



PVO CHILD SURVIVAL

Over the past 30 years, we in government have learned a very important lesson in international development -- governments cannot do the job alone.

In the fight for child survival, private voluntary organizations are the critical link. From Africa to Haiti, such groups have been a partner with government in bringing life and hope to children in need across the globe. PVOs prove that "a hungry child knows no politics."

Acknowledgments: The PVO Child Survival Support Office would like to thank the Agency for International Development, Bureau for Food for Peace and Voluntary Assistance, Office of Private and Voluntary Cooperation for their continued support of PVO Child Survival Implementation Workshops and Lessons Learned Conferences. We would also like to thank the Bologna Center at The Johns Hopkins School for Advanced International Studies, for providing superb conference facilities and for the tireless effort put forth by their staff in assisting the conference organizers. Lastly, a special thanks goes to all who participated in the 1988 Lessons Learned Conference for their dedication to Child Survival and their willingness to share information and experiences so openly. It is the culmination of these collaborative efforts that has enabled us to present such an informative publication.

The Conference Organizing Team
PVO Child Survival Support Program
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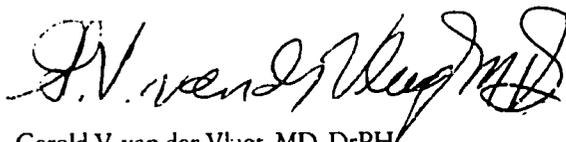


In an increasingly interdependent world confronted by imponderable challenges such as the third world debt crisis, AIDS, substance abuse, and the specter of environmental degradation on a grand scale, it is clear that the ability of the private sector to deliver people-to-people assistance is becoming increasingly important. During the past decade, private voluntary organizations (PVOs) have significantly increased their technical and organizational ability to carry out needed development assistance programs, specifically in the area of child survival and health.

In 1986, the 178 PVOs registered with the United States Agency for International Development expended over \$3.3 billion in development assistance. Additionally, it is estimated that an equal number of PVOs, active in development assistance, chose not to register with the agency, but still account for a significant resource flow. Also, these expenditure figures do not capture the unrecorded magnitude of volunteer services that have been mobilized by PVOs throughout the world. An example of the mobilization of private sector services involved all the lumber companies in one country. For three days, they closed down in order to provide their personnel, vehicles, and gasoline to help carry out a nationwide immunization campaign. The sheer magnitude of the flow of resources from PVOs is often not appreciated by many development offices.

The PVO community is significantly strengthening their in-house technical capability in the health and child survival area as they organize to carry out grassroots-level programs. Technical staff positions are, increasingly, being filled with medical, nursing, and public health professionals who contribute to technically strong Child Survival projects.

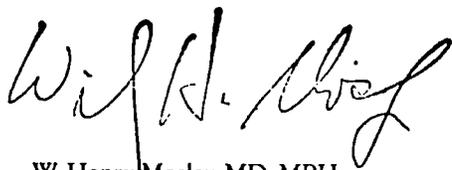
As the U.S. Government explores more flexible international development strategies—utilizing relatively smaller shares of government resources—the diverse, evolving PVO community offers exciting, alternative avenues designed to support the international development process.



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For the most part, the technological advances in the control of diseases have been the products of biomedical scientists working in clinical or laboratory settings. Thus, we have the powerful antibiotics, drugs, and vaccines which have proved highly effective under carefully controlled conditions. But in reality, diseases occur—and interventions must operate—under social conditions beyond the control of the biomedical scientist. Therefore, most health interventions are fundamentally social interventions. To be effective, there must be fundamental changes in the conditions under which poor health occurs. When these changes are imposed—as is typically done with environmental interventions—one may see dramatic effects, in particular because the greatest benefits may accrue to the most disadvantaged segments of society. When behavioral change can only be encouraged by cost subsidies and informational activities, the impact may be marginal with the most resourceful members of society reaping the greatest benefits.

A major attractiveness of Child Survival technologies to governments (and donor agencies) is their very low cost, coupled with an extraordinarily high potential effectiveness. Yet, the efficiencies and the potential can only be realized if these technologies are fully integrated by families into their own health-producing endeavors. The research and programmatic challenge is how to achieve this integration in the diverse societies of the developing world.



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TABLE OF CONTENTS

Strengthening PVO Child Survival	1
Lessons Learned: Special Topics	5
Potential of Women in Health and Development	
Training Health Workers, Mothers, and Other Members of the Community	
Integrating Health with Other Development Activities	
Monitoring a Project and Use of a Computer	
Mobilizing the Community for Health	
In-Country Coordination among MOH, WHO, UNICEF, and PVOs	
Supervision of Community Health Workers and Volunteers	
Baseline Studies and Midterm Evaluation	
Technical Task Force Recommendations	8
Diarrheal Disease	
Expanded Program on Immunization	
Reports from the Field	
<i>Africa Region</i>	11
World Vision Relief & Development Child Survival Project, WV/Zimbabwe	
Salvation Army World Service Office Child Survival Project, SA/Kenya	
Minnesota International Health Volunteers Child Survival Project, MIHV/Uganda	
Adventist Development & Relief Agency Child Survival Project, ADRA/Malawi	
Save the Children Federation Child Survival Project, SCF/Zimbabwe	
International Eye Foundation Child Survival Project, IEF/Malawi	
Adventist Development & Relief Agency Child Survival Project, ADRA/Rwanda	
<i>Haiti</i>	25
Foster Parents Plan International Child Survival Project, PLAN/Haiti	
International Child Care Child Survival Project, ICC/Haiti	
Salvation Army World Service Office Child Survival Project, SA/Haiti	
Cooperative for American Relief Everywhere Child Survival Project, CARE/Haiti	
Adventist Development & Relief Agency Child Survival Project, ADRA/Haiti	
What Child Survival Has Meant to Me . . . Impressions from the Field	33
Next Steps	35
Africa Region	
Haiti	
USA	
List Of Participants	37

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STRENGTHENING PVO CHILD SURVIVAL



In 1985 the Child Survival Action Initiative came into full force as Congress set aside special funds for growth monitoring, oral rehydration therapy, breastfeeding, and immunization activities. Since FY 1985, \$43 million in Child Survival (CS) funds have been directed toward private voluntary organizations (PVOs) through the central funding mechanism of the Agency for International Development, Bureau for Food for Peace and Voluntary Assistance, Office of Private and Voluntary Cooperation (AID/FVA/PVC). Funding of PVOs implementing Child Survival activities takes place annually through a competitive grants program. Child Survival I is the first group that received funding in 1985. There are currently 67 Child Survival projects, managed by 22 PVOs, in 21 countries that receive funding under the competitive grants program.

A diverse group of PVO Child Survival projects receives central funds from FVA/PVC. Some PVOs have large-scale health projects in a dozen countries where service delivery is the main focus, while others have relatively small, low-cost projects in one country, which focus on community mobilization. In both very ambitious and more modest projects the PVO field personnel are dedicated workers, striving to reach the goal of improving health conditions for the most vulnerable of all populations,

namely, children. Child Survival project managers, nurse mid-wives, health educators, and voluntary health workers (VHWs) worldwide face similar setbacks and successes, and experience similar frustration and elation as their projects progress. The Johns Hopkins University, Institute for International Programs (JHU/IIP), PVO Child Survival Support Program, through a cooperative agreement with FVA/PVC, provides implementation support to these Child Survival projects through orientation to new PVO CS field projects, monitoring and evaluation assistance, technical documents review, brokering of specialized technical assistance, field-based implementation workshops, and lessons learned conference activities.

The Implementation Workshop. Year 1 of the Child Survival project's life is very exciting. Once funding is awarded, PVO field staff spend months building the project's infrastructure and formulating the Detailed Implementation Plan, which acts as a guide to project activities, objectives, targets, and progress throughout the life of the project. As implementation begins near the end of the first year, projects from the same region, at the same stage in the project cycle, are brought together for an Implementation Workshop. These workshops are hosted by a PVO, organized with assistance from the PVO Child Survival Support Program and funded through FVA/PVC technical



Deey Storms



Robert Patterson

"A.I.D.-sponsored implementation workshops and Lessons Learned Conferences have helped PVOs working in the same area to learn about one another. Having this opportunity to share ideas gives you a new confidence, new energy."

—PVO Representative

support monies.

Implementation Workshops are unique in that they are rural based, making use of PVO Child Survival project sites as a classroom. During the Implementation Workshop, issues relevant to the projects represented are discussed. Through village visits, participants receive experience in performing surveys, meeting with health committees, etc. Each participant has a role in making the workshop a success. A participant may lead a task force, present a special interest topic, or help plan a Networking/Fellowship Dinner.

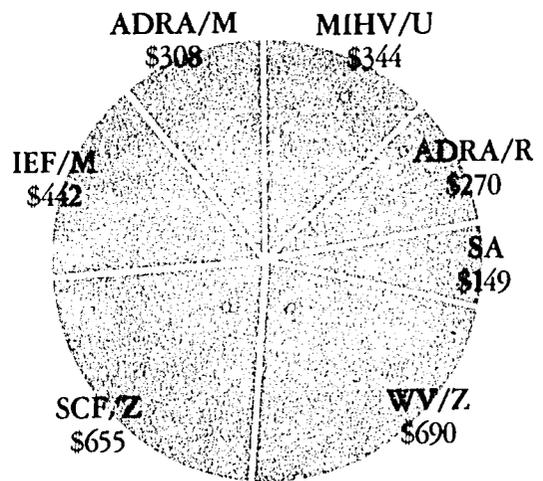
Workshop content is determined, in part, by way of a needs assessment, which each participant completes months before the workshop. Follow-up evaluations from Implementation Workshops have shown that these workshops provide useful information and skills training as well as a forum for idea sharing.

Overall objectives of the Implementation Workshop are to:

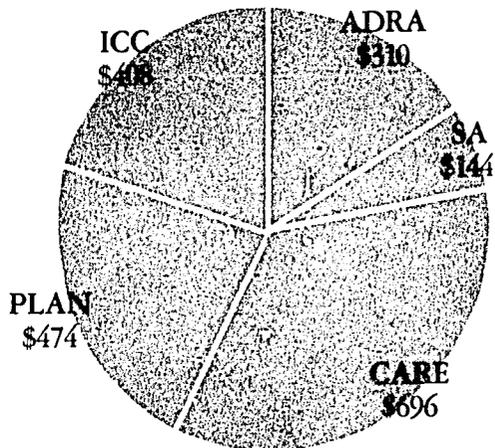
- Promote collaboration and information sharing among PVOs who have FVA/PVC-funded Child Survival grants.
- Facilitate the exchange of ideas and experiences among field personnel of PVOs working in Child Survival.
- Improve health information system (HIS), including monitoring, baseline surveys, evaluation, and the establishment of project indicators.
- Provide PVO field staff with practical training to improve the delivery and effectiveness of Child Survival interventions, including immunization, oral rehydration, growth monitoring, breast feeding, and birth spacing.
- Familiarize the PVO field staff with A.I.D. reporting requirements.
- Identify ways to improve the in-country coordination and communication of PVO Child Survival activities between host country governments, bilateral, international, and other non-governmental organizations working in health.
- Promote networking among PVOs in the same region and/or country.

The Problem Solving/Resource Sharing Workshop. Another vitally important member of the PVO Child Survival project team is the technical staff member, located at PVO Headquarters, who backstops the field project. Each winter the PVO Child Survival Support Program hosts a Problem Solving/Resource Sharing Workshop for Headquarters' technical personnel in order to help strengthen the link between headquarters and field offices, and to promote collaboration between PVOs.

A.I.D.\$ FOR PVO CHILD SURVIVAL I PROJECTS
1985-1988 Life of Project Budget



Africa: \$2.858 million



Haiti: \$2.032 million

African Projects: SA/Kenya, IEF/Malawi, ADRA/Malawi, ADRA/Rwanda, MIHV/Uganda, WV/Zimbabwe, SCF/Zimbabwe

Overall objectives of the Problem Solving/Resource Sharing Workshops are to:

- Facilitate the exchange of ideas, experiences, and materials among those PVO headquarter personnel responsible for technical support to Child Survival field projects.
- Provide PVO technical support staff with useful techniques for monitoring, reporting, and evaluating Child Survival interventions.
- Serve as a forum for PVO technical staff to give guidance to FVA/PVC on the conduct and direction of the PVO Child Survival Program.

The Lessons Learned Conference. The funding cycle of the first centrally funded PVO Child Survival projects (CSI) ends in the fall of 1988. These projects experienced the birth, growing pains, and maturity of the Child Survival Action Initiative. It is certain that a project which has worked over a three-year period, sometimes in adverse conditions, has stories to tell, experiences to share, and les-

sons learned to pass on. Those at FVA/PVC and the PVO Child Survival Support Program felt it was vital to create a forum in which CSI project representatives could share information about the accomplishments of their Child Survival project, with the plan of then disseminating this information to a widespread audience. The Lessons Learned Conference created this environment as CSI field project representatives gathered for an intense week of reviewing lessons learned and presenting recommendations to PVO Headquarter Offices, A.I.D., and collaborating agencies, such as the World Health Organization (WHO).

The following pages summarize the lessons learned and recommendations made by Africa Region and Haitian CSI projects at the 1988 Lessons Learned Conference held June 5-10 in Bologna, Italy.

1988 LESSONS LEARNED CONFERENCE • CHILD SURVIVAL I PROJECTS, 1985-1988 AFRICA REGION AND HAITI • June 5-10

Objectives:

To share the accomplishments, lessons learned, and recommendations of the first PVO Child Survival projects funded in Africa and Haiti.

To look closely at project activities that relate to the achievement of stated goals.

To identify ways of sustaining gains made in stimulating community demand for effective and affordable child health activities.

To share materials developed for Child Survival project management, supervision, training, social mobilization, health promotion, and assessment.

To CELEBRATE in recognition of hard work!

Participants:

The 1988 Lessons Learned Conference was attended by representatives from Africa Region and Haitian CSI projects. In FY85, the following 12 projects were funded:

Adventist Development & Relief Agency/Haiti,
Malawi, Rwanda*

Cooperative for American Relief Everywhere/Haiti
Foster Parents Plan/Haiti
International Child Care/Haiti
International Eye Foundation/Malawi*
Minnesota International Health Volunteers/Uganda
Salvation Army/Kenya, Haiti
Save the Children Federation/Zimbabwe
World Vision/Zimbabwe

One country national from each of these PVO Child Survival projects was sponsored by the PVO Child Survival Support Program and FVA/PVC to take active participation in the conference. Additionally, one representative from each of the nine PVO Headquarter offices attended. Collaborating agencies represented included the World Health Organization, The Johns Hopkins University School of Hygiene & Public Health, International Science & Technology Institute, and John Snow, Inc./Resources for Child Health.

*Representatives from ADRA/Rwanda and IEF/Malawi Child Survival field projects, and IEF USA Headquarters were, regrettably, unable to attend the 1988 Lessons Learned Conference.



LESSONS LEARNED: SPECIAL TOPICS



uring the conference, eight special topic sessions were held. The purpose of these sessions was to formulate a list of strategies that worked, strategies that did not work, and recommendations for the future in regard to each topic area. Each group was directed by a facilitator who encouraged maximum participation from the PVO field project representatives.

POTENTIAL OF WOMEN IN HEALTH AND DEVELOPMENT

Recommendations

Involve women in all levels of Child Survival interventions.

Realize that women have the greatest impact on the health of children and can impact on the community as well by promoting new ideas and encouraging other women to participate in community development schemes.

Recruit older, married women to work as community health workers (CHWs) in order to increase community acceptance of new ideas. Train all CHWs locally.

Combine individualized health education with the small group approach. Discussion sessions should be home based. Groups should consist of women with common interests in order to maximize health education effectiveness.

Consider male/female cultural relationships when designing structure of staff.

Provide maternity leave policy for female staff.

Coordinate project workplan with seasonal events (i.e., planting season, school calendar, traditional holidays).

Introduce Child Survival activities through existing women's groups (i.e., income-generating projects) in order to maximize long-term impact.

Promote increased involvement of women in decision making and membership in community organizations.

Educate men about the nature and content of Child Survival activities. As each section of the population gains an understanding of health issues, the effectiveness and impact of the program increases.

Promote family involvement by including men/fathers into some aspects of "women's" activities.

TRAINING HEALTH WORKERS, MOTHERS, AND OTHER MEMBERS OF THE COMMUNITY

Recommendations

Planning for the training and retraining of CHWs, and adequate budgeting for these activities, should be considered carefully.

CHW roles should be well defined and they should be given time to gain confidence in their role.

CHW task analysis and job descriptions should be used for developing activities and content of their training.

Materials and manuals should be tested before the training.

Adult/non-formal education methodologies should be used for information transfer.

Themes to be focused on during training should be limited.

Training-of-trainers sessions should be held and, when possible, mothers should teach other mothers.

Training should take place in local settings using small groups and the local language.

Evaluation of the effectiveness of the training should be based on whether key messages of the training were transmitted.

Pressure to accelerate the training process should be resisted as rushing training may produce negative impact on the overall structure of the Child Survival project.

INTEGRATING HEALTH WITH OTHER DEVELOPMENT ACTIVITIES

Recommendations

The Child Survival project should be integrated into and should build on existing structures in the community.

Community Health Coordinating Committees should be organized and urged to expand their focus.

Family registration, used for Child Survival project management, should also be used for identifying potential participants in other development activities.

Child Survival efforts should be coordinated with the development activities of other outside agencies.

The definition of Child Survival needs to be broadened.

A percentage of the Child Survival project budget needs to be set aside for use in funding activities that complement Child Survival efforts. These activities should be defined by the targeted beneficiaries.

If development activities that complement Child Survival are implemented, skills training, adequate time for implementation, and proper resources must be assured.

The time frame for Child Survival implementation needs to be lengthened so that integration of Child Survival with other development can successfully take place.

Projects moving into new geographic areas should take at least six months for community assessment and planning. The staff involved in this phase should come from the target geographic area.

Because adequate amounts of potable water are so basic in improving health, water supply programs should receive first priority when considering integration of Child Survival with other development activities.

MONITORING A PROJECT & USE OF A COMPUTER

Recommendations

When starting a health information system, first identify all reporting requirements. Work with the Ministry of Health (MOH) to develop a unified data requirement form.

Delineate a strategy for collecting the data and limit the data collection to project needs.

Train workers to collect data.

Utilize specialized technical assistance for starting the health information system and setting up surveys.

Use survey data collected for project monitoring and evaluation not merely to respond to donor reporting requirements.

Explore the possibility of using outside resources for data analysis.

Use a computer as a management tool when and if appropriate.

Keep the community involved during project planning, information collecting, and project monitoring.

Use graphics to present findings from data collected to community health workers.

MOBILIZING THE COMMUNITY FOR HEALTH

Recommendations

Be very specific in defining the "community." Consider the political and cultural issues that exist in the target area as mobilization efforts begin. Political boundaries do not always correctly define a community.

Perform a community needs assessment taking into consideration both felt and unmet needs. Apply the findings of the needs assessment when planning Child Survival project activities.

Set a slow and patient pace to project activities. Encourage community ownership of the project, realizing that implementation efforts may be slowed down as community education and mobilization take place. Project staff should refrain from being overly directive, letting the community make decisions and solve problems.

An additional, low-cost project year should be funded. During this year a member of the project staff would, working with a counterpart, perform a community needs assessment and orient the community to their role in upcoming development activities.

Use an integrated development/multisectorial approach in order to address equally important felt needs of the community and encourage active participation in development activities. Health development, in itself, is not complete and cannot stand alone.

Child Survival activities should be incorporated within, or include, a water supply or existing source protection project. Accessible water creates more free time for community participation in Child Survival activities.

Value of qualitative outcomes should be given more merit and achieving these outcomes (i.e., increased community participation) should be encouraged.

Feasibility studies should be funded in potential Child Survival project sites. These studies would provide the community a mechanism to influence the planning process as their ideas could be incorporated into Child Survival project proposals.

Include full-time, experienced community development personnel on the field project staff. Use health trainers from the national level to train regional staff.

Seriously commit time, money, and manpower for promoting community ownership of the project. Demonstrate that this program objective is a priority.

IN-COUNTRY COORDINATION AMONG MOH, WHO, UNICEF, AND PVOs

Recommendations

A PVO consortium should be organized in the country to allow for a coordinated and consistent approach to Child Survival activities in the country. Sub-committees that focus on specific development areas should be designated, i.e., Child Survival, agriculture.

In order to emphasize the importance of field-based activities, the PVO consortium should form a regional committee to meet in the field and facilitate local coordination.

Where national commissions for Expanded Program on Immunization (EPI), oral rehydration therapy (ORT), etc., exist, PVOs should become involved by attending meetings and supporting commission activities.

When planning Child Survival activities, there should be coordination with the MOH in identifying available resources, existing programs, etc. If project implementation does not occur jointly, there needs to be strong coordination between the PVO and MOH.

Communications between agencies should be constant, particularly regarding planning and evaluation of activities. Regular meetings, which are set up in advance, should take place.

Interagency visits of field sites should take place regularly in order to share, firsthand, information and experiences about project successes and constraints.

While a difficult undertaking, joint surveys should be attempted.

If the MOH is operating in the target area of the PVO, support (i.e., logistical) should be given, if needed, in order to help the MOH reach its program objectives.

The appropriate use of MOH personnel by the PVO project must be considered carefully. For example, hiring MOH personnel as part-time consultants may not foster coordination between agencies, but rather, could create confusion.

SUPERVISION OF COMMUNITY HEALTH WORKERS AND VOLUNTEERS

Recommendations

The primary health care team should develop a plan or protocol for supervision of CHWs and volunteers. Key elements to include are a definition of the supervisory methodology, a schedule of on-site supervisory visits, provisions for providing feedback to CHWs on their performance (i.e., checklists).

A job description should be written for each category of health worker. The job description should include the requisite knowledge, skills, attitudes, and experience. It should also include an area for task analysis and expected results reference, thus establishing standards by which performance can be assessed.

Joint MOH/PVO training and supervision should be encouraged. The curriculum used for training midlevel man-

agers should include a module on supervision. Trainers should also be involved in supervising CHWs.

Behavioral incentives should be used to foster mutual problem solving between the CHW and the supervisor. Supervision should offer opportunities for in-service training.

The supportive nature of supervision should be emphasized by listening to the CHW, acknowledging good performance, and giving rewards.

The community should be encouraged to take a greater role in supervising CHWs.

Mechanisms that allow CHWs to monitor their own performance should be devised. Involve CHWs in designing supervisory tools.

Anxiety and fear of reprisal should be diminished by separating the act of providing technical assistance from the act of evaluating the project.

Identify forums for PVOs to share their experiences with supervision of CHWs. One method would be through joint site visits.

BASELINE STUDIES & MIDTERM EVALUATION

Recommendations

Continue to use population-based approach.

Evaluations and surveys should be managed by well-trained and supervised staff.

PVOs should have access to a core set of rapid assessment techniques. A.I.D. guidelines on evaluations must be more explicit in regard to data requirements and collection techniques.

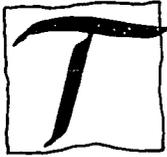
Requirements for annual reports, baseline survey, midterm and final evaluations must be readjusted in order to lessen time, money, and effort spent on these activities.

Data should be analyzed on-site and used for program decision making.

New strategies for mortality surveys are needed, particularly as the information impacts on program design and operations.

Field personnel and communities must receive feedback on survey results.

PVO TECHNICAL TASK FORCE RECOMMENDATIONS



Technical Task Force groups were formed at the beginning of the conference week and met daily to study the problem at hand and develop useful recommendations for A.I.D., PVO Headquarters, and collaborating agencies. The Technical Task Forces consisted of only field project representatives who are most directly involved with Child Survival implementation. The recommendations of the PVO Technical Task Force on Diarrheal Disease and the PVO Technical Task Force on EPI are as follows:

PVO TECHNICAL TASK FORCE ON DIARRHEAL DISEASE

Recommendations

Program development should be coordinated with the Ministry of Health/Combating Diarrheal Disease(CDD) programs to ensure consistency with national policy and norms.

Appropriate feeding practice in the management of childhood diarrhea should be emphasized.

Oral rehydration therapy should be reinforced by providing continuing education for project staff, VHWs, and families. This population should receive this educational contact on an average of twice per year.

VHWs should be provided clear and simple guidelines for the training and follow-up of families in the preparation and use of ORT. Clear and simple guidelines that address appropriate referral should also be developed.

Alternatives to the primary ORT strategy, for those cases in which recommended ingredients are not available, should be identified.

The emphasis on pretesting, reinforcement, and evaluation of CDD communications activities should be increased.

Education about preventive and rehabilitative interventions should be integrated into CDD activities, i.e., promotion of good nutrition, home gardening, vitamin A, etc.

PVOs should be encouraged to update strategies to reflect the current state of the art in the management of diarrhea.

PVOs should be encouraged to work with the government to develop effective CDD policy.

The training of select mothers to act as local resource persons while ORT skills are being transferred to the community should be encouraged.

Support for water and sanitation activities should be increased. The integration of ORT and water and sanitation activities should be encouraged as ORT does not prevent diarrhea and should only be used as a short-term development strategy.

ACTIVITY IN ORT*

	Distribution of ORT Packets, # of projects	Home-Made Based Fluid, # of projects
++	6	8
+	0	4
-0-	4	0
DK	2	0
Total # CSI projects	12	12

ACTIVITY IN EPI*

	Mass Immunization Campaign, # of projects	Fixed Immunization Centers, # of projects	Mobile Vaccination Teams, # of projects
++	3	5	7
+	2	2	2
-0-	6	3	3
DK	1	2	0
Total # CSI projects	12	12	12

*Each PVO may be involved in one or more activities

++: substantial activity +: minor activity -0-: no activity DK: don't know

This data is from the USAID Health & Child Survival reporting questionnaire.

ACTIVITY IN NUTRITION*

	Feeding Practice, # of projects	Growth Monitoring, # of projects	Supplementary Feeding, # of projects	Breastfeeding # of projects
++	9	7	4	6
+	0	0	3	4
-0-	1	2	3	1
DK	2	3	2	1
Total # CSI projects	12	12	12	12

*Each PVO may be involved in one or more nutrition activities.

++ : substantial activity

+ : minor activity

-0- : no activity

DK: don't know

This data is from the USAID Health & Child Survival reporting questionnaire.

PVO TECHNICAL TASK FORCE ON EPI

Recommendations

PVO EPI data and nationally reported data should not be compared unless both sets of data have been collected through reliable surveys.

PVOs focusing strictly on community involvement/social mobilization activities should consider utilizing the drop-out rate between DPT1/DPT3, or the "fully protected" rate, as a measure of their progress.

PVOs should work with the MOH to improve supply of vaccines, needles, and syringes and their transfer to the field.

PVOs should collaborate with each other and the MOH on joint EPI surveys within a country, developing similar management information systems and indicators of descriptive data.

The use of tetanus toxoid should be promoted by conducting surveys to determine community problems, community education campaigns, distribution of women's health cards, and strongly promoting the vaccination of all women ages 15-45 years.

Children who are referred elsewhere for vaccination should be followed up to assure compliance.

PVOs should adhere to the EPI policy of targeting the under-one population by focusing their education, promotion, and referral activities on these infants.

PVOs working in the same country should use the same EPI training curriculum.

All field staff should receive training in EPI policy issues and be provided with updated information regularly.

Technical assistance should be utilized to conduct baseline surveys and to develop EPI monitoring systems.

Technical assistance for EPI programs should be acquired at the local or regional levels. Lists of suitable individuals or groups should be compiled and shared with all.

The project budget should incorporate extra funds to pay for supplies in the event that the national program supply system breaks down.

PVO HQ staff should work in consort with the field staff in developing the project proposal to ensure that the field staff is prepared and knowledgeable upon receipt of Child Survival grant monies.

A.I.D. should consider funding pre-implementation planning grants to PVOs prior to funding fully developed proposals.

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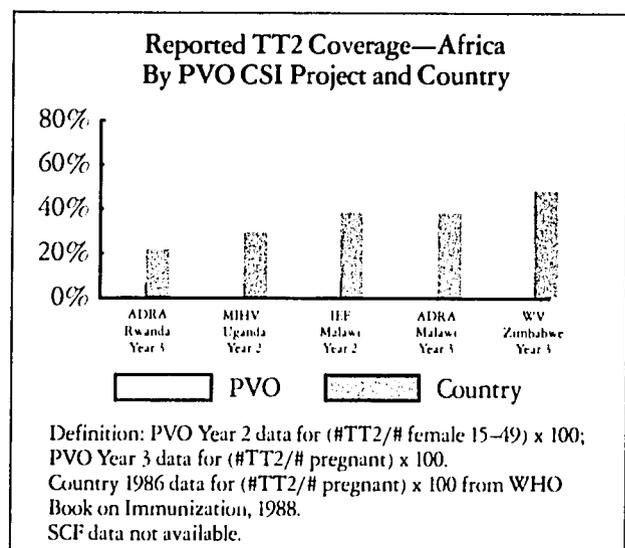
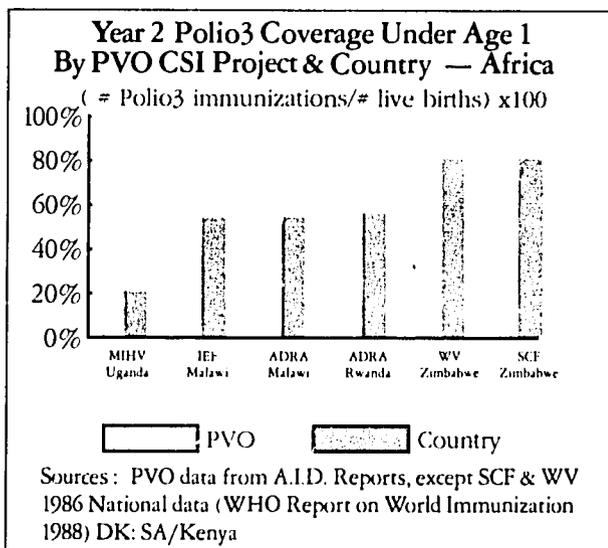
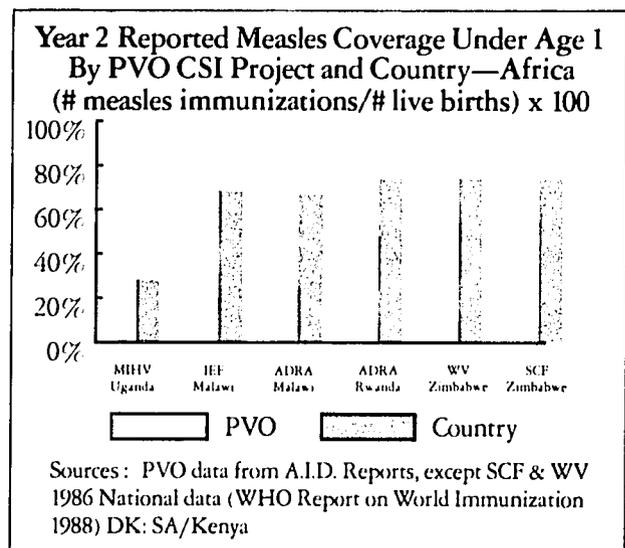
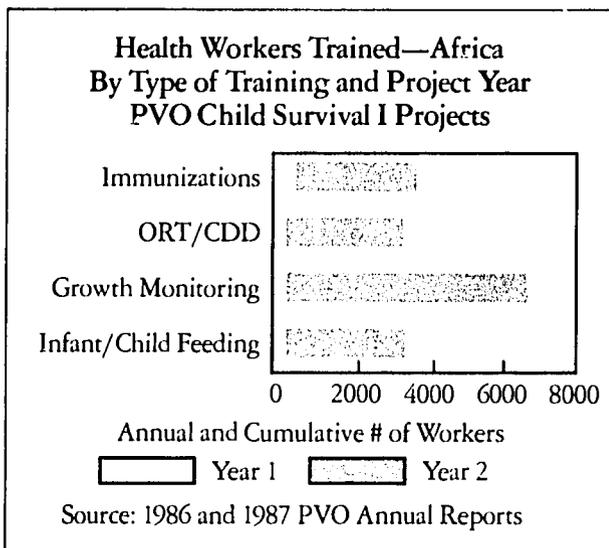
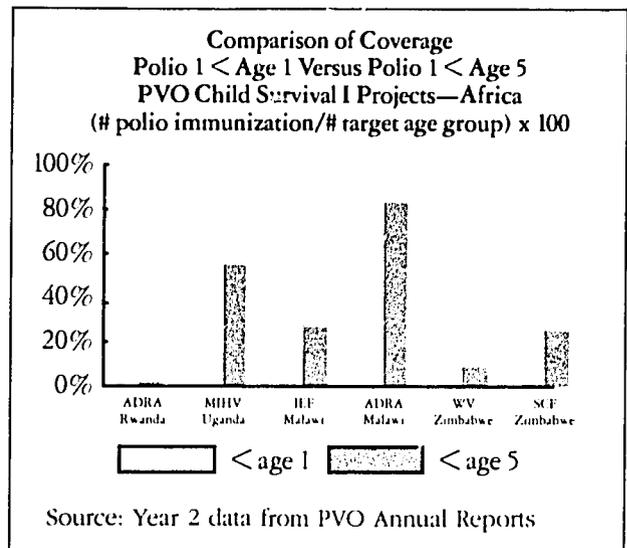


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REPORTS FROM THE FIELD · AFRICA



The conference week centered around Child Survival project presentations by field staff. A general guide for the presentation was provided to PVO field staff prior to the conference. Field staff were asked to prepare a written report and present it at the conference. An enormous amount of valuable, specific information was shared during these sessions as project representatives spoke candidly about project accomplishments, constraints that were faced, and lessons learned. The following pages contain abbreviated versions of the Child Survival project presentations. The information that follows remains in the basic report format that was used by each project representative. Editing has been kept to a minimum in order to preserve the essence of the experience we all had while listening to these presentations at the Lessons Learned Conference.



WORLD VISION RELIEF & DEVELOPMENT,
INC. CHILD SURVIVAL PROJECT
WV/ZIMBABWE

Project Overview. The WV/Zimbabwe Child Survival project is situated in the district of Murehwa, one of Zimbabwe's 55 districts, 85km northeast of the capital. The district covers an area of 203,000 hectares/507,000 acres. The total population of this district is 152,000 (1982 census). The majority of the people in this district are farmers. Due to its proximity to the city, most of the male population work in town, and women are left to take care of the children and agricultural production. The district suffers from the problems of poverty and poor soil quality.

The project was first implemented in a small area within the district, covering a population of about 18,000. The purpose of taking a small area was to learn and assess whether to expand the project and to correct mistakes. The Child Survival project is divided into three sections, commonly referred to as impact areas (i.e., Areas I, II, and III).

The activities of Areas I and II include oral rehydration therapy, growth monitoring/nutrition, training and social mobilization, other maternal health activities, and family registration.



Sick Danforth

The district has two hospitals and 10 rural health centers (RHC). They are fixed facilities that carry out maternal and child health activities daily. The Child Survival project has established 36 outreach points and outreach teams have been designated to implement the selected Child Survival interventions at each of the 36 outreach points. The outreach team circulates to each of the points on a monthly basis where they immunize pregnant mothers and children, demonstrate good water usage and sanitation habits, and perform growth monitoring on all 0-5 year olds. The outreach team is joined by family planning pill distributors on all their activities, including training.

The oral rehydration therapy intervention has been the project's focus for implementing the Control of Diarrheal Diseases Program in the project area. The approach has been through the training of community health mobilizers (preschool teachers, community leaders) and the re-training of various extension workers of the government of Zimbabwe and other non-governmental organizations. Training has included oral rehydration solution preparation and nutrition education.

For the Child Survival project to have a demonstrable impact and to fulfill the long-term objectives, the community must be actively involved in all aspects of the project. Training at the village level, then, is based on the key strategies of community or social mobilization. This people-oriented approach in project implementation has truly given ownership of the project to the people.

"Pungwe" is a cultural gathering, open to all, which allows maximum participation through the spontaneous contribution by an individual or group and encourages all members to join in the songs, drama, and dance. In recent years, the pungwe has played an important role in the social and, particularly, the political mobilization of the people. It was this existing communication channel that the World Vision Child Survival project incorporated into its own social mobilization strategy. The community took an active part in identifying additional needs in relation to maternal and child health through these meetings.

Preschools were identified by the communities as a priority need so they were integrated into the Child Survival project, eventually evolving into village development centers (VIDECs). Immunization, growth monitoring, nutrition demonstrations, family planning education, agricultural meetings, and women's club meetings all take place in the VIDECs. The centers are comprised of a community hall, demonstration kitchen, nutrition garden, protected well, and Blair toilet.

In this same way, the community was mobilized to take an active part in planning the initial implementation strategy by involvement in data collection. This data collection exercise enabled community members to increase their awareness of the health problems and conditions that

confront them and to discuss progress and setbacks at regular village meetings and be directly involved in the ongoing supervision and monitoring of the project.

The level of community participation resulting from the social mobilization process is demonstrated in every contact with the villagers. Their enthusiasm is evident as they tell the history of the Child Survival project in their village, as they describe the problems encountered and solved, and as their plans and aspirations for the future are mobilized. Songs and drama remain the most effective media of expression.

Project Accomplishments

Coordination/Collaboration. The collaboration of the Zimbabwe Child Survival project is from the national, provincial, and district levels. The team belongs to the various health committees in the Ministry of Health. There are monthly meetings on the Expanded Program on Immunization, of which the Child Survival project is a member at the national level. There are donors' EPI meetings once every quarter in which the health department participates. There are also provincial meetings every month, which the Child Survival project members attend to give reports on their activities.

Community Participation/Motivation. In Areas I and III, 36 Village Health Committees have been established. Representatives from these committees meet with the Child Survival team every two months to discuss progress and review project activities.

At every VIDEc, a toilet and a protected well have been constructed to act as a demonstration to the whole community. The community contributes considerably in the construction of the VIDEcs by molding bricks, digging holes for toilets, digging wells, and carrying sand and stone.

Oral Rehydration Therapy. Role play is used as a method of training in the preparation of the solution. 73% knew how to prepare sugar-salt solution (SSS) properly; 84% had used it; 76% had used it correctly; 36% had toilets and, of these, 17% had the government of Zimbabwe standard Blair toilet; and 26% had protected wells.

Immunization. 70% of the children 0-11 years old will have completed their immunization by their first birthday. 80% of all 0-5 year olds will be completely immunized by the end of the project life span. Accomplishments to date are Measles-79.3%, DPT 3-83%, BCG-96.7%. The dropout rate was estimated to be 17.4%.

Lessons Learned

Three years is a short period of time for a project to be implemented with all the required planning processes. The foremost thing is to identify the needs at the field



level prior to writing the proposal, i.e., involve the field workers and staff.

Next, needs differ from country to country according to the policies.

Control of diarrheal diseases cannot be treated in isolation. Water and sanitation improvements need to complement ORT activities. Local resources need to be evaluated in setting realistic goals.

Finally, a factor that has to be considered is the duration/life span of the project. The first year is usually spent on planning, the second year on mobilizing the community and resources. By the end of the second year and in the third year, you may start implementing. Thus, three years are over when the community is starting to understand project intentions.

Another major issue that needs to be addressed is the technical nature of Child Survival. This area needs highly qualified staff in the respective areas, and people hired here must be attracted by the opportunities and challenges.

Both at the international and field levels, health capabilities for WV were strengthened by the recruitment of staff specializing in the health field.

The PVO Child Survival Implementation Workshop, hosted by WV, was an extremely good way to enhance interagency collaboration by creating the opportunity for idea and experience sharing.

Presented by Sibonginicosi Mushapaidze, WV/Zimbabwe

SALVATION ARMY WORLD SERVICE
OFFICE CHILD SURVIVAL PROJECT
SA/KENYA

Project Overview. The major premise of the SA/Kenya Child Survival project is to provide health education for rural women in GOBI-F strategies. This is to be provided through the SA "Home Leagues," a weekly meeting of women held in SA churches. There are approximately 50,000 Home League members in Kenya. This project was designated to train the leaders in the Home League so that they could then share their knowledge with other members and in the wider community. Since the SA has no health services delivery infrastructure in Kenya the project was designed to operate by drawing upon government health services.

The project area includes 20 rural communities of the Machakos District with an estimated population of 1.5 million. The communities' predominant means of livelihood are subsistence farming, coffee growing, and tanning hides. The area is extremely dry with a constant water supply problem.

All the local women who are trained are volunteers. Incentives given are tea and bread, soap for washing their uniforms, badges and ribbons as they pass various stages of the training, and bags to carry their equipment for home visiting.

A qualified community health professional was hired to coordinate project activities and train the women.

Project Accomplishments

Coordination/Collaboration. Support from the MOH has been excellent, project staff meet regularly with MOH officials at the district level, and there are ongoing interactions with the MOH District Health Management Team.

The project has experienced the approval of community leaders. The Machakos district medical officer of health takes a close interest in the project and is a regular visitor when seminars take place.

Oral Rehydration Therapy. While approved by the MOH, ORS packets are in short supply. The project found it best to purchase plastic measuring spoons and to teach women to mix homemade sugar and salt solution. Women are given a demonstration of how to prepare SSS using the local languages. They are then asked questions to ensure they have understood and, finally, they are asked to demonstrate the mixing of SSS.

Immunization. The project attempts to motivate mothers to seek MOH immunization services for their children. In 19 of the project communities mothers are sent to the MOH dispensary for immunization. In one project community there is no dispensary so the project vehicle is used to bring MOH staff to the site to provide

immunization services.

Growth Monitoring and Nutrition. The project puts strong emphasis on teaching the importance of good nutrition and, in conjunction with this educational activity, trains Home League leaders in growth monitoring using weighing scales and arm bands. When serious nutritional problems are discovered these cases are referred to MOH clinics and health centers.

Training. The major achievement of the project has been the training of Home League trainers. The women are given training in stages and are tested by the project coordinator at each stage. The MOH district medical officer of health is warm in his praise for the effectiveness of this training and the degree of proficiency that the women have reached. He has now requested that women trained under the project should be used to pass on their knowledge under MOH training schemes. The women have gained a sense of self-respect because of the higher standing they have gained in the community.

Constraints

In the community of Ukalani a difficulty was encountered when nutrition surveys uncovered a malnutrition rate of approximately 40%. The project had no means to address this issue. The dryness of the land, the lack of food and of income meant that there was no simple answer to improving the children's nutritional status. The only solution that could be found was to introduce supplementary food distribution on a temporary basis.

But, the volunteer workers found themselves overwhelmed by the volume of work they were asked to do, both in weighing sessions and in record keeping, and as a result were discouraged. It was found necessary to limit the weighing sessions and to simplify the record-keeping system. Reporting requirements as a whole were found to be very demanding.

Targets were found to be too optimistic. While the project has kept on schedule, it has not been able to achieve all its goals.

It was disappointing not to have been able to carry out a baseline survey. Though a consultant was engaged for this purpose, the task was never completed, which limited our ability to determine real effects of the project activities.

Lessons Learned

Plans to recruit and engage qualified personnel and needed equipment should be made early and should be budgeted for realistically.

The most important factor in making this project possible was the close cooperation with the MOH. Obtaining the support of the local community has also been a critical factor in our project's success.

Presented by Margaret Taylor, SA/Kenya

MINNESOTA INTERNATIONAL HEALTH VOLUNTEERS CHILD SURVIVAL PROJECT MIHV/UGANDA

Project Overview: The site for the MIHV/Uganda Child Survival project is the Kasangati Health Center (KHC). KHC is in a periurban area 14 km from Kampala, the capital of Uganda. The area served has 35,000 people living in homes scattered over green rolling hills. Most of the people are peasant farmers who grow plantain, cassava, maize, sweet potatoes, beans, fruits, vegetables, and coffee. Educational and economic levels are above average for the country. The climate is comfortable with two rainy seasons and a mean annual maximum temperature of 27°C. Most of the people are Baganda and either Christian or Muslim.

MIHV began the rehabilitation of the KHC in 1983. In 1985 the community based health care (CBHC) program, headquartered at KHC, was planned. The CBHC program was first formulated and managed by the health educator of the KHC and MIH volunteers. Now the staff members managing the CBHC are a health visitor (HV), two assistant HVs, a driver, and a clerk who has been hired to keep statistics for the required A.I.D. reports. Most of the training and supervision of community health workers is directed by the HV. CHWs make home visits and when necessary refer patients for medical care to KHC where they are treated by the KHC staff, which includes a medical officer, medical assistant, nurse, midwives, and nurse

aides. As an affiliate of the Institute of Public Health, Makerere University, patients can also be referred to Mulago Hospital, a teaching hospital 12 km. away.

The CHWs function in a two-tier system: 1) there is one primary health care worker (PHCW) for each of the 10 zones of the target area who is responsible for 250 to 1400 households, and 2) there are family health workers (FHWs) within each zone who visit 30 homes each. So far 150 FHWs have been trained and more PHCWs are currently needed. None of the CHWs are being paid by the project, but an experimental cost recovery scheme may provide a small stipend to the PHCWs in the future, but none is planned for the FHWs. The PHCWs have the use of bicycles, which were donated by Rotary International via the KHC. PHCWs are also entitled to free medical care at KHC.

Resistance Committees (RC) are the locally elected bodies who select the CHWs.

Project Accomplishments

Community Participation/Motivation. Resistance Committees have been used to introduce workers, explain immunization, and plan spring protection. RC members support the CHWs by participating in graduation (from training) ceremonies and workshops. Some CHWs are active members of the RCs.

A nearby dispensary ward has been made available for inpatients who do not require a regular hospital. These



John Grant



Daniel Smith

patients are attended to by the dispensary's medical assistant or the KHC medical officer.

One MIH volunteer has worked closely with the subcounty health assistant on spring protection. She has brought him together with the PHCWs who mobilize the people to collect material and to build the springs when the Water Development Department (WDD) brings cement. This activity requires the cooperation of the PHCW, the health assistant, the MIH volunteer, the WDD engineer, and a craftsman.

Oral Rehydration Therapy. The project follows the guidelines of the national CDD program; thus, ORT is used for diarrhea treatment. CHWs have been taught the prescribed method of mixing a sugar-salt solution. They teach families this method during home visits, or in small groups, and distribute oral rehydration solution (ORS) packets.

Immunization. Vaccines and all material for immunization are supplied by UNEPI, the national EPI program. KHC keeps immunization statistics by age and forwards these data via the district medical officer to UNEPI. The highest number of vaccinations was given in the first quarter of 1987 (3,500/mo). Now the monthly average is 1,300.

Most vaccines are now given to infants rather than, as was previously done, to older children. We made a special effort in our smallest zone to stimulate attendance for immunization by house-to-house visits before the monthly clinic day. Seventy children were brought instead of the

usual 20. Thirty of these were already fully immunized but had come for weighing. Last year 72% had received BCG, 73% had immunization cards, and 53% of under fives were fully immunized.

A special study was conducted to find out people's knowledge and attitude about immunization. 90% said that measles could be prevented; 50% mentioned immunization and 40% described various traditional means to keep the disease from entering the house or the body. The ability to prevent polio by immunization is recognized by 55% of the population. Two-thirds of the population immunize their children to prevent disease. Others immunize their children only because so ordered or because immunizations are given during visits for treatment of illness. Reasons given for not immunizing include fear of consequences, grandparents' beliefs, and inconvenience. 95% are aware of the KHC program. Home visiting and health education were cited as the best ways to increase immunization coverage. Three-quarters of the population are already reached by health education.

Growth Monitoring. Every child who is seen for immunization or because of illness is weighed and the weight is plotted on the growth chart. About 55% of those attending the clinic were weighed in the previous two months, 65% are gaining, and 20% are losing or not gaining. The rest are newcomers who have not been weighed before. 11% weigh less than the third percentile for age.

We try to evaluate all children whose growth falters and to give some advice. When this occurs on several occasions, that is, the shape of the curve or the appearance of the child is cause for concern, referral is made to our nutrition clinic or to a health worker. Attendance at the nutrition clinic is variable and might be more regular if we would again carry out cooking demonstrations and distribute some food. This clinic is part of a national nutrition rehabilitation program centered in the capital.

Health Information System. PHCWs file a monthly report listing their activities. They meet with their supervisor monthly to visit homes with problems. All workers meet at KHC monthly for discussion of their work, continuing education sessions, and planning. Sometimes they are tested, i.e., in the use of drug dosage cards, ORT, etc. An evaluation form is used which evaluates the PHCWs status as a role model, i.e., immunization of their own children, cleanliness of their home, etc., and includes random visiting of their homes.

A KAP study regarding PHCWs was done in 1986. Two-thirds of the population had heard of the program, half knew the name of their PHCW, half had been visited, and one-third had sought advice. 88% were satisfied with service received and 99% said they would help to pay their PHCW.



John Grant

"We need to educate men about the nature and content of Child Survival in order to increase the effectiveness and impact of the program."

—PVO Representative

Constraints

One PHCW died, one moved away, and one abandoned his work. One replacement was trained individually, an inefficient use of resources. A new training cycle is needed to replace and to add PHCWs to the biggest zones.

About 50% of FHWs became inactive soon after finishing their training. Many are young people who take up new jobs or marry and move away. Others find that they are too busy with their own families and cannot, or do not want to, spend time home visiting. Dropout of CHWs delays complete coverage of the area. Village committees are slow to appoint candidates because they have other duties.

The project director became involved in a nationwide education program keeping him away from KHC much of the time. The health visitor had a difficult pregnancy and a long maternity leave. These situations curtailed supervision, but with help from the assistant health visitors the project continued to function.

A military coup forced postponement of the start of the CBHC project. Computer problems at the Institute of Public Health delayed transmittal of results of the baseline survey.

Monitoring of measles, polio, neonatal tetanus is attempted by asking the PHCWs to report any case to us. However, such reporting tends to be incomplete and the accuracy of the diagnosis is in doubt. Several cases are

reported nearly every month by the PHCWs, even at a time when none appear in the clinic.

Lessons Learned

PHCW and FHW selection, which is made by the community, is not always ideal. It is best if the CHW does not have a regular job outside the village. Our best workers are local farmers, housewives, and retired men.

Home visiting was identified as the best way to get children immunized.

Supervision of, and frequent contact with, CHWs is difficult to maintain. Supervisory visits must be scheduled and HC staff must realize that supervisory visits are as important as their other duties. Rewards, benefits, or lack thereof must be clearly understood by the CHWs before and during training.

It is difficult for the Resistance Committee members to be aware of all the work done by the CHWs as they have other concerns and responsibilities. Although we are available to inform RCs of CHW activities, we are rarely asked to speak at their meetings.

Health education is a difficult job. It does not merely consist of formal talks, rather, every contact the community has with a health worker is part of health education. Lecturing is not an effective form of health education. But it is very difficult to change techniques or to know the best way to promote the immunization program. The scientifically based explanation reaches only some people.

Record keeping by CHWs is incomplete. It should not have priority.

Weighing children every two months until age 5 is not likely to get done. But, a special effort should be made to increase weighing for the most vulnerable age of 1-3 years.

Presented by Mary Kagwa, MIHV/Uganda

ADVENTIST DEVELOPMENT & RELIEF AGENCY CHILD SURVIVAL PROJECT ADRA/MALAWI

Project Overview. In Malawi, a political commitment to preventive as well as curative health services has fostered the growth and development of primary health care. Recent emphasis on Child Survival is consistent with the long-term emphasis on the health of children and mothers.

Almost half of the health services in Malawi are provided by church-related health institutions working in close collaboration with, and partially supported by, the MOH. The ADRA/Malawi Child Survival project was conceived to initiate a movement toward community-oriented PHC with emphasized interventions in immunization, ORT, growth monitoring, nutrition, and home gardening. The scope of the Child Survival project includes areas that lie in the vicinity of 13 medical/health centers operated by the Seventh-Day Adventists. Seven of these clinics lie in the Northern Region and six in the Southern Region. The target population includes Malawian children (age 0-5) living within a 5-mile radius of the medical/health centers.

The strength of ADRA projects in Malawi is the personnel. Child Survival personnel include three regional supervisors, 52 CHWs, 12 Community Health Committees, and 112 voluntary village health workers (whose incentives are clothes and shoes). These staff aim to provide comprehensive services to the population. Marketing activities include discussing times and dates of clinics with local leaders, displaying times and dates of outreach clinics in prominent places in the communities, i.e., market, headman's office, school, and the traditional birth attendants/(TBA) house. Project staff strive to keep the clinic running regularly, at the appointed date and time, so that families are not disappointed. Unfortunately, we will have to discontinue services during the rainy season, but we will inform the local community in advance.

Project Accomplishments

Community Participation/Motivation. The local community is encouraged to provide resources to assist in running the clinic, i.e., buildings, volunteers, and the Village Health Committees encourage the families whose children are behind in immunizations to attend clinic. The Village Health Committee appoints someone, once a month, to make a list of all children under two years of age, to add the names of new children as they are born, and to check immunization records to assure that they have received all their immunizations.

Immunization. Immunization clinics are conducted daily at the dispensary and twice a month away from the clinic. Clinic days and times are posted and are advertised during health education sessions. Antenatal clinics are also scheduled at regular intervals and all women who attend receive immunization. At the end of the year, coverage rates for each vaccine are evaluated. During the period January-December 1987, there was a total of 15,029 children fully immunized, and during January-March 1988, the total immunized was 8,128.

Outreach. We visit the labor ward every day and inquire as to whether there are women or infants for discharge. We carry vaccines with us, immunizing mothers and infants in need. At the same time we issue Under Five Cards and give appointments for the Under Five clinic. Villages are also visited monthly in order to see how many children have been born or have died.



Dorothy Stearns

Home visits are carried out to see immunization dropouts, growth monitoring dropouts, and to check health cards of babies. Health education sessions are also carried out in the homes once a week for the mothers of high-risk children. These sessions give mothers the opportunity to ask questions.

Sanitation. Project personnel do home inspections to look for good conditions, i.e., pit latrine, enough food, rubbish pit, drying rack for dishes, source of clean water, bathing shelter, shelter for cattle, and kitchen garden. We also discuss parasitic disease control during health education sessions.

Health Information System. On a routine basis we estimate the progress of our interventions and identify areas where we can reorganize and improve services.

Presented by Ellestina Nkumba, ADRA/Malawi

SAVE THE CHILDREN FEDERATION CHILD SURVIVAL PROJECT SCF/ZIMBABWE

Project Overview. SCF/Zimbabwe (ZIMSAVE) Child Survival activities are fully integrated into the SCF development program. Child Survival activities are being implemented in three areas of the country: Mupedzanhamo, Muusha, and Mutema.

Mupedzanhamo is located in the commercial farming section of Harare's rural south District of Mashonaland-East Province. It begins just eight miles south of the city of Harare and extends for approximately 20 miles on both sides of Beatrice Road. Child Survival is being implemented in 32 relatively large commercial farms. The target population, as of February 1988, was 1,893 families, with a total population of 9,318 persons. The population in Mupedzanhamo represents the most seriously disadvantaged segment of people in Zimbabwe. Since they live on private property, there are no government services available and generally there are not health services. Prior to the Child Survival project, there were no farm health workers in this area.

Child Survival activities in Muusha cover four wards: Chikwakwa, Mhakwe, Shija, and Gudyaga. SCF has been operating in this area since 1983 and has well-developed projects in the fields of school construction, water development, assistance to early childhood education centers, sanitation, and income-generating projects. The population is made up of small-scale farmers with limited cash income. The terrain is bad, making some areas inaccessible to vehicles. The target population, as of February 1988, was 2,626 families, with a total population of 13,052 persons. Ministry of Health programs are well established in Muusha, but resources are inadequate to fully cover the population.

Mutema is the area in which Child Survival was implemented last. As of February 1988, the target population was 2,500 families, with a total population of 13,850 persons. Child Survival, in conjunction with other SCF projects, is being implemented in two wards, Chisungo and Bangwe Maunganidze. The population here, like Muusha, is made up of small-scale farmers with limited cash income. The area has marginal rainfall, which impacts on the nutritional status of 0-5 year olds.

ZIMSAVE Child Survival project, which is designed to supplement and augment the MOH program, is being implemented with the community development approach. The program involves the community at all levels and utilizes Village Development Committees (VIDECs) and Ward Development Committees (WADCOs), many of whose members serve on the SCF Coordinating Commit-

tee. These committees mobilize the community as well as give feedback on all activities within their areas. The committees hold monthly meetings where they discuss all development projects in their area. Progress or problems in Child Survival are also discussed at these meetings.

The resources available to the ZIMSAVE Child Survival project are: 1) funding from A.I.D., 2) community contribution through VIDEK and WADCO, 3) SCF Child Survival staff, 4) rural health center staff and other MOH staff who play a major role in the immunization intervention, 5) schools and early childhood education centers for outreach points, and 6) village health workers/farm health workers (VHWs/FHWs) who train, mobilize, and supervise the community.

VHWs/FHWs are part of the community and are voluntary workers who attend monthly meetings with their supervisors to report on births, deaths, migrations, etc. While they are supposed to be part-time workers, due to their commitment to the project, they have found themselves working on a full-time basis on a very small allowance.

The Ministry of Health employees directly involved in Child Survival are from the rural health centers. These are nurses (some of whom are midwives) whose main role has been to work with the Child Survival staff in vaccinating the children and giving antenatal care at outreach points. In addition, MOH staff attend Child Survival meetings and are sometimes utilized as resource people for Child Survival training programs.

Next is the district health team made up of a district medical officer (DMO) and district nursing officer (DNO), whose major role is to oversee Child Survival activities and give technical support. This team compiles data from their district, including Child Survival statistics, which are reported at the provincial level. The district medical officer calls monthly meetings which ZIMSAVE Child Survival staff attend. Any problems the project is faced with are dealt with at this level.

The provincial medical officer (PMO) is the overall health administrator for the province. This office calls quarterly meetings, which ZIMSAVE Child Survival staff are invited to attend.

The main tool for monitoring the project is the health information system, which includes family enrollment forms, registers for each intervention, monthly report forms, births/deaths reports, and Road to Health Cards. The project has trained one VHW/FHW per 50-100 families for each impact area. Even with little formal education these VHWs/FHWs are able to collect data and give feedback to their supervisors and community. VHWs/FHWs meet with their supervisors to update them on activities in their area on a monthly basis and discuss problems and new strategies.

Project Accomplishments

Oral Rehydration Therapy. ZIMSAVE Child Survival has accomplished a 100% utilization rate on the ORT intervention to date. This can be attributed to intensive training of families by VHWs/FHWs, as well as the 1985 extensive national CDD campaign by the MOH. VHWs/FHWs have been trained to recognize dehydration, the preparation and use of ORS, feeding of the child during and after diarrhea, and when to refer a child to a clinic. The strategy used to train families is mostly through individual or group demonstrations in homes, at rural health centers and at outreach points. VHWs/FHWs visit all children with diarrhea and supervise the ORT until the child recovers.

Immunization. ZIMSAVE Child Survival has documented an increase in immunization coverage in all three impact areas. This can be attributed to the additional outreach points established with MOH in each area, as well as the motivation of families to attend immunization sessions at rural health centers and at outreach points. Child Survival provides transportation for MOH staff and assists the rural health center staff at outreach points. MOH provides most immunization supplies, sterilizers, cold chain equipment, and vaccines.

Constraints

Lack of rural health centers in some parts of the impact areas has created a problem of distance for MOH and Child Survival staff in servicing outreach points. In areas where the terrain is bad, supervision of VHWs and families is still very difficult. The one vehicle used for outreach activities and supervision is not adequate.

The drought in Zimbabwe, for the last three years, has created a problem for the nutrition intervention component of the project.

The Ministry of Community and Cooperative Development and Women's Affairs (CCDWA) has recently been given managerial responsibility over the VHWs. As a result, the VHWs are involved in several development activities, in addition to Child Survival. Thus, it will not be possible for VHWs to supervise families as intensively as they used to.

ZIMSAVE Child Survival experienced a mass exodus of its staff in the third year of the program when it was not certain that the program would be refunded. The situation has been alleviated by the reallocation of staff and the utilization of interns for data collection but, still, the Child Survival staff is working under strenuous conditions.

Lessons Learned

It is essential to hire and train all staff prior to implementation of any project.



John Grant

The future of a project, after the agreed period, should be clarified to avoid massive exodus of staff.

Vehicles and all other equipment for any project should be procured ahead of time to avoid delays in initial project implementation.

A sound health information system is necessary for the success of any project.

Any Child Survival project needs clear and attainable objectives and indicators of its success.

It is advantageous to have close involvement of the beneficiaries and the host government for project support and sustainability.

It is essential to make budget estimates for each intervention, leaving unallocated funds available for inflation and unpredicted expenditures.

VHWs/FHWs with little formal education can be trained to maintain rosters, registers, etc.

It was advantageous to implement projects in areas where SCF had already established itself.

It was advantageous that the staff recruited for Child Survival had all previously worked within the MOH and, therefore, were familiar with MOH policy for the various interventions.

Presented by Gladys Furusa, SCF/Zimbabwe

INTERNATIONAL EYE FOUNDATION CHILD SURVIVAL PROJECT IEF/MALAWI

Project Overview. The IEF, a private voluntary organization dedicated to prevention of blindness in third world countries, is carrying out Child Survival activities in the Lower Shire Valley of Malawi, located in the southernmost portion of the country. The population in this area is approximately 400,000, of which almost 80,000 are children under the age of 5. In addition, another 300,000 Mozambican refugees are estimated to have settled in the Lower Shire Valley over the last two years, placing an even larger burden on an already overextended health system.

The significant health problems found in the target population range from childhood diseases to most of the chronic, debilitating parasitic infections and tropical diseases. The IEF project focuses on addressing those problems arising from vitamin A deficiency and malnutrition, trachoma, measles, and diarrheal disease. These diseases are interrelated and have common risk factors, such as access to potable water, sanitation, poverty, and lack of education—all conditions that are present in the Lower Shire Valley. The childhood mortality rate in Malawi is estimated at 330 per 1,000, and the infant mortality rate is 151 per 1,000 live births per year.

Project health interventions being implemented can be broken down into five main categories: provision of services, training, provision and distribution of project and training material, provision of logistical support for the Ministry of Health EPI- and ORT-related activities and personnel, and strengthening of data collection and analysis.

Provision of services consists primarily of distribution of vitamin A capsules and tetracycline ointment through a network of government health personnel (e.g., ophthalmic medical assistants, health surveillance assistants, clinical officers).

Training is a major focus of IEF's project. This involves workshops in primary eye health care for ophthalmic medical assistants (OMAs), health assistants, nurses, and health surveillance assistants who staff the rural health centers and posts. The other aspect of training involves the routine teaching of EPI/ORT as well as personal hygiene, sanitation, nutrition, growth monitoring and village health committee establishment, supervision and monitoring—both to the government core health staff at rural centers, and at the community level to traditional birth attendants, village health committees, women's groups, traditional authorities, etc.

IEF has provided to the network of government health staff involved in the project those training materials

which have been developed for Child Survival activities by government, WHO, and other organizations. In addition, new training materials have been developed and incorporated into the training curriculum in order to ensure that EPI/ORT skills of the training program are more effectively applied in the field.

In order to ensure maximum coverage in the field IEF surgeons and project staff have set up travel schedules that permit piggybacking by the maternal and child health (MCH)/EPI supervisors and government outreach staff to support their transport needs. To assist the health surveillance assistants in the field with their transport needs seven motorcycles have been provided through a collaborative effort with the local Rotary Club.

In addition to IEF's primary goal of recognition and treatment of eye disease, a key secondary goal is the establishment of a strong capability for advancing EPI/ORT coverage levels. Data coverage already exists but needs more quantifying to be useful. IEF is developing monitoring techniques in order to expand the data collection and facilitate quantification.

Project Accomplishments

Service Delivery. As a technical organization with a long history in the delivery of medical services, IEF has been particularly successful in the provision of direct services to the target population—most notably, vitamin A capsule and tetracycline ointment distribution. Coverage of the target population, children under the age of 5, was over 60% by the second year of the project.

Training. IEF has also been successful at accessing existing training materials as well as developing materials, and making them available for distribution. Technical training of government health staff (e.g., ophthalmic medical assistants, health assistants, health surveillance assistants) both in regional and district workshops has been another successful component of the project.

Health Information System. Data collection systems for the project are in place and some quantifying and analysis have been carried out in the beginning years of the project. However in-depth analysis and subsequent incorporation of this data to enhance project interventions have been only partially achieved as of the end of the first two years of the project.

Constraints

IEF has been almost completely dependent on government personnel for training activities at the village level. IEF staff have consisted mainly of medical personnel (i.e., ophthalmologists) who, while able to train the core health staff, have had to rely on government personnel to take the training to the village level. Problems of transportation and motivation of government health agents have

been a major constraint to reaching the goals of providing adequate training at all levels. Part of the target area in the Lower Shire Valley is only accessible by foot. Government health workers are often unwilling to travel to those areas on a regular basis because of the travel difficulties involved, rugged living conditions in the villages, and the government's inability to provide per diem for overnight visits.

Another constraint has been the difficulty in organizing and training village health committees to promote basic Child Survival activities at the village level. Although these committees were said to exist in most villages, health workers reported that such committees were not in place and were difficult to start up and maintain as viable village committees. Given that the Child Survival project relies on the village committees, this is a major constraint to the institutionalization of the basic interventions of the project.

Data collection and monitoring of project interventions have been problematic. For the first two years of the project, IEF personnel in Malawi were predominantly medical (i.e., physicians), with insufficient provision at the outset for someone with the time and skills required to create data collection and monitoring systems. Secondly, the three computers which were acquired under the project have been regularly out of service due to mechanical problems caused by power fluctuations. In the second year of the project, IEF placed an experienced public health administrator in the field to focus on putting a data collection and monitoring system into place.



Baxter McLendon

“Effective data collection and monitoring systems are crucial to all Child Survival Projects.”

—PVO Representative

Lessons Learned

Even though it is a high budget item, transportation for health workers is essential. Project objectives, particularly those as ambitious as IEF's, cannot be achieved with health workers performing outreach work on foot or with bicycles. In the future, plans for adequate logistical support must be made at the outset to assure effective project implementation at the field level.

Some motivation is necessary for government health workers to encourage them to spend more time at the village level. Though provisions for per diem are usually covered by the government, sometimes responsibility will fall to the collaborating PVO to supply these funds. Budgeting, to cover these costs, should be assured from the outset of project.

Staffing with both expatriate and national, technical as well as administrative personnel is required in order to be able to deal effectively with the variety of issues that arise throughout the life of a project. Overdependence on MOH staff to carry out most aspects of field level activities has proven detrimental to achieving the project's planned interventions.

Finally, as is often the case, coverage levels laid out in the project objectives were, from the outset, unrealistically high.

Submitted by International Eye Foundation/HQ, U.S.A.

ADVENTIST DEVELOPMENT & RELIEF AGENCY CHILD SURVIVAL PROJECT ADRA/RWANDA

Project Overview. The Government of Rwanda (GOR) is committed to relieving rural poverty and promoting self-reliant development. Protection of the land and increased agricultural production are the highest priorities of the GOR. Population and health are also considered urgent. Long-established international organizations and non-governmental groups have an excellent rapport with the GOR and have been able to agree on the setting of priorities in the health sector. Church-affiliated health facilities provide 60% of the services in the health sector. Since 1974, they have been grouped under the umbrella of the Bureau des Formations Médicales Agrées au Rwanda (BUFMAR) in order to facilitate the coordination of their activities with the government.

ADRA began activities in Rwanda in 1980 when it was awarded an Outreach Grant to support the distribution of PL-180 commodities. In cooperation with USAID/Rwanda and the GOR, ADRA began a pilot school feeding and Food for Work (FFW) project in a resettlement community. The school feeding activities expanded into other areas before ending in 1982. FFW grew rapidly into a major program supporting diverse community-initiated projects throughout the country. In 1983 ADRA began a project to support an outreach program in conjunction with Association of Adventist Health Services in Rwanda (ASSAR) health clinics. In the first phase 28 CHWs were trained to go into the communities and conduct health and nutrition education at the family level. In the second phase the program has been expanded by adding a cadre of volunteer workers in order to reach a much higher proportion of the population.

A Child Survival grant awarded in 1986 is supporting the implementation of Child Survival interventions in the ASSAR clinics. The ADRA Child Survival project was designed to enhance the health clinic program by strengthening the interventions specifically designed to improve Child Survival. The interventions include vaccinations, oral rehydration therapy, nutrition and growth monitoring, and child spacing. The project focuses on supporting the training of additional community health workers as vaccinators and upgrading all of the CHWs so they can provide Child Survival services.

The childhood vaccination program is the best developed of the Child Survival interventions as it complements a high priority GOR effort to vaccinate 90% of all under ones against the targeted diseases by 1990. All the ADRA health clinics have effective vaccination programs.

All the ADRA clinics have been teaching mothers about ORT. Recently, the GOR decided to promote the use of prepackaged ORS versus the homemade solution, and prepackaged ORS supplies were made available to ADRA clinics. Growth monitoring is done at all ADRA health clinics. This is a new program for ADRA and it is not yet fully integrated with Child Survival activities. In some centers nutrition rehabilitation programs have been introduced. Family planning is also offered in all ADRA clinics.

Project Accomplishments

Immunization. There is a functioning cold chain in all the clinics.

Training. Twenty-five CHWs have been trained as vaccinators and at least two of these vaccinators have been posted at each ADRA health clinic.

Constraints

The rates of tetanus toxoid coverage are currently poor. This, in part, reflects a previous GOR policy to begin vaccination only in the seventh month of pregnancy. A new policy to begin vaccination at the time of the first prenatal visit should result in better coverage.

Mothers are using a variety of recipes and measurements for the homemade oral rehydration solution, and there is no widespread use of the prepackaged solution. This is due to early confusion in the national program about homemade versus prepackaged ORS issues.

At least three different growth monitoring cards are commonly used in nutrition centers.

The GOR requires that there must be a separate building for nutrition rehabilitation centers, thus, ADRA has not been able to introduce nutrition programs into all centers.

*Submitted by Adventist Development and Relief Agency/
HQ, U.S.A.*



REPORTS FROM THE FIELD · HAITI

The conference week centered around Child Survival project presentations by field staff. A general guide for the presentation was provided to PVO field staff prior to the conference. Field staff were asked to prepare a written report and present it at the conference. An enormous amount of valuable, specific information was shared during these sessions as project representatives spoke candidly about project accomplishments, constraints that were faced, and lessons learned. The following pages contain abbreviated versions of the Child Survival project presentations. The information that follows remains in the basic report format that was used by each project representative. Editing has been kept to a minimum in order to preserve the essence of the experience we all had while listening to these presentations at the Lessons Learned Conference.

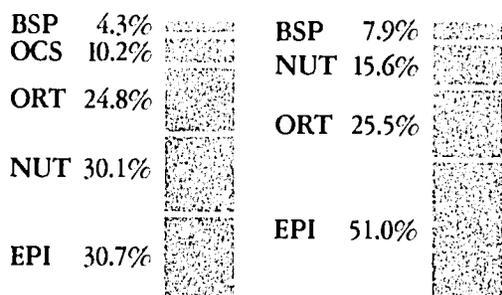
PVO Child Survival I, Haiti % Coverage & % Dropout for Polio Immunization under Age 1

	% Polio1	% Polio3	% Dropout
ADRA-yr. 3	20.5	15.7	23.3
CARE-yr. 3	12.0	8.0	32.8
ICC-yr. 3	88.8	43.0	51.5
PLAN-yr. 2	54.7	16.7	69.5
SA	DK	DK	DK

Coverage = (# immunizations / # live births) x 100
 DK: Don't know
 Dropout = $\frac{\text{Polio1}-\text{Polio3}}{\text{Polio1}} \times 100$

These figures are computed from the A.I.D. Health & Child Survival Reporting Schedule.

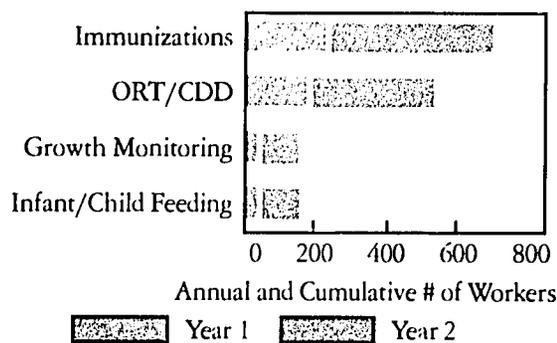
PVO Child Survival I Projects % Major Interventions, Africa—Haiti



AFRICA CSI HAITI CSI

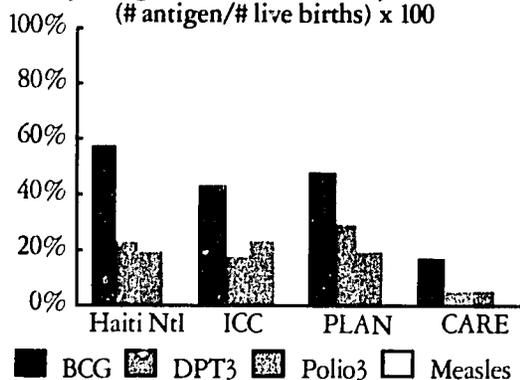
Haiti: ADRA, CARE, ICC, PLAN, SA
 Africa: ADRA, IEF, MIHV, SA, SCF, WV
 BSP: Birth Spacing Promotion
 OCS: Other Child Survival

Health Workers Trained—Haiti By Type of Training and Project Year



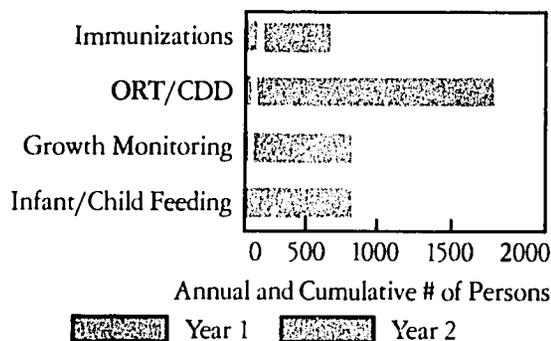
Source: 1986 and 1987 PVO Annual Reports

Year 2 EPI Coverage Under Age 1 By Antigen and PVO CSI Project—Haiti (# antigen/# live births) x 100



Sources: 1986 Haiti Ntl data (WHO 1988)
 1987 PVO Annual Reports, DK = SA and ADRA

Community Members Trained—Haiti By Type of Training and Project Year



Source: 1986 and 1987 PVO Annual Reports

FOSTER PARENTS PLAN INTERNATIONAL CHILD SURVIVAL PROJECT PLAN/HAITI

Project Overview. The PLAN Child Survival project covers the Jacmel area, in southeastern Haiti. PLAN's work area has been divided into five zones which cover the urban, suburban, and mountainous areas. About 40 kilometers of paved roads facilitate transit between the southeast and the rest of the country.

The climate in the non-coastal southeast region is usually hot, between 23°C and 28°C, with two rainy seasons. Hurricanes are frequent during the second rainy season.

Haitian farmers have small plots of land where they grow their agricultural products, which include coffee, cocoa, roots, and tubers (including plantain), citrus fruits, and vegetables. Many of the agricultural products are used for domestic consumption. Pig raising has become a popular activity in the Jacmel area.

The PLAN health project is preventive in nature, emphasizing health education as it relates to ORT and immunizations. Construction of potable water systems and latrines are other essential components of PLAN's preventive health project. Additionally, support is provided to other health agencies who have field projects with both curative and preventive health features.

PLAN has a total of 59 promoters working with families on community development projects. Each promoter works with an average of 135 families. Their activities include several home visits each year and additional contact with these families at the PLAN offices.

There are 47 preschool monitors who have received health training in numerous topic areas and include discussion of these health topics in the preschool curriculum. They also promote ORT and immunization during monthly meetings with the parents of preschool children.

Project Accomplishments

Coordination/Collaboration. The promoters have good relationships with MOH health agents and invite them to participate in the monthly health meetings. The promoters also take part in rally post activities that are organized by the MOH, contributing to their success by encouraging PLAN families to participate. Approximately 100 rally posts are planned each month in the project area by the MOH and collaborating agencies.

Community Participation/Motivation. The communities manifest their support by participating in the Health Education Committee meetings each month, making the effort to travel to a clinic for immunization, or for other reasons, after being referred, and by contributing to

the availability of ORS packets by running 50 ORS selling posts.

Key ORT and EPI messages are relayed by using a variety of strategies, i.e., Health Education Committee meetings, radio programs, calendars, T-shirts, caps, fliers, ORT bottle recipe stickers, shopping bags, street theater, and home visits.

Growth Monitoring/Nutrition. A comparison was made between the PLAN survey results and the 1978 Haitian Nutrition Study of children 3-59 months of age by Gomez classification. Assuming that the age and sex distribution are similar in both populations, the children in the PLAN study show a significant improvement over children living in the region in 1978.

Health Information System. A survey of 552 mothers/guardians was conducted in the PLAN project area. Survey questions covered the areas of ORT, breast-feeding, immunization, and growth monitoring activities.

Approximately 19% of mothers/guardians were able to correctly explain the meaning of the growth curve on the Road to Health Chart. 73.9% of mothers/guardians stated a child should be weighed every month and 3.8% of mothers/guardians stated a child should be weighed every two months. 98% of mothers/guardians knew of a growth monitoring site. 12% of the children 0-11 months and 16% of the children 12-23 months have been weighed two or more times in the last six months.

Family Planning. 11% of women in union currently use a contraceptive method. 35% of the women who are pregnant have at least one living child less than 24 months of age. 32% of the women in union were unable to name a contraceptive.

Of all interventions, the women found family planning to be the least available and accessible. 63% of the women state that services are available only at the hospital. 30% state services can only be found very far from their home.

Constraints

The project objectives were not specific and measurable; yearly targets needed to be defined according to an accurate time frame.

The scope of the target group was too broad and needed to be concentrated on fully immunizing the most vulnerable groups, those under one year of age.

PLAN had only one set of objectives for the different areas even though current levels of health service coverage vary considerably between the areas.

The PLAN Child Survival project strategy did not permit a population-based approach.

The health information system, especially in regard to immunization, was not specific enough and did not allow the



Devy Norton

PLAN social promoters to make the required analysis of the data or to make the necessary decisions to facilitate the project's progress toward the stated objectives.

The project experienced some delay in the hiring of personnel, receipt of funds, and obtaining baseline data.

Lessons Learned

The most important lesson learned to date from the Child Survival project experience is the necessity of defining very clearly and specifically "the targeted group." This accurate definition leads to more specific objectives and orients the project strategy toward the achievement of the stated objectives.

The second lesson learned is that the health information system should be aimed at the collection of specific data, which is required to make decisions and to ensure that the project progresses toward the stated objectives.

The third lesson learned is that staff as well as targeted communities should be involved in the planning, implementation, monitoring, and evaluation phases of the project in order to ensure active participation and sustainability of the project.

Lastly, collaboration with the MOH and outside agencies was a critical factor in helping the PLAN/Jacmel Child Survival project achieve its goals.

Expectations for the Future

A refocusing of the Child Survival project objectives, with the 0-1 year olds as the priority group.

A simplification of the immunization information system with concentration on data collection and analysis that aids the decision-making process and leads to direct action.

Increased involvement of community members in the identification of 0-1 year olds who have not received immunizations.

Increased ORS packet availability by increasing the number of PLAN-sponsored ORS selling posts causing an eventual decentralization of the system.

More messages on breastfeeding and weaning foods by the use of radio programs.

The transformation of Health Education Committee meetings from solely education meetings into action groups with the purpose of identifying all 0-11 month old children and assuring their full immunization.

More training provided to staff in regard to group dynamics and community organization.

Presented by Maria Jove Castera, PLAN/Haiti

INTERNATIONAL CHILD CARE CHILD SURVIVAL PROJECT ICC/HAITI

Project Overview. ICC has been operating in Haiti for 21 years. It is recognized as an organization whose major field interests are tuberculosis prevention and treatment and vaccination programs. ICC began operating in Haiti with the opening of a hospital in Port-au-Prince, dedicated to children suffering from tuberculosis. In 1975, under contract with the MOH, ICC extended its program to the rest of the country by developing a BCG mass vaccination campaign. With the advent of the Expanded Program on Immunization, ICC has incorporated other vaccines into its program.

The ICC Child Survival project has been implemented in three areas of the country. Field sites are located in the North, the center, and the South. The total population of these three areas is estimated at 513,095. The target groups of the project are children under 2 years of age, with emphasis on the 0-1 year group, and women 15-45 years of age.

The target areas in the North have better health coverage than those in the center and South. Community participation in health and other development programs seems higher here than in the rest of the country.

The areas covered by ICC's Child Survival project in the very dry, central region are among those with the greatest needs. The health infrastructure is very weak and consequently health coverage is very low.

Most of the areas of the South covered by this project are very isolated. These areas have been assigned to ICC by the director of the Southern Health Region because of their poor conditions and the lack of health facilities.

Vaccination activities take place by the use of mobile vaccinators who travel the countryside on motorcycles. The vaccination posts are established throughout the target areas in such a way that the distance mothers must walk to them is one hour or less. The approach used by ICC to cover the different areas depends on various factors, i.e., motivation of the local health personnel, the existing health infrastructure, the level of collaboration between the regional health authorities and ICC field workers. In the Northern region, some of the vaccination posts are covered jointly by ICC vaccinators and the local health personnel.

Originally, ICC had planned to focus on two different health interventions, vaccinations and ORT. Later, it was recognized that the number of field workers available would not be sufficient to cover both areas effectively so the ORT component of the project was put on hold tem-

porarily. During the second year some attention was given again to ORT. Such activities were limited to educational and demonstration sessions held on vaccination days or on days especially scheduled for that activity.

The ICC Child Survival project employs 42 country nationals: 11 field vaccinators, 2 field supervisors, 24 surveyors, a project director, a statistics and evaluation coordinator, a statistical clerk, an accountant, and a purchasing agent.

Project Accomplishments

Coordination/Collaboration. ICC vaccination activities are strongly supported by the Ministry of Health and the regional health authorities. Because of this, ICC has access to materials provided by UNICEF such as vaccines, syringes, needles, and cold chain supplies.

Community Participation/Motivation. Community leaders such as priests, pastors, and schoolteachers also strongly support ICC activities, especially in regard to motivating the population. Circulars regarding locations and dates of vaccination sessions are regularly forwarded to these community leaders who then encourage the community members to attend. These leaders also readily assist with project logistics by opening their homes to the vaccinators who must stay overnight at a field site.

Oral Rehydration Therapy. 27,587 mothers (23.6% of the target group) have been reported as having attended ORT educational sessions. Many mothers in the intervention areas also listen to ICC radio messages on ORT.

Constraints

The main constraint that the project faced during implementation is connected with the political situation in Haiti. Some vaccination sessions were cancelled because of riots, violence, strikes, demonstrations, and/or road blocks.

In some places, there were suspicion-causing rumors saying that tetanus toxoid, administered to women ages 15-45 years, was really a contraceptive.

Due to the unavailability of an external team, the baseline survey was conducted six months after the scheduled date.

Because of a long period of negotiation with the director of the Southern Region, project activities in this area began late. Because of the increase in the cost of living, additional funds had to be used for personnel expenses.

Presented by Blaise Severe, ICC/Haiti

SALVATION ARMY WORLD SERVICE OFFICE CHILD SURVIVAL PROJECT SA/HAITI

Project Overview: SA is a religious organization that attempts to meet the needs of the "whole" man, physical, spiritual, and social. SA is operating in 91 countries, with international headquarters in London. In 1950, SA began work in Haiti and has spread to 40 field sites throughout the country. There are 20 Child Survival project areas in Haiti, seven of which are easily accessible and 13 of which vary in distance from half an hour to two days by foot or one day on horseback.

SA/Haiti Child Survival project activities have been incorporated into women's development groups, which are called "Home Leagues." Twenty Home Leagues were targeted for Child Survival education activities. Three leaders from each of the Home Leagues were selected to receive primary health care training after which time they would return to their Home League center, or "rally post," and train 10 women. These 10 women would then visit the homes of 10 families and discuss issues regarding growth monitoring, oral rehydration therapy, breastfeeding, immunizations, and family planning.

The Child Survival I project was funded in 1985, but did not become fully active until May 1986 as there was difficulty in employing a project coordinator. In June 1986, training of the Home League leaders began in Port-au-Prince. The training was done by the Haitian National Institute of Community Health (IHNSAC). By March 1987 the training/outreach cycle of leader-Home League members-families covered 150 homes.

Many families are being educated in the GOBI-F program. There was an incident where one Home League leader, living in the North, was transferred to the South with her husband where they were responsible for a church. The leader used her initiative in starting a Home League and, immediately, introduced the Child Survival project. She has an average weekly attendance of 35 women. Where results cannot be measured by figures, there is certainty that the message is being spread to the families in need and the success of the Child Survival project will, certainly, be revealed in the future.

Project Accomplishments

Coordination/Collaboration. The project maintains a close relationship with several health and development organizations in Haiti. Project leaders maintain close contact with Ministry of Health representatives to ensure that project implementation is in accordance with national health policy. The project coordinator has been in close contact with personnel at the Health Education Materials

Design Unit at the MOH and has obtained valuable advice on the design of a project logo and other health education materials.

Project staff participate in regular meetings with representatives of other voluntary organizations who are also implementing Child Survival projects in Haiti. The PVO Child Survival Consultation Committee has been organized to provide an opportunity for sharing of Child Survival information and for project leaders to discuss new strategies, concerns, and implementation issues.

Community Participation/Mobilization. In order to create interest in the Home League Seminars, rallies and camps were planned and carried out beginning in October 1986. This provided an opportunity to clarify the roles and responsibilities of women involved in all levels of project activities and served to motivate them for the CS activities. A bag showing the Child Survival logo was given to each of the members doing visits. The bags contained educational guides for teaching GOBI-F to mothers, T-shirts inscribed with the Salvation Army shield and slogan, and badges.

Health Information System. The 54 Home League leaders are responsible for the collection of data at the community level. This data is reviewed by the field supervisor and then forwarded to the coordinator and director of Women's Organization in Port-au-Prince. From here, necessary information is forwarded to SAWSO/Washington.

Constraints

Many of the Home League leaders had no previous technical knowledge of health. With frequent training sessions (one week each month), there was not enough time for the leaders to assimilate the knowledge before passing it on to the Home League members.

Home visits by some of the leaders were problematic. They were uninterested in carrying out activities without some sort of compensation.

Because baseline population figures were not available, many of the village level activities were delayed as it was a requirement of the MOH to have such information before the supplies of weighing scales, vaccines, contraceptives, vitamin A capsules, and nutritional supplements would be given. Registration of the target population is important not only from the standpoint of obtaining realistic target population figures but also as a means of establishing rapport and enlisting households for participation in project health promotion activities.

There has always been some difficulty in receiving reports from the field at the end of each month.

Presented by Eudora Louissant, SA/Haiti

COOPERATIVE FOR AMERICAN RELIEF EVERYWHERE CHILD SURVIVAL PROJECT CARE/HAITI

Project Overview. The Community Integrated Nutrition and Education Centers Outreach (CINECO) is a CARE/Haiti project that provides basic maternal and child health service to pregnant and nursing women and infants in 33 communities. The project was designed by CARE to complement the health and nutrition service, for children from one to five years of age, provided in national primary schools which have CARE's CINECO preschool centers attached. The original CINECO design stipulated the implementation of services in 120 CINECO communities and the use of outside paraprofessionals such as CINECO preschool teachers and Ministry of Public Health and Population (MSPP) auxiliary nurses to provide services. These strategies have been amended to include project implementation in 33 communities and the development of local health resources.

In collaboration with the MSPP, CINECO provides a variety of MCH services: training in the use and preparation of packaged and home mix ORT, growth monitoring for infants, weight monitoring and the distribution of vitamins with iron for pregnant and nursing women, vitamin A distribution, immunizations, and health education. Health education is the project's core. CINECO staff spent over a year developing a series of 17 short lessons with songs, skits, and riddles to reinforce each lesson's two or three major points. Six lessons were designed specifically for pregnant women (i.e., the need for two doses of tetanus toxoid, the four danger signs of pregnancy for which to seek immediate medical help), six lessons are targeted for nursing women (i.e., the importance of exclusive breast feeding for the first three months of infancy, immunization for young children), and five lessons are applicable to both groups (i.e., the importance of mother's milk, vitamins with iron).

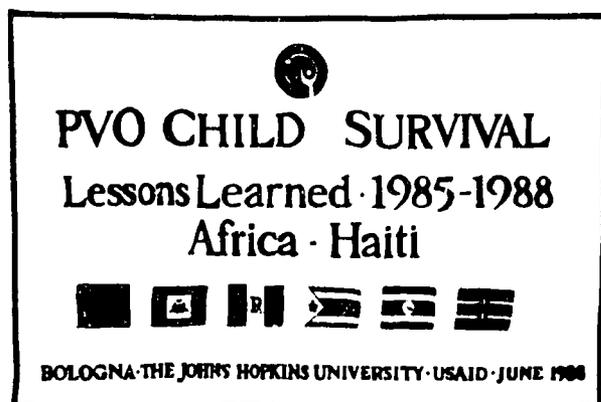
CINECO is specifically designed to develop community-based MCH resources and, in the process, to strengthen community organization and structure. To this end, the project assists communities in forming health committees of 10-15 respected community members and in selecting literate local women to be trained as community health collaborators (CHCs). CARE is responsible for training health committee members and CHCs, for start-up materials and supplies, for short-term payment of stipends for the CHCs, and for supervision. Health committee responsibilities include building or supplying a center, developing an auto-financing plan for continuation of services once CARE withdraws, motivating community women to participate in the project, and gradually assuming supervision and evaluation functions.

Project Accomplishments

Gradually, in response to these changes, a new CINECO strategy was formed. The new strategy replaced the dependence on outside paraprofessionals with the development of local community resources. The project asked each community to form health committees and to nominate two or three women, with basic literacy, who would be trained as community health collaborators.

Coordination/Collaboration. The new strategy placed more emphasis on collaboration with regional and district MSPP offices. For example, the MSPP has cosponsored immunization campaigns with CINECO in several districts; in others, it has supplied health agents and auxiliary nurses to provide monthly immunization services and, in one district, the MSPP has trained local project personnel to do immunizations. This strategy has taken much longer to organize and implement than simply procuring immunization supplies from the MSPP in Port-au-Prince, transporting them to the regions, and giving them to project staff trained to do inoculations. Regional and district offices often have considerable problems getting supplies they need from the capital. CINECO staff believe, however, that this method of incorporating the communities into the local MSPP immunization delivery system increases the chances of project sustainability once CARE leaves the areas.

Health Education. Because of the new emphasis on developing local health resources and because few MCH materials existed with which to train community people with limited literacy, the project began to develop its own training courses and materials. For example, CINECO has a field-tested curriculum and MCH guide in Creole, complete with songs, riddles, games, and skits for each lesson with which to train local health workers. Although still in draft, the guide has already been shared with other Child Survival projects and the MSPP. Several MSPP district directors have expressed interest in using these materials



on local radio health broadcasts.

The project originally planned to implement services in 121 CINECO communities, but had to alter this plan and only implemented in 33 CINECO communities. This was done because several organizations supported by Child Survival I central funds work in CINECO communities. Furthermore, other CINECO communities had, or were relatively near, MSPP clinics or dispensaries. CARE staff decided against duplicating services in these communities and instead resolved to implement the project only in isolated communities without access to MCH services.

Training. With the new strategy, which emphasizes the development of local resources and education, a new training plan was formed. The CHCs receive four months of training before they can initiate services in their communities. Training is followed by weekly supervisory visits and inservice training days according to need.

Constraints

The original strategy designed to implement CINECO services relied on paraprofessionals from outside the communities. As planned, services would be implemented by the teachers, MSPP auxiliary nurses who would be assigned to the schools, and extension agents for the National Organization for Adult Education and Community Development (ONAAC). In communities in which they were present, MSPP health agents would also assist.

In 1985 agitation to oust the government regime began. The schools became a focus of political protest. Schools were first boycotted by students and families, and then closed by governmental decree. Communities also became politicized in a manner never experienced in Haiti.

First, the paraprofessionals were suddenly unavailable for a variety of reasons. Schools remained closed due to teacher's strikes and other forms of political expression. ONAAC was dissolved and ordered to suspend work until a major reevaluation had occurred. Second, the atmosphere in the communities mediated against the use of non-local people. For the first time, community members were loudly vocal about their right to participate in the development of their own communities. Third, project staff who had been hired after the proposal writing judged that its design did not conform to CARE programming principles. Not only were community members opposed to the "development from without" design of the original, but CINECO personnel were as well. By 1986 it was apparent that the original CINECO design was inappropriate to the existing situation.

Presented by Shelagh O'Rourke, CARE/Haiti

ADVENTIST DEVELOPMENT & RELIEF AGENCY CHILD SURVIVAL PROJECT ADRA/HAITI

Project Overview. The ADRA/Haiti Child Survival project emphasizes five points: vaccination, ORT, growth monitoring, family planning, and a pregnant mothers' program. The main target center, in Bizoton, has a population of 100,000. A second area is Limonade, with a population of 25,000. The Adventist Hospital in Port-au-Prince complements the current MOH initiatives in PHC prevention and promotion services by interfacing with local community health committees. Each community selects one of its members to act as a local health agent.

Project Accomplishments

Coordination/Collaboration. The ADRA/Haiti Child Survival project works closely with the hospital's MCH recuperation center. There is collaboration with the MOH in family planning activities and in referrals to government institutions for high-risk pregnancies and AIDS. There is a Child Survival Committee that meets once a month, which has members from the private and public sector.

Community Participation/Motivation. Mother's Clubs, where mothers discuss their health problems, have been developed. During a typhoid episode these mothers decided, by themselves, to collect money and buy vaccine.

Oral Rehydration Therapy. Mothers learn how and when to use prepackaged ORS, and it is made available at the clinic or in a specified home. Mothers are also taught how to prepare ORS from sugar, citron, and water.

Immunization. Vaccination is targeted for children 0-5 years of age and tetanus for women 15-45 years of age. During the past year we have operated rally posts at six centers in the area. Volunteers have been trained as health agents to promote the Child Survival services and to reach the dropouts. A physician examines pregnant mothers and, at this time, administers a tetanus shot.

Health Information System. A record of Tier II indicators is kept, which shows what has been accomplished by the project. An in-depth evaluation is planned to collect final Tier II data. The Johns Hopkins University and the Child Health Institute have been very supportive in tabulating the baseline survey data.

Growth Monitoring and Nutrition. Mothers are taught how to weigh their children and to use the Road to Health Chart. Young children are weighed and those who are suffering from malnutrition are sent to a recuperation center where their care and the mother's education are specific for their needs.

*Submitted by Adventist Development and Relief Agency/
HQ, U.S.A.*



IMPRESSIONS FROM THE FIELD...

...WHAT CHILD SURVIVAL HAS MEANT TO ME

In an attempt to capture some of the more elusive, but nonetheless real, effects of PVO Child Survival, the field project representatives at the 1988 Lessons Learned Conference were individually interviewed. Though abstract ideas are often difficult to articulate, some themes did emerge during these interviews. According to the field workers, the following comments express some of what Child Survival has meant to them:

Enhanced capabilities

- Almost everyone mentioned that A.I.D.'s stress on data collection, for all its difficulties, is proving helpful to PVO activities. Marie-Jose Castera, of PLAN/Haiti, noted that the midterm evaluation had been especially helpful in refocusing the project and the data collection procedures developed for the Child Survival project would be used in PLAN's new, non-A.I.D. funded project in Cap Haitien. Gladys Furusa says that SCF/Zimbabwe is using its experience in Child Survival data gathering and analysis in other SCF development work. Similarly, Bongi Mushapaidze says that World Vision/Zimbabwe now calls for Child Survival-type registration, preplanning, analysis of resource capability, etc., on all its projects. On the other hand, Margaret Taylor, Salvation Army/Kenya, noted that data collection was "too difficult for the Home League ladies," who evidently had problems determining children's ages and deciding how to report home visits.
- In Kenya and Haiti, Salvation Army Home League members are benefiting because their leaders have been trained in communicating ideas and structuring lessons. Margaret Taylor, of SA/Kenya hopes that "they (the women Home League leaders) can pass this training on to their husbands."
- Child Survival has also enhanced the standing of PVOs in the eyes of host governments and local people. "I tell World Vision that we've been put on the map in Zimbabwe because of Child Survival," says one field worker. "Child Survival has given the Salvation Army and their Home Leagues great standing in Kenya", says another.

Reduced isolation

- A.I.D.-sponsored, regional Implementation Workshops and Lessons Learned Conferences have helped PVOs working in the same area and/or on similar projects to learn about one another. At the Lessons Learned Conference, in Bologna, representatives from Haiti decided to follow up with regular meetings back home. One participant from Haiti commented that "it's great to discover that all the PVOs have the same problems." Another discovered that she lived close to a field worker in another project, so

they arranged to meet back home.

- Shelagh O'Rourke thinks that CARE headquarters has come to realize the importance of working with local health committees. "We have gained the trust of the village women through these committees," she says. "Now they're actually asking us for family planning."
- Child Survival projects have given PVOs an opportunity to work with government ministries, which has proved to be mutually beneficial. Dr. Blaise Severe says that ICC has helped government workers in planning and managing EPI. Shelagh O'Rourke says that CARE shares know-how and information with local government agencies, which helps everyone. In Zimbabwe, the government takes an active role in deciding where PVOs should work, concentrating on remote, hard-to-reach areas, thus filling gaps in its health infrastructure.
- The Child Survival Program has opened up the opportunity for dialogue between PVO grant recipients and A.I.D. Since PVOs represent a substantial portion of the health infrastructure in many countries, this is useful from a development perspective.

Broader programs

- Child Survival has sparked some expansion of PVO programs, either geographically, as in PLAN/Haiti, or programmatically. SCF/Zimbabwe is looking to gradually ex-



Cynthia Carter

"Child Survival is the reason I stay in Haiti. With this, I feel I am making a difference."

pand its Child Survival activities. In Haiti, one woman who had been trained by the Salvation Army project, started a new Home League on her own when she moved to another part of the country; she now has 50 members. CARE/Haiti, having set up health committees for Child Survival education, now wants to use them for family planning education. In Zimbabwe, villagers are asking World Vision to help in other areas, such as constructing wells and latrines. In Kenya, Salvation Army Home League workers are frequently approached for counseling on non-health matters and have been asked, by an agency implementing a family planning project, if the Home League workers would assist in education activities.

Professional growth

- Field workers at the conference had very different backgrounds. One was a European working in Africa. One was an expatriate anthropologist. Several were nurses or nurse/midwives, three trained in Europe and the U.S., others trained locally. Another, trained as a nurse aide, was promoted within the project, and had never been out of her country before coming to Bologna. Several had worked for their government before joining the PVO, and one was seconded by the government to the PVO. All found Child Survival work challenging and satisfying. "The World Vision job has been an eye-opener", says Bongzi Muchapaidze. "I've been to six other African countries -- all through Child Survival. My thinking is less limited." "I've



Dorey Soutaris

gained so much experience," says Gladys Furusa. "When giants share ideas with you at a conference like this, it gives you new confidence, new energy."

Opportunity to serve the nation

- Dr. Blaise Severe returned from European training and took a job with ICC/Haiti because he saw an opportunity to "understand my country, its health problems." Dr. Ariel Henry, of ADRA, says that Child Survival "is the only reason I stay in Haiti. With this, I feel I am making a difference."
- A few field workers noted that their projects were having an impact on the way people think and act. Dr. Ariel Henry says you can see the difference between an ADRA project village and others. "Our homes and streets are cleaner. Also, people are beginning to ask for vaccinations." Eudora Louissant, SA/Haiti, says the message is beginning to get out that spirits are not the cause of diarrhea. Gladys Furusa considers the training of families the most important contribution of the SCF Child Survival project. "You can hear the enthusiasm in the way they talk," she says. "Who can take that knowledge away? They will never again let their children die of diarrhea because they know ORT works. We know we have made a difference."



Robert Patterson

Interviews by Patricia W. Blair

NEXT STEPS

During the closing sessions participants from Africa, Haiti, and the United States formed work groups to determine possible follow-up activities they could engage in upon return to their respective countries. The following pages outline the "Next Steps" that will be taken in the promotion of child survival.

AFRICA REGION

Health information systems and sustainability were the two burning issues raised in the Next Steps in Africa discussion.

Comments from the floor:

"We need to look for help in setting up a good health information system. I will start locally by inquiring at the local school of medicine and of public health. If I do not get help from them, I will approach the local WHO and UNICEF offices."

"There is a need to demystify statistical data. As project managers we need more training on the interpretation and use of data. I will ask for help from local consultants or in-house PVO technical consultants."

"There will be a WHO-sponsored workshop on 'Integrated Interventions for MCH/FP' in January 1989, in Zimbabwe. I will explore how I can receive some of the training modules and/or participate in the workshop."

"I will reassess the factors that affect sustainability in my project when I get back (from this conference)."

"I will discuss some issues of sustainability in my project with the Ministry of Health. I am most concerned about the manning of outreach points, record keeping, and other project activities which may not keep going due to lack of funds."

"The issue of costs is the most difficult one to resolve. My ministry knows that they do not have the funds to assume the responsibility of keeping the project's activities going. This is in spite of the fact that practically all the other factors, like training, are already in place. We really need to spend time reflecting on this issue."

"I recommend regional, inter-PVO visits and collaboration. I would like to see how other projects are dealing with the issue of sustainability."

"I will include PVOs on the mailing list of the next issue of OUTREACH, which will address the issue of sustainability."

"I will invite Mrs. Mugabe to visit my project and ask for her ideas on sustainability."



ROBERT PATTERSON

"In order to strengthen the Child Survival Program, technical information networks must be developed between the PVOs and with collaborating agencies."

"I am going to focus more on these issues: cost reduction, better management of resources, and exploration of other resources outside of my PVO and the MOH."

"We must keep exchanging ideas and experiences with other groups who are involved with the issue of sustainability."

"We need to receive continuous training on better management of resources like time, money, personnel, and material. I recommend this as a theme to discuss in the next Lessons Learned Conference."

Group Members: Milton Amayun, Gladys Furusa, Bongzi Mushapaidze, Ellestina Nkumba, Mary Harvey, Agnes Guyon, P.M. Shah

HAITI

The Next Steps in Haiti group set individual goals for the future of each PVO.

The Adventist Development & Relief Agency plans to carry out operations research to identify ways of increasing utilization at health posts, implement Child Survival activities at two new sites, and conduct a final project survey.

Cooperation and Relief Everywhere (CARE) will continue Child Survival services at 29 sites, instituting family planning services at 12 sites, and will also conduct a final survey.

International Child Care would like to offer technical assistance for immunization services to other PVOs while maintaining services at existing sites. A final survey for Child Survival I projects will also be carried out.

Foster Parents Plan will continue services at existing sites, expand services at two new sites, and conduct a final survey for Child Survival I projects.

Salvation Army will continue education of mothers and growth monitoring activities and carry out a final evaluation in January 1989. They will also request assistance from ICC and PROFAMIL for immunization and family planning activities.

Child Health Institute will hold a workshop on survey methods and data management for PVOs. They will also design a modular instrument for Tier 2 surveys and rapid assessment tools for Child Survival project evaluation. There are also plans to publish nationwide child mortality and service utilization survey results.

All the PVOs agreed to identify their strengths and weaknesses as a starting point to institutionalizing inter-PVO technical assistance. They also hope to establish a formal link with the EPI National Executive Committee. Finally,

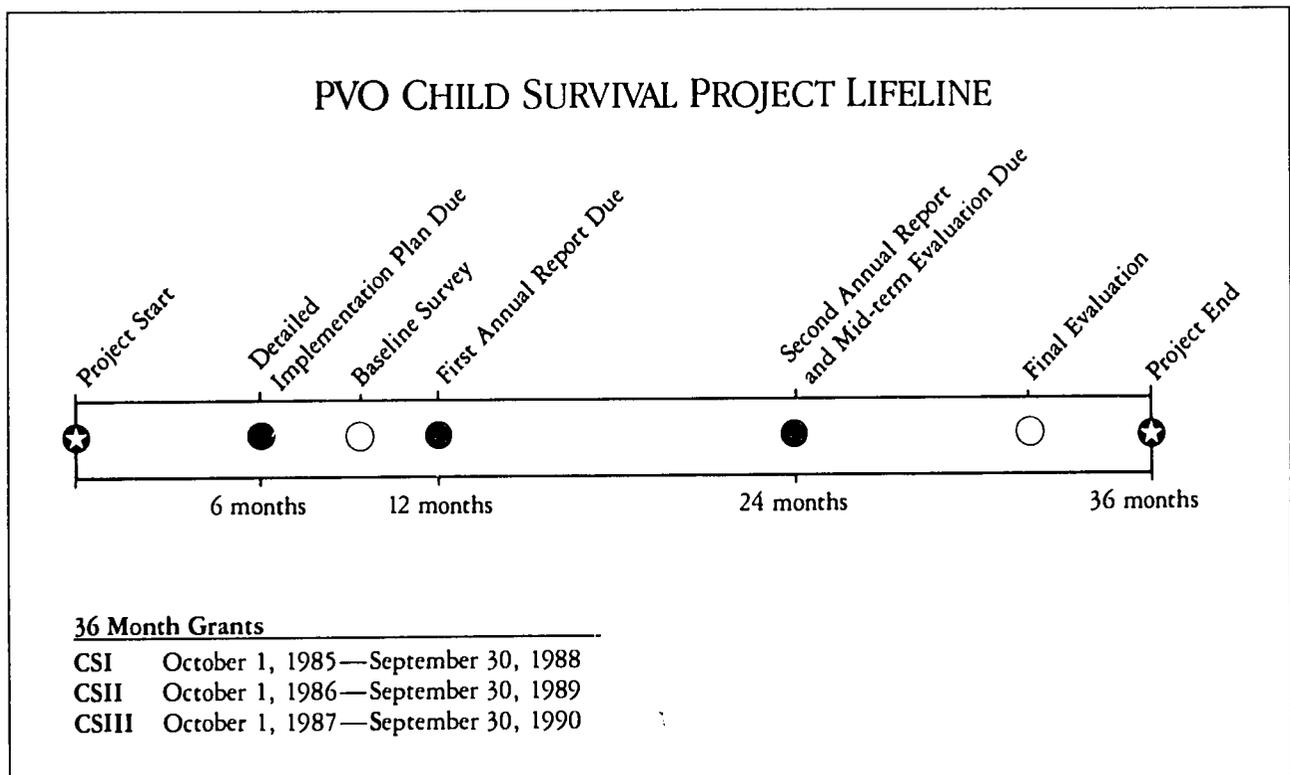
they would like to organize a Lessons Learned Conference for Haitian PVOs.

Group members: Tony Augustin, Ariel Henry, Blaise Severe, Marie Jose Castera, Shelagh O'Rourke, Eudora Louissant

U.S.A.

The Next Steps in the USA group plans to compile and distribute a mailing list of all PVOs with Child Survival I-IV projects; ask A.I.D. to establish and maintain a computerized bulletin board (with modem access) that shares information on programs, publications, meetings, etc.; ask to receive proceedings from other Child Survival workshops and conferences; explore availability of space in the weekly newsletter, *Monday Developments*; agree (by the end of Summer '88) on a 1989 meeting date for PVO home office representatives.

Group members: Thornton Anderson, Karen Roesing, Mona Moore, Susan Eastman, Victor Lara, Ken Flemmer



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