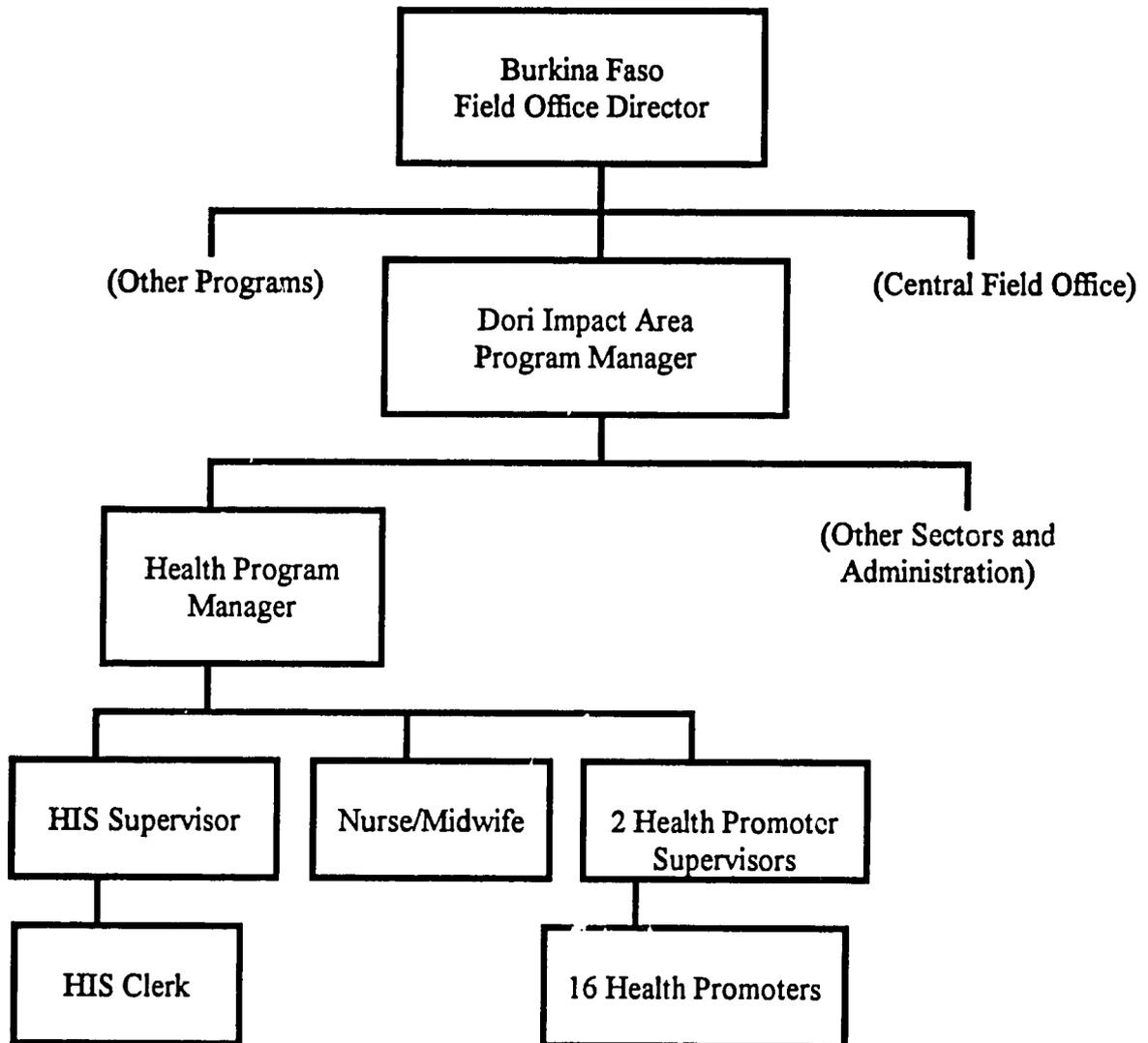
A. Major Budget Revisions

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

B. Pipeline Analysis

The project's pipeline analysis is appendix B.

ORGANIZATIONAL CHART



**SAVE THE CHILDREN
Pipeline Analysis**

Appendix B

COOPERATIVE AGREEMENT OIR-0500-A-9149

CHILD SURVIVAL V- BURKINA FASO

21-Oct-93

BUDGET VS. ACTUALS FOR YEAR 4 AND TOTAL EXPENSES TO DATE VS. TOTAL GRANT *

	YEAR 4: EXPENSES VS. PLANNED BUDGET *							PLANNED BUDGET YEAR 5	LIFE OF GRANT: CUM TOTAL VS. TOTAL GRANT *			
	EXPENSES YEAR 1	EXPENSES YEAR 2	EXPENSES YEAR 3	EXPENSES 07/31/93	PLANNED BUDGET	BALANCE	% SPENT		CUMULATIVE ACTUALS	TOTAL PLANNED BUDGET***	BALANCE	% SPENT
Procurement												
Supplies***	8,040.52	10,835.35	12,561.07	10,744.42	25,313.58	14,569.16	42.4%	7,051.48	48,190.36	70,611.00	22,420.64	68.2%
Assets***	3,076.17	(66.17)	0.00	0.00	(0.00)	(0.00)		0.00	3,010.00	3,010.00	0.00	100.0%
Consultants	7,160.73	2,190.13	0.00	0.00	(1,101.05)	(1,101.05)		3,102.09	9,302.88	11,303.00	2,000.14	82.4%
Sub-Total:	18,292.42	18,865.31	12,561.07	10,744.42	24,211.03	13,467.21	44.4%	10,853.57	60,503.22	84,904.00	24,420.78	71.3%
Evaluation	2,155.17	(2,155.17)	1,540.02	3,000.00	8,450.00	5,450.00	35.5%	0.00	4,540.02	10,000.00	5,450.00	45.4%
Other Program Costs												
Personnel	50,413.69	106,917.00	93,835.64	90,931.20	144,030.47	53,099.19	63.1%	73,749.00	342,097.61	488,940.00	126,848.19	73.0%
Travel	31,159.83	12,225.93	3,505.10	1,595.03	7,101.97	5,500.14	22.2%	2,302.17	40,500.69	50,535.00	7,006.31	85.9%
Other	15,922.69	52,057.68	33,390.85	44,632.45	47,744.78	3,112.33	93.5%	60,369.00	148,003.87	209,485.00	63,481.33	69.7%
Sub-Total	97,490.21	171,200.61	130,811.79	137,159.50	198,857.22	61,707.66	68.9%	136,500.17	530,608.17	734,900.00	190,297.63	73.0%
TOTAL	117,843.80	188,010.75	144,912.88	150,903.98	231,628.83	80,724.85	85.1%	147,453.74	601,771.41	829,950.00	228,178.59	72.5%

* Final expenses for Year 3; Year 4 expenses through 07/31/93

** Revised budget from DIP Year 4 includes balances from Year 3

*** Assets are any individual items \$500 and over. Supplies are individually under \$500 per item.

Year 1 - Sept. 1, 1989 - Aug. 31, 1990
 Year 2 - Sept. 1, 1990 - Aug. 31, 1991
 Year 3 - Sept. 1, 1991 - Aug. 31, 1992
 Year 4 - Sept. 1, 1992 - Aug. 31, 1993
 Year 5 - Sept. 1, 1993 - Aug. 31, 1994

LINE ITEM FLEXIBILITY: No flexibility between Procurement, Evaluation and Other.
 100% flexibility within each group.

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