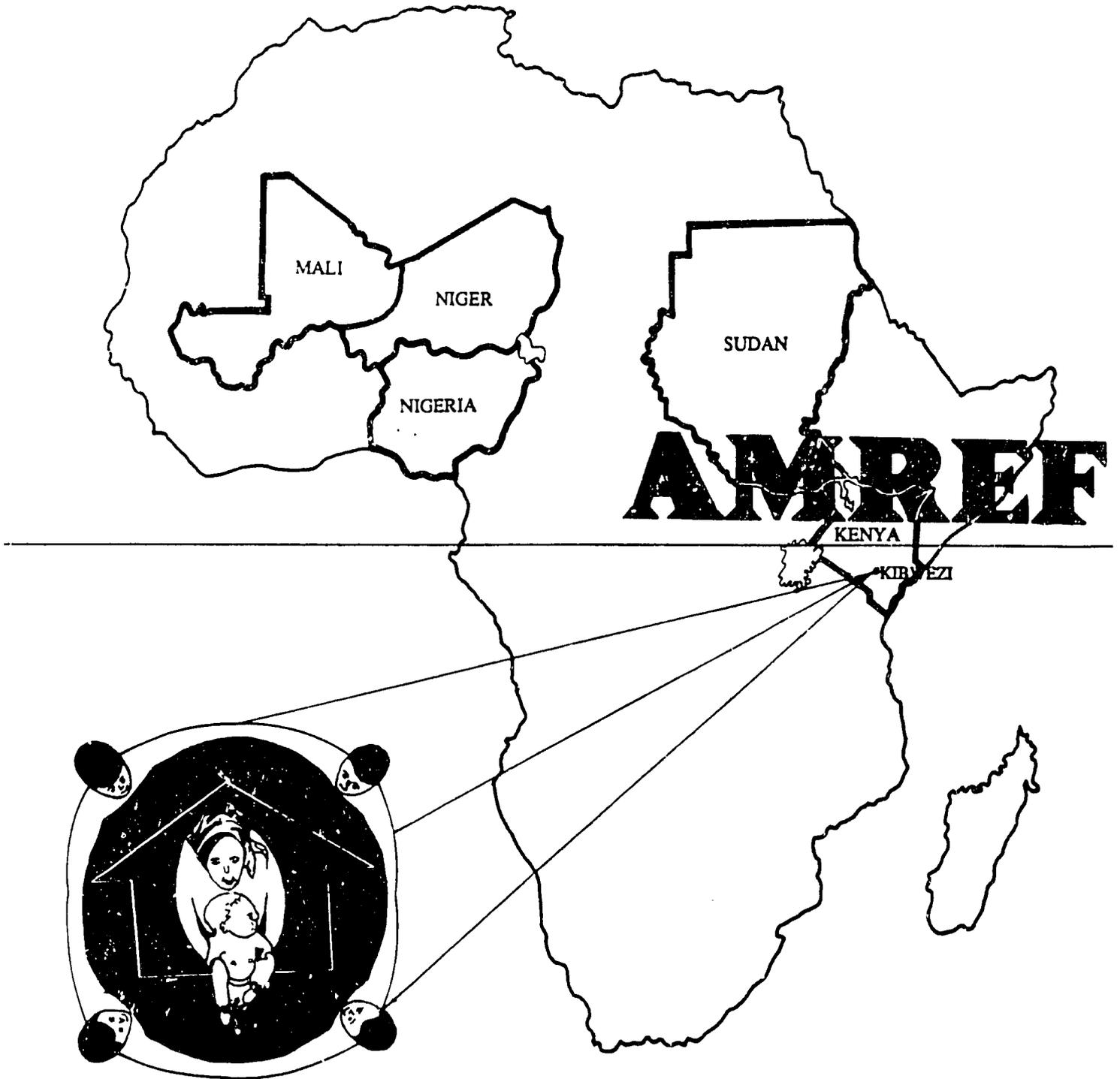


CHILD SURVIVAL WORKSHOP REPORT

June 18 - 24, 1988

Hunter's Lodge and Club - Kibwezi, Kenya.



COMMUNITY PARTICIPATION
FOR
CHILD SURVIVAL IN AFRICA.



REPORT OF THE KENYA WORKSHOP:

"COMMUNITY PARTICIPATION FOR
CHILD SURVIVAL IN AFRICA"

HUNTERS LODGE, KIBWEZI, KENYA

JUNE 18-24, 1988

A regional training workshop for implementors of Child Survival projects carried out by Private Voluntary Organizations in Africa

Sponsored by
U.S. Agency for International Development
(A.I.D.)

Hosted by
African Medical and Research Foundation
(AMREF)

Report Prepared by
Paula Walsh, MPH
Consultant/PVO Child Survival Support Program
The Johns Hopkins University

with

AMREF
Community Health Department
P.O. Box 30125
Nairobi, Kenya

December 1988

ACRONYMS AND ABBREVIATIONS

ADRA	Adventist Development and Relief Agency
A.I.D.	Agency for International Development
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
BCG	Bacille Calmette Guerin (TB Vaccine)
CBHC	Community Based Health Care
CDD	Control of Diarrheal Diseases
CHW	Community Health Worker
CS	Child Survival
CSH	Child Survival & Health
CSP	Child Survival Program
DIP	Detailed Implementation Plan
DPT	Diphtheria/Pertussis/Tetanus
EPI	Expanded Program on Immunization
FVA/PVC/AID	Bureau for Food for Peace & Voluntary Assistance/Office of Private & Voluntary Cooperation/Agency for International Development
HIS	Health Information System
HKI	Hellen Keller International
KAP	Knowledge / Attitude / Practice
MCH	Maternal Child Health
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts (Solution)
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PVO	Private Voluntary Organization
REACH	Resources for Child Health
SAWSO	Salvation Army World Service Office
SCF	Save the Children Federation
SSS	Sugar/Salt Solution
TA	Technical Assistance
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VMI	Vision Mondiale Internationale
WHO	World Health Organization
WV	World Vision
WVRD	World Vision Relief & Development, Inc.

CONTENTS

	PAGE
1. INTRODUCTION	
1.1 Executive Summary	4
2. WORKSHOP DESCRIPTION	
2.1 Background	5
2.2 Workshop Theme	7
2.3 Workshop Goals	7
2.4 Workshop Objectives	7
2.5 Workshop Venue	9
2.6 Workshop Agenda	9
2.7 Participants & Resource Persons	11
2.8 Workshop Evaluation	12
3. WORKSHOP CONTENT	
3.1 EPI	14
3.2 CDD	16
3.3 Growth Monitoring/Nutrition.....	18
3.4 Health Information System & Reporting Requirements ..	20
3.5 Sustainability	22
3.6 Resources/Technical Assistance	26
3.7 Special Interest Groups	27
3.8 Vitamin A	27
3.9 Activities in the Field	27
3.9.1 Focus Group	28
3.9.2 Training of TBAs	28
3.9.3 Supervision of a Mobile Clinic.....	28
3.9.4 Training of CHWs	29
3.9.5 Immunization Coverage/CDD KAP Survey	30
3.9.6 Village Health Committee	31
4. PVO CS PROJECTS	
4.1 Project Summaries	32
4.2 90-Day Action Plans	35
5. RESOURCES FOR FUTURE WORKSHOPS	
5.1 Resource Room	37
5.2 Resource Packets.....	38
5.3 Workshop Operational Budget	40
6. RECOMMENDATIONS OR FUTURE WORKSHOPS	
6.1 Accomplishments	41
6.2 Recommendations to A.I.D.	42
7. ANNEXES	
7.1 Participants	43
7.2 Resource Persons & Facilitators	45

1. INTRODUCTION

1.1 EXECUTIVE SUMMARY

The African Medical and Research Foundation (AMREF) in Nairobi, Kenya, was designated to host the 1988 Africa Regional Child Survival Workshop by The Bureau for Food for Peace and Voluntary Assistance, Office of Private Voluntary Cooperation, Agency for International Development (FVA/PVC/AID). The workshop was planned in coordination with the PVO Child Survival Support Program, Institute for International Programs, The Johns Hopkins University. This was the fourth PVO Child Survival Workshop sponsored by the FVA/PVC office, A.I.D., to be held in Africa.

PVOs with Child Survival projects that were funded in 1987 (CS III), from Nigeria, Sudan, Kenya, Mali, and Niger, participated in the workshop. Several PVOs with CS II projects and one with a CS IV project also participated. The 24 invited participants comprised country nationals and PVO staff most directly involved with project implementation. The 15 resource persons attending the workshop were from A.I.D., The Johns Hopkins University, the Kenyan Ministry of Health, CARE-Kenya, University of Nairobi, Liverpool School of Tropical Medicine, REACH, and AMREF.

The workshop theme was "Afya Pamoja na Watu" (Health with the People) which stresses community involvement in primary health care for child survival. The goals of the workshop were to provide an opportunity for participants and resource people to exchange ideas, discuss issues in project management, and review state-of-the-art technologies for CS interventions, and to increase awareness of the need for coordination with the government and participation from the community to enhance sustainability.

As with the previous workshops, the venue was a rural area where the host PVO has a CS project. This enabled the participants to go to the field and experience some of the project activities during the workshop. Field activities in the project area included a mini immunization coverage/demographic/KAP survey, focus group discussions with a women's group and village health committee, supervision of an outreach clinic, and training and supervision of CHWs and TBAs. The technical areas covered during the workshop included EPI, CDD, Growth Monitoring/Nutrition, Health Information Systems, Sustainability, and Resources/Technical Assistance. The PVOs also presented summaries of their own projects at the beginning of the workshop, and throughout the week developed 90-day action plans.

2. WORKSHOP DESCRIPTION

2.1 BACKGROUND

The 1988 Africa Regional workshop was hosted by the African Medical and Research Foundation (AMREF) which is headquartered in Nairobi, Kenya. AMREF has a Child Survival project operating in three areas of Kenya that was funded in 1986 by The Bureau for Food for Peace and Voluntary Assistance, Office of Private Voluntary Cooperation, Agency for International Development (FVA/PVC/AID). The workshop was planned in coordination with the PVO Child Survival Support Program, Institute for International Programs, The Johns Hopkins University. FVA/PVC has a cooperative agreement with The Johns Hopkins University to provide appropriate specialized technical assistance to PVOs that have been awarded Child Survival Grants. Technical assistance activities include organizing regional and country workshops for PVO field staff to help improve service delivery and provide enhanced access for field staff to state-of-the-art technologies essential to achieving A.I.D.'s Child Survival Action Program goals. The 1988 Africa Regional workshop is the fourth PVC Child Survival Workshop sponsored by the FVA/PVC office, A.I.D., to be held in Africa. Previous workshops were held in Sierra Leone (1986), Zimbabwe (1987), and Rwanda (1987). PVOs with Child Survival III projects funded in 1987, from Nigeria, Sudan, Kenya, Mali, and Niger participated in the Kenya workshop. The 24 invited participants comprised country nationals and PVO staff most directly involved with project implementation.

The workshop coordinators from AMREF were Dr. B.O.N. Oirere and Ms. Margaret Okelo. Both B.O.N. and Margaret were participants at the Zimbabwe Child Survival workshop that was held in August 1987 for CS II projects. After the Zimbabwe workshop, Dr. Oirere suggested to Dr. Jake van der Vlugt, Child Survival & Health Coordinator of AID/FVA/PVC, that AMREF might be interested in hosting the next Child Survival workshop in Africa. In October 1987, Dr. van der Vlugt wrote to Dr. Oirere saying that A.I.D. was supportive of an AMREF hosted workshop and suggested that Ms. Paula Walsh, who worked through the Johns Hopkins technical support grant, visit AMREF in Kenya to begin planning.

Paula Walsh visited the workshop site in Kibwezi, Kenya, in November 1987 and began discussions with Dr. Oirere and Ms. Okelo. Over the ensuing five months, Paula and the AMREF coordinators made preliminary arrangements and corresponded by mail and phone. It was decided that a meeting should be held among the core group of planners sometime in April 1988 in order to discuss the workshop goals, develop the schedule, and identify resource persons.

Planning Team Meeting - Baltimore

The planning meeting was held April 11-13, 1988, in a conference room at the Society Hill Hotel - Hopkins in Baltimore. Dr. Oirere and Ms. Okelo came from Nairobi for the meeting, and the facilitator, Mr. Dale Flowers, came from California. (Dale Flowers was unable to participate in the workshop but was very helpful in the planning stages.) Also in attendance for this meeting were Paula Walsh, Dr. Dory Storms, and Ms. Cindy Carter, all of Johns Hopkins, and Ms. Kate Burns, CARE's regional representative in Kenya. The main tasks accomplished at this meeting included: 1) establishing workshop goals, theme, and outcomes, 2) establishing a workshop timeline and structure, 3) developing a preliminary workshop schedule, 4) identifying possible resource persons and materials, and 5) determining next steps and task assignments.

From mid-April through the first week in June, Paula continued working with Margaret and B.O.N. mainly by telex, letters, and occasional phone correspondence. As the participants' names were received at Johns Hopkins, they were relayed to AMREF in Nairobi. Also during this time period, Paula developed materials about the workshop to send to the participants, gathered resource materials, revised workshop documents as changes were made, and lined up the resource people for the workshop. B.O.N. and Margaret continued working in Nairobi to arrange all travel and logistics for the participants, make final arrangements for the workshop venue, and arrange for supplies, transportation, and site visits.

Planning Team Meeting - Nairobi

One week prior to the workshop, June 14-17, the resource persons and facilitators met in Nairobi at the Boulevard Hotel for final preparation. Dale Flowers was unable to facilitate the workshop because of a family emergency, but fortunately the co-facilitator, Dr. Dan Kaseje, was able to attend. The planning meeting in Nairobi consisted of Dan Kaseje, facilitator; Ms. Penina Ochola, AMREF facilitator; Ms. Mary Harvey, EPI resource person; Dr. Mary Carnell, HIS resource person; Kate Burns, CARE's Regional Representative; Dr. John Alwar, ORT resource person; and Margaret Okelo, B.O.N. Oirere, and Paula Walsh, coordinators. At this stage of planning, Margaret and B.O.N. were very busy with last minute travel and logistic details. Therefore, the other members of the team formed the core group that planned the workshop process and content. Since the facilitators were mainly responsible for the flow and process of the activities during the workshop, it was decided that Mary Carnell should be the Technical Coordinator for the workshop. Mary worked with the resource people on the content of their technical sessions and saw that key messages were emphasized during the workshop.

During the Nairobi planning meetings the resource people developed ten objectives for the workshop based on the theme, goals, and intent of child survival implementation workshops. These objectives then served as a guideline for refining the schedule and determining the content of the technical sessions. Once the specific technical sessions were determined, a time frame for the workshop was finalized and one of the resource persons or facilitators was made responsible for each session or activity.

2.2 WORKSHOP THEME

The theme of the workshop was "AFYA PAMOJA NA WATU", Health with the People, which stresses community participation in primary health care for child survival. Throughout the workshop, community participation was mentioned repeatedly by the participants as one of the key factors in a successful child survival program. The need for community involvement was highlighted during all of the technical sessions dealing with child survival issues, including sustainability, EPI, CDD, Nutrition, and was particularly evident during the field visits. Community participation is a very strong component of AMREF's Kibwezi Child Survival project, which was the setting for the workshop field activities.

2.3 WORKSHOP GOALS

The workshop goals were determined during the first planning meeting in Baltimore and were based on A.I.D. guidelines for implementation workshops and on the needs of the PVOs that had recently received funds from A.I.D. for new Child Survival projects. Setting the goals early in the planning stages provided a basis for developing workshop content and structure. The workshop goals were to:

- provide the opportunity for participants and resource people to exchange ideas, materials developed, and experiences gained in the first year of project implementation.
- discuss issues in project management, review state-of-the-art technologies and share strategies for staff training, and supervision and monitoring of key child survival interventions at the local level.
- increase the awareness of the need for coordination with the government and participation from the community to enhance the possibility of sustaining the gains made through child survival activities.

2.4 WORKSHOP OBJECTIVES

The final objectives were a synthesis of the participants expectations and the ten original objectives set by the facilitators and resource people. On the first day of the workshop, the participants were asked about their expectations for the workshop. These expectations were then merged with the

original objectives to give a final list of 11 objectives for the week. As part of the final evaluation exercise on the last day, the participants were asked to rate how well they thought each objective was met.

It was decided that by the end of the workshop participants would:

1. Present their project to the rest of the group, stressing constraints, innovations, and progress.
2. Develop or design a 90-day Action Plan to address stated problem area(s).
3. Be introduced to A.I.D.'S reporting requirements for the life of the project.
4. Assess the current status of Health Planning, Management, and Information system, and develop ways to build on it, including baseline surveys, monitoring and evaluation systems, monitoring of high-risk groups, and ways to integrate A.I.D.'s reporting requirements.
5. Identify and share ways and mechanisms for increasing communication, collaboration, and networking within organizations, and with the government, other PVOs, and donor agencies.
6. Analyze their Child Survival Project activities and state their potential/plans for sustainability beyond the A.I.D. funding period.
7. Share ways, mechanisms, and resources to identify tasks and roles with the community that members could undertake in order to ensure community ownership and contribute to future sustainability of improved health activities.
8. Update their knowledge on the key child survival activities (growth monitoring, oral rehydration therapy, promotion of breastfeeding, immunization, and family planning), vitamin A, and HIV, including key messages in all technical areas through workshop sessions and resource materials.
9. Develop supervisory guidelines for child survival interventions.
10. Share experiences on:
 - (i) Methods of training at the community level.
 - (ii) CHW training, motivation, and incentives.
 - (iii) Management of urban/nomadic child survival activities.
 - (iv) Integration of several child survival activities in one program.
11. Make a commitment to meet again with those who work in their country.

2.5 WORKSHOP VENUE

The workshop was held from Saturday, June 18, through Friday, June 24, 1988, in Kibwezi, an area of southeast Kenya where AMREF has a Child Survival project. The venue was a lodge in an isolated rural area with few outside distractions and very pleasant surroundings. The accommodations were comfortable, and there were few food or lodging problems except for an occasional lack of hot water. Large group meetings were held in a three-sided tent in an open area behind the lodge. Small meeting rooms were also available, as well as a staff room for the resource persons and a room for the secretaries and resource materials.

2.6 WORKSHOP AGENDA

The workshop began Saturday evening, but the official opening did not take place until Monday when the officials were available. The workshop was officially opened by Mr. Wasike, Permanent Secretary of the Ministry of Health. Other speakers included Mr. John McEnaney of A.I.D.; Mr. Simon Shitemi, Deputy Director General of AMREF; and Dr. George Rae, the District Medical Officer of Machakos; the keynote speech was given by Mr. Mutie, Director of the Family Welfare Centre of the Ministry of Health.

The workshop agenda, which follows, is a schedule of all the activities that were carried out during the week. Most evenings were left open to allow participants to meet informally with each other and share interests. Occasionally, a small group met with a resource person to continue with a topic discussed earlier in the day or to prepare for a session the following day. The cultural evening was a lot of fun, with most participants dressed in their traditional costume. The group was entertained by traditional African dancers from the community, and the certificates for attending the workshop were distributed along with a few mementos of the week.

At the end of each day, a wrap-up session was held at which the key messages were reviewed and the participants were asked for any feedback. The participants also filled out an assessment form at the end of the day that indicated the activities or happenings during the day that they found most and least useful. The planning team met in the evening to review the assessment forms and the day's activities and to prepare for the following day.

Details of each of the technical sessions held during the week can be found in Section 3: Workshop Content.

WORKSHOP SCHEDULE

SATURDAY 6/18	SUNDAY 6/19	MONDAY 6/20	TUESDAY 6/21	WEDNESDAY 6/22	THURSDAY 6/23	FRIDAY 6/24
7-8am	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST	BREAKFAST
	Service 8-8:45 Ice Breaker Expectations 8:45-10:45 Break 10:45-11 Project Briefings 11-1	Reflection 8-8:15 EPI 8:15-10:15 Break 10:15-10:30 HIS/Reporting Requirements 10:30-12:30	Reflection 8-8:15 CDD 8:15-10:15 Break 10:15-10:30 Preparation Site Visits 10:30-11:30	Reflection 8-8:15 Site Visit Discussion 8:15-10:30 Break 10:30-10:45 Nutrition/ Growth Monit. 10:45-12:45	Reflection 7:30-7:45 Site Visits 7:45-2:00 - Health Com. - Coverage Survey	Reflection 8-8:15 TA/Resources 8:15-9:00 Action Plans 9-11 Evaluation 11-11:30 Closing 11:30
	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
Arrival/ Registration 4:00	Project Briefings 2-3 Sustainability 3-4:30 Break 4:30-4:45 Intro To Action Plans 4:45-5:00 Wrap Up 5-5:30	Official Opening 2:30-4:00 Break (picture) 4-4:30 Wrap Up 4:30-5:15	Site Visits 12-6 -Mobile Clinic - CHWs - TBAs -Women's Group	Action Plans 2-3 Spec. Interest Groups 3-4 Break 4-4:15 Preparation Site Visits 4:15-5:45 Wrap Up 5:45-6	Site Visit Discussion 3-5 Vitamin A 5-5:30 Wrap Up 5:30-6	Depart For Nairobi 2:00
DINNER	DINNER	DINNER	DINNER	DINNER	DINNER	
ORIENTATION				Questions & Answers with A.I.D. Rep	Cultural Evening	

2.7 PARTICIPANTS AND RESOURCE PERSONS

Participants

Country nationals and PVO staff most directly involved with project implementation were invited to participate in the workshop. Two participants from each of the following PVOs with CS III projects were invited: WVRO/Kenya, ADRA/Nigeria, ADRA/Sudan, ROTARY/Nigeria, CARE/Niger and WVRO/Mali. In addition, SAWSO/Kenya (CS I), AMREF/Kenya (CS II), CARE/Sudan (CS II), HKI/Niger (CS II), HKI/Sudan (CS II), and MIHV/Kenya (CS IV), (which was recently funded), were also invited to participate. There was a total of 22 workshop participants representing PVOs and Regional representatives.

Resource Persons

The AMREF coordinator for the workshop was Dr. B.O.N. Oirere who was assisted by Ms. Margaret Okelo. Dr. Oirere and the AMREF staff arranged logistics and communications for the workshop, planned cultural activities and visits to the project site for the participants, and provided the support staff for the workshop. Ms. Paula Walsh was the workshop coordinator for the PVO Child Survival Support Program and worked with Dr. Oirere on needs assessment, workshop content, and coordination of the resource persons.

Dr. Dan Kaseje from Kenya and Ms. Penina Ochola of AMREF facilitated the workshop. Other resource persons included: Dr. Mary Carnell, technical coordinator and HIS resource person; Ms. Mary Harvey, EPI resource person; Dr. John Alwar, ORT resource person; Dr. George Rae, District Medical Officer in Machakos; Ms. Kate Burns, Regional representative from CARE; Mr. Ben Osuga, Research & Information Officer for AMREF; and Ms. Robina Biteyi, coordinator of the Kibwezi Applied Nutrition Project for AMREF. The A.I.D. representative was Mr. John McEnaney of the FVA/PVC/CSH office in Washington. (For a full list of participants and resource persons and their addresses see ANNEXES 6.1 and 6.2).

2.8 WORKSHOP EVALUATION

On the last day of the workshop before the final wrap-up session, the participants were requested to complete an anonymous evaluation questionnaire. In addition to giving comments on all aspects of the workshop and recommendations for future workshops, they were requested to rate the degree of achievement for each of the 11 objectives of the workshop.

Achievement of Objectives

Four-fifths of the group considered the following objectives to have been very well achieved:

- To identify and share ways and mechanisms for increasing communication, collaboration, and networking within our organizations and with government, other PVOs, and donor agencies.
- To share ways, mechanisms, and resources for identifying tasks and roles with the community that members could undertake in order to ensure community ownership and contribute to future sustainability of improved health activities.
- To update participants' knowledge on the key child survival activities (comprising growth monitoring, oral rehydration therapy, breastfeeding promotion, immunization, and family planning), vitamin A, and HIV, including key messages in all technical areas through workshop sessions and resource materials.

No objective was rated as not being achieved at all, and only one was rated as being moderately achieved. The objective with the moderate rating was:

- To analyze Child Survival Project activities and state their potential/plans for sustainability beyond the A.I.D. funding period.

Other Comments & Recommendations

The field visits, field survey, and project briefings were judged very useful by the participants. Accommodation and food were on the whole assessed as satisfactory, with only four of the 24 participants considering the accommodation and food poor. All considered the venue to be good or very good.

Some of the responses to the three open-ended questions were as follows:

1. What did you like best about the workshop?

- Field visits and surveys
- Sharing between participants in discussions
- Amount of information generated
- Sustainability as a topic
- Democratic atmosphere and lack of tension
- Key messages for growth monitoring, CDD, and EPI.

2. What did you like least about the workshop?

Thirteen of the 25 did not name an aspect that they liked least. Other answers were:

- Time schedule not respected
- Discussion of vitamin A appeared as an after-thought
- Expectations session was too long
- Arrangement of topics was not systematic
- Not enough reference to DIPS brought by participants
- Too little time in the field
- Sharing rooms

3. What recommendations would you make for future workshops?

The participants recommended that important technical issues should be discussed thoroughly in the technical sessions in order to minimize subsequent discussions when the points are raised during the key message reviews. It was also suggested that either too much was attempted or the time for the workshop should have been extended. Several people recommended follow-up workshops in order to go into more detail on some of the interventions and issues. A thoughtful recommendation was that the whole workshop should be built around a more detailed field survey and that the sessions could be devoted to analyzing and working out activities and suitable interventions responding to the survey findings. This could then be related to participants' own projects, and theory and practice could be better integrated in one comprehensive exercise. (For additional recommendations see Section 5.4: Recommendations for Future Workshops.)

3. WORKSHOP CONTENT

3.1 EXPANDED PROGRAM ON IMMUNIZATION (EPI)

By Mary Harvey with Dr. G. O. Rae

The goal of this session was to identify and discuss the concept of vaccination series completion in children under age one and tetanus toxoid vaccination in women of child-bearing age and/or pregnant women. The objectives of the session were to:

- Define series completion and identify children not completing series correctly.
- Identify and discuss missed opportunities and drop-outs.
- Develop ways/strategies to follow up/track defaulters (focus on urban and rural dwellers, nomads, migration).

The session began with a presentation of the Kenya EPI vaccination schedule (see Table 1). The reason for delivering polio vaccination at birth was explained and the importance of minimum intervals between doses was highlighted. The TT schedule for women was presented separately, and the importance of this vaccine and who should get it (i.e., women of child-bearing age) was discussed. It was emphasized that the program focuses on children under age one, which is considered the high-risk group for the six diseases covered by EPI. Calculation of the under-one population was then demonstrated. For the next half hour the participants, working in groups, assessed the immunization status of ten children whose vaccination histories were recorded on sample vaccination registration cards.

When the large group reconvened, the small groups presented the vaccine schedule of one child and explained why that child may or may not have completed the vaccination series. Recognition of the correct intervals between doses and identification of recording errors and missed opportunities were noted. A short presentation on why people do not complete their immunization series, based on data from surveys conducted in 18 countries, completed the session. Strategies to increase vaccination coverage among special populations such as nomads and urban dwellers was postponed for a special interest group session.

Key Messages of EPI Session -

1. Series completion means children receiving all their immunizations at the proper intervals.
2. There are no contraindications to vaccination (except for BCG in a child with AIDS).

3. All clinic visits should be taken advantage of to ensure that the child is vaccinated if needed.
4. Supervision of clinic records is important to ensure that children are being properly vaccinated and that no opportunities are being missed.
5. Health workers should be trained to understand the importance of respecting the minimum interval between doses of vaccines.
6. Better strategies to identify and follow up on defaulters should be developed.

IMMUNIZATION SCHEDULE IN KENYA

0-1 year

Antigen	Schedule	Remarks
BCG	at birth	or first contact
OPV-1	at birth	with infant
DPT-1	6 weeks	not less than one
OPV-2	6 weeks	month interval
DPT-2	10 weeks	not less than one
OPV-3	10 weeks	month interval
DPT-3	14 weeks	not less than one
OPV-4	14 weeks	month interval
Measles	9 months	or at first opportunity thereafter

Table 1.

3.2 CONTROL OF DIARRHEAL DISEASES (CDD)

By Dr. John Alwar

A CDD case study was issued to participants to generate discussion of problems with CDD programs. The case study follows:

"Kiboko Progressive Society has heard of Mr. Pesa Nyingi who was prepared to sponsor CDD as part of the Child Survival strategy. The funding consisted of establishment of an ORT corner at their local health centre and to finance purchase of ORS sachets, as well as finance health education activities.

"At a certain point Mr. Pesa Nyingi sent an investigator who found that the sachets were not being utilized, the IV treatment was still common and was most preferred by health workers and the community but there had been no change in the rate of deaths due to diarrhoea. When the workers were interviewed it was found that the centre recently introduced sachets from different firms who were selling sachets of different sizes with different mixing instructions. The health workers found it difficult to remember all the instructions and instruct patients appropriately. Therefore, the health workers mixed the ORS themselves and gave the patients a pre-mixed solution. The investigator moreover asked several workers to recite mixing instructions and found out that each of them mixed the ORS differently totally irrespective of sachet size.

"The health workers interviewed were very proud of the programme because they had established an ORT corner and started most of their patients on ORT, but when asked why they thought the programme was good, they said most mothers liked it because they could be starting treatment while IV drip was still to be prepared and sometimes the child might not have to be put on the drip. Moreover, more children were being brought for treatment.

"The investigator then asked the health workers in Kiboko Progressive Society what the strategies for the comprehensive CDD programme were and what their targets or high risk groups were but apart from promoting ORS, and in the absence of SSS they did not have any targets nor did they know their high risk groups, neither were there any other strategies.

"(NB: In the same centre there were immunization and growth monitoring activities)."

Discussion

After reading the case study, the participants made a list of the problems they noted with the CDD program in Kiboko. The participants then broke up into small groups, in which they chose three problems and came up with possible solutions. When the large group reconvened, each solution was discussed and critiqued by the participants and resource persons. A discussion then followed about which indicators could be used to determine whether diarrhea is a serious problem in a particular community. The following indicators were identified:

- Identification of the problem by survey
- High rate of protein energy malnutrition
- High incidence of measles (ineffective measles vaccination)
- Diarrheal diseases among top common causes of hospital admission, consultation, and death
- High infant/child mortality rate
- The community recognizes it as a problem

Key Messages of CDD Session -

1. ORT is to prevent or correct dehydration, death, and complications and is not a method of preventing diarrhea or vomiting.
2. Develop CDD where measles, malnutrition, and diarrhea exist.
3. The community should be involved in planning CDD programs that establish the need for awareness/training.
4. Develop a standard practice and let the community and implementors gain confidence in using it correctly.
5. Train and develop confidence in the health workers before involving them in the CDD program.
6. Continue breast and other feeding as part of ORT.
7. Mothers are the best doctors for their own children - involve them.
8. Mothers need to know when to seek further help (bloody stools, fever, worsening diarrhea).

3.3 GROWTH MONITORING/NUTRITION

By Robina Biteyi and Dr. John Alwar

To begin the session, a problem-posing story was presented to the participants. As with the CDD session, the story was used as a case study to generate discussion. The story, which is true, follows:

"The Story of Syombua

"Syombua is a fourth child of Nduku, a single mother. The third child died of diarrhoea at 6 months. Nduku works in town as an office messenger. She is out the whole day, but has asked her younger sister to care-take her 3 children.

"The mother has been maintaining the Child Health Card for Syombua from the third month when she brought her for treatment for acute respiratory infection. The child was weighed and her weight was below the top-line. She did not return until the 6th month, when the third child had diarrhoeal episode. The health worker told her off for defaulting. Thereafter, Syombua attended the clinic regularly but was brought by her aunt. The health worker gave some nutritional advice to the aunt.

"The mother at 9 months brought Syombua for measles immunization. At this time the weight had dropped below the lower line. The health worker advised the mother on continued breastfeeding and supplementation. At this time the mother told her that she was pregnant and had stopped breastfeeding. Ten days later, Syombua developed measles which was complicated by severe broncho-pneumonia. She was taken to the dispensary for treatment but unfortunately her life could not be saved - she died."

Discussion

After reading the case study the participants discussed the events leading to Syombua's death and identified specific risk factors such as growth faltering and incomplete immunizations. Could these problems have been identified earlier by the family or health workers? Were there missed opportunities, given the health workers contact with the child and care-givers? The participants discussed the factors that led to missed opportunities and listed some activities that might have been taken to prevent the death.

Discussion ensued on the possible patterns of health and welfare care during the period when the child was not weighed. There may have been episodes of weight gains, followed by losses. It was noted that "catch-up" slopes after infection provide opportunities to assess the health and nutrition of a child. Most health workers do not understand the relevance and

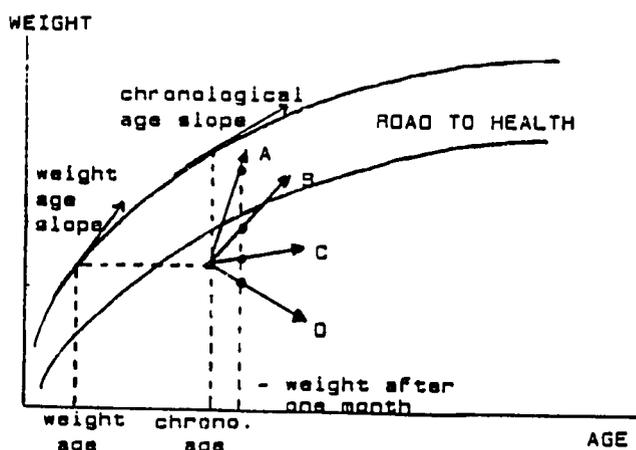
significance of catch-up slopes. Dr. Paget Stansfield used this opportunity to share further experiences on some aspects of growth monitoring of both child and mother.

In growth monitoring, slopes are more important than position on the "Road to Health" chart (see Figure 1). Apart from the general slope, one of the most important things to notice is the slope of the "catch-up" weight after an infection. Children "step" into malnutrition because of less and less adequate rehabilitation weight slopes (gains) following weight loss during acute infection. Weight gain after infection should be equal to or greater than the child's "weight age" slope. If this does not occur, no catch-up is possible and the child is "at risk" even if he or she is gaining weight.

Key Messages of Nutrition/Growth Monitoring Session -

1. Growth monitoring helps health workers, families, and mothers to appreciate normal growth and development as a measure of health and to see its relation to appropriate health activities.
2. It is important to identify at-risk children and follow them up. For example, assess the nutritional status of the younger siblings of malnourished children.
3. Catch-up growth after infection is necessary to prevent growth faltering.
4. Growth monitoring is one of the more difficult components of child survival interventions but it is a sensitive and useful index of the child's well-being.

ROAD TO HEALTH CHART



A, B, C, and D are possible age slopes during rehabilitation.

A and B are catch up slopes.

C and D will never "catch up" and are "at high risk" unless rehabilitation improves.

Figure 1

3.4 HEALTH INFORMATION SYSTEM (HIS) AND REPORTING REQUIREMENTS

By Mary Carnell & John McEnaney

The HIS session began with an explanation of what a HIS is and why it is important. The steps involved in establishing a HIS were then outlined, and the monitoring and evaluation of EPI coverage were used to illustrate how a HIS works.

Definition of HIS:

A system designed for collecting, compiling, analyzing, and reporting data to measure achievement and to direct action.

Discussion

Although A.I.D., PVO headquarters, and other donors have needs for reports from projects in the field, the most important use of a monitoring system is to provide internal information to CS project managers. An appropriate monitoring system allows project managers to understand the current project status and make informed management decisions. The system should accomplish reporting needs without overburdening the health workers. Where possible it should use available sources of information to meet reporting needs.

To design a monitoring system that is simple, easy to use, and answers the most important questions takes considerable skill and experience. PVOs may need to call on local or external technical assistance for help in the design of their monitoring systems to get them started on the right track so as not to lose valuable time and energy. The development of a HIS should begin in the planning stages of a program. The following sequential steps are undertaken in establishing a HIS:

SET OBJECTIVES > LIST ACTIVITIES > SELECT INDICATORS > SET TARGETS > COLLECT DATA (DURING IMPLEMENTATION) > ANALYZE DATA > GENERATE REPORTS > MAKE DECISIONS AND TAKE ACTION FOR IMPROVED IMPLEMENTATION.

Creating a monitoring system that is useful and relevant to the peripheral worker who collects the information should help ensure that the data are of high quality. The closer a person is to the work being performed for a particular indicator, the better that person can set a realistic target. Feedback at all levels is essential. Communities need feedback of important results, using methods appropriate to their level of understanding. Likewise, project managers must give feedback to their supervisors, and supervisors to their peripheral workers. Similarly, feedback from PVO headquarters to the field can be a powerful incentive for field staff to continue in the difficult environment in which they work.

3.5 SUSTAINABILITY

By Dr. Mary Carnell

Definition of Sustainability:

Continuation of valued benefit flows or outcomes, with or without the programs or organizations that stimulated those benefits in the first place.

The major reasons for failure in sustainability are:

- Failure to consider process in project planning
- Failure to plan to mobilize resources
- Lack of resources to maintain worthwhile activities begun with project funding

To the extent that the beneficiary population is interested enough in project activities to make direct commitments to them in time, labor, land, and/or money, costs will be decreased, local ownership will be developed, and sustainability will be enhanced.

Discussion

Participants broke into groups to discuss the following question:

"What are you doing now (or could you plan to start doing) that would increase the possibility of the benefits of your project continuing after your PVO leaves? Place an emphasis on community level".

The participants were encouraged to consider some important questions and factors as they discussed the sustainability of their projects:

1. What benefits are to be sustained?
2. What resources will be required to fund long-term benefit flows?
3. Do projected benefits justify the investment of external resources in view of competing needs and constraints?
4. Does the administrative capacity exist or is it being developed locally to maintain essential systems for benefit continuation?
5. Is the project dependent on administrative support of a single key person or group?

6. Are permanent aspects of service delivery being institutionalized in government structure or viable private sector delivery systems?
7. How much can be undertaken locally - financially and administratively?
8. It is important to differentiate between short-term activities and long-term benefits: for example, ORT activities versus decreased mortality from diarrhea.
9. Recurrent costs must be distinguished from start-up costs, allowing for replacement of capital investments such as vehicles, refrigerators, etc.
10. Project activities are often begun with "money looking for projects"; when outside funding ends, there will be "competing activities looking for money."

Group work on sustainability classified under four headings, also revealed further ideas.

1. Community Involvement in Health Action

Income-generating activities ensure some funds. TBAs, fortunately, have traditional ways of being remunerated. Feedback to communities keeps up the interest and further development of activities. Sustainability is further ensured if appropriate technology is used and there are available resources within the community. Follow-up and supervision ensure village health worker continuity. Communities that provide food for training and supervision are also diminishing the recurrent expense problem. Incentive should come from the community and not from the donor.

2. Community Involvement in Planning and Training

Community involvement in training is more likely to ensure continuity if the communities actually participated in planning the curriculum. Community determination of priorities is also important. Communities can also plan to split up responsibilities and labor contribution by groups and decide which groups are concerned with which aspects of a program. Existing committees or groups should be involved in planning.

3. Good Communication within a Community

Increased awareness of groups and community professionals and leaders in solving their problems is ensured if good communication is initiated and maintained. More time spent on this aspect of communication helps to ensure sustainability.

4. Coordination with Government and other NGOs

It is important to involve government workers and, where possible, local PVO service staff in continuing the project even after the donor pulls out. The local district development committee should take over and local authorities should continue any health center activities.

Key Messages for Sustainability -

Achieving sustainable benefit flows has been an elusive goal in development experience, largely because sustainability has been treated as an afterthought as projects are implemented. Planning for sustainability will require new ways of thinking about project objectives, implementation strategies, and evaluation.

Important factors in achieving sustained benefit flows are reviewed below.

- Begin by carefully defining what ought to be sustained. Activities are not the same as benefits, though some activities may have to continue in order to support lasting benefit flows.
- Plan projects in the light of sustainability criteria. What resources will be required when external funding ends? What will be their source?
- Consider the importance of local traditions and practices for sustainability. Local involvement in defining needs and planning activities to address them is a critical determinant of what will and will not work in a particular setting.
- Pay particular attention to recurrent cost obligations. Such costs lack glamor but are essential to benefit maintenance. Do not ignore depreciation of initial capital facilities such as buildings and equipment. When operating costs are temporarily subsidized by a project, avoid confusion of gross revenues with actual profits.
- Identify the need for organizational and administrative infrastructure. Utilize slack resources where possible. In any case, targeted training and capacity-building efforts will be required.
- Emphasize local resource and management inputs. Local control reduces dependency and increases the predictability of inputs. Local government revenues, user charges, or direct beneficiary investment are possibilities.

- Create incentives that support staff attention to capacity-building objectives. Pressure for short-term visible results should be balanced with recognition of efforts towards creating a sustainable management system.
- Use evaluation as a planning tool. Link criteria to sustainability objectives and use evaluation as an ongoing information source to support redesign and other adjustments. Involve local staff and beneficiaries in the information system.
- Remember that the central aspect of development is the capacity of people to solve problems for themselves. Plan and evaluate development initiatives accordingly.

(Material for this session was largely based on an article, "Benefit Sustainability", prepared for the US Advisory Committee for Voluntary Aid by Jerry Van Sant, Development Alternatives, Inc., Washington, DC, September 21, 1987.)

Comments and Recommendations to A.I.D. -

"Success of A.I.D. projects is measured in terms of how effectively funds are used during the project period. Development of strengths necessary to carry on a project is costly and does not generate immediate project benefits, thus reducing the rate of return. Thus, the A.I.D. system does not encourage investments that will yield results after A.I.D. funding ends." (From "Current Status Report on an Evaluation of Factors that Generate Sustainable Health Programs," A.I.D./ICIPE, draft 1987.)

Inherent in the CS project design are significant obstacles to sustainable PVO activities or benefits. Adequate time to develop community ownership in the planning, implementation, and evaluation of CS activities is required. Allotment of the time and resources necessary to develop local management and leadership is less glamorous than short-term results. However, the potential for long-term sustainability benefits to the community cannot be realized without this.

3.6 RESOURCES/TECHNICAL ASSISTANCE

By Kate Burns and Paula Walsh

Many aspects of CS projects are complex, requiring full use of resources and technical expertise and ideas. Participants discussed the need for creating a network and sharing ideas on where to seek additional help and support nationally, regionally, or internationally.

Suggested Resources

- Resources for Child Health (REACH) - assistance for EPI and health care financing and a newsletter called "Outreach" which is available to PVO headquarters.
- PRITECH - technology for primary health care for CDD/ORT and program management.
- PRICOR - operations research and health care financing
- AED (Academy for Educational Development) - Mass media and health education/promotion.
- AMREF - for East Africa
- UNICEF and WHO regional offices
- Local universities - computer facilities, technical assistance, etc.

Within countries PVOs can link up. Many countries have a national NGO coordinating mechanism. In Kenya, the Ministry of Health, UNICEF, and NGOs hold a coordinating meeting. Inter-agency exchanges of information are an important resource-sharing mechanism.

Intra-PVO exchange is also an important way to share expertise and resources. Site visits, sharing of evaluation teams, and assistance with new project proposals are other ways of forging linkages.

Sharing technical assistance within the same countries or regions is another mechanism for resource sharing. Outside people can often act as a catalyst for pulling groups together and initiating exchanges. Health education materials and newsletters can be exchanged, linked, and shared. Mailing lists should be coordinated for newsletters. Ministry of Health linkages are important for sharing reports.

Keep in mind that PVOs can do many things that bilaterals cannot do and are part of the forefront of development. PVOs are not restricted to health activities, and thus broader linkages with development activities can be useful and important.

3.7 SPECIAL INTEREST GROUPS

One session towards the end of the week was set aside for special interest groups. The participants gathered in small groups to discuss vitamin A, CHW incentives, special problems with nomadic populations, and A.I.D. reporting requirements.

3.8 VITAMIN A

A short session on vitamin A was presented during the workshop by the participants from HKI/Niger and HKI/Sudan. The presentation began with a discussion of how one determines whether vitamin A deficiency is a problem in selected areas. The group then discussed the advantages of including vitamin A supplementation in CS programs. Usually, the children requiring supplements are the same ones receiving the other CS interventions such as vaccinations and growth monitoring; thus vitamin A supplementation can be simple and cost effective if included with other activities.

In addition to supplementation, vitamin A activities can include gardens that produce vitamin A rich vegetables, although the benefits take longer than with supplementation. Health and nutrition education is another activity that can support long-term prevention of vitamin A deficiency. As with other CS interventions, targeting high-risk children, such as those malnourished, should be a priority.

Vitamin A activities need a well designed program to ensure cost-effective delivery. A.I.D. is preparing a package of technical assistance for PVOs to enable them to assess the need for vitamin A distribution and to establish a program.

3.9 ACTIVITIES IN THE FIELD

Two full days during the workshop were devoted to field activities. The day before the field visits, the activities were posted to allow the participants to sign up for the activity that most interested them. On Thursday, the majority of the group participated in the survey activity.

Field activities - Tuesday:

- 1 - Focus group discussion with a women's group
- 2 - Training of TBAs
- 3 - Supervision of a mobile clinic
- 4 - Training of CHWs

Field activities - Thursday:

- 5 - Immunization coverage/CDD KAP survey
- 6 - Review of a Village Health Committee

3.9.1 FOCUS GROUP

A focus group discussion was held with the Mikuyuni Women's Group to find out whether knowledge and resources from a women's income-generating activity (IGA) could be used to improve the nutritional status of children. Background for the focus group activity included discussion of what a focus group is, indications for using the focus-group type of interviews, methodology, and preparation for and facilitation of focus groups. The participants formulated a guide for the focus group discussion with the following questions:

- Why did you start the activity?
- How did you intend to spend the money generated?
- What are your future plans?
- How have these activities changed the lives of members?

The income-generating activity was intended to improve the personal and household socioeconomic status of the members and to help with education of their children. Thus far the group had not generated any money, nor would they for some time. There were other gains, however, such as improved knowledge of health practices, mutual support, facilities, some increased food production, improved nutrition, and less severe dehydration of children with diarrhea. The group was also in the process of developing more projects such as provision of water and establishment of a shop. It was concluded that the group support was something that had changed the lives of the women's group members.

3.9.2 TRAINING OF TRADITIONAL BIRTH ATTENDANTS (TBAs)

An interview was held with eight TBAs to determine their knowledge, attitude, and practice regarding their work. The TBAs discussed prenatal care, birthing practices, registration of births and deaths, and identification of high-risk pregnancies. The TBAs also sang a song for the group which described how to treat a pregnant woman and who to select for high-risk referral to the hospital. After the interview, the participants categorized their findings into knowledge, attitudes, and practices to help formulate what type of training programs should be developed for TBAs.

3.9.3 SUPERVISION OF A MOBILE CLINIC

A group of six participants developed a supervisory checklist for a mobile clinic that carries out immunizations, growth monitoring, and prenatal care. The group then went to the field to observe the clinic as if they were making a supervisory visit.

The group found that developing a supervisory checklist was important to ensure that they covered the important elements of the program activities that they reviewed. This checklist helped them focus on the key elements of the activities and identify problems that needed action.

In developing the checklist, queries were raised as to the breadth and depth of the questions included. Not all activities needed to be monitored/supervised on a weekly, monthly, or yearly basis, and one checklist might not be adequate for all circumstances. The checklist, when developed, may need to be revised for the different levels and types of activities that are being monitored/supervised. A place for observations and comments should also be included somewhere on the checklist form.

This field visit provided an opportunity for training of health staff, reinforcing good quality work and eliciting comments concerning the staff needs and desires. The group recommended that the AMREF Kibwezi health staff supervising the clinic provide feedback to the health workers on the information they were collecting, such as the number of children immunized, weighed, etc.

3.9.4 TRAINING OF CHWS

The purpose of this exercise was to interview CHWs so as to determine what they do, what they know, and what areas they need more training in. The group concentrated particularly on what the content of a refresher training program might be.

The CHWs interviewed during the visit were trained and had been working in the field for some time. Initially six CHWs were trained but three of them dropped out of the program. In order to determine what specific activities the CHWs were carrying out and the extent of their knowledge and skills, the group developed a list of questions to ask the CHWs.

The group found the CHWs to be very knowledgeable. They knew the MOH immunization schedule and the importance of vaccination, and explained how they teach mothers to prepare ORS. The CHWs could not speak or read English but they were very clear about interpreting the growth curve on the child's health card. The greatest problem for the CHWs was incentives for continuing with their work. The group thought that the CHWs should be supported by the community so as to promote the sustainability of the CHWs' activities. Income-generating activities were suggested as a way for the community to support the CHWs.

3.9.5 IMMUNIZATION COVERAGE/CDD KAP SURVEY

On the second day of field visits, the majority of participants took part in a mini survey. Preparation for the survey began with a discussion of what information should be collected and how it would be used. Basic survey methodology was also discussed, including sampling, questionnaire design, conducting the interviews, and processing the data. The importance of carrying out a baseline survey was emphasized, as was the fact that most PVOs would require some technical assistance for this activity.

The survey instrument that was used covered three areas: demographic information, immunization coverage, and management of diarrhea. Demographic information collected included: (1) number of households, (2) number of persons in specific age and sex categories, and (3) average number per household. From this information, the following indicators were calculated:

- % Males in community
- % Females of child-bearing age
- % Children 0 to 5 years
- % Children under 1

Immunization Coverage

The target age group for the survey was children aged 12-23 months. Immunization status was verified by the child's health card if available. BCG was verified by scar. Most children had received polio 4 as claimed by the mothers, but it was not recorded on the vaccination forms. In addition to the number of vaccines received, vaccine intervals were also scrutinized. Some children had received DPT and polio vaccines but they were not given at the same time.

A problem was discovered for TT because mothers did not have cards. Suggestions were made to amend the child's card to include the mother's TT or to give mothers their own TT cards (AMREF is currently pilot testing an Antenatal/Child Health Card). In looking at the immunization coverage, the group determined that in most cases, the opportunity had been missed for monitoring the child's growth. Since CHWs had motivated mothers to travel long distances for immunization, growth monitoring should have been included in the visit.

Control of Diarrheal Diseases

A short questionnaire was administered to the mothers of children reviewed for immunization status. Questions were open-ended and intended to form the basis for a more detailed structured questionnaire later. Areas covered were management of diarrhea, preparation of oral rehydration solution, continuation of breastfeeding, knowledge of the danger of diarrhea, and recognition of ORS packets and knowledge of their use.

When the survey was completed, the forms were compiled and the indicators were tabulated. In the group session after the survey, calculation of the coverage rates was demonstrated, and the participants discussed their experiences and concerns about carrying out their own surveys.

3.9.6 VILLAGE HEALTH COMMITTEE (VHC)

The purpose of interviewing the Village Health Committee (VHC) members was to find out whether they were active and aware of their role in the AMREF program, and to seek information on topics such as sustainability and supervision of their committee by AMREF. The group developed some questions as a guide for the VHW interview.

The group found that the committee included well-respected and responsible CHWs and TBAs. The initial VHC set up in the village did not work well and was taken over by village health workers. The main role of the committee was to identify problems in the community and report these to the chief. The committee was then to help with the community mobilization necessary to deal with the problems.

Support and supervision of the committees is done through discussions with AMREF staff every month. The committee thought that sustainability was not a problem since CHWs get no financial assistance. In addition, the committee was formed with community involvement and support.

4. PVO CHILD SURVIVAL PROJECTS

4.1 PROJECT SUMMARIES

When participants first arrived at the workshop, they were asked to fill out a brief information sheet describing their projects, such as which CS activities they were carrying out. This information from all the projects was entered on a large poster board hung in the main tent, and was referred to throughout the week. A copy of the table can be found on the next page.

On the first day of the workshop, the participants were asked to make a short presentation on their projects to the rest of the group. These presentations were structured so that the participants focused on i) two areas that had been successful in the progress of their project, ii) two areas that had been problematic, and iii) something about the project that made it unique. From previous workshops it was evident that the participants needed a session to present and share their projects with each other. This also provided an opportunity to discover each individual's areas of interest and expertise for further networking during the workshop.

Asia Regional PVO Child Survival Workshop
Project Summaries

PVO/Country	ACRA Sudan	ACRA Nigeria	CARE Niger	CARE Sudan	WRVO Mali	WRVO Kenya	Rotary Nigeria	SAUSO Kenya	HKI Niger	HKI Sudan	MIHV Kenya	APREF Kibwezi	APREF Urban	APREF Nonacetic
Target Population	250,000	49,945	147,375	526,503	68,728	73,000	23,400,000	170,000	193,536	250,000	50,000	150,000	32,000	93,150
Per 1 Pop.	7,775	7,034	15,753	21,534	9,385	1,930	20,400,000	7,000	37,286		1,700	7,500		3,632
Per 3 Pop.	NA	14,772	30,106	63,180	9,289	3,893	3,000,000		93,217			22,000		14,809
Per 15-45	NA	28,139	78,763	105,300	49,614	70,633		34,000	44,388		11,700	27,000	15,000	19,340
Life of Proj (yrs)	3	3	4	3	4	4	4	3	3	2		4	4	5
Level-Total	581,771	204,446	700,000	900,000	1,000,000	-	957,000	-	366,000	457,000		750,000		
Level-USAID	-				567800									
MO Field Staff	5	16	1	8	5	10		2	4	5	3		2	10
PROJECT ACTIVITIES:														
Project Complete	Yes	No	No	Yes	No	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes
Monitoring Activ														
PI	Yes	Yes	No	Yes	Yes	-	Yes	No	No	No		Yes	-	-
RT	Yes	Yes	Yes	Yes	Yes	-	No	Yes	No	No		Yes	-	-
er:	No	Grv.Monit	Grv.Monit		Nutrition			Grv.Monit	Vit A	Vit.A		Nutrition		
	No	F.P., Vit			F.P.			Nutrition				Brstfeed		
	No	A,Malaria						F.P.				Food prod		
Monitoring Syst.	-	YES	NO	NO	NO	YES	NO	YES	YES	YES		Yes	Yes	Yes
Face														
Revision Tools	-	-	Yes	Yes	Yes	YES	Yes	Yes	Yes	No		Yes	Yes	-
of Mass Media	-	No	No	No	No	NO	Yes	-	No	No		No	No	Yes
EPI			NA						NA	NA				
Target age grp	-	under 2		under 1	0-6 years	0-2 yrs	0-2 years	under 1				-	under 5	under 5
activities	-	Deliv.		-		-	soc.mobil. advocacy					-	cold chain	-
Age Levels(%)														
0	-	21		76.8	27	-	-					81.0	22	
lio 1	-	-		81.2	-	-	-					82.4	5	
lio 3	-	-		47.9	0.2	-	-					75.4	12	
l 1	-	-		81.2	0.2	-	-					82.8	6	
l 3	-	37		47.9	0.2	-	-					79.1	36	
ssles	-	22		40.3	15.5	-	-					77	71	
2	-	15		-	-	-	-					68	36	
Source		UNICEF		MOH,CARE	MOH		FROM WHO					survey		
EPI Activ	provis.of	-					national					-	cold stor	trainings
	cold chain						immuniz.						of vaccin	
	equip.						days							

PVO/Country	ACRA Sudan	ACRA Nigeria	CARE Niger	CARE Sudan	WVVO Mali	WVVO Kenya	Rotary Nigeria	SAWSO Kenya	FXI Niger	FXI Sudan	NIHV Kenya	APREF Kibvesi	APREF Urban	APREF Maadi	
ORT							NA		NA	NA					
of CRT Packets et Distr here	yes yes	Yes No	Yes -	Yes Yes	Yes No	Yes Yes		- -				No No	Yes Yes	Yes Yes	
ow many pe for packets w such	- no	-	Yes 11 US\$	No	TBD	No		-				No	No	No	
Mix ORS measur equip. mula for ORS	yes tea glass	YES 1Beer or 2soda bottles 1 tsp.	YES 2 pinches + 8 cubes in 1 liter water	NO 1 litre jugs	YES 1 litre cup + glass no. 8	YES kiabo can		YES kimoo can + spoc. spoon				Yes 250mg tin pinch salt scoop sugar	Yes 1 glass water + pinch salt pinch salt 1tsp. sug	Yes Yes	Yes
of CRT whom	yes health staff	Yes mobile team commun.	Yes health agents mothers	Yes role play mothers	Yes CHM	Yes commun. nurses mothers		Yes Home Leag Leaders commun.				Yes health staff commun.	Yes nurses mothers	Yes health educator mothers	
R ACTIVITIES							NA								
outh Monit trition	no no	Yes Yes	Yes Yes	No No	Yes Yes	Yes Yes		Yes Yes	No No	No No		Yes Yes	Yes Yes	Yes Yes	
tain A ily Plan er Activ	no no C.S. workshops	Yes Yes Malaria	Yes No	No No	Yes Yes	No Yes		- Yes	Yes No	Yes No		No Yes	No Yes	Yes Yes	
								Hlth. Ed Brstfeed	Operation Research				Training VHWs		

4.2 90-DAY ACTION PLANS

The action plan is a program of activities for a 90-day period after the workshop which the PVO participants plan to follow when they return to their project sites. The participants develop the action plan to address a specific problem in their project; the problem should be something they can feasibly do something about, and the activities should be practical and attainable in 90 days. The participants were given the following guidelines for developing their action plans:

1. Identify a problem or a need of your project that you want to focus on for the next 90 days. This problem/need should be something that you can reasonably do something about in a 90-day period.
2. Define the specifics of the problem.
3. Identify the activities that will be necessary over the next 90 days to achieve a resolution or solution to your problem.
4. Identify who will be responsible for acting on each activity.
5. Identify what resources will be needed to achieve each activity (money, materials, and manpower).
6. Develop a time-frame for completing each of the activities.

ACTION PLAN FRAMEWORK

Problem	Specifics of Problem	Planned Activities	Responsible Persons	Resources

Planned Activities	Month 1 (time)	Month 2 (time)	Month 3 (time)

Throughout the week, time was set aside for working on the action plans with the assistance of the resource people. A common problem for all the participants was defining a problem that was specific and for which resolution was feasible in the 90 days. Unfortunately, time became short towards the end of the week and there was no opportunity for the participants to present their plans to each other. An example of an action plan that was developed during the workshop follows. (Table 2)

90-Day Action Plan

HKI/Sudan - Vitamin A CS Project

PROBLEM	SPECIFICS OF PROBLEM	PLANNED ACTIVITIES	RESPONSIBLE PERSON	RESOURCES
<p>Recognised problem of Vitamin deficiency. Need for training of Health workers before initiation of capsule distribution nutrition education</p>	<p>Lack of motivated, trained, & competent Trainer Teams to conduct district level training sessions of CHWs.</p> <p>Need 6 district trainer teams of two members each</p>	<p>Phase 1 -Formation of district level training teams.</p> <p>Activities:</p> <ul style="list-style-type: none"> -conduct 3 planning meetings with Regional MOH - allocate budget -set selection criteria for candidates - determine facilities/location -choose dates -schedule with central MOH -assemble trainer team - logistics - conduct training - evaluate pre/post 	<p>Regional - Coord. Nutr. Officer</p> <p>Central - Senior Nutr. Officer</p> <p>HKI - S.Iyasu</p> <p>Head Nutr. Deptmt of Central MOH</p> <p>Region. Coord & HKI</p> <p>Head, MOH Region. Coord HKI</p> <p>Supervisor, ophthalmologist</p> <p>Central Nutr. Officer, Supervisor</p>	<p>Funds</p> <p>2 vehicles</p> <p>15 barrels fuel</p> <p>training materials</p> <p>trainers</p> <p>opthal. slide projector</p> <p>HKI Rep</p> <p>Building facilities</p>

Table 2

5. RESOURCES FOR FUTURE WORKSHOPS

5.1 RESOURCE ROOM

A large room was available at Hunter's Lodge for resource materials put together by the workshop facilitators and AMREF'S Health Learning Materials/Book Distribution Unit. The workshop participants also brought health education materials, which they were able to display and share with others. AMREF provided a video camera, recorder, and cassettes for the workshop. Participants were able to watch cassettes about primary health care (developed by AMREF) as well as videos made during the workshop itself. A partial list of the materials available in the resource room follows.

Resource Room Materials

1. Children in the Tropics - International Children's Centre Paris. 5 issues:
 - "Xerophthalmia and Blindness of Nutritional Origin," No. 165, 1986.
 - "Teaching Nutrition to Young Children," No. 166, 1987.
 - "Weaning Foods," Nos. 167-168, 1986
 - "Women's Lives, Mothers' Health," No. 159, 1985
 - "Early Mother-Child Interaction," No. 164, 1986.
2. Storms, Doris M., Training and Working with Auxiliary Health Workers: Lessons From Developing Countries, APHA International Health Programs, Monograph Series No. 3, 1979.
3. Treatment and Prevention of Acute Diarrhoea, Guidelines for the Training of Health Workers, WHO, Geneva, 1985.
4. Child Survival Action News, NCIH, Washington, DC. 6 issues:
 - "Immunization = The Global Picture," No.4, Summer 1986.
 - "Communicating the Child Survival Message," No. 3, Spring 1986.
 - "Proper Birth Spacing: A Key Factor in Child Survival," No. 5, 1986.
 - "Breastfeeding for Child Survival," No. 6, 1987.
 - "Diarrhoea: Leading Killer of Children," No. 2, Winter 1985-86.
 - "A Chance for Survival.....," No. 1, Fall 1985.
5. How to Weigh and Measure Children, National Household Survey Capability Programme, United Nations, New York, 1986.
6. Information Systems, Primary Health Care Issues, APHA International Health Programs, Series 1, No.6, Jan. 1983.
7. Guidelines for Training Community Health Workers in Nutrition, WHO offset publication No. 59, Geneva, 1981.

8. Nutrition Training Manual Catalogue, International Nutrition Communication Service.
9. Information for Action Resource Guide, World Federation of Public Health Associations, Geneva. 9 issues.
 - "Information for Management of Primary Health Care," 1984.
 - "Oral Rehydration Therapy," May 1983.
 - "Improving Maternal Health in Developing Countries," August, 1984.
 - "Maternal Nutrition," July 1983.
 - "Growth Monitoring," September 1985.
 - "Primary Health Care Bibliography and Resource Directory," August 1984.
 - "Program Activities for Improving Weaning Practices," July 1984.
 - "Immunizations," May 1984.
 - "Training Community Health Workers," July 1983.

5.2. RESOURCE PACKETS

At the beginning of the workshop, each participant was given a locally made Kenyan basket with a resource packet containing the following materials:

1. Robbins, Katy, "Undoing the Curse of Neo-natal Tetanus," Child Survival Action News, NCIH, No. 9, April 1988.
2. USAID, "Child Survival: A Third report to Congress on the USAID Program," A.I.D., Washington, DC, April 1988.
3. "Oral Rehydration Therapy (ORT) for Childhood Diarrhoea," Population reports, Series L, No. 2, January 1985.
4. "AIDS - A Public Health Crisis," Population Reports, Series L, No. 6, June 1987.
5. "Immunizing the World's Children," Population Reports, Series 1, No.5, March-April 1986.
6. "Breast-feeding, Fertility, and Family Planning," Population Reports, Series J, No. 24, March 1984.
7. "Healthier Mothers and Children Through Family Planning," Population Reports, Series J, No. 27, May-June, 1984.
8. Suva, Evangeline, "Gathering Information for Health," World Health Forum, Vol. 7, 1986.
9. "Why Monitor Growth," Salubritars, 8:4.
10. "How Mothers Measure Growth," Mothers and Children, Vol. 5, No. 1, Nov-Dec 1985.

11. "Healthy Children: Strong Communities," Mothers and Children, Vol.#4, No.#3, Dec-Jan 1985.
12. "Vitamin A: Partner in Child Health," Mothers and Children, Vol.#5, No. 3, 1986.
13. "Growth Monitoring - A Child's Road to Health Report Card," Child Survival Action News, NCIH, June-July 1987.
14. Dialogue on Diarrhoea, Issue No. 25, June 1986.
15. Dialogue on Diarrhoea, Issue No. 26, September 1986.
16. "Immunization Policy," Expanded Programme on Immunization, WHO/EPI/GEN/86/7 REV 1.
17. "Expanded Program on Immunization," WHO Weekly Epidem. Rec., No. 9, 1987, pp. 53 - 54.
18. "Immunization: A Chance for Every Child," World Health Day 1987 WHO.
19. "Immunize and Protect Your Child," EPI Newsletter, Vol. VI, No. 5, October 1984.
20. Foster, Stanley, "The Epidemiology of Non-Vaccination," Unpublished paper presented at the International Symposium on Vaccine Development and Utilization (Washington, DC, June 9-10 1986).
21. "How to Use the Vaccine Cold Chain Monitor," Expanded Program on Immunization, EPI/IO/84/27.
22. Malison, Michael, et.al., "Estimating Use of ORS, Vaccine Coverage, and Childhood Mortality: A New Approach from Experience in Uganda," unpublished manuscript, May 1986.
23. "Prevention of Neonatal Tetanus through Immunization," Expanded Programme on Immunization, WHO/EPI/GEN/86/9.
24. List of Articles in the Weekly Epidemiological Record, 1977-1987, Expanded Programme on Immunization, WHO/EPI/GEN/88.2.
25. Report of the Expanded Programme on Immunization Global Advisory Group Meeting, 9-13 November 1987, Washington, DC, Expanded Programme on Immunization, WHO/EPI/GEN/88/1.
26. Galzka, A.M., et.al., "Should Sick Infants be Vaccinated?," World Health Forum, Vol. 5, 1984.
27. Monitoring & Evaluation: A Guide for PVO Managers, Mitchell & Harrison, Management Sciences For Health, Boston, MA 1985.

5.3 WORKSHOP OPERATIONAL BUDGET

1. PLANNING

1.1 Travel (Organizers)

1.1.1 Perdiems - 2 persons in USA - 11 days	3,000
- 2 persons in Kenya - 5 days	
1.1.2 Fares (2 persons Kenya USA return)	4,000
1.1.3 Transport hire abroad	500

1.2 Communication

1.2.1 Telephone/Telex	250
1.2.2 Postage, Freight	250

2. WORKSHOP ORGANIZATION

2.1 Travel (Participants and Facilitators)

2.1.1 Perdiems 10 persons 3 days each @ \$100	3,000
2.1.2 Fares - 2 Mali - 2,000)	
- 2 Niger - 2,000)	
- 3 Nigeria - 2,200)	11,300
- 3 Sudan - 1,100)	
- 1 USA -)	
- 1 UK - 1,500)	

2.2 Accommodation 30 persons for 7 days @ \$30	6,300
2.3 Transport hire local	1,000

21,600

3. WORKSHOP OPERATION

3.1 Operation

3.1.1 Workshop material etc.	1,000
3.1.2 Secretarial duties and reporting etc	1,000
3.1.3 Printing works etc	2,000
3.1.4 Consultants' fees - Facilitator etc. 4,000)	
Local 1,500)	6,000
Local 500)	

10,000

Direct costs	39,600
Overheads	10,200

TOTAL 49,800

NOTE: AMREF was given \$45,000 by A.I.D. for the workshop.

6. RECOMMENDATIONS FOR FUTURE WORKSHOPS

6.1 ACCOMPLISHMENTS

1. During the workshop two secretaries were available and a recorder was responsible for collecting all the information generated during the technical sessions. The resource persons wrote summaries of their sessions, which were then collected and organized by the recorder. By the end of the workshop, all of the material to begin a first draft of the workshop report had been typed and compiled.
2. Holding the workshop in a field project area with easy access to community activities was very useful for fieldwork and provided a realistic working atmosphere with few distractions.
3. The resource room was very useful. A lot of material was available to the participants and they were able to share their own materials with others. It also provided an opportunity to disseminate information that could not be introduced during the busy workshop schedule.

Lessons Learned

1. Some of the participants felt that the project briefings did not give them enough information about all of the projects. Perhaps an exhibition could be set up one evening at which participants could present small displays describing their projects which could include their health education and other materials. People could walk around the room looking at the displays and talking to the project implementors.
2. Participants felt that if DITs are requested to be brought to a workshop, they should be used as a basis for some of the activities in the workshop program.
3. The development and presentation of the participants' action plans were pushed towards the end of the week. The participants should be encouraged to identify problems earlier in the week so that resource persons could give them more assistance in developing the action plan.
4. Some of the participants suggested that the workshops should be more structured around the field visits. This would include first working with a community to assess their health problems, then analyzing the problems and working out suitable activities for improving child survival. Technical discussions could then be linked to this shared reality.
5. The field visits were well liked by the participants but some thought they could have been a greater learning experience with better preparation. The participants should have been involved in developing the survey tools based on survey work some of them had done in their own projects.

6. The workshops could be longer by one to two days for a total of seven days to allow more time for technical sessions and field activities.
7. Some of the participants thought that the workshop tried to cover too much information in one week. The facilitators wished to stress, however, that the purpose of the workshop was not for training but for introducing ideas and making the participants aware of areas where they may need technical assistance.
8. Facilitators should be as realistic as possible in setting the schedule and the length of the individual sessions. Keeping time is important, and sessions should not be allowed to run over the allotted time.
9. Daily staff meetings, sometimes with ten people, were too long (up to two hours) and covered housekeeping, technical issues, and scheduling for the next day. Shorter staff meetings could be held to go over events of the day and general issues, followed by smaller group meetings to work on specific issues.

6.2 RECOMMENDATIONS TO A.I.D.

1. Regional workshops involve many persons from countries where health policies and activities differ. Country workshops may be an excellent follow-up to regional workshops so that technical areas can be more focused and PVOs can form stronger networks. Perhaps A.I.D. could support the PVOs to some extent in conducting these country workshops. It is necessary to point out, however, that country workshops are sponsored by the local A.I.D. Mission and a sufficient number of PVO CS projects in the country is necessary to justify the use of resources.
2. It was important to have an A.I.D./Washington representative attend the workshop since these are centrally funded projects. The PVOs were able to ask questions about the funding process and the A.I.D. representative learned a lot about the PVO's activities and constraints.

7. ANNEXES

7.1 PARTICIPANTS

1988 AFRICA REGIONAL PVO CHILD SURVIVAL WORKSHOP
JUNE 18TH - 24TH, 1988
KIBWEZI, KENYA

NAME AND POSITION	ADDRESS
1. Dr. Solomon Iyasu Country Director	Helen Keller Intern'l PO BOX 48, KHARTOUM, Sudan
2. Benjamin Ireri Njeru Programmes Coordinator	ADRA Kenya PO BOX 42276 NAIROBI, Kenya
3. Adil Mohammed Mohmoud Logistics - Administrator	CARE SUDAN PO BOX 2702 KHARTOUM, Sudan
4. Abdelgadir Musallam Program Manager	ADRA SUDAN Northern Region PO BOX 3030 KHARTOUM, Sudan
5. Mrs. Margaret Kiruhi Training Coordinator	World Vision - Kenya PO BOX 50816 NAIROBI, Kenya
6. Mrs. Beatrice Mutua Coordinator/Supervisor	Salvation Army Child Survival Project PO BOX 1082 MACHAKOS, Kenya
7. Mrs. Ruth Simiyu (Major) Divisional Home League Secretary	Salvation Army Machakos Division PO BOX 160 MACHAKOS, Kenya
8. Peris W. Kamau Coordinator/Organiser/Trainer CBHC/CS	MIHV KENYA Dagoretti PO BOX 30292 NAIROBI, Kenya
9. Daouda Coulibaly Technical Team Leader	WVRO Mali BP 2347 BAMAKO, West Africa

- | | |
|---|--|
| 10. Justus Malonza Kimanzi
CBHC Coordinator | M.O.H. Kibwezi
PO BOX 72
KIBWEZI, Kenya |
| 11. Elizabeth S. Wajiru Ngari
CBHC Trainer | AMREF CBHC-Support Unit
PO BOX 30125
NAIROBI, Kenya |
| 12. John N. Ntore
Health Educator | AMREF Nomadic Health Unit
PO BOX 30125
NAIROBI, Kenya |
| 13. Jedidah Wamzitha Mwawinga
CBHC Trainer | AMREF CBHC-Support Unit
PO BOX 30125
NAIROBI, Kenya |
| 14. Ezeigbo Ndubuisi
Assistant Project Manager | ADRA NIGERIA
PO BOX 207
IKEGA, LAGOS, Nigeria |
| 15. Dr. Ahmed Zayan
Country Director | Helen Keller Intern'l
BP 10155
NIAMEY, Niger |
| 16. Col. Nduku Michael Okwechime
Contact Person
PolioPlus programme | 37 ALGUOBASIMWIN CRESCENT
Gov't Reservation Area
PMB 1409
BENIN CITY, Nigeria |
| 17. Samuel Manyoh Asare
Project Manager
WWRD Koutiaa (Mali) CSD | Vision Mondiale
Internationale
BP 2347
BAMAKO, Mali |
| 18. Dr. Jibrin Michael Apese
Medical Director | SDA Hospital
Adventist Rural Health
Programme (North Nigeria)
GENGRE PMB 2054
JOS, Nigeria |
| 19. Mr. J. Karanja Mbugua
Research and Evaluation
Officer | AMREF
PO BOX 30125
NAIROBI, Kenya |
| 20. Mr. Michael Pensak
Project Manager | CARE/NIGER
BP 10155
NIAMEY, Niger |
| 21. Zephenia Nyamongo
Project Manager | World Vision (Kenya)
Child Survival Project
PO BOX 50816
NAIROBI, Kenya |

7.2 RESOURCE PERSONS & FACILITATORS

1988 AFRICA REGIONAL PVO CHILD SURVIVAL WORKSHOP
JUNE 18 - 24, 1988

NAME AND POSITION	ADDRESS
1. John McEnaney Project Officer	Agency for International Development, FVA/PVC/CSH SA-8 WASHINGTON, DC 20005, USA
2. Mary Carnell Johns Hopkins University Institute for International Programs.	4010 Deepwood Road BALTIMORE, MD 21218 U.S.A. Tel. (301) 235-5326
3. Dr. G. O. Rae District Medical Officer Machakos	M.O.H. Machakos PO BOX 19 MACHAKOS, Kenya
4. Kate Burns Regional Technical Advisor Primary Health Care for East Africa	CARE INTERNATIONAL PO BOX 43864 NAIROBI, Kenya Tel 726255
5. Dr. John Alwar CSD Fellow PRITECH/CDD KENYA Lecturer University of Nairobi.	PO BOX 51169 NAIROBI, Kenya
6. Paula Walsh	The Johns Hopkins University School of Hygiene and Public Health Dept. International Health 615 N. Wolfe Street Baltimore, MD 21205 USA (301) 675-0316.
7. Dr. Dan Kaseje	Liverpool School of Tropical Medicine Pembroke Place, Liverpool L3 5Q, United Kingdom OR PO BOX 76, KISUMU, Kenya
8. Margaret Okele AMREF Urban Child Survival Coordinator	AMREF CEHC-Support Unit PO BOX 30125 NAIROBI, Kenya

9. Penina A. Ochola
Head, CBHC-Support Unit
AMREF CBHC-Support Unit
PO BOX 30125
NAIROBI, Kenya
10. Mary Harvey
JSI/REACH
PVO/EPI Technical Advisor
1100 Wilson Blvd
9TH Floor
Arlington, VA USA
(703) 528-7474
11. Ben Osuga
Research and Information
Officer
AMREF - KRHS
PO BOX 72
KIBWEZI, Kenya
12. Dr. B. O. N. Oirere
Project Leader
AMREF Kibwezi Rural Health
Scheme (KRHS)
PO BOX 72
KIBWEZI, Kenya
13. Robina Biteyi
Coordinator - Applied
Nutrition Project
AMREF Kibwezi Rural Health
Scheme
PO BOX 72
KIBWEZI, Kenya
14. Dr. John Bennett
AMREF
Health Learning Material
Specialist
PO BOX 30125
NAIROBI, Kenya
15. Dr. Paget Stansfield
AMREF
Paediatrician,
c/o Community
Health Department
PO BOX 30125
NAIROBI, Kenya