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HELEN KELLER INTERNATIONAL

ASSESSMENT OF THE VITAMIN A TECHNICAL ASSISTANCE PROGRAM (VITAP)

ANNEX 8. NIGER COUNTRY REPORT

November 5 - 13, 1992

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Helen Keller International
Vitamin A Technical Assistance Program
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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 to join HKI 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, its PVO collaborators and USAID 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 Niamey, Niger. The methods used were interviews with the PVO and international donor communities and an exhaustive document review. Field visits were not possible due to time and distance constraints.

Niger has had a long and fruitful association with Helen Keller International. The Ministry of Public Health is committed to the prevention and eradication of blindness, both those caused by nutritional deficiencies and by diseases. The national level includes two discreet working groups on nutrition and vitamin A, as well as a national program on blindness prevention. HKI is well-known for its technical expertise in blindness prevention and has been a frequent collaborator with the Ministry on these issues.

Helen Keller International is also recognized in the PVO community as the lead agency for blindness prevention and for related technical assistance. USAID has funded four projects with Helen Keller International over the last five years, including the Vitamin A Mini-Project, a Primary Eye Care Project and an Onchocerciasis Project. HKI has also recently received funding for a Vitamin A Project. HKI has also played a role in training Peace Corps Volunteers in nutrition and vitamin A activities.

Niger has received technical assistance from VITAP since 1989. VITAP has thus far assisted primarily two agencies (CARE and Africare) to conduct a total of five workshops to educate project staff and to train trainers and supervisory nurses on the district level. Both project staff and Ministry personnel attended 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. In addition, Africare also benefitted from a project design

consultancy to include vitamin A activities after the consultant was able to convince the then Director of the presence of clinical symptoms far above WHO's basic indicators.

Specific impacts of VITAP's initiatives include, among others:

- o at least one PVO, and possibly two, have made a commitment to begin vitamin A activities on a regular basis;
- o a total of 117 health personnel attached to CARE and Africare projects have participated in vitamin A training workshops;
- o almost 250 participants attended a one-day seminar on vitamin A sponsored by CARE in Zinder;
- o dramas of the Awa story have been videotaped; and
- o Peace Corps Volunteers working on health are being trained routinely to conduct VAD surveillance as a result of a VITAP initiative.

Additional VITAP impacts, in conjunction with Helen Keller International's on-going programs in Niger, are:

- o the Ministry of Public Health has a nutrition policy that includes the need for vitamin A interventions; and

- o international organizations, including FAO, UNICEF, and WHO are actively pursuing the integration of vitamin A activities in the programs as a result of VITAP having raised the issue of the need for vitamin A initiatives in the country.

VITAP/New York has been instrumental in providing on-going support for VITAP activities in Niger, creating a near constant flow of information. The initial two consultancies to Niger were based on initiative and probing from the New York office. A constant comment from the PVOs was on VITAP/NY's responsiveness to requests for technical assistance and/or information.

Both PVOs with which VITAP has worked have recently been awarded AID Child Survival Grants. In the case of Africare, this will mean that its target area will expand to three additional districts in Diffa. Given that three separate workshops have been provided to health personnel attached to this project, VITAP should aggressively follow up on the location and performance of those staff members. If the trained staff are no longer posted to their original sites, VITAP should consider a second wave of new staff training in vitamin A activities and nutrition education techniques if these can then be institutionalized into Africare's own staff development.

One of the drawbacks to the training for both PVOs was its brevity, and the subsequent absence of more direct, on-site, follow up to the training. As in the Africare training, evaluation forms were distributed at the completion of training, but this is not sufficient

to determine if the information has been understood, is being accurately disseminated, or if the target population is being served. VITAP should assess the training needs very precisely so as not to fall into a continuous cycle of retraining, and should incorporate a monitoring function to follow up on any additional training activities.

It should also be mentioned that both of these Child Survival programs emphasized diarrheal disease control and growth monitoring, often despite stated project goals to address other nutritional issues. VITAP's training program provided both new educational techniques and new technical information (on vitamin A) that could be attached to existing project infrastructure (i.e., the village health educators). Combining two different types of information made the VITAP training more generalizable, which the PVOs valued.

The national health system in Niger is a definite confounding factor in determining any impact that VITAP has had, as the Ministry transfers its personnel frequently. These transfers prohibit establishing loyalties, and inhibit individual initiative. Many of the Ministry health personnel have participated in project-funded training, and, when they are transferred, they may or may not incorporate that training into the activities of their new post. Projects must generally keep training the Ministry staff that have transferred into the project area. As a result, many projects get trapped in a never-ending cycle of seminars and workshops, rather than on supervising outreach activities.

If the national health system is a confounding factor, the international donor community is a resoundingly supportive one regarding vitamin A activities. While working with the UN agencies is outside of VITAP's mandate, the positive environment in which VITAP has operated can be attributed both to increasing pressure to incorporate vitamin A elements into ongoing programs (such as the Expanded Program of Immunization) and to the groundwork laid by Helen Keller International.

In a more general fashion, VITAP can continue to foster this positive environment in several ways:

- o urge PVOs and international organizations to collaborate with information sharing and through working group participation;
- o develop guidelines for VAC distribution within and among the development community: this should include the development of VAD indicators, training personnel in their use, and follow up;
- o encourage the ministry to work with international agencies to ensure a reliable, nation-wide distribution system for VAC, as well as reliable VAC supplies;
- o extend the collaboration between FAO and HKI to other PVOs to determine and disseminate efficient methods for increasing production and consumption of food rich in vitamin A (especially dark green leafy vegetables);

- o design 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 investigate the possibility of introducing the Awa flip charts for training health personnel on nutrition and vitamin A, as well as use in primary school classrooms;
- o encourage a review of record-keeping systems for obtaining health and vitamin A information to monitor project progress;
- o design and implement a strategy for routine follow-up training for personnel working on vitamin A activities, possibly extending this into a tracking system;
- o develop a national plan for VAC distribution in famine mitigation;
- o extend the VITAP interventions to the NGO community, especially in the urban areas;
- o integrate vitamin A training into the agricultural and educational sectors; and, finally,
- o identify nationals able to conduct vitamin A training workshops, as well as other local resources in the PVO and health communities. This would foster future cost-sharing activities.

VITAP's role in Niger has been hampered by the gap in funding which curtailed much of VITAP's in-country activities for differing lengths of time after the midterm in the spring of 1991. Momentum created as a result of the five early training workshops in 1989 and 1990 will need to be revived for future VITAP activities to succeed. A positive step in this direction has been taken with workshops in the latter part of 1991 and the spring of 1992. There is optimism that, because of the perceived value of the previous VITAP inputs and the favorable development climate for vitamin A activities, that the initial momentum can be easily regained, especially by extending the Awa messages to the education and agricultural sectors.

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ACRONYMS

AED	Academy for Educational Development
AID	Agency for International Development
CFA	Communauté Financielle Africaine; currency unit exchanged at an average rate of 250CFA to U.S. $1.00 in November 1992
CM	Conscription Medicale; Medical Center
DR	Dispensaire Rurale; Rural Dispensary
EPI	Expanded Program for Immunization
ESV	Equipe de Santé Villageoise; Village Health Team
FAO	Food and Agriculture Organization
GON	Government of Niger
HKI	Helen Keller International
JNSP	Joint Nutrition Support Project
MCH	Maternal and Child Health
MOH	Ministry of Health
MPH	Ministry of Public Health
NGO	Non-Governmental Organization[1]
PCV	U.S. Peace Corps Volunteer
PVO	Private Voluntary Organization
TA	Technical Assistance
TBA	Traditional Birth Attendant
UNICEF	United Nations International Children's Emergency Fund
USAID	AID mission
VAC	Vitamin A Capsule
VAD	Vitamin A Deficiency
VHE	Village Health Educator
VHW	Village Health Worker
VITAL	Vitamin A Field Support Project
VITAP	Vitamin A Technical Assistance Project
WHO	World Health Organization

[1]For the purpose of this analysis, NGO is used to mean a local organization, sponsored and supported by Nigeriens. PVO is used to refer to the U.S. international development community. This usage was an arbitrary decision, made for clarity in the report.

I. COUNTRY INTRODUCTION

Niger was part of French West Africa, a colonial heritage that still manifests itself in many facets of its governmental organization, as well as language and currency. It is West Africa's second largest country, approximately twice the size of Texas. In 1990, Niger's population was estimated at 8.2 million, with an annual growth rate over 2.5 percent. It is typically Sahelian in terms of climate and resources, subject to periodic droughts and pests. The critical nature of the food deficit here, and Niger's central location, has meant that several international organizations which focus on famine prediction are based here. While this has meant advance warning in famine years, the limited resource base for the government prevents either more sustainable national efforts or large-scale capital improvements, such as irrigation systems. Niger experienced a boom in the 1970s when the price of uranium ore skyrocketed, and most of the capital improvements in the country date from that time. There has been little capital investment since then, given that the price for uranium ore has relapsed and lacking any other mineral or natural resources to replace that as the primary source of revenue.

There are seven departments in the country: Agadez, Diffa, Dosso, Maradi, Tahoua, Tillabery and Zinder. Agadez is the only northern department, and the rest of the departments divide the southern third of the country. Most Nigeriens live in the six southern departments, unevenly divided into rural and urban populations. This southern region has traditionally been the most arable, watered by a 500-kilometer stretch of the Niger River and its tributaries. Niger is no longer self-sufficient in food, and many of its younger men leave in a labor migration for several months each year, which brings back necessary money to augment the family's food supply (through purchase) and to prepare for the next agricultural cycle. The northern two-thirds of Niger is increasingly inhospitable, due both to desertification and political insurgencies from the nomadic population. As a result, most of the development activities in the country have relocated to the southern third, which has resulted in a greatly increased concentration of PVO and government resources.

II. ORGANIZATION OF NATIONAL HEALTH SYSTEM

The health system in Niger is organized like a pyramid, with the base representing services designed to reach local communities throughout the country. The national health system is divided into the seven regions (departements), which are then further divided into 35 districts (arrondissements). Each district then subdivides its health care into three additional levels: medical centers (conscription medicale, CM), rural dispensaries (dispensaires rurales, DR), and village health teams (equipes de santé villageoise, ESV). The DR and ESV levels are filled by community volunteers.

The dispensaries cover a number of villages, and supervise village health teams, consisting of a traditional birth attendant (TBA), or matrone, and a village health worker (VHW), or secouriste. Even though they are generally illiterate, these health workers have, in principle, attended a two-week training course, followed every two years by a 10-

day refresher course. All government health services have previously been provided free of charge on every level, and village health teams receive no salary from the state, although this policy is now starting to change. The TBAs have traditionally relied on the gifts villagers have given them for services, a custom that continues. Since the secouriste is a relatively new category of health worker, compensation for services is less certain, but still generally expected.[2] A major problem with this arrangement is that men typically leave the villages to find work on a seasonal basis, and because there are often insufficient resources in the villages to compensate the secouriste, it appears likely that there is, for the most part, only the TBA in the village. Without adequate supervision, most illnesses undoubtedly receive little or no treatment.

Throughout the country, health services reach just over 40 percent of the population[3]. One indicator of the general level of health coverage is that the ratio of doctors is 1.3 per 100,000, while the ratio of nurses is 22 per 100,000. Even these figures are somewhat deceptive, however, as there is a much greater concentration in urban areas (especially in Niamey) than in the rural areas. Most of the rural population goes either to the rural dispensaries and the VHWs for Western medical services or to the traditional healers.

Islam has played a major role in forming the social characteristics of village life in Niger, with the result that the marabouts, or traditional religious figures, are also an important part of the local health resources. Many mothers, unable or unwilling to travel to the dispensaries, rely on the marabouts for charms and treatment of diseases. PVO or MOH health activities can be perceived as undercutting these religious authorities, not only by the marabouts, but also by the villagers themselves.

A major drawback to the health system is that personnel from the dispensary level on up are frequently transferred from one position to another, sometimes after only one year at post. Health personnel who receive training for project activities (such as vitamin A, child survival, EPI or others) are likely to move on and are soon lost. One additional constraint has been the lack of operating costs to maintain outreach services (such as gas or repairs for motorcycles), which results in very little supervision and/or follow-up of village health workers. Moreover, with supervision and in-service training at a minimum, it is difficult to assess the outcome of the training or whether new information is being accurately and effectively disseminated. There is a new initiative, largely at the

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[2] The secouriste was a new position, created in the mid-80's as part of a USAID project. At the time, it included a cost-recovery aspect, which has apparently been dropped in the continued iteration of this function across projects and throughout the government's implementation.

[3] Many of the PVOs, however, have found coverage rates closer to ten percent in their target areas.

instigation of the World Bank population project, where health personnel will sign a three-to-five-year contract. During that time, they will not transfer from that location.

The need to improve nutrition in Niger is well documented and recognized in the Ministry of Health, which has a division head responsible for improving nutritional status in the country. USAID has also provided an on-site nutrition advisor at the Ministry to assist with planning, coordinating and evaluating activities. The final draft for the national nutrition plan is on hold until after the international conference on nutrition in Rome in December 1992: the draft will probably be extensively revised to accommodate any new directions. There are no existing national strategies for nutrition, except what the individual programs have developed. This means that the ministry health personnel are less likely to include vitamin A information, given that it is not yet an 'official' policy. Most observers believe that VAC will need to be distributed for the foreseeable future. One strategy the Ministry of Health hopes will improve the country's health status is a strategy proposed by the Bamako Initiative. This emphasizes cost recovery for goods and services in some combination, and is predicated on what the market will bear. Health programmers hope that a new strategy of charging small amounts for basic medicines will encourage pharmacists and health workers to provide villagers with such items as vitamin A capsules, iron and iodine pills. Health workers would also have more incentive to improve their work and widen the coverage of their services if some remuneration were received as payment of fees.

There is currently no national policy on the two WHO directives regarding vitamin A. The first of these is the prescription of vitamin A for measles, and the second is the integration of vitamin A into EPI (Expanded Programs of Immunization). Without these directives being approved by the General Secretariat, there will be no regional or ministerial guidelines for vitamin A use and distribution, nor would HKI be able to incorporate these initiatives in the ongoing ministry health programs. As a result, vitamin A information has not filtered to either the dispensary level or their district administrators, except via PVO personnel. While vitamin A interventions are taught at all levels, there is little indication of the impact on the village health team, except insofar as more VAC are required each year.

The Ministry drafted a nutrition policy in April 1992 which includes recommendations for diagnosing, treating and preventing vitamin A deficiency disease. WHO guidelines and indicators have been followed to determine the extent of vitamin A deficiency disease. Vitamin A capsule prescriptions are also recommended for "all infectious diseases with fever" and families are encouraged to consume vitamin A-rich foods. Finalization of this document is scheduled for early 1993 after the International Nutrition Conference in Rome in December 1992. An implementation plan will also be worked out at that time. Because of the many food taboos in Niger associated with traditional rites and customs, education and counseling will have to be a major part of any strategy to improve nutrition among the general population.

III. HELEN KELLER INTERNATIONAL

Niger has had an HKI office since the late 1980s, and HKI is well-known in the PVO community as an important source of information and technical assistance on any matter related to eye care. Over the last four years, HKI has managed three USAID or AID projects: Primary Eye Care Rehabilitation, the Vitamin A Mini-Project, and VITAP. In addition, two new activities are just beginning. One of these is an Onchocerciasis project and the other is a Vitamin A project. This latter builds on the experiences of the Vitamin A Mini-Project.

The Vitamin A Mini-Project is a pilot effort with the Academy for Educational Development (AED) to build upon the ideas and outputs (such as the flip charts) from VITAP and other, similar, non-formal methods. This has attracted considerable attention and enthusiasm, both from the USAID nutrition advisor and the PVO community, much of it generated by a video of impromptu skits put on by villagers. One of the important changes in the mini-project that made it different from other initiatives was the formation of a five-person village training committee that would take the lead from the health cadres in training people in the village. This has been extended in the new Vitamin A Project. They plan on working in four districts of Maradi: Guidan Roumji, Aguie, Marahi and Dakoro, and in four districts of Tahoua: Birni N'Konni, Madaoua, Bouza and Illela. The planned activities are in the areas of VAC distribution, nutrition education/social marketing, training, integrating capsules with EPI program, monitoring and evaluation. The target population is children 6 months - 6 years old, of which there are about 376,808 in the eight districts. Of the 201 people in the health services throughout the eight districts, 62 have already been trained during the mini-project.

The plan of action calls for building on these existing activities and stresses the coordinating role of HKI with regards to vitamin A activities undertaken by UNICEF, FAO, EPI program, and WHO.

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. Although these contacts are not as easy to monitor in-country as more visible interventions, such as technical assistance or training, VITAP reports show that Niger received among the highest volume of packets and other documentation. It is useful to remember that VITAP is not simply in-country interventions, although those are certainly the focus of this impact assessment.

VITAP sponsored five workshops and several TA sessions in Niger between 1989 and 1992. Beyond this fairly bald description, however, is VITAP's considerable involvement in vitamin A activities within the PVO community and the role that VITAP/NY has played in supporting these training and outreach activities.

In July 1990, a one-day orientation session on vitamin A deficiency disease was held at the HKI office in Niamey for representatives of CARE International, PRITECH, Africare and USAID by the HKI Country Director at that time. This workshop started the process of organizing VITAP activities in Niger through CARE and Africare, with funding from USAID for Child Survival projects.

VITAP's principle beneficiaries in Niger have been Africare and CARE International. VITAP has thus far assisted these two agencies by holding a total of five workshops to educate project staff and to train trainers and supervisory nurses on the district level. They attended sessions on the symptoms of vitamin A deficiency disease, distribution of vitamin A capsules, including social marketing, the role of nutrition in infant and childhood growth, techniques of monitoring growth, and the identification of sources of vitamins and minerals in the foods already available in their environment.

VITAP/NY provided two initial consultancies, which resulted in the subsequent training workshops. In addition, VITAP/NY has been the long-distance manager for most of VITAP's lifespan in Niger, maintaining a steady flow of information and training materials to the field. They have managed to keep alive the interest in vitamin A activities, either directly through their PVO contacts, or indirectly via their support of the Mini-Project (which uses materials created as part of VITAP).

A. Overall Results

Specific impacts of VITAP's initiatives include, among others:

- at least one PVO, and possibly two, have made a commitment to begin vitamin A activities on a regular basis;
- a total of 117 health personnel attached to CARE and Africare projects have participated in vitamin A training workshops;
- almost 250 participants attended a one-day seminar on vitamin A sponsored by CARE in Zinder;
- videotaped dramas of the Awa story; and
- Peace Corps Volunteers working on health are being trained routinely to conduct VAD surveillance as a result of a VITAP initiative.

Additional VITAP impacts, in conjunction with Helen Keller International's on-going programs in Niger, are:

- o the Ministry of Public Health has a nutrition policy that includes the need for vitamin A interventions; and

- o international organizations, including FAO, UNICEF, and WHO are actively pursuing the integration of vitamin A activities in the programs as a result of VITAP having raised the issue of the need for vitamin A initiatives in the country.

These results are further elaborated upon in the remainder of the assessment, together with brief descriptions of the interventions themselves. A more complete overview of the PVOs' programs can be found in Annexes 3 - 7.

B. Private Voluntary Organizations

Project Design Consultancy: Africare

Africare representatives in Niger were first briefed on vitamin A deficiency disease by the HKI Country Director, who spent 20% of his time as the VITAP Coordinator, in July 1990. Africare's interest in VAD was reportedly more stimulated, however, by a VITAP consultant's invitation later that year to the Africare Director to investigate the possibility that VAD may have become a serious public health problem in Niger. Both the Secretary General of Health in the MOH and the Africare Director had expressed doubts to the consultant that there was enough evidence of VAD in Niger to warrant the distribution of VAC for both preventive and curative purposes.

A 1989 nutritional survey for Africare in the Department of Diffa in connection with its Child Survival Project had not addressed the issue of VAD, despite existing evidence that malnutrition had become an urgent national health problem. Some measures had been started to counteract possible 'sub-clinical' symptoms of VAD that stressed long-term solutions, such as nutrition/vitamin A education and vegetable gardening to promote production and consumption of high B-carotene fruits and vegetables.

The VITAP consultant cited three studies from 1986, 1987 and 1989 conducted by FAO and UNICEF (as part of the Joint Nutrition Support Project, JNSP) which showed considerable evidence of both nightblindness and xerophthalmia significantly higher than WHO guidelines of 0.5 percent to one percent. On the basis of this information, the consultant and the Africare Director visited both Diffa and Dosso, where they found unmistakable clinical evidence to confirm the figures presented in the previous studies[4].

[4]These studies had reported nightblindness levels of 3.9, 11.8 and 2.08 percent respectively for 1986, 1987 and 1989. The differences were probably due to the studies being done at different seasons, but they are still significantly higher than the WHO thresholds.

Outcomes

On the basis of the VITAP consultant's recommendations in 1990, Africare recognized the need to add a vitamin A component to its Child Survival Project, begun in 1987 in Diffa, and in 1989 in Dosso. These recommendations included:

1. emergency measures (including the prescription of VAC) for those children with clinical symptoms of vitamin A deficiency disease and for those at risk;
2. a study to determine the real extent of the problem in the area;
3. a training program for nurses, VHWs, PCVs and other health personnel in the diagnosis and prevention of vitamin A deficiency;
4. a vitamin A/nutrition education program; and
5. the promotion of community gardens for vitamin-rich produce.

Africare embarked on a project to include the proposed activities in both Dosso and Diffa, except for the second item. No study has been done, possibly because of the absence of an on-site project coordinator until October 1992.

Training Activities: Africare

Vitamin A activities in the Africare projects started with intensive training workshops conducted by a VITAP consultant in Diffa and Dosso in December 1991 and January 1992, respectively. These trained a total of 32 nurses at both sites. Each workshop lasted for five days and covered the essentials of vitamin A deficiency disease and related topics. The participants were also trained in the correct techniques for counseling and educating mothers on proper nutrition.

In preparing for these workshops, the trainer was able to carry out a brief training needs assessment in four dispensaries of the Dosso district. None of the nurses (mostly male) interviewed felt they had received adequate formal instruction in nutrition, nor had they received any in-service training. They acknowledged that their nutritional advice in well-baby clinics, as well in nutrition rehabilitation clinics, was ineffective, although they tended to place the blame on the mothers for failing to follow their instructions rather than on the possible inadequacies of their own counseling techniques.

The trainer dealt with specific gaps in the nurses' knowledge, using information from pre- and post-session testing. The trainer also recommended that follow-up supervisory visits would be necessary to counter-act long ingrained practices not easily corrected by attending one five-day workshop. They also needed to improve nutrition education and counseling techniques for these nurses, both in terms of the nurses' own counselling skills and in the results of the application of those skills.

A fifth VITAP-sponsored workshop (the third for Africare) was led by the same VITAP consultant in March 1992. This was based on the previous two workshops for dispensary nurses, but was designed to train them to conduct training sessions for VHWs. It included sessions on needs assessment, design of training workshops, mock training sessions, as well as practical experiences in a village working with VHWs over five days. Only trainees who had participated in the previous two workshops, and therefore already had the basic skills, were eligible. Eight male nurses were chosen and given intensive comprehensive instruction on informal approaches to health education.

Outcomes

Education and counseling techniques introduced by the VITAP consultant to teach the trainers, and, in turn, the VHWs, were diametrically opposed to traditional didactic methods. The VITAP consultant's recommendations for follow-up training were particularly important in this instance because of the time needed to internalize the subject matter. Much practice and additional guidance will undoubtedly be required until the new teaching methods become habitual. The consultant recommended at the time that each newly trained trainer, now responsible for eight VHWs, would need supervision and guidance. In turn, the trainers would need to ensure the follow-up and supervision of the VHWs they trained.

There was great variety in the training techniques used in the workshops, which included felt boards, role playing, etc. There has been no subsequent inquiry as to how many of these were actually done by the people trained, and their use and effectiveness must be determined before further training is undertaken. Also the overall ratings for this training averaged 1.9 on a four scale, with four being high: was there some number confusion about the direction of the scale, or were the methods just too different to be readily grasped? Monitoring the trained personnel would be the best guide to answering this question.

In general, Africare was pleased with the results of the VITAP training. The outgoing director was explicit in attributing VITAP training to one of the factors leading to USAID renewal of its grant. Nevertheless, there is as yet no evidence that results have been obtained on the village level, the ultimate target of the project. There has been no impact measured at the village level since this training, and the director felt that it was probably too soon to say whether the training's program had been institutionalized. The baseline survey conducted in Diffa for Africare has not been followed up, despite a specifically stated intention to do so after two years of project activities. Whether there is a need to create receptivity to nutrition education on the village level is another question to be addressed, and measures to deal with it need to be articulated.

In terms of future VITAP support, Africare would request assistance to continue the vitamin A/nutrition training, extending the training to levels not previously contacted and expanding the training area to all three districts. The previous VITAP consultant

developed a lot of training materials in conjunction with the nurses and health professionals over the course of the training, which could be revised and then incorporated into the materials for any future workshops. Previously trained health personnel might be able to assist in training others.

Training Activities: CARE International

CARE International has been active in two arrondissements (districts) in the Department of Zinder since early 1989. A project coordinator was assigned to the Departmental Health Office to direct activities designed to improve infant and early childhood nutrition, including treatment and prevention of early childhood diarrhea.

VITAP conducted two workshops for dispensary nurses to equip them for training VHWs in 48 villages in nutrition and diarrheal prevention and control. These five-day workshops were for dispensary nurses and midwives. Vitamin A was the topic for one entire day in these workshops, which reached 85 dispensary nurses in January 1991. These nurses are responsible for supervising village health teams, as well as dispensaries.

CARE and VITAP also sponsored a day-long training for 250 participants drawn from the project area. These participants were not part of the health personnel attached to either the PVO or to the Ministry, but there was little information on how they were selected. Perhaps more problematic, there was also little information on what these women had done with the information afterwards.

Outcomes

A final evaluation of the CARE project completed in June 1992 pointed out that project activities placed almost total emphasis on diarrheal prevention and treatment, and for the most part ignored the nutrition component. The project had concentrated on oral rehydration therapy (ORT), training in sugar-salt-solution, and weighing babies, rather than on foods rich in specific vitamins or the provision of certain foods to target populations. No specific goals for nutrition activities had been formulated and the need to change traditional practices, such as failure to give colostrum at birth, had not been articulated. It appeared that the nutrition training provided by VITAP was never followed up or reinforced. Even so, some changes in nutrition practices were registered on the village level by the follow-up survey for the final evaluation of the project. The most striking evidence was that while there was essentially no improvement in weaning practices, there was an appreciable increase from 13 to 31.2 percent in starting breastfeeding the day of birth.

How much of this change can be accorded to the VITAP training and how much to other sources, such as the presence of trained Peace Corps volunteers as part of the project, has not been measured, either qualitatively or quantitatively. Since CARE has

recently received a five-year extension of its project, there should be ample opportunity to increase emphasis on the nutrition part of the project.

C. Other Organizations

There are approximately 20 Peace Corps Volunteers working at present on health and nutrition in Niger. They are involved in training villagers in gardening of vitamin-rich produce, dispensing family planning information, and training village health workers in information and education techniques. The health volunteers are knowledgeable about vitamin A nutrition as a result of training they receive on arrival in Niger.

While serving as the VITAP Coordinator, the HKI Country Director was instrumental in encouraging Peace Corps to incorporate vitamin A training as part of their three-month long health orientation, and, in fact, the HKI director assisted in several training sessions. The health volunteers also distribute vitamin A capsules, as do agricultural volunteers upon request, but this is not part of any national strategy. While vitamin A was always an important component of the nutrition program, it has only been in the last three or four years that volunteers have started distributing VAC. Other volunteers in other programs also receive the same training in nutrition education and vitamin A. There are many gardening projects, and many agricultural volunteers distribute VAC, which are provided by HKI.

Health volunteers have only worked for the last three years with Africare (i.e., the duration of the Child Survival project). One of the major problems was that the volunteers were in charge of their own district, but that there was no overall coordinator for the region, although each volunteer does have a counterpart. Together they travel to the villages for which that counterpart is responsible. The integration of the volunteers within programs also contributed to problems in coordination, but these are useful in pointing to areas where the entire program could be strengthened. In Dosso, the agricultural technician was integrated into the project: this could easily be replicated at Diffa if the agricultural volunteers were interested.

There are four components of the Africare project with which volunteers are involved: family planning, training of the VHWs, gardening, and training of other personnel. Many PCVs also design spin off projects from AID projects (i.e., small grant activities), which are very small, specific interventions, and requested by the community. The Africare director has noted also an increase in interest in and information about gardening and wells.

V. DISCUSSION AND CONCLUSIONS

It has been stated that the largest industry in Niger is international assistance, a fact borne out by the large number of agencies working on health in the country. Many

international organizations, private voluntary organizations and bilateral programs are present in the country, all without having much to do with one another. These groups are, however, able to cultivate counterparts on the district level. Africare, for example, was unable to work out an overall strategy with the MOH for its nutrition project. On the other hand, its relations with the Diffa District Health Officer have been good, and activities in that region are increasing from six villages to eighteen, because of project funding and the district's cooperation.

The northern, more arid and sparsely populated area of the country is currently too unstable for effective interventions. This has resulted in a greater concentration of PVOs in the southern departments, and, judging from documents available and contacts with other PVOs, the MOH has now embarked on a policy of dividing up the southern part of the country among those agencies able to obtain funding.

This increases the need for coordination, especially among the AID-funded projects that include a vitamin A component. USAID is funding at least three separate projects through three separate PVOs. These are the renewal of the CARE and Africare projects, plus the implementation of the HKI Country project in Tahoua and Maradi. In addition, a joint FAO/VITAL gardening project will begin in 1993. Given that the Measles Initiative is also beginning, and that VAC is distributed through all these projects, Peace Corps and UNICEF, there needs to be a specific plan for sharing training resources, as well as a vitamin A policy from the Ministry of Health in the near future.

Since the WHO representative has stated his intention to assist the MOH in its overall management and supervision of health activities in Niger, VITAP could make an important contribution in keeping vitamin A concerns from getting lost in the innumerable health demands throughout the country. Considering frequent personnel movement from post to post, at the minimum an inventory and tracking system should be kept up-to-date on the locations of VITAP-trained individuals. More coordination among these projects, sharing successes and mutual problems, might lead to more project effectiveness. Such a model could then be adopted by the Ministry of Health for better managed nation-wide efforts.

While the Ministry of Health's national nutrition plan fails to take into account the results of past PVO activities, USAID itself could be responsible for bringing some sense of order into analyzing the results of the projects they fund and making use of their strengths while correcting deficiencies. AID is planning a workshop to bring together all the various components for health with the PVOs it funds. It is hoped that this will reduce duplication and waste, and possibly even foster more coordination among the various entities. Another possibility is that an inter-ministerial committee, which is just being formed, which would include all bilateral donors, international agencies and PVOs working in this area, could direct such an effort.

A. Potential for a National Education Campaign

Because of the many food taboos and detrimental breastfeeding and weaning practices reported throughout the country, a national education and information campaign would be an appropriate activity, similar in scope to the centers developed in Mali. The objective would be to target specific groups to educate them about the possibility of exploiting specific sources of nutritious foods and nutrition services already available in country. Two recent examples, from the mini-project and CARE's project areas are particularly illuminating.

The first of these is a videotape of the mini-project. Plays are already an important component of Hausa social life, and the project taped villagers putting on plays about vitamin A and other nutrition topics. Some of these took place in sequestered villages, where the women are not allowed out in public. Some of the skits had people using shoes as a prop for a child, men dressing up as women and being treated as wives by another man, visits to nurses, and preparing food rich in vitamin A. Particularly telling was the perfect body language demonstrated in the visit to the nurse, where the nurse is sitting down and being very impatient with the pregnant patient. The project gave the participants a certificate and a t-shirt that had pumpkins on it, rather than paying them for their time. An AED evaluation of this initiative noted that the actors would often be called by their stage names by other villagers, and would occasionally be asked questions about health practices. The techniques for transmitting the messages should be reviewed with an eye to using traditional storytelling, dramas or puppet shows. There is an immediacy for the viewing audience that produces a greater impact than is possible through the electronic media.

The second example concerns the potential feasibility of a national effort to promote breastfeeding at birth for the colostrum. This would increase the newborns' intake of vitamin A, and giving VAC to post-partum mothers would prevent additional deficiencies. If CARE was able to increase this practice appreciably in its project area with a minimum of effort, it would seem that there is already a receptivity to changing old practices in this regard. Colostrum behavior as demonstrated in a CARE report was relatively easy to modify. The midwives in one village were trained to give vitamin A to mothers right after birth, under the premise that this was something you do to make the baby well. By extension, this therefore rendered the first milk harmless to the baby, since the cultural norm was that the first milk was harmful in some way. So vitamin A 'cured' the milk, and both the mother and the newborn benefitted from the capsules, even if the reason for ingesting the capsule was not the usual health message.

B. PVO Constraints

Training in both Dosso and Diffa consisted of presentations, questions, discussions, demonstrations fostering participation, practice sessions with a critique afterwards, practice exercises and case studies. Despite the consultant recommending monitoring

the trained personnel, there has been no follow up, either the documents or in lengthy discussions with the Africare Country Director. He attributed this to the relatively low priority given to what is construed as a passive activity, especially given the ongoing concerns about staff movement, the shift to concentrating on Diffa, new inputs from PCVs and the coordinator, and spending attention on issues other than vitamin A.

Gardening can be a problem because of water availability, which is limited to certain months of the year. Capsules will have to be continued to ensure that vitamin A does get out into the vulnerable population. Liver is not available in sufficient quantities to make it a reliable source of vitamin A, and it is still very expensive. Information on the nutritional content of various foods considered rich in vitamin A and the effect that drying has on them is available, including a report done by the consultant who worked on VITAP training for Africare.

C. Echo Effects of Training

Having incorporated vitamin A into the PCV training is important for two reasons. The first is that PCVs are now working with both the CARE and Africare projects, and frequently receive additional small grants from USAID for specific village-level activities. This creates a substantial network of trained personnel, committed and often eager to embark upon activities that larger projects may not be able to undertake. While it is certainly true that most volunteers leave after their two year service is completed, a substantial cadre remain and are then hired by various PVOs, further widening the pool of personnel trained in vitamin A detection and treatment. The second factor is that the incoming HKI director has excellent ties with Peace Corps/Niger, having been employed by them for the last eight years. The director already plans on reinforcing the professional connections made during a previous director's tenure.

D. Conclusions

There are four major conclusions that can be drawn from this assessment. These refer to the effects of VITAP's training, information availability, PVO cost-sharing, and VAC use and availability. Within these major conclusions are the very tangible community impact of the PVO projects, and some indication of where future VITAP or VITAP-style technical assistance might be most appropriate, although that is developed further in Section VI of this report. These major and minor conclusions need, however, to be made in the context of two categorical statements. First, VITAP's mechanism of PVO to PVO technical assistance is not only viable, but potent. Second, the close working relationship between VITAP/NY and HKI/Niger, and the overlap between HKI/Niger and VITAP/Niger (insofar as HKI staff provided a considerable portion of the technical assistance) provided additional focus and reinforcement for both programs.

The first of the conclusions relates to the effectiveness of the training. Despite the lack of follow up of trained personnel, especially those from the ministry, the two PVOs

contacted have incorporated at least some parts of the vitamin A messages into their program. Africare has been somewhat more successful with this aspect, largely due to the more intensive training of project staff, and to previous experience with a successful gardening component. While CARE has concentrated more on growth monitoring, the findings regarding colostrum use are compelling indicators for it having integrated VAC into its program, although the messages about vitamin A and growing foods rich in vitamin A will still need reinforcement. It is important to note that despite the time elapsed between the provision of VITAP technical assistance, despite staff turnover and funding problems, there was still an institutional memory of the training, training modules were available and both programs were making concerted efforts to develop their nutrition education components using methodologies from the VITAP training.

The second conclusion refers to the availability of information, which is amazingly plentiful. Training modules are already in place. VITAP has made the flip charts available, and HKI clearly serves as a resource for the PVO community on both materials and technical assistance. This position has been reinforced by the Vitamin A Mini-Project, as well as by the participation of USAID's nutrition advisor in the subsequent videotaping of vitamin A skits. Training has been provided to ministry, PVO and Peace Corps personnel. The USAID mission, UNICEF and FAO are all clearly aware of the importance of vitamin A with regards to child survival and general health, and have taken measures to integrate VAD information into EPI, gardening, and measles programs. VITAP/NY provided several hundred information packets, which were distributed during the various training sessions, and other PVOs frequently request additional copies from HKI/Niger. In addition, PVOs which received the information packets also receive a newsletter with more current information on vitamin A strategies and initiatives in other countries. Given the availability of vitamin A information, it is somewhat surprising that there is still so little coordination and cooperation among the various development agencies. Strategies developed in CARE/Zinder may or may not work in Africare/Diffa, but it would be useful to have collected these varied strategies in a central location so that they could be reviewed, especially with some additional technical supervision.

The third conclusion is on the relative cost-effectiveness of the training, especially, and, to a lesser extent, of the technical assistance. VITAP and HKI identified a local resource, one with a strong background in nutrition and a gift for training. VITAP was able to use HKI/Niger staff for some of the training, which not only reduced consultant fees and travel costs, but which also provided the PVOs with a known quantity. The VITAP consultant who worked with Africare in its trainings was resident in Niger at that time. Both of VITAP's principal trainers were known to and well respected by the PVO community; neither required the very long lead time that bringing a consultant from the States usually necessitates. Both PVOs also contributed to the training sessions, through per diems for their staff and locations for the training.

The final major conclusion concerns the dissemination of information regarding VAC and its availability. At the moment, the PVOs occasionally distribute VAC. PCVs in a variety of sectors distribute it. UNICEF and FAO are planning to distribute it. The Ministry may also distribute VACs, once its national plan is approved and set in motion. It seems clear that the 'silver bullet' effect of VAC is well understood. This extremely positive result, however, could lead to problems of toxicity if the distribution system is not monitored. This would seem especially true now that all of the development agencies are operating in the southern third of the country, and given that this picture of VAC distribution leaves out other bilateral donors (such as the Europeans, Canadians and Japanese) who may also be distributing VAC.

One additional point is the ongoing enthusiasm and local initiatives noted in both the CARE and Africare projects. A good example is the prevalence of water projects now underway that use a solar pump, which were started after a great deal of training and consciousness-raising. The villagers put someone in charge of each faucet, with the responsibility of collecting a 5CFA charge per bucket. The villagers also chose a treasurer, someone else to clean the solar panels, and finally the village committee to oversee the funds. Village level efforts such as these require a tremendous 'frontloading' of training and an appropriate rationale for the change in behavior, as well as ongoing follow-up and monitoring. This type of model of village involvement for a concrete achievement may signal, however, the real potential for the village health committees being tried by other PVOs in the region.

VI. RECOMMENDATIONS AND FUTURE STEPS

Building on these conclusions, there are some specific steps that VITAP might undertake. These include developing additional collaborative mechanisms and technical assistance for VAC and more sustainable vitamin A initiatives. Briefly put, VITAP could:

1) urge PVOs and international organizations to collaborate with information sharing and through working group participation;
2) develop guidelines for VAC distribution within and among the development community, including the development of VAD indicators, training personnel in their use, and follow-up;
3) encourage the MOH to work with international agencies to ensure a reliable, nation-wide distribution system for VAC, as well as reliable VAC supplies;
4) extend the collaboration between FAO and HKI to other PVOs to determine and disseminate efficient methods for increasing production and consumption of food rich in vitamin A (especially dark green leafy vegetables);

5) design a more formal coordination mechanism (such as a working group) among the PVOs, MOH, and international donor community to reinforce vitamin A messages and share information about strategies;
6) investigate the possibility of introducing the Awa flip charts for training health personnel on nutrition and vitamin A, as well as use in primary school classrooms;
7) encourage a review of record-keeping systems for obtaining health and vitamin A information to monitor project progress;
8) design and implement a strategy for routine follow-up training for personnel working on vitamin A activities, possibly extending this into a tracking system; and, finally,
9) identify nationals able to conduct vitamin A training workshops, as well as other local resources in the PVO and health communities. This would foster future cost-sharing activities.

Health personnel shift frequently, creating a situation which requires constant training and refresher courses. On the positive side, this situation also presents an interesting possibility for sustainability, i.e., staff that attend a training session on one topic would be considered for the role of trainer when that topic recurs on the training schedule, if they had been using that information in the course of their own work. Staff that had moved on to another post could be invited back. The training materials themselves could be developed by the PVO staff working with their counterparts, and then reused, with revisions and updates for subsequent training. Staff that had attended one topic could become part of that revision process, as well.

The effect that the vitamin A messages have had on the non-literate population needs to be monitored more closely. Many of the PVOs have KAP studies planned at some point in their project cycle, and their final evaluations often include another in-depth study. VITAP could participate in the planning stages of these studies, building on its recent efforts to develop qualitative indicators. The numerous spin-offs from the Awa story need to be examined in more depth in terms of their impact on their target population. This might be coordinated with AED's upcoming KAP study of the Nutrition Communications Project, or might be a useful addition to VITAP's final evaluation.

VITAP should also examine the techniques currently used by the PVOs for transmitting vitamin A messages and assess their effectiveness. These could then be modified and incorporated into training interventions, or form the basis for a specific working group meeting on effective strategies. This might be the pre-workshop planning for the regional staff responsible for EPI, as UNICEF has found that these are the most appropriate persons for vitamin A training. This would also be a manageable group to train for policy choices, rather than inviting all of the health personnel in one project area.

VITAP should expand its efforts to the local NGO community, which has been outside of VITAP's prior mandate to this point. NGOs were strongly discouraged under the previous administration in Niger, but the current environment is very favorable. This becomes key given that, while the PVOs work in predominantly rural areas, many of the incipient NGOs have targeted Niamey itself. The rapidly growing population, the dearth of sanitation, and the relative paucity of health facilities makes an urban vitamin A program important. Linking this urban effort with the PVOs' prior rural experience would increase the existing networking between and among the PVOs and NGOs.

There are two additional areas into which VITAP could usefully extend its vitamin A messages. The first of these is to broaden its catchment pool of target personnel to include those in the agricultural and educational sectors. Peace Corps, FAO, Africare and CARE have made some tentative steps in this direction, but this needs to be very actively fostered in Niger. Integrating training initiatives would allow compartmentalized staff to view their own activities through fresh eyes, and to determine the viability of collaborative efforts by examining parallel strategies.

The second area is in the domain of famine mitigation and relief efforts. It seems clear that the GON does not have a sufficient policy for stockpiling VAC or for distributing them in famine areas. Most prior relief efforts have operated out of the northern region, however, due to poor harvests and other natural disasters, famine is still an-all-too common feature of the southern tier also. Developing a famine mitigation plan with the GON and its PVO collaborators would facilitate relief efforts, on an as-needed basis.

VITAP's on-site presence in Niger was overwhelmed by the HKI Director's other tasks, but having him available for the early efforts did add to VITAP's training activities and to their acceptance by the PVO community. While it would not be cost-effective for VITAP to maintain a country coordinator for each of the twenty-two countries in which they operate, 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 one of the existing HKI offices, 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

HKI:

Mme. Else Sanogo, Director
M. Issa Camara

Africare:

M. Jeffrey Gray, Director
(by fax) Mlle. Judith Lane, Diffa Coordinator

UNICEF:

M. Ouoba, Director, Health Programs
M. Bob Davis
M. Denis Valot

WHO:

Dr. Yankalbe P. Matchock-Mahouri, Country Representative
Dr. Duntalbe, former Country Representative

USAID:

Mlle. Nancy Lowenthal, Health Office
Mme. Nancy Keith, Health Office (Measles Program)
Mlle. Sylva Etian, AID/CDC Ministry Technical Advisor

Peace Corps:

M. Mahmadou Issa, Deputy Director and APCD/Health

CARE:

Mme. Susan Farnsworth, Acting Director (by phone)

Ministry of Public Health:

Mme. Guimba, Chef, Direction de la Santé Maternelle et Infantile (DSMI)
Mme. Mahdoul, Technicien, Division de la Nutrition

FAO:

M. M. Mansour
M. Benedict Tissa
M. Muterwelba, Project Manager at Bouza

ANNEX TWO: DOCUMENTS REVIEWED

1. Logistique Formation VITAP (Matameye-Magaria: Zinder)
2. Trip Report by Anne Ralte October 16 -25
3. VITAP information sheets (various HKI publications)
4. memo from Kirsten Larsen re: Training for Africare with Ming Hung (no date)
5. memo from Cheryl Combest, HKI/Niger Director, 4/28/92 re: HKI/VITAP assistance to Africare
6. memo from Cheryl Combest, HKI/Niger Director, 4/17/92 re: VITAP training
7. memo from Cheryl Combest, 4/8/92 re: Africare request for TA
8. memo from Cheryl Combest, 3/17/92 re: VITAP assistance to Africare and Orbis film
9. memo from Cheryl Combest, 11/7//92 re: Africare training
10. letter from Dr. Tetevi, HKI/Niger Director, to HKI regarding training schedule
11. letter to VITAP from Cheryl Combest including bibliography from VITAP library
12. letter to Carl Rahman, USAID/Niger Health Officer, in response to issues raised about cost and logistics of VITAP assistance
13. 6/10/91 Draft Plan of Action for assistance to Africare
14. 1/19-21/91 Report on Vitap Training for Care International by Dr. Tetevi Logovi
15. Rapport de la Journeé Survie de l'Enfant/Vitamine A 12/8/90
16. Trip Report Mali-Segou VITAP Training 10/19-27/90 Dr. Tetevi Logovi
17. Africare Request for Assistance 27 June 1990
18. VITAP Materials Package
19. HKI 6/91 VITAP Vitamin A Reference Library inventory and requests

20. HKI (no date) Manuel pour les formateurs Vitamine A et Survie de l'Enfant

21. Monthly narrative reports by Issa Boubacar Camara, Acting HKI/Niger Director
July 1992, May 1992
Statut du Rapport d'Activite 30 April 1992

Monthly narrative reports by Cheryl Combest, HKI/Niger Director
March 1992, February 1992; October - December 1991
Project de programme de formation des cadres de la Santé 3 - 8 November 1991
List et Nombre d'Exemplaires produits et distribués pour l'information et l'education de la population (no date)
Assistance Technique autres ONGs

Monthly narrative reports by Dr. Tetevi Logovi, HKI/Niger Director
March - June 1991, January 1991; August - December 1990, February 1990
Liste et Nombres d'exemplaires produits et distribués pour l'information et l'education de la population

22. Projet Africare pour la Survie de l'Enfant/VITAP: Modules de formation en nutrition. Man-Ming Hung; December 1991 and January 1992

23. Africare/Niger Child Survival Project for Diffa and Dosso. Training Report on Workshop on Nutrition and Vitamin A. Man-Ming Hung, January 30, 1992

24. Africare. Baseline Child Survival Survey in Dosso and Diffa, 16 July 1990

25. Demographic Indicators of Niger (no date, after 1988)

26. Plan d'Action 1992, Division of Nutrition, MOH/Niger

27. Analyse de la Situation des Activites du Project VA. Maradi-Tahoua, Janvier 1991. Ministère de la Santé Publique

28. Plan d'Action du Programme National de Lutte contre l'Avitaminose A: Volets preventif, curatif. 1990 -1995.

29. Politique Nationale d'Alimentation et de Nutrition, Fevrier 1992. Ministère de la Santé Publique

30. Evaluation à mi-parcours du Projet Survie de l'Enfant; Departements de Dosso et de Diffa; Africare/Niger; juin 1991

31. Vitamin A Nutrition Strategy, USAID/Washington, September 1991

32. Nigerian National Workshop on Vitamin A Interventions and Child Survival, Otta, Ogun State, Nigeria; October 30 - November 2, 1990; Proceedings

33. East, Central, and Southern African Regional Workshop on Vitamin A Interventions and Child Survival, Lusaka, Zambia; 21-24 June 1990; Proceedings

34. Report of Reconnaissance Visit to Niger, July 6 - August 3, 1991. The Women and Infant Nutrition Support (WINS) Project, Bibi Essama of the Educational Development Center, Inc.

35. Rapport Final: Enquête sur l'Avitaminose A dans le Departement de Tillaberi (Niger). Ministère de la Santé Publique, Direction Santé Maternelle/Infantile, Division de Nutrition, mai 1990

36. Mid-term Evaluation Report of the Zinder Child Health Project, May 1990

37. Rapport d'Evaluation Finale du Projet Santé Infantile à Zinder, juin 1992

38. Report on the Results of the Child Survival Evaluation Survey. July 1992; CARE International in Niger, Zinder Child Health Project.

39. Report on the Vitamin A Workshop for PVO. Niger July 27, 1990 (sponsored by VITAP).

40. Niger Country Proposal. A Proposal for Vitamin A Prevention and Control Project; Tahoua and Maradi Regions. 18 December 1990. (proposed dates: August 1991 - July 1994).

41. Rapport de la Formation des Agents de la Santé du Ministère de la Santé Publique et du Ministère des Affaires Sociales et de la Condition Feminine dans les Arrondissements de Matameye et de Magaria. Projet de Santé Infantile. CARE International au Niger, Aout 1989.

42. Module de la Formation des Agents de Santé de Matameye et Magaria axeé sur l'Education Nutritionelle. Janvier 1991.

43. Rapport de Mission Projet Santé Infantile (Zinder) du 19 novembre au 6 decembre 1990.

44. Niger Country Report: A Focus on Nutrition. Centers for Disease Control. Silva Etian, March 1991

ANNEX THREE: Africare

Africare started its nutrition project as part of the Child Survival program in the Departments of Dosso and Diffa in 1989 after 20 years in Niger, including at least 10 years in Diffa. Most of Africare's emphasis in Niger has been on primary health care, which has included well building, potable water, gardening, and child survival. The emphasis of the Child Survival project has been twofold. The first has been on training dispensary nurses and village health teams in nutrition and vitamin A interventions and the second on community outreach.

Because Dosso is close to Niamey and therefore receives adequate attention from various agencies there, Africare was recently asked by the Ministry of Health to concentrate its efforts in Diffa, nearly 1300 kilometers east of Niamey and without regular air service. Diffa is probably the most difficult southern department in which to work, as there are few resources, little water, and transportation is difficult. An expatriate coordinator recently stationed there is overseeing the expansion of the Africare project to 12 more villages. According to the Africare Director, it was the successful training of the dispensary nurses by the VITAP consultant that led to the expansion and continued funding by USAID of this project.

In Diffa, Africare is principally involved with primary health care, including wells, hospitals, child survival projects and small vegetable gardens. The gardens were integrated with VITAP later in the project cycle, together with a pepper (tatasi) project along the river that required a sluice gate to control and capture the flow of water.

There is a distinct gender responsibility differentiation at Zinder: eastward from Zinder, men garden, and westward (as in most of West Africa) women garden. Thus the project in Diffa needed to be adjusted from what had been one of the more successful components in Dosso. This occurred in the village of Badje Kora, and its success can be attributed to the interest and involvement of the femmes relais (part of the five member village health committee), who were also trained to talk about nutrition and child survival as a facet of the gardening activity.

The involvement of PCVs has advantages and disadvantages. In terms of community level work, especially outreach for women and within the community as a whole, they are hard to replace. However, they are generally at a disadvantage when it comes to coordinating with either a larger area or a bureaucracy, due to both training and their perception by the bureaucratic structure. Having a coordinator should mitigate this disadvantage.

Africare's Child Survival Project was reviewed for renewal in 1991 and an evaluation report was issued before the vitamin A workshops held by VITAP. As would be expected, the report found the project almost totally devoted, up to that point, to oral rehydration and diarrheal control activities. As a result, the report's recommendations

emphasized the need for a substantial start on nutrition activities by training dispensary nurses, VHWs and VHEs in nutrition education and counseling, identification of malnourished children and the appropriate foods they need. Other recommendations included the need to educate villagers at their level on what constitutes good health and nourishment, and to address the need to work with the Ministry of Health to ensure sustainability of project activities. The latter included the need to involve health personnel in follow-up supervision that educates rather than polices. and to ensure periodic in-service training to reinforce the new concepts and practices already learned.

VITAP was involved with two training sessions for Africare, and one training of trainers. All of these took place with participants from Dosso and Diffa and all were conducted by a single VITAP consultant. Africare's perception of VITAP was that the TA was good and especially effective in integrating nutrition and vitamin A, as the Africare coordinator's strength was in training. The training was useful for both the MOH and DR levels.

One additional factor was that the funding for VITAP's Phase I ran out in June, so follow-up and additional training had to be delayed until restart. By that point, the PCVs had completed their service, so the project lost momentum. It might have been a good idea to have the VHW training at the end of the DR training whether or not it was successful (so the momentum would not have been lost). All of the materials were in place, so only logistical support would have been required.

Between June 90 - January 91, the National Development Bank failed. This froze all of Africare's project assets and only about 80 percent of the funds were subsequently recovered. This contributed to the relative paucity of project activities and especially their follow-up, as considerable staff time and effort went toward retrieving this money.

The new project has a budget of $1,063,453 over three years. It is a matter of some concern that less than 10 percent of the project is going towards training activities, although twenty five percent of the budget is devoted to nutrition and nutrition-related activities. The project has five major components: 25 percent for family planning (the rationale for AID funding), 30 percent for diarrheal disease control, 25 percent for nutrition, 10 percent for health education and 10 percent for pre/post-natal care.

There is a follow up study planned for the two new districts in Diffa, perhaps using the old baseline survey district as the baseline. Africare acknowledges that it would also be useful to do another survey in the old district. This would give them a more precise idea about the scope of their previous interventions, but the staff think that this would be very time-consuming. AID has requested that they follow the CARE format for surveys to make sure that the various nutrition projects can be roughly comparable.

ANNEX FOUR: CARE

The Child Survival Project began in late 1988 in two districts of the Zinder Region. These were Matameye and Magaria, which had a total population of 563,182. The project operated in 48 villages, 15 of which had rural dispensaries (DR) and the rest VHWs. The goal was for mothers to improve the nutrition management of their children under 3 years old and to improve the management of diarrheal disease. A lesser goal was to strengthen the capacities of the Ministry of Health.

The principal finding from CARE's mid-term evaluation was that giving colostrum to newborns had increased in this area from 13.1 percent in 1989 to 31.2 percent in 1992, with the conclusion that it was possible for some practices to change. As this was the only project stressing the importance of colostrum (as distinct from ongoing breastfeeding and weaning activities, which were also included), the possibility of this being a real behavioral shift cannot be dismissed as part of the general nutritional environment.

The VHW training was overall satisfactory in that it permitted three full days of training on one subject, but there were still problems with the VHWs. The secouristes were not always there, as they would leave to find work elsewhere, and, in a Moslem environment, it is often difficult for men to interact with women in public. The problem discussed with the TBAs was simply that they were elderly and resistant to changes in techniques.

One of the most positive interventions was the Child Survival Day in Zinder that HKI/VITAP helped organize. This had five objectives: 1) understand the management of diarrheal disease, 2) understand the role of vitamin A in maternal and child health, 3) make the connection between #1 and #2, 4) inform/sensitize health professionals about the problem and how to combat it, and 5) make known the types of interventions HKI, MOH and CARE do. There was cooperation between the training center for nurses located in Zinder, CARE and departmental health officials to make the day possible, with an estimated 250 participants and 12 trainers.

Despite considerable problems starting up, there were, at the time of the mid-term, about half of the activities were either underway or completed. Most problems were due to poor coordination between CARE and the departmental level bureaucrats, as there was lots of enthusiasm at the village level, as evidenced by their participation in building four meeting/training places throughout the project area.

The recommendations from the mid-term evaluation were to hold a workshop, develop local leadership, supervise interventions more actively, improve and expand the training, ask for more technical assistance with nutrition, and integrate with other projects.

The conclusion of the evaluation was that there still remains a tremendous amount of work to be done on nutrition, especially in the absence of a National Plan on nutrition.

The volume and kinds of foods given to children is insufficient in terms of both calories and vitamins, although one of the results was that mothers are providing better care to children who suffer from diarrhea.

ANNEX SIX: FAO

The Food and Agricultural Organization (FAO) is just starting up a project in a southern district of Tahoua with technical assistance from the AID-funded Vitamin A Field Support Project (VITAL). This TA involves a baseline survey on VAD, including its design, implementation and analysis. Health personnel are being trained to conduct a baseline survey to be completed in February 1993, and then to follow up with identification of the population at risk of VAD. The survey is using the food consumption methodology developed by a former VITAP staff member, and the FAO project director is interested in benefitting from HKI's experience in Niger.

The FAO baseline survey at Bouza will have six control villages as well as the six target villages. FAO is currently training two survey teams of six people each. The instruments are almost completed, and they expect the survey to take place 13 - 24 December. Results should be available some time in February, at which point they will have a seminar to discuss them.

The project has also had about three months of TA from a VITAL consultant. VITAL's intervention in this is primarily to assist in the survey design, implementation and analysis. It is expected that the people trained during the survey will also be the health technicians who will be learning to diagnose and treat VAD as they go through the survey training exercise.

FAO's main focus will be to increase production and consumption of vitamin-rich garden produce. Since there may be some resistance from the men to switching from cash crops, FAO plans to increase the available water supply to encourage enlarging women's garden plots. While the project is in an area with relatively good access to water, it is also one with the highest prevalence rates of VAD in the area. There are several garden sites already chosen in the project area for which the selection criteria were women's access to land and the presence of active women's groups in the villages. This project is located fairly close to the site of the Vitamin A Mini-Project, and FAO has already indicated the need for training materials from VITAP for this gardening project. While specific training requirements were not discussed, FAO is already sensitive to the need for additional information on vitamin A-rich foods and for additional techniques to encourage changes in food behavior.

The difference between the Vitamin A Mini-Project and the FAO one will be that the former will concentrate primarily on training and education, while the latter will include these but stress gardening and agricultural production. So they are somewhat complementary and will not take place in the same target villages. This creates the possibility of comparing the two projects in a couple of years, to see which type of focus had more of an impact on knowledge, attitudes, and practices.

FAO is also planning an intervention in the sale and commerce of garden produce. There has already been some resistance on the part of the target villages in Bouza because people are more interested in growing onions (a major cash crop) than tomatoes or carrots. FAO is going to provide seeds and some of the gardening tools for other vegetables as well, but at a nominal cost, so it is not perceived as a give-away.

The biggest stumbling block so far has been in finding village health educators. FAO is looking for young, dynamic, literate women, which pretty accurately describes the type of person who would have left the village. They are offering the inducement of remunerating the VHEs at a rate of 15.000CFA/month. Part of the problem may be the men in the area, who are reluctant to sanction an activity that is entirely geared towards the women. Another problem is that FAO will need to introduce supervision for these village health educators, i.e., they cannot just let them be trained and then assume that they will be able to do the job without monitoring and follow up.

ANNEX SIX: UNICEF

During 1984 - 1990 in the Department of Maradi, UNICEF implemented a Joint Nutrition Support Program (JNSP) in a collaborative effort with WHO. After a baseline survey in one pilot area indicated the presence of VAD, vitamin A capsules were made available for distribution in the three target districts as part of an integrated rural development project that included educational programs for school children and demonstration gardens. They are very interested in incorporating vitamin A because of its connection with reducing infant mortality due to measles. In Niger, measles is endemic and also present at epidemic levels with a fatality rate between 8 - 12 percent. Only about one-third of the children are vaccinated as part of the EPI.

JNSP began in 1984/85 with the cooperation of UNICEF, WHO and GON. This was part of an integrated rural development project which had as its purpose to improve the nutritional status of the target population, through using the local level to develop the local level. There were three interventions planned at the village level: to understand the problem, to analyze the possibilities for action, and to determine the appropriate interventions. There was a baseline survey done in Tillabery, after which VAC were made available for distribution in the three target districts.

As part of the Bamako Initiative, UNICEF is now extending its nutrition program to four more districts of the Maradi region (Madarounfa, Tessaoua, Aguie, and Mayahi), emphasizing cost recovery and provision of VAC with routine vaccinations. When preparation for project activities is complete, UNICEF expects to have 290 health centers fully operational to deliver services (including immunizations, maternal and child care, among others), with outreach activities available from 70 of these.

UNICEF did a training for trainers in the four districts involved with the project, and has an Action Plan for their project for the next two years. They would be very interested in different types of collaborative activities. While VITAP was a new acronym for the UNICEF nutrition coordinator, he had had contact with HKI/Niger through JNSP. This program ended two years ago, but there are still a number of requests for training and expressions of interest from the project area.

One of UNICEF's initiatives has been in the domain of schoolchildren's health, both through further educational programs and demonstration gardens for vitamin A-rich foods. They have found that the most appropriate person for vitamin A training and activities is often the regional person responsible for EPI. The difficulty is that overall decision-making for most of the activities is at the ministerial level, with the district-level staff responsible for implementation, but the latter often receive no support or follow-up from the former.

ANNEX SEVEN: WHO

The World Health Organization (WHO) supports seven programs in Niger, which are primary health care, medicines and vaccinations, maternal and child health, training of health personnel, MOH office support, country program support, and disease vector control.

The WHO Representative, relatively new to the country, is just beginning to organize these programs. Among his primary goals are the following:

- o to improve the stability of health personnel in their posts in order to prevent frequent change of posts,
- o to improve supervision and follow-up of training,
- o to formalize coordination among health projects to improve project design and implementation, and
- o to institute comparative evaluation of project results.

In this connection, he also plans a comprehensive survey of health programs supported by the wide array of organizations working in the country, an achievement he was responsible for in his previous post, Chad.

By and large, PVOs had the option to initiate programs in areas that were of interest to them. As a result, one of the tasks for the WHO office would be to create national plans by asking the various responsible entities to submit their strategies for review and consolidation. At the moment, the EPI, MCH and Malaria divisions of the MOH all submit plans; and other ministries have also submitted theirs so that this national plan is already in progress. They expect to have a presentation of it by December 1992. It would be of considerable interest to extend their activities to the community level, although this does not appear to be an immediate priority, given the expressed need for coordination at the ministry level.