
HELEN KELLER INTERNATIONAL

ASSESSMENT OF
THE VITAMIN A TECHNICAL ASSISTANCE PROGRAM (VITAP)

ANNEX 5; BURKINA FASO COUNTRY REPORT

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EXECUTIVE SUMMARY

Vitamin A deficiency is one of the leading causes of blindness, morbidity and mortality worldwide, especially among preschool children in developing countries. In 1988, Helen Keller International was awarded a five-year grant from AID to develop a program which would provide technical assistance and resources to other private voluntary and non-governmental organizations. This program, called VITAP (Vitamin A Technical Assistance Program), is designed to motivate and engage other organizations in joining Helen Keller International and the host government in the fight against vitamin A deficiency.

In 1991, the mid-term evaluation of VITAP was conducted, but no visits were made overseas to the field sites of VITAP's collaborators due to travel restrictions during the war with Iraq. In 1992, Helen Keller International (HKI), AID and collaborating PVOs reviewed VITAP's activities in 22 countries and chose a group of five countries (Burkina Faso, Indonesia, Mali, Niger and the Philippines) and two international workshops which would be the focus of an in-depth assessment. Objectives of this assessment were to identify, describe and quantify the impact which VITAP was having on its collaborators and subsequently on the communities where those collaborators were working.

This impact assessment was conducted over a two week period in Burkina Faso. The three methods used were interviews with the PVO and international donor community, an exhaustive document review, and field visits to Africare, Save the Children and CRS project sites.

Helen Keller International did not have an in-country staff in Burkina Faso until 1991, but they have still been active in vitamin A activities, generally managed by the then HKI country director in Niger. In particular, HKI started a vitamin A project with the Ministry of Health and UNICEF in 1986. This covered four northern provinces and ended in 1989, and included a target population of 237,000 children aged 6 months to 5 years, 450,000 children aged 6 to 10 years, and 189,000 nursing mothers. The nutrition education component of the project reached 1500 village health workers, 38 trainers and 390 health personnel, and included the development and dissemination of brochures, t-shirts and radio spots. One final aspect of the project was the intensive and extensive distribution of VAC: capsules of 200,000 IU were distributed every four months, rather than every six months, because of the Ministry's determination that a crisis situation existed. A new project, building on this one, has recently been signed and will extend the project to eight northern provinces, expanding both the target population and the training objectives.

HKI has had far less contact with the PVO community in Burkina Faso than in other African countries, partially due to the absence of an in-country presence, and partially due to its focus on working with the Ministry itself. This does not mean that the PVOs are unaware of HKI's reputation, but rather that they have not been directly involved with HKI regarding, for example, technical assistance. As a result, the primary contact with the PVO community in Burkina has been through VITAP itself, which has

minimized one of the confounding factors in determining the source of vitamin A technical assistance, training, and other information.

VITAP has thus far assisted four **PVOs** to conduct a total of five workshops. These **PVOs** are Africare, Save the Children, World Relief and Catholic Relief Services. Three of the workshops included sessions on the symptoms of vitamin A deficiency disease, distribution of vitamin A capsules, social marketing, the role of nutrition in infant and childhood growth, techniques of growth monitoring, and the identification of vitamin and mineral-rich foods already available in the local environment. A fourth workshop was on gardening techniques for indigenous plants rich in vitamin A, and the fifth was on problem-solving techniques. There have also been several consultancies on project design, primarily with Save the Children Federation.

The first four workshops and all of the consultancies occurred in 1989-90, while the fifth took place late in 1992. The three vitamin A workshops resulted in the four **PVOs** incorporating this information as part of their nutrition education components, in particular in the Child Survival projects of Africare and Save the Children, and in the CREN outreach sponsored by CRS. In addition, vitamin A education was then included as part of the year-long curriculum in World Reliefs training. This last is perhaps the most innovative strategy used in Burkina Faso. Villages nominate a couple, who are then supported by the village for a year's worth of training in health and agriculture. Rather than expecting information on a wide variety of topics to be processed in a two week period, the year long commitment permits topics to be developed more fully, and different training techniques actually practiced. World Relief uses the flip charts as part of this curriculum.

While the technical workshops on vitamin A were well-received, the gardening workshop was rather less so. This was quite clear from both the consultant's reports and from the notable absence of any demonstration gardens at the Save the Children project site in Dori. The message of creating a sustainable local source for vitamin A-rich foods was clearly understood, but implementation faltered due to lack of staff support and follow up.

The most recent workshop was based on Africare and Save the Children's finding that the village health educators often had difficulty in presenting the various health messages and particularly in enabling villagers to identify and resolve health problems. The workshop focused on that process of enabling, using examples provided by the **VHEs** and other PVO staff. During two of the field visits, it became apparent that this process had been imperfectly mastered by the **VHEs**. Additional reinforcement from the PVO project staff might develop this skill further, especially if it can be tailored to their specific cultural requirements. It should also be noted that this type of process training works best outside of the traditional didactic methods.

There have also been several consultancies on project design, primarily with Save the Children. In working with CRS, World Relief and the Ministry of Health on a story line about a family with a child suffering from VAD, VITAP was able to make a major contribution in providing a dramatic tale that has been used in many forms throughout the Sahel -- from flip charts for training purposes to theater pieces presented in schools and local communities. The collaboration with **AED** has resulted in a specific output -- the flip charts -- which are now in their second edition and being produced locally in Ouagadougou.

Included among VITAP's specific achievements are the following:

- o in the space of two years, four **PVOs** (Africare, Save the Children, World Relief and Catholic Relief Services) have made solid commitments to provide information on vitamin A at the community level through project activities, and to introduce measures to control and reduce VAD;
- o a total of 45 project staff, as a result of VITAP training, are fully aware of the need to improve consumption of vitamin A-rich foods among their target populations;
- o a total of at least 87 communities have already received vitamin A information from PVO project staff;
- o at least 11 Ministry of Health personnel in a wide variety of fields have participated in VITAP training;
- o the national child growth monitoring chart has been revised to include a section devoted to vitamin A and VAD before the end of 1993;
- o VITAP played a role in encouraging the Ministry to pursue the formulation and implementation of a national nutrition plan that includes a vitamin A component; and
- o **VITAP's** story line about the family with the malnourished child has been adapted for flip charts used for training health personnel and teaching primary school children. UNICEF plans to distribute the charts to schools.

The national health system in Burkina Faso is both a confounding and a supporting factor in determining any impact that VITAP has had. While the Ministry transfers its personnel frequently, inhibiting individual initiative, it has also undertaken several large-scale vitamin A programs, including training, outreach and the formation of a national plan. Many projects can get trapped into a never-ending cycle of seminars and workshops, rather than on supervising outreach activities. This cascade training is

endemic to all of the projects examined, but, at the same time, many project activities are perennially stalled by delays in finding trained personnel.

There are several specific recommendations for future VITAP initiatives in Burkina Faso, mainly regarding VITAP's role as a coordinator for vitamin A activities in the PVO community. These include:

- o designing a system for consistent follow-up training of PVO and Ministry personnel trained to identify VAD and provide follow-up care;
- o identifying nationals able to conduct vitamin A training workshops. The Africare Co-coordinator may be one possibility;
- o promoting cooperation and collaboration among PVOs for more effective use of resources and interchange of ideas on raising village-level awareness of vitamin A requirements;
- o encouraging the Ministry to establish a reliable, nation-wide distribution system for VAC;
- o designing a more formal coordination mechanism (such as a working group) among the PVOs and international donor community to reinforce vitamin A messages and share information about strategies;
- o consolidating the various echo effects of the flip charts and disseminating them to other PVOs. As further training is apparently needed in their use at the village level, additional applications, such as the skits presented at the SCF and World Relief project sites, may help convey both the message and the training;
- o reinforcing the vitamin A messages at the VHE refresher courses, usually given annually;
- o extending the audience for the vitamin A message by collaborating with the CRS school feeding program and the UNICEF/HKI project to the primary schools, possibly through dramatic presentations developed by World Relief or from other VITAP sites in West Africa;
- o extending the scope of VITAP activities specifically to the education and agriculture sectors;
- o reviewing the existing KAP studies for their use of vitamin A indicators and fostering additional staff development on their monitoring and evaluation;

- o extending **VITAP's** interventions to the NGO community;
- o reviewing, enhancing and/or developing an urban vitamin A prevention and control program; and, finally,
- o disseminating successful strategies from other VITAP programs, especially those in Niger and Mali throughout the PVO community.

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ACRONYMS

AED	Academy for Educational Development
AID	Agency for International Development
CFA	Communauté Financière Africaine: currency exchanged at an average rate of 250CFA for U.S.\$1.00 in November 1992
CHW	Community Health Worker
CREN	Centre de Recuperation des Enfants Malnouris; Center for the Recuperation of Malnourished Children
EPI	Expanded Program for Immunization
FAO	Food and Agriculture Organization
GRAAP	Groupe de Recherches et d'Appui à l'Auto Promotion Paysanne; Research and Farmers' Self-Sufficiency Support Group
KAP	Knowledge, Attitudes and Practice Survey
HKI	Helen Keller International
MCH	Maternal and Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization'
ORT	Oral Rehydration Therapy
PEV	French acronym of EPI above; Programme Elargi des Vaccinations
PVO	Private Voluntary Organization
SCF	Save the Children Federation
TA	Technical Assistance
TBA	Traditional Birth Attendant
UNDP	United Nations Development Programme
UNICEF	United Nations International Childrens' Emergency Fund
USAID	AID mission
VAC	Vitamin A Capsule
VAD	Vitamin A Deficiency
VHE	Village Health Educator
VHW	Village Health Worker
VITAL	Vitamin A Technical Assistance Information
VITAP	Vitamin A Technical Assistance Project
WHO	World Health Organization

'NGO is used in this report to represent local development agencies and organizations, and is not used interchangeably with PVO. PVO, instead, refers to **VITAP's** targeted first level beneficiaries.

I. COUNTRY INTRODUCTION

Burkina Faso is one of the smaller Sahelian countries in terms of land area, but its population of more than nine million ranks it between Niger and Mali. The northern part of the country is arid and inhabited by semi-nomadic people who treasure their independence and resent outside interference. However, as part of the Sahel which has been subject to a succession of droughts, the north also requires frequent assistance with food supplies and interventions from relief agencies. The land in southern Burkina Faso receives adequate rainfall for crop production, but large plantations have been devoted to growing market produce for export, reducing food supplies for local populations.

There are three major river basins in the country, the White, Black and Red Voltas, from which was the old name of this country (Upper Volta) was derived. The rivers flow part of the year, depending on the rainfall, and may dry by November or December. To the north the country grows visibly drier and more desert-like, and is correspondingly poorer in terms of agricultural resources. The rainy season lasts from June - September, which is when most of the agricultural activity is done. Millet and sorghum are the staple crops. The dry season is from October - May, during which many men migrate looking for work, especially to the Cote d'Ivoire. There are not many dry season gardens because of the scarcity of water.

Burkina Faso was part of French West Africa until independence, and Bobo-Dioulasso was a major regional capital for the French. As a result, it has most of the same government institutions, language, currency, and educational system, as do other French colonies. Two key distinctions were the preservation of the indigenous monarchy (now purely ceremonial) and recent communitarian reforms under the previous president, Sankara. There are more than sixty ethnic groups in Burkina, but the ethnic group which holds most of the power in the country is the old hereditary monarchy, the Mossi. Another major group is the Fulani, Sahelian pastoralists found primarily in the northern provinces.

There are thirty provinces in Burkina Faso, each with a variable number of districts, townships and villages. The administrative structure is hierarchical, again based on the French model: the central ministry level gives directives which are then more or less implemented farther down the line. Government personnel are transferred relatively frequently at all but the lowest levels in government, which tends to stifle local initiatives.

It is difficult to assess the potential of other avenues (especially agriculture and education) by which health messages might be transmitted. The vast majority of the crops raised in Burkina are either for family consumption or are attached to larger, wealthier areas, where the available water supply fosters the production of cash crops for export. While there is a network of agricultural extension agents, this suffers from similar problems of motivation and methods as do the health and education sectors. One advantage, which is being exploited by FAO, is that agricultural extension agents tend to stay in one location far longer than those in the other two sectors and thus have

a more vested interest in the communities. In terms of the potential of the formal educational sector, however, the impact of the French scholastic pattern is felt early, with rote memorization being the primary teaching device. Literacy rates vary widely from rural to urban areas, and school attendance falls off sharply after elementary school. Many of the project areas which had had baseline surveys reported literacy rates of 6 percent for males, and below one percent for females. Non-formal education methods, targeted at the communities, would have greater impact: if these could be delivered in coordination with the health and agricultural sectors, and via the additional vector of the available pool of schoolchildren (as was the case in the Africare project in Mali), that impact could conceivably be multiplied.

II. ORGANIZATION OF THE NATIONAL HEALTH SYSTEM

Burkina Faso has a centrally organized, hierarchical health system designed to deliver services ultimately to the village level.

There are primary health care centers (poste de santé primaire) each with a catchment area of 7500 villages. Communities of 15-20,000 people have health and social welfare centers (Centres de Santé et de Promotion Sociale), while medical centers are available in regions with a population of 150-200,000. Districts with 400-500,000 inhabitants have access to regional hospital centers (Centres Hospitaliers Rerriens). The capital city, Ouagadougou, and the largest regional city, Bobo-Dioulasso, each have large hospitals. In practice, however, the national health system reaches only about 40 percent of the population².

The health status of young children has been well documented. Levels of malnutrition among children under the age of five are estimated at 40 percent³ in the more arid northern areas of the country, where food shortages appear first. At least seven percent of malnutrition cases are severe. As would be expected in a nutritionally vulnerable cohort of children (one to four years), about 68 percent of child mortality is due to measles and diarrhea, while respiratory infections are the major cause of death for infants under *one* year.

*This figure is the UN estimate. Many of the PVOs report rates around 10 percent in their project areas.

³This percentage includes all three levels of malnutrition. The north is considerably more at risk than the more southern, arable, region of the country. In one village visited, more than half the children attending a health talk were demonstrably malnourished, as evidenced by the malnutrition armbands used by the animatrice. While this was in a very poor district in the north, it was also only a few months after the harvest, when malnutrition should have been at its lowest level.

Surveys conducted in 1984 and 1986 in seven provinces among children under the age of ten found considerable levels of nightblindness (2.36 percent), Bitot's spots (2.15 percent) and corneal ulceration/keratomalacia (0.18 percent), considerably higher than WHO-established thresholds for public health concern. Another survey conducted in 1989 confirmed even higher levels, as nightblindness in particular reached levels of 5.59 percent.. Two of the provinces covered by this survey were also able to report, however, that the prevalence of nightblindness and Bitot's spots had been reduced. A UNICEF/HKI pilot project that distributed VAC up to 1989 was considered to be responsible.

Most observers seem convinced that it is not simply a lack of nourishing food that manifests itself in such high malnutrition figures. There are as well the problems of failure to provide colostrum at birth, widespread premature weaning, inadequate weaning foods and failure to exploit available sources of vitamin-rich foods. Another major problem is feeding practices within families.

Since nutritional deficiencies vary markedly from north to south in Burkina Faso, most efforts to improve nutrition are aimed at the northern populations, which also tend to be more individualistic with somewhat less community spirit. It is obvious, however, that communities do have to work well together in that harsh environment just to survive. New ideas are, nevertheless, less easily received in the north, where some villages have consistently refused even to bring their children for vaccination.

The village level, in principle if not in practice, should have village health workers (**VHWs**) and traditional birth attendants (**TBAs**) trained to provide simple remedies for common illnesses and basic pre- and post-natal health care. While the majority of **TBAs** have received training in sterile methods for deliveries, most have not attended the sessions on pre-and post-natal health care that have been planned for some time. There are village health educators (**VHEs**) who are trained to promote good health practices, but these are mostly project personnel belonging to international or Burkinabe non-governmental organizations (**PVOs** and **NGOs**) and not integrated into the formal health system. It was not clear whether the **TBAs** already had vitamin A information as part of their training, or whether this would be added once the national policy had been approved. The **VHEs** from many of the **PVOs** have included vitamin A information in their training, generally as a result of the VITAP orientations and/or consultancies.

Most of the nutritional blindness occurs in the north, which has chronic food deficits, but it is also necessary to treat and sensitize the people in the southern provinces, where this still occurs. Fifteen provinces (out of thirty) are considered seriously at risk for VAD. **HKI's** original four provinces had VAC distribution and currently manage it correctly, but the other provinces have had problems. The normal procedure for VAC distribution now is for the **NGOs** to contact the Ministry to get information, help and the capsules themselves (the old procedure was to ask UNICEF about them directly). Part of the

Ministry's current interest is that the prophylactic vitamin A works like magic on active Bitot's spots and nightblindness -- it is a sort of silver bullet.

The Ministry believes that the statistical evidence on which it bases its judgment is outdated and/or too narrowly focused. An example is the lack of information on breastfeeding practices, which differ from region to region. Any effort to change and improve these customs must address long-standing practices that have been ingrained in families for generations. One example of this pan-generational education is from the Africare project in Zorgho. The grandmother often insists that the newborn's system needs to be cleansed with a tisane⁴. Since this is usually made with insufficiently boiled, impure water, the child will probably suffer from diarrhea. However, the mother is going to find it hard to resist the grandmother's advice despite having heard messages to the contrary from the village health educator. The status of the messenger and his/her integration into the community play a considerable role in the receptivity of the audience to adopt the message, and providing feasible alternatives to established practices takes time. Concerned observers believe a thorough understanding of the range of such practices is necessary before adequate measures can be developed to counteract them.

According to the Ministry, the exact nutritional status of the population also needs further study in order to articulate an appropriate national policy on nutrition. Such a policy is nevertheless nearing completion and will be finalized after the International Conference on Nutrition in Rome in December 1992, sponsored jointly by FAO and WHO. In general, the Ministry of Health is highly attuned to working with international organizations and welcomes frequent contact and consultation with them, as well as with the many **PVOs** operating throughout the country.

III. HELEN KELLER INTERNATIONAL

HKI has had an intermittent presence in Burkina Faso for the last six years, but has not had a country director until 1991. During that time, the Director had worked with UNICEF, MOH and U.S. **PVOs** on vitamin A activities, in concert with VITAP activities (which were largely managed by VITAP/NY and the cooperating **PVOs**). The current director of the program is Dr. Tetevi Logovi, who had been the **HKI** country director in Niger, and had been responsible for many of the VITAP activities in Niger, Burkina and Mali in the preceding years. **HKI/Burkina** works more with the government and the

⁴A tisane is an herbal tea. The herbs used vary depending on the server's ethnic background and the plants' seasonal availability. While many of the herbs may have some medicinal properties (and their nutritional and medicinal properties have been the subject of a recent study), the danger to the infant is the relative potability of the water used in making the tisane.

ministry level than other **NGOs**, tending to emphasize technical assistance and training, rather than projects at the community level.

HIU and UNICEF have been collaborating on vitamin A activities since 1987, working in conjunction with the Ministry of Health. UNICEF, the Ministry and HKI collaborated on the pilot project as well as on this follow up: it is unusual to have this arrangement. HKI is responsible for training, education and surveys, UNICEF provides VAC and gardening, and the Ministry provides personnel and buildings. The pilot project emphasized training health personnel and trainers: 1500 **VHWs**, 38 trainers and 390 health personnel trained in total. In terms of nutritional education, the project distributed brochures and t-shirts, made a film, conducted cooking demonstrations, taped messages for the radio, etc. During the first project, more than 3 million VAC were distributed to the target group, with about 50 percent of the 0-10 year olds covered.

They completed this pilot project in 1989, and HKI and UNICEF are building on their experiences by extending these activities through MOH personnel to four other provinces not currently benefitting from vitamin A interventions. Its new project will work entirely within the existing health system in eight northern provinces. The training will be for four levels: nurses, regional health personnel, central health personnel and primary health care personnel, including 1400 **VHWs**, 350 health personnel and 64 trainers. They are going to create a central training team of seven people, who will then train the provincial level personnel, who in turn will train those under them. **HKI** plans to backstop the central team as needed and to incorporate an aggressive follow up approach.

This new project will have three components: a VAC coverage in the target provinces, a xerophthalmic prevalence survey in one province (because a baseline already exists in seven of the target eight provinces), and a **KAP** study in the three different ecological zones of the project. The four original provinces of the project are Yatenga, Namentenga, Barn and Sanmatenga. To these will be added Oubritenga, Tapoa, Passore and Soum. Oubritenga will be the site of the prevalence survey; Yatenga/Namentenga, Tapoa, and Soum the three ecological zones for the KAP study. This will mean that of the thirty provinces in Burkina, **HKI** is working in eight.

The target population is threefold: children 6 months to 5 years (of whom there are 237,000 in the various provinces), children 6 - 10 years (**450,000**), and nursing mothers (189,000). In developing the project, the HKI Country Director has been able to include a section on the recommended prophylactic provision of vitamin A in the standard height and weight growth chart for newborns and pre-school children. This will be available for national distribution, and to the PVO community at large, in 1993.

IV. VITAP INTERVENTIONS AND RESULTS

VITAP's mid-term evaluation conducted a thorough review of the types of contacts that VITAP/NY maintains with the PVO community, both in-country and stateside. This type of 'behind the scenes' work of telephoning and networking has contributed in no small measure to the ongoing favorable environment in which VITAP has operated. These contacts are not as easy to monitor in-country as more visible interventions, such as technical assistance or training. It is useful to remember that VITAP is not simply in-country interventions, although those are certainly the focus of this impact assessment.

There are many PVOs working in Burkina, as well as most of the major international donors, organizations, and local NGOs. The assessment team only interviewed those that had had contact with VITAP, either through training or technical assistance, and thus the following list does not convey the complete picture of development assistance in Burkina Faso. It does, however, provide a reasonably complete picture of those entities with which either HKI or VITAP has established formal ties, as well as several strong possibilities for future work.

A. Overall Results

VITAP/NY maintained close ties with the PVOs in Burkina Faso and with their headquarter offices stateside. It is interesting to note that the VITAP activities here have begun again with the least damage due to the funding lacuna, largely due to proactive efforts between VITAP/NY and the PVO community. VITAP/NY had close ties with the PVO headquarters, regularly telephoning them and determining if additional assistance or a specific type of technical intervention, was required. Additional written materials were sent on a regular basis. Whenever possible, visiting VITAP/NY staff would also visit the PVO offices in Ouagadougou for additional follow-up. In addition, the Academy for Educational Development (AED) began a more widespread program of disseminating the flip charts, so that the nutritional messages had a consistently growing audience. It is also possible that the funding lag may have had less effect here because of the duration and stability of the PVO programs in Burkina, as both Catholic Relief Services and Save the Children have been operating since the late 1970s. However, the fact remains that both these PVOs and others with whom VITAP had provided assistance, continued and expanded vitamin A activities in their programs.

VITAP's mandate was to work with U.S. PVOs, which ruled out many of the organizations working in Burkina. Two of the four PVOs described in more detail below have incorporated vitamin A components into their Child Survival projects. The remaining two have incorporated vitamin A into their own nutritional education components, either as part of health programs directly or in conjunction with a community based health education program. Since most of the VITAP interventions

involved two or more **PVOs**, these are discussed as specific activities. The **PVOs'** overall programs and more specific detail about evaluation results are described in Annexes 3 - 7.

One contribution made by the Ministry of Health (MOH) in helping to increase awareness of symptoms and treatment of VAD was their collaboration with the **PVOs** and a VITAP consultant in the development of an illustrated story. They wrote a storyline featuring a mother named Awa with a young child afflicted with nightblindness, and two outcomes on how the family reacts -- one successful, the other not. This story has been widely disseminated throughout Burkina Faso, Mali, and Niger in the form of flip charts. They are now being widely used for many purposes in all three countries, including training village health educators, primary school nutrition education, and as the basis of **dramatic** skits and theater pieces. One of their designated uses, as illustrations in village nutrition discussions, has been a qualified success, although better training in their presentation could make it more effective still.

Included among VITAP's specific achievements are the following:

- o in the space of two years, four **PVOs** (Africare, Save the Children, World Relief and Catholic Relief Services) have made solid commitments to provide information on vitamin A at the community level through project activities and to introduce measures to control and reduce VAD;
- o a total of 45 project staff, as a result of VITAP training, are fully aware of the need to improve consumption of vitamin A-rich foods among their target populations;
- o a total of at least 87 communities have already received vitamin A information from PVO project staff;
- o at least 11 Ministry of Health personnel in a wide variety of fields have participated in VITAP training;
- o the national child growth monitoring chart has been revised to include a section devoted to vitamin A and VAD before the end of 1993;
- o the Ministry has been encouraged to pursue the formulation and implementation of a national nutrition plan that includes a vitamin A component; and
- o VITAP's story line about the family with the malnourished child has been adapted for flip charts used for training health personnel and teaching primary school children. UNICEF plans to distribute the charts to schools.

B. Private Voluntary Organizations

Project Design and Training Workshops.

Save the Children first began vitamin A activities in 1989 with the assistance of a VITAP consultant who helped design a nutrition project to be added to SCF's community development program in the northern province of Seno.

Following this project design consultancy, VITAP provided a vitamin A trainer in 1990 to organize sessions in Dori, the principal city in the province. The two day session for seven SCF health staff members, 12 VHEs and 11 MOH workers included topics on blindness prevention, nutrition, child survival, VAD symptoms, and production of vitamin-rich foods. Discussions were also held on the development of appropriate educational messages and the consequences of the interaction of VAD, malnutrition and infectious diseases in the Burkina Faso context. A list of foods consumed in villages each season by order of importance led to a compilation of the recommended daily intake of nutritious foods.

Gardening Consultancy.

The VITAP training consultancy to SCF in July 1990 was followed in October of the same year by a consultant who was to assist the VHEs to expand and extend dry-season gardening in the northern province of Seno. The consultant's mandate was to assess the current garden component in the SCF project, including its application in SCF's vitamin A program as currently implemented, assisting staff in identifying traditional home garden crops which can be promoted as vitamin A sources, and upgrading staff skills in garden extension techniques.

Twenty people attended the four-day workshop, including four SCF field staff members and 12 SCF VHEs and community development agents, as well as a CREN staff member from CRS. The sessions focused on changing the goal of gardening from market produce to foods necessary for improving family consumption and nutrition. Methods for prolonging traditional family gardens (usually cultivated during the rainy season) into the dry season were discussed, as well as the need to improve preservation techniques and increase the variety of vitamin-rich plants available in local gardens. As a result of the gardening workshop, the SCF staff decided to plant two small demonstration gardens in the office compound to use as training plots for growing traditional vegetables.

Vitamin A Training for World Relief and Catholic Relief Services (CRS)

The purpose of this training, held in Ouagadougou in March 1990, was to increase program staffs awareness of the importance of vitamin A and to provide them with the skills and knowledge to initiate vitamin A activities in the field. World Relief sent ten people whose responsibilities included agricultural activities as well as women in

development. Catholic Relief Services also sent 10 persons responsible for coordinating CREN activities. SCF also sent a health coordinator.

Problem-Solve and Information. Education and Communications (IEC) Workshop.

By 1992, after working with villagers for over a year on nutrition and vitamin A activities, SCF and Africare staff concluded that more training was needed for the **VHEs** to interact more effectively with the villagers on these topics. To fill this need, VITAP conducted a five day workshop in Dori in September for 23 SCF and five Africare **VHEs**.

Outcomes.

The Assessment Team was able to visit village talks at two of the Child Survival projects -- SCF in Dori and Africare in Zorgho -- to watch the performance of the **VHEs** and their interaction with their supervisors. While a comparison of the benefits of the IEC workshop may be faulty based on a one-time observation, it may be worth noting that the Africare project seemed to have benefitted more. The supervisor there better understood the need to use the same techniques learned in the workshop in the follow-up sessions with the **VHEs** during routine in-service reviews. The superior performance of the Africare VHE during the village discussion, her interaction with the supervisor, and vice versa, indicated a high degree of confidence in the use of the new techniques learned at the workshop. This was even though the workshop in Dori indicated that the Africare **VHEs** did not perform as well as those from SCF.

The educational techniques at the World Reliefs institute for community development use the materials developed by VITAP with input from the Academy of Educational Development (**AED**), among others. The flip charts with the stories of Awa have formed the basis for dramas and songs emphasizing the need for vitamin A in a varied diet for children being weaned, as well as pregnant and lactating women. World Relief has, in fact, found that the flip charts used alone were considerably less effective than when reinforced with dramatically presented pieces with live performers. World Relief does not plan to use the flip charts for educational sessions with villagers, but does use them as part of their year-long training (see Annex Five).

On-site evaluations of training effectiveness were possible, if not necessarily comprehensive. The CREN coordinator had participated in the 1989 project design workshop, as well as the 1990 training program in Ouagadougou. The results of her training were very much in evidence (as well as CRS refresher courses and her initial training) in the Koudougou CREN. Growth charts with standard height and weight curves were in use, and each chart had an indication of the last prophylactic dose of vitamin A each child received. Although the clinic primarily served a well-baby population, it has seen cases of malnutrition of varying degrees in about 30 percent of its patients. For this reason vitamin A is administered routinely twice a year in standard

WHO-recommended doses. Children with health problems are followed up at home by the CREN health educator. Usually these children are about one year of age, the usual age of greatest vulnerability to malnutrition associated with improper weaning practices.

The VITAP consultant who conducted the gardening workshop strongly urged that a follow-up session be planned to reinforce the confidence of the trainees. It is unfortunate that this suggestion was not taken up. No gardening activities were reported to the Assessment Team by either SCF or CRS, despite the former's specific plan to put a garden in the staff compound for demonstration purposes.

AED recently opened an office in Burkina Faso. Having had long involvement with HKI and VITAP, this organization has been instrumental in adapting the VITAP story-line on VAD developed with the MOH in Burkina Faso for illustrated flip charts used to train **VHEs**, agricultural workers and for classroom use. **AED** is managing several projects for the national nutritional program, as well as working on non-formal educational methods.

The **PVOs** interviewed saw VITAP as something of a double-edged sword: it focused vitamin A training effectively but at the same time created a bit of 'tunnel vision' apart from the rest of nutrition education. One of the pluses was **VITAP's** willingness to extend the focus to all nutrition education and more generalizable training techniques. This was especially true in the last workshop, on problem solving, and most of the **PVOs** mentioned that the proactive visits/telephone calls from VITAP/NY were the primary reason that they knew about the availability of the training and services. It is also worth noting that the **PVOs** felt comfortable enough with VITAP/NY to schedule this last training session when it was most convenient for the **PVOs'** own workplans, which moved it back several months on VITAP's own internal scheduling.

V. DISCUSSION AND CONCLUSIONS

VITAP activities in Burkina Faso have undoubtedly been beneficial, from CRS and World Relief activities in the south with adequate rainfall, to the parched northern area. As the SCF coordinator in Dori stated, "There is not a woman left in the villages where we work who has not heard of vitamin A." Hearing about vitamin A does not necessarily mean doing something about it, or acting on the knowledge gained. In the Burkinabe setting, there are many constraints working against improvements in family nutrition, not the least of which include generations of traditional practices, like tisanes for newborns and the village woman's crushing workload. The latter seemed more severe in the north and the attitudes of the women attending the session observed during the visit there tended to reinforce this impression. **VHEs** also confirmed this by commenting on poor attendance at their health talks.

A. PVO Constraints in Vitamin A Activities

While data for 1992 are being collected by the SCF staff in Dori, the 1991 annual report suggested that nutritional status had not changed noticeably since the beginning of the SCF project. Part of the reason may be the absence of more direct follow-up with the participants at the gardening and vitamin A workshops, either from SCF's office in the capital city or from VITAP itself. Considering the difficult circumstances under which the project operates, however, it is possible that too little time has elapsed for favorable trends to develop. As one observer noted, it would take at least 10 years to begin to see a change in the nutritional practices and health status of Burkina Faso.

Many of the PVOs were reluctant to begin or restart VAC distribution. The prevailing philosophy was that VAC distribution was not sustainable activity; as such, it gave a mixed message and was not a useful part of nutrition education components. More sustainable vitamin A activities, such as nutrition education itself or gardening, would be more appropriate, despite perceived problems with the previous SCF gardening consultancy.

B. The Potential of the Flip Charts

Certainly a strong beginning has been made in the technical education of a nucleus of project and Ministry of Health personnel. Available evidence indicates that the VITAP training on the role of vitamin A in child and adult nutrition has been understood and efforts have been made to act upon it. Strategies now exist to pass on this information to the general population. Nevertheless, the step from training the staff to changing villagers' health practices and nutritional status does not yet appear to have been made. The story of Awa is a beginning, but at the village level use of the flip charts alone in the hands of VHEs has not been found to be effective by project personnel, especially CRS and World Relief.

In the Seno Province, SCF has used the flip charts in training VHEs, but has no plans to use them for village training sessions because pre-testing there has not demonstrated their usefulness in educating illiterate persons about good nutritional practices. Static images have little impact on the population. Another specific complaint is that the flip charts do not give enough specific guidance for applying the traditional practice of eating liver to counteract nightblindness. There are local flannelographs (designed by GRAAP - Groupe de Recherches et d'Appui à l'Auto Promotion Paysanne; Research and Farmers' Self-Sufficiency Support Group) available from Bobo-Dioulasso which have had more success. This is partially due to the fact that the GRAAP materials are only sold as part of a training package. While this makes them much more expensive than the flip charts, it also means that staff have more of a vested interest in using them. Because the various felt images can be used to create slightly different versions of the same message, and because the VHEs found that this fostered participation (people at the talks could

actually move the bits of felt, and the images were very clear), these are more commonly used. They are extensively used in training the **VHEs**, as well.

The value of these strategies as they stand lies primarily in the hands of teachers and instructors with already literate students, or where they can be used continually over some period of time for illiterate adults, as World Relief does in its community development training. UNICEF plans to have several thousand copies of the flip charts reproduced in Ouagadougou for distribution in schools and other training centers.

All of the **VHEs** have come up with jingles for their talks, but SCF would like to see this used on a national or provincial level and transmitted over the radio. One of the problems with the existing theater groups is that they really do not go out to the village level. There is a strong oral tradition locally, and lots of interest in dramas, especially melodramas.

C. Conclusions

There is no coordinating mechanism in place for PVO inter-communication, although there is considerable social contact among the expatriate staff. Some efforts have been made to institute this type of coordination, but this has been a problem, as no agency has taken the lead in this. One of the most positive developments was Africare's presentation of its mid-term evaluation results to both the Ministry and the PVO community. The PVOs would strongly support additional dissemination, either of evaluations or other monitoring activities.

SCF considered that the IEC training was the most useful of the three trainings because it provided specific skills as opposed to technical information, or the gardening interventions, which were perceived as interesting but not very relevant by the PVO staff. They felt that the gardening training had gone on a little too long, but that the IEC training had not gone on long enough. They would have liked to see more field experiences. They also had problems with the **VITAP** consultant's examples (sewing on a button, playing a game) which did not seem to have much connection with vitamin A activities. It is interesting to note that the PVO staff interviewed had not made the connection that it was the techniques they were practicing, but had instead wanted all of the examples to come specifically from the types of subjects that the trainers and the **VHEs** really use. The PVO staff clearly wanted problem solving to solve their problems, more than to enable them to solve their own, which is not unreasonable.

The PVO to PVO mechanism is extraordinarily useful for providing technical assistance. The PVOs have been able to proceed fairly independently in incorporating vitamin A strategies into their programs once that initial investment was made. That this would also be a cost-effective mechanism is the strongest argument for replicating it elsewhere. The PVOs contributed time and resources (especially per diems for their staff) to the

workshops initially. VITAP bore the cost of the consultants, but this would have cost, at a minimum, five times as much if each PVO had conducted a separate training. The spread effects and ongoing programs, in which the PVOs have invested their own resources, attest to the value of a coordinated training effort.

VITAP TA has been specific, to a specific purpose, for a specific output -- the focus has been very useful, especially in terms of giving a PVO a helping hand. Most useful VITAP interventions have been those that had the broadest focus, especially those that stressed skill development.

VI. RECOMMENDATIONS AND FUTURE STEPS

There are several specific recommendations for future VITAP initiatives in Burkina Faso, mainly regarding VITAP's role as a coordinator for vitamin A activities and as a cost-effective TA provider in the PVO community. These include:

- o designing a system for consistent follow-up training of PVO and Ministry personnel trained to identify VAD and provide follow-up care;
- o identifying nationals able to conduct vitamin A training workshops. The Africare Co-coordinator may be one possibility;
- o promoting cooperation and collaboration among PVOs for more effective use of resources and interchange of ideas on raising village-level awareness of vitamin A requirements;
- o encouraging the Ministry to enhance and extend a reliable, nation-wide distribution system for VAC;
- o designing a more formal coordination mechanism (such as a working group) among the PVOs and international donor community to reinforce vitamin A messages and share information about strategies;
- o consolidating the various echo effects of the flip charts and disseminating them to other PVOs. As further training is apparently needed in their use at the village level, additional applications, such as the skits presented at the SCF and World Relief project sites, may help convey both the message and the training;
- o reinforcing the vitamin A messages at the VHE refresher courses, usually given annually;

- o extending the audience for the vitamin A message by collaborating with the CRS school feeding program and the **UNICEF/HKI** project to the primary schools, possibly through dramatic presentations developed by World Relief or from other VITAP sites in West Africa; and, finally,
- o disseminating successful strategies from other countries, especially those in Niger and Mali, throughout the PVO community.

The story of Awa has been used with apparent success as the basis for dramatic presentations in Niger, at the World Relief-supported CREN in Burkina Faso and in Mali. The VITAP vitamin A trainer in 1990 recommended such an effort for a follow-up workshop in Dori (Seno Province), and more requests to do so were reported from SCF and Catholic Relief Services. There should be an opportunity for SCF, Africare and CRS to work with World Relief on creating such dramatic skits.

Collaboration and more interaction among child survival projects are also needed. Although there are occasional contacts among project directors and other PVO staff, the strengths and weaknesses of each are not analyzed in any systematic fashion. Neither **USAID** nor the Ministry of Health is taking the lead in such an effort. VITAP began a very useful process, but this needs to be institutionalized, perhaps through lead agencies. The Child Survival program at USAID/Mali, where one PVO is designated as the lead agency for a specific group of **PVOs** in one technical area, may be a possible starting point.

One example for improving training techniques would be for the superior training capability seen in the Africare project to be observed by other project coordinators and trainers, as well as by project directors. Coordinating training sessions provides **PVOs** with much more cost-effective options for staff development, and hopefully encourages collaboration among the various **PVOs**.

Planning to ensure the sustainability of the activities they have initiated is being addressed variously by the different projects. However, all the child survival projects visited, and the independently-funded Plan International project, are attempting to set up village committees. The outcome of this similar intervention could be nurtured by providing a forum for the **PVOs** to share their experiences and to compare notes on successful strategies. VITAP might be able to assist in the creation of that type of forum, especially if VITAP's input was specific to the vitamin A strategies that have been used throughout Burkina in health, agriculture and education. The **PVOs** have already demonstrated their ability to apply technical assistance from VITAP in other sectors, and are clearly eager for additional collaborative efforts.

This forum would be a logical outcome if VITAP was able to extend its messages more specifically into new sectors, especially agriculture and education. While these have never been excluded from VITAP's mandate, most of the projects that include nutrition

education have been in health, which has resulted in the concentration of **VITAP's** interventions into that sector. One strong possibility in the educational sector would be to develop a collaboration between the CRS schoolfeeding program and the proposed UNICEF VAC distribution. Another strong possibility for agriculture would be to extend the **VHEs'** talks to include the agricultural extension agents, especially for the Africare project, where there has already been a sizeable investment in well-building.

Most of the **PVOs** interviewed had very specific ideas about what types of technical assistance they would welcome from VITAP. Some of these ideas emphasized the need for a Burkinabe point of view in the training workshops to ensure that practical approaches to problem-solving used in the sessions are appropriate for the local context. **VITAP's** technical assistance in Niger has already benefited from having long-time residents serve as consultants, and using the resources that already exist in Burkina would considerably reduce the lead time required for a stateside consultant. It might also foster collaboration among the **PVOs** if their own staff could be chosen to assist at a VITAP training.

In terms of fostering collaboration, however, there has been one large group previously excluded from VITAP interventions. The resident **NGOs** need to be a part of any new initiative. Future VITAP activities should also include the **NGOs** in the various departments. In addition, many of the **NGOs** base their operations in Ouagadougou, and this would be a perfect springboard for urban VITAP interventions, given that most of the PVO project sites are in rural areas. With the burgeoning rural to urban migration, reinforcing existing capabilities and developing new ones could make a significant contribution to mitigating declining services. A coherent urban model of VAD prevention and control would also be a useful addition to the existing national vitamin A policy.

Most of the **PVOs** have already done KAP surveys at the beginning of their project cycle, and most plan on repeating these at the project's completion. VITAP could sponsor a monitoring and evaluation workshop, drawn from David Rosen's recent work on qualitative indicators. The follow up to this type of assistance would be reviewing the indicators used in upcoming PVO surveys to ensure that both vitamin A prevalence and behavioral changes are appropriately incorporated. Many of the **PVOs** also requested assistance in rapid rural appraisal techniques, primarily to determine if VAC distribution was (still) necessary. The KAP and rapid rural appraisal represent almost polar opposites in terms of complexity, but concentrating on vitamin A would reduce the scope of the workshop. It would, however, give the **PVOs** the type of assistance that they most value from VITAP: technical assistance and skill development at the same time.

Another possibility in terms of monitoring vitamin A behavioral change would be for VITAP to do its own RAP study, focusing on the Awa story, the flip charts and the varied spin-offs throughout the country. This could be done in collaboration with a

planned **AED KAP** study on their nutrition communication project, as a separate initiative, or as part of **VITAP's** final evaluation.

The final recommendation for VITAP concerns the possibility of an in-country presence. While VITAP has done a phenomenal job without an on-site presence, there is no denying that a coordinator would have made follow up easier. It would not be cost-effective for VITAP to maintain a country coordinator for each of the twenty-two countries in which they operate, but there are several other alternatives for coordination. First, VITAP might recruit a regional coordinator, responsible for several countries. This individual could be based in one of the countries where HKI currently maintains an office so that administrative costs could be shared. Another alternative would be to increase the time currently spent on VITAP activities in the **HKI** office, so that the staff person would be readily identifiable as working half-time on VITAP. Still another alternative builds on a **Malian** model, where one PVO could designate one of its own staff as the country VITAP coordinator. While the current situation in Mali is less than ideal, this might be a possibility if the exact terms of their VITAP duties could be defined and compensated.

ANNEX ONE: LIST OF CONTACTS

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Save the Children Federation (Fondation pour le Developpement Communautaire):

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ANNEX TWO: DOCUMENTS REVIEWED

1. Africare: Detailed Implementation Plan (DIP): The Ganzourgou Child Survival Project Ganzourgou Province, Burkina Faso, September 1990 - August 1993. Amelia Duran-Bordier and Phyllis Z. Jones, authors (no date)
2. Africare: Baseline Survey Report Ganzourgou Child Survival Project (Burkina Faso). Amelia Duran-Bordier, December 1991.
3. Africare: Quarterly Progress Report: Number Four October - December 1991. Claudia Williams, May 1992.
4. Save the Children (U.S.): Report on the Baseline Study Executed in April 1991 in 27 Villages of Dori Impact Area, November 1991.
5. **HKI/VITAP:** Trip Report to Save the Children (training sessions and TA: 14 July - 1 August). Anne Paxton, August 7, 1990.
6. **HKI/VITAP:** Training Traditional Home Gardens for Nutritional Improvement (Save the Children, October 5-28, 1990). Tia Rudd, no date.
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8. Save the Children Burkina Faso Field Office: Child Survival 5 Mid Term Evaluation. May 19 - June 1, 1992.
9. SCF-Burkina Faso: Training: Traditional Home Gardens for Nutritional Improvement
10. VITAP Trip Report Burkina Faso (Save the Children). Lauren Blum, October 24-31, 1989.
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12. Rapport de Fin de Mission: novembre 1986 - 31 juillet 1989. Programme Tripartite (Gouvernement du Burkina Faso, UNICEF, Helen Keller International) de Lutte contre l'**Avitaminose A** dans les Provinces du Barn, Namentenga, Sanmatenga and Yatenga. Dr. LOGOVI Tetevi Dodji, 31 juillet 1989.
13. **Projet de Communication pour la Nutrition: Rapport de l'Enquete** de base sur le public, (NUTRICOM/AED), novembre 1991.

14. HKI: A Proposal for Expanding Vitamin A Supplementation and Nutrition Education for the Prevention and Control of Vitamin A Deficiency to Cover 8 Provinces. Dr. David French, 18 December 1990.
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16. FDC/DORI: Surveillance de Croissance Trimestrielle: janvier 92, avril 92, juillet 92.
17. GRAAP: Cheminement Pedagogique.
18. FDC/DORI: Secteur Sante/Nutrition Rapport Armuel 1990-1991, novembre 1991.

ANNEX THREE: AFRICARE

In 1990, Africare was awarded a three year Child Survival project to work in the east-central section of the country. Two project co-coordinators manage a staff of six village health educators and 28 community health workers (CHWs). The project includes vitamin A activities, including VAC distribution, which were to comprise about 10 percent of total project activities. The vitamin A activities only began in 1992 after project staff participated in a VITAP workshop on communication techniques. They now hold talks on the role of vitamin A in maintaining health and child development, with house visits to monitor child growth in 14 villages, reaching approximately 2800 mothers.

A baseline survey undertaken as part of the project design found that on the average 35 percent of the children were malnourished. As would be expected, the cohort most severely affected was the one between 12-23 months. Although children were breast fed an average of 29 months, it was not the usual practice to give colostrum. Despite nightblindness indicators in the baseline (82 percent knowledge, 50.5 percent family experience), consumption of vitamin A foods seemed adequate and the question about the value of the capsule distribution was raised from the original plan of the project. They planned to consult with VITAP during the third quarter of 1991 regarding incorporating this activity.

The project hoped to improve the nutritional status of 2100 women and weigh 75 percent of the children under three years old every quarter by the end of the project in October 1993. The specific result expected was that 60 percent of those weighed would experience adequate monthly weight gain as recorded by the VHE. Encouraging improved breastfeeding and weaning practices, including the provision of colostrum, and initiating growth monitoring were to be the principal nutrition activities in this integrated community development project. Other planned activities included well-digging, gardening, family planning, vaccination, AIDS education and diarrheal control. However, the late start of activities in July 1991 may have compromised project objectives. Africare has nevertheless been active in establishing ongoing relations with villagers by assisting with the organization of village committees. Through an understanding and appreciation of the activities Africare has started, the committees may be able to ensure the continuation of these activities.

The Africare project is located in Ganzourgou Province, Meguet Department, and incorporated 14 villages, or about half the departmental total of 33. There are five active VHEs, each taking about three villages. The village distribution is a function of the distances between the various compounds and the number of their inhabitants. There is a sixth VHE held in reserve for when the other five take leave. There were two refresher courses during September - November 1992 for the VHEs: one for two days, and another for one day. The number of beneficiaries in the target area is 15,700, including women 15 - 49 years old. There are four target groups of children: 0 - 11

months, 12 - 23 months, 24 - 59 months and 0 - 71 months. The last group is for VAC distribution only.

The Ministry of Health and Social Action targeted this province, and **Meguet** was selected based on available statistics that showed very high level of diarrheal diseases. The target area was then selected because it is least served by the local clinic (there are fifteen communities that use this facility, versus five each for the other three clinics in the district. Villages are located quite far apart, which requires transport for the health workers. People are also very busy during the rainy season, so health activities in the area are scheduled to take place during the dry season; with personnel training scheduled during the rainy season.

During the rainy season, agricultural activities are the primary occupation. During the dry season, there are some men who have vegetable gardens, or do some cloth weaving, animal husbandry, small markets, butchering, basketweaving -- but the men basically migrate to Cote d'Ivoire. The women spin cotton thread and do pottery.

There are five basic activities in the Child Survival Project:

- 1) ORT (35 percent), including training, promoting a home-mix, dietary management of diarrhea, and hygiene education;
- 2) immunization (15 percent), including promotion;
- 3) nutrition (35 percent), including distributing scales and growth charts, counselling mothers on breastfeeding and weaning, promote growth monitoring, training in 'good' practices, and training in growth monitoring. Of these activities, 5 percent will be spent on breastfeeding, 20 percent on weaning, 10 percent on vitamin A activities; and
- 4) high risk births (15 percent).

Note that the VAC distribution was to be contingent on TA from **VITAP**: they are still not distributing VAC and are still asking for assistance in a rapid assessment of prevalence. The nutrition education component was scheduled to begin in October 1992, with the big push initially in diarrhea control, growth monitoring and vaccination.

Family registration has been the primary activity of the project, which has taken twice as long as planned because there was still a lot of organizational work. It is now completed, and of the 1472 households, there are 3176 women between 15 and 49 years, and 2504 children 0 - 5 years old.

Africare's other projects in the country include natural resources management, emphasizing reforestation, distribution of **PL480** commodities and integrated agriculture and water projects (in terms of commercial agriculture and also small loans for dam projects). By and large the focus is on the provision and potability of water resources.

ANNEX FOUR: SAVE THE CHILDREN

Save the Children's integrated community development project began in 1977 in Dori in a northern province. Few services exist here for the local semi-nomadic population. There are even very few traditional birth attendants (TBAs). SCF still experiences difficulty convincing many villagers of the value of vaccination for young children. The harsh environmental conditions in this area on the southern edge of the Sahara desert make mere survival difficult, much less a minimal standard of living.

The child survival project fits well with the overall portfolio of integrated community development, which also includes projects in: primarily health care, gardening, credit/cereal banks, literacy, schools, well-building, and irrigation. Overall, health is the biggest intervention in terms of number of villages affected; but they would like to do integrated work in all of the target villages, rather than single interventions.

The current project, begun in 1986, included promotion of credit and savings, well-digging and literacy activities. With the receipt of a five year child survival grant from USAID in 1989, SCF expanded previous efforts and included a southern province, Sapone. They planned to address the issue of infant and childhood mortality by training 10 - 12 literate women as village health educators (VHEs) to promote vaccination and oral rehydration therapy (ORT). These are young women recruited from the area who speak French and Ffulfulde, with a ninth grade education on average. The VHEs are paid by SCF which has provided them with mobylettes for outreach activities. They work in the 49 SCF target villages with a total population of 39,000. One result of this emphasis was registered in the vaccination rate, which had risen from 17 to 38 percent.

The primary functions of the VHEs are to encourage the village volunteer health workers, and promote community development activities, such as ORT training. They also help people get to vaccination days, do growth monitoring on quarterly basis (although that may change to monthly for malnourished kids), visit homes to follow up, and occasionally distribute VAC. This last usually happens at every other weighing for the group between 6 months to 5 years. There is also a mass distribution for women who have given birth in the last two months.

A mini-survey of four villages in Seno in May 1992 found only 21 percent of the children in good nutritional status. While breastfeeding was prolonged, specific weaning foods were absent⁵ or inadequate. Estimated weight gain for a one year period for children under age three was 230 grams. The only CREN in the area had closed and there was

⁵Mothers generally prepared one meal daily, and weaning children ate what the adults ate, rather than some sort of enriched porridge or other food that might be easier for children to digest. The mother's time constraints seemed to be the primary reason for not preparing a separate meal.

no reliable source of VAC. These conditions existed even though project staff had participated in a VITAP workshop in 1990, with the addition of a component emphasizing nutrition and the role of vitamin A in child development. A second VITAP workshop in 1990 addressed the possibility of expanding the production of native vitamin A-rich foods, and a third was held in September 1992 in an effort to address some of the reasons for the failure to make more of an impact on childhood malnutrition.

SCF has noticed some signs of progress, as 70 percent of children aged six months to five years attend growth monitoring sessions, and 60 percent of postpartum women receive VAC. As a result, the project is beginning to ensure the sustainability of the project activities. An effort to organize village committees to help their neighbors with health problems is underway and the few village health workers (VHWs) in the area have been invited to the in-service training for VHEs. SCF believes that developing a strong community interest in health will ensure the continuity of some of their activities. In addition, SCF is promoting a network of credit organizations among villages and creating financial systems, which can reinforce village interaction.

Save used to hold nutrition education workshops for two weeks for thirty women at a time, which would cover the whole range of topics. While there was a tremendous group spirit at the end of the training, it was too long and too burdensome for the women to get away for the entire two weeks. This year, they are no longer using this method (called FODEN, for Foyer d'Education Nutritionelle). Now the schedule of nutrition education is to assign a single subject each month. This allows time for the VHEs to reach all of the women in their target group, as well as the health personnel. Last year, Save paid for the provincial officer to conduct a training of the health personnel from 10 villages in the target area.

There are solid impacts in terms of nutritional change already noticeable: there are fewer mothers who don't know about vitamin A. Mothers give colostrum here, but also, from birth, give the child herbal teas: the water in which those are made not necessarily being potable, which causes quite a few instances of diarrhea. The intervention that they are working on to correct this practice is to train mothers that you give only breast milk to the child for the first four months and that the herbal teas can cause diarrhea (because of the water).

There are few health personnel in the province -- both in terms of infrastructure and in terms of personnel. The project works closely with PEV and also with the provincial health official. An example of this collaborative effort is that the VHEs are directed to announce the schedule for vaccinations and to encourage people to come. They also know from their own records which children need vaccinations (because of the growth monitoring program), and they will go to the individual household to encourage the parents to bring the child for vaccination. Since the value of vaccination is known, there is less resistance to this initiative, especially as the community rarely knows otherwise what the vaccination schedule would be. There are 80 percent rate of mobilization in

cases where the VHE has been able to get to the target population, but there are still problems with the PEV team not showing up as scheduled. But there is a certain community inertia -- even the school figures are the lowest for the country.

SCF is now building up the community health workers (**CHWs**), but the problem is finding functional primary health care posts. Another strategy that Save has inaugurated are the groupement villageois: these are people recruited to work with the cereal banks, small credit activities, health and sanitation efforts. SCF trains them to have parallel and sometimes overlapping responsibilities with the government workers, such as the VHW or the government agricultural extension agent. The final strategy for sustainability has been the development of village health volunteers. After two years, the project has identified the village volunteers, who needed to demonstrate knowledge of the project and enthusiasm for it. There are 73 volunteers in 34 villages, and they will become part of the groupement villageois. They are being taught about social mobilization for the PEV, educational themes, how to use arm bracelets for identifying children at risk⁶, and emphasizing that pregnant women should go to the village midwives, rather than having children at home.

For the problem-solving workshop, new techniques were emphasized, rather than technical information. During an early discussion on specific problems they face in dealing with villagers, nearly a dozen specific difficulties were identified which **VHEs** had not been able to solve. They fell in the following four general categories: (1) villagers' failure to understand the importance of growth monitoring; (2) villagers's failure to understand the need to provide nutritious weaning foods; (3) lack of time to prepare nutritious meals; and (4) lack of villagers' means to deal with food scarcity and child deprivation. It is intriguing to note that only the first two are conditions which the **VHEs** might be able to rectify through nutrition education. And it is not surprising, therefore, that these should be perceived as the villagers' problems, rather than the **VHEs'** inability to convey the nutritional messages successfully. This is not simply a matter of 'peasant mentality', but rather also clearly illustrates where the project needs additional support. The **VHEs** have understood the technical information, but still lack the training to convey this as effectively as possible, especially in the context of the third and fourth problems listed above: the villagers' time and resources.

During the workshop evaluation, it became obvious that this kind of approach, the complete opposite of the lecture style to which the **VHEs** were accustomed, was not easy for them to learn. Only three were able to absorb all the steps necessary to engage their audience in the topics. As a result, the consultant recommended to **VITAP/NY** that a follow-up training take place within six months.

'The SCF staff felt the arm bands were a more effective growth monitoring tool than trying to force the volunteers to maintain the complicated and time-consuming growth monitoring charts.

In terms of additional visual aids, the staff at SCF/Dori was clear that photos or film would have been ideal, but these are the most expensive option of all. Theater and songs would also be useful within the existing sociocultural context, and, in fact, SCF has in fact considered sponsoring a competition for the best story, song or playlet, but this is still in the planning stages. They would also be very interested in new techniques of drying fruits and vegetables.

ANNEX FIVE: WORLD RELIEF

World Relief has an ambitious integrated community development project which includes a year-long training for couples who are chosen by their villages and then return to work with them on improving living standards. This training emphasizes health education, agricultural production and literacy, Nutrition education plays a large part in the health component. Vitamin A-rich foods are emphasized for garden production, since World Relief does not distribute vitamin A capsules outside the CREN. They train 24 couples a year during this activity, which takes place in Dedougou, one of the more fertile regions of the country. The couples receive a financial stipend from World Relief.

World Relief supports a CREN whose coordinator attended the VITAP workshop. VAC are only provided at the CREN. Mothers receive nutrition education there and at home during follow-up visits by the VHEs. The staff actively encourage women who bring their malnourished children to the clinic to plant dry-season gardens. A specialist on their staff works with women in their homes during follow-up visits to increase home cultivation and consumption of vitamin A-rich foods. The World Relief CREN also keeps acutely ill children at the clinic until they are well enough to return home. Since the mother stays as well, there is ample opportunity to hold educational sessions, using the Awa flip charts in sessions with these women on health education, nutrition and vitamin-rich foods for home gardens.

The CREN uses both theater and role playing, both drawn from the storylines in the flipcharts. The drama has had more success because it is more active, the women recognize the players and understand the contexts better. They have even gone on a tour of the surrounding villages with the plays, which are acted by the VHEs and members of the villages.

The educational techniques at the World Reliefs institute for community development also use the materials developed by the Academy of Educational Development (AED) for VITAP. In addition, World Relief staff in Ouagadougou had two half days for training in using the flip charts and participated in the design phase. More recently, both Peter Gottert and Christian Stengel have asked them about use and problems. The staff said that they had found that the flip charts were too long and involved for the talks given at the CREN, but that they worked very well with the women at the agricultural center, who have had longer and more intensive training in their use.

The flip charts with the stories of Awa have formed the basis for dramas, theater pieces, and songs emphasizing the need for vitamin A in a varied diet for **children** being weaned, as well as pregnant and lactating women. World Relief has, in fact, found that the flip charts used alone were considerably less effective than when reinforced with dramatically presented pieces with live performers. World Relief does not plan to use the flip charts for educational sessions with villagers.

ANNEX SIX: CATHOLIC RELIEF SERVICES

The CRS site of Koudougou is in the southern part of Burkina Faso. This is one of the more productive areas of the country for agriculture and is the center of diocese activities in that region. One of the major differences between CRS and other **PVOs** in Burkina is that its project area reflects ecclesiastical structures, rather than secular governmental ones. As a result, the diocese extends into four different provinces, but does not completely blanket the area. Another, parallel, difference is in the staffing and funding of the varied development activities. Rather than being dependent on government or multilateral funding, most of the ongoing expenses are paid by the staffs home churches, which support missionary work.

CRS also works in their school activities with **USAID's PL480** program, which provides food for schoolchildren. The school feeding program is the major activity for CRS. This which covers all 30 provinces, including 1,500 primary schools, distributing 14,000 tons of food to 350,000 children. They would have been interested in coordinating a VAC distribution with this population.

Catholic Relief Services operates its health program in the diocese of Koudougou and supports a network of nine clinics for the rehabilitation of malnourished children (CRENs). These facilities provide well-baby care as well as special care to cases of severe malnutrition among young children, Excellent record-keeping of height and weight charts for each child immediately signal if there is a developmental problem. Vaccinations and other standard well-baby practices are followed. As a result of 10 CREN staff and clinic personnel attending a VITAP workshop in 1990, vitamin A capsules are provided twice a year routinely to children under five because CREN staff see malnutrition in about 30 percent of the children coming to the clinic. There is a charge of CFA 25 (about 10 cents) for services.

The health project was scheduled to last for three years, but it has been slightly extended to go until May 1993. They expect to have an assessment in January 1993 which will determine if the project will be extended for several more years. The staff thought that it would probably be funded again, and possibly extended to the diocese of **Fada N'Gourma**.

The diocese staff report that the population growth in this area has led to quantum leaps in the numbers of children they serve. At the Koudougou CREN, an extension to their building is being constructed in order to serve better the nearly 700 children brought monthly to their clinic.

The CRENs are usually busy in the mornings, rather than in the afternoons. One of the extra activities they have been considering is income-generation so that the CRENs can be made self-sufficient, but this is still at the research stage.

Despite the careful recordkeeping at the CREN, no statistics are kept at the clinic to show the results of these activities. They are sent to the provincial Ministry of Health statistical office for data collection and analysis, and incorporated in provincial reports to the central office in Ouagadougou. Given that the diocese and the government do not have the same administrative divisions, this raises some additional concerns about the utility and use of the data collected.

The flip charts have been available, but there was no training in their use. They are used in the health talks at the CRENs, together with other visual aids, especially the flannelographs (GRAAP). They also developed a guide for conducting the talks that provided instructions pictorially. Each year the staff holds a refresher course in the use of the various visual aids, technical information and materials development.

Most of the nutrition education is conducted at the CRENs, but there is some that takes place in the home, mostly to follow up on children as well as to determine the actual practices being followed. Children are brought to the CRENs when a problem is identified; now there is also a health committee in the parish that can urge families to bring the children in and to treat the condition as a health problem.

Catholic Relief Services, with its more clinically-based activities, has not used the Awa flip charts for educational purposes, although the interest in doing so was specifically expressed. CRS would like to request VITAP's assistance in training its staff to use the flip charts.

ANNEX SEVEN: PLAN INTERNATIONAL

Also known as Foster Parents in some countries, Plan has a comprehensive community development project much like SCF. It does not have a Child Survival Grant from **USAID/Burkina**, but they do in other countries. VITAP has worked with Plan in the USA and in other countries, but not yet in Burkina Faso.

Plan manages a broad spectrum of activities in a northern province. These include well-drilling, promotion of vegetable gardens, growth monitoring of young children, and nutrition education. **VHEs** and MOH personnel have been trained in nutrition education and communication techniques to work with local populations. Many of the activities have been designed to foster sustainability through the formation of village committees.

Growth charts have been translated into the local language, and data collected and subsequently analyzed. Women are encouraged to follow and understand the implications of their children's health records. Plan also has a literacy program in the local language and uses the growth charts as an example of practical benefits of literacy training.

The nutrition program includes education, growth monitoring, well-drilling and a program for women's vegetable gardens in conjunction with the wells. The staff at Plan have noticed progress in nutrition education for women, as well as in the growth monitoring and gardening activities, but all of this is limited by the economic situation of the villages.

The wells program has been in existence for almost ten years, although nutrition education has only been part of this program for the last two. Green leafy vegetables and beans are produced along the lake area in Barn, where there is a large irrigation project. The villagers know that these are foods that will help prevent nightblindness, but instead produce them for sale and/or export. The economic situation in the villages does not permit purchase of other than subsistence foods.

Plan created village volunteers in the target areas, 5-10 in each village responsible to train mothers. They also set up training for village health educators and MOH personnel in nutrition education and communication techniques. They made contact visits in villages where they had installed wells, and then trained the subsequent cadre of volunteers in growth monitoring and nutrition education for mothers. Training manuals and materials have been translated into Moore. Plan has also been conducting a parallel literacy campaign among women for the last seven years. In general, the volunteers are literate women, with regular follow up from the village health educators so that they are not left unsupervised or unsupported.

Because Plan places so much emphasis on achieving sustainability, it has not actively sought to participate in short-term solutions like VAC distribution. Its hopes for lasting effects lie in the formation of village committees that would be responsible, after Plan leaves, for various aspects of village welfare, including the good health and nutritional status of residents. There was some interest, however, in participating in a VAC distribution program in the near future, particularly for acute cases of vitamin A deficiency disease.

ANNEX EIGHT: UNICEF

Having completed a joint pilot nutrition project in 1989 with HKI that included vitamin A activities and VAC distribution, UNICEF now plans to extend these activities to four more provinces not benefitting from vitamin A interventions. This project will work entirely within the existing health system by training provincial health trainers, nurses, midwives and 1400 village health workers (VHWs). Activities will include distribution of VAC, nutrition education and communication for villagers, and efforts aimed at increasing local production and consumption of vitamin A-rich foods.

According to the UNICEF nutrition director, the pilot project demonstrated the need to work on long-term solutions to eliminate nutritional deprivation. Improved gardening methods, thought to be the primary activity for reaching that goal, have failed to catch hold because new foods were introduced to villagers who labeled them “for the rich”, and not for the ordinary person. The Director reported a greater need to meet the villagers on their own terms with agricultural techniques and training methods based on village resources and village knowledge of their environment.

UNICEF usually prefers, as the first step in improving the environment, to dig a well and install a pump. With a secure water supply, many possibilities are opened up, including the expansion of the growing season for kitchen gardens. UNICEF has had success with water projects by establishing village committees to supervise the wells and working with them to maintain the pumps. Small fees are sometimes charged users to avoid waste and overuse.

In discussing the new project, the UNICEF nutrition director emphasized the need to educate villagers on nutrition and health in the context of their own experiences. In his opinion the oral tradition among mostly illiterate people needs to be addressed with songs, skits and puppet shows that dramatize the issues and illustrate how to deal with them effectively. For this reason, he expected that the flip charts would have a limited role in village-level education programs. There are currently five flip charts - the first two were developed by VITAP, CRS, World Relief and the MOH and the subsequent three were developed by AED and the MOH. UNICEF does expect, however, to distribute them in schools and to agricultural workers to assist them in improving their discussions on production of nutritional foods.

The problem seems to have been in integrating the health message with the agricultural one; but the fundamental problem is that the project still includes enormous amounts of time and resources for trickle-down training (formation en cascade) This means that they still start out spending lots to train the ministerial and provincial level people, and then provide progressively smaller amounts of time and resources for each of the lower levels in the health system.

Because UNICEF has few project staff and is limited in Burkina Faso to working directly with the MOH, there will be difficulties in providing village populations with educational programs on vitamin A. The MOH has no provision for village health educators in its staffing pattern. Project activities may also rely on Agriculture Ministry agents who are continually in direct contact with local populations and who have already been involved in **FAO's** vitamin A initiatives. The UNICEF nutrition director was convinced that 10 years is the minimum necessary before a reduction in malnutrition levels becomes apparent. For the foreseeable future, he believes that systematic VAC distribution will be necessary to reduce morbidity and mortality among young children in Burkina Faso.

ANNEX NINE: FAO

FAO believes it has had good experience in introducing gardening techniques for vitamin A-rich foods as a result of a pilot project now going on in the same area where HKI and UNICEF have planned their project. With an emphasis on dry season gardening based on foods native to the area, FAO was able to involve agricultural extension agents, teachers and local officials in training **VHEs** to work in essentially all the villages within a **45-kilometer** radius of their project site. Although the project was directed toward women who are mainly responsible for these gardens, men have also adopted the same methods and have added to food production. At local clinics, as well, some nurses have put in such gardens and used them to demonstrate to mothers the value of the foods produced. They have also made contact with schools to start gardens using these types of vegetables.

Some of the problems encountered include improper food preservation techniques. Drying methods using sunlight in particular need to be changed to reduce vitamin loss. Nevertheless, FAO believes that real sustainability of this project has been achieved because of the number of agricultural workers involved who will remain there, and because the United Nations Development Program (UNDP) is expected to work with FAO to include a similar garden component in its new five year project.

The **VHEs** were recruited specifically for this project, but at the same time, FAO also trained the agricultural extension agents and rural development people. This meant that there would be other avenues for the message about vegetables to get through to the village level.

FAO has a pilot project for the production and consumption of foods rich in vitamin A. This project is complemented by the regional rural radio project which VITAP helped FAO to develop. Most people know about vitamin A rich foods, but there is still a lot of work to be done in getting people to eat them (when they can be sold, and when they are perceived as being eaten by foreigners). This is in the province of Nanmetenga, which was chosen because the people there neither produce nor consume many foods rich in vitamin A. The project is scheduled to run for two years. The project has also had technical assistance from VITAL and UNICEF at some level, mostly in terms of following up on the mid-term evaluation of this project, which was just recently completed. One key finding was that the improved gardening methods, thought to be the primary activity for reaching the goal of sustainability have failed to catch hold because new foods were introduced to villagers who labeled them “for the rich”, and not for the ordinary person’.

‘During the course of the FAO interview, the project manager related the following case. Bell peppers in French are poivrons, but in the target areas, the villagers called them piments blancs. This literally means ‘white peppers’, referring not to their color but rather to the group of people who would eat them.