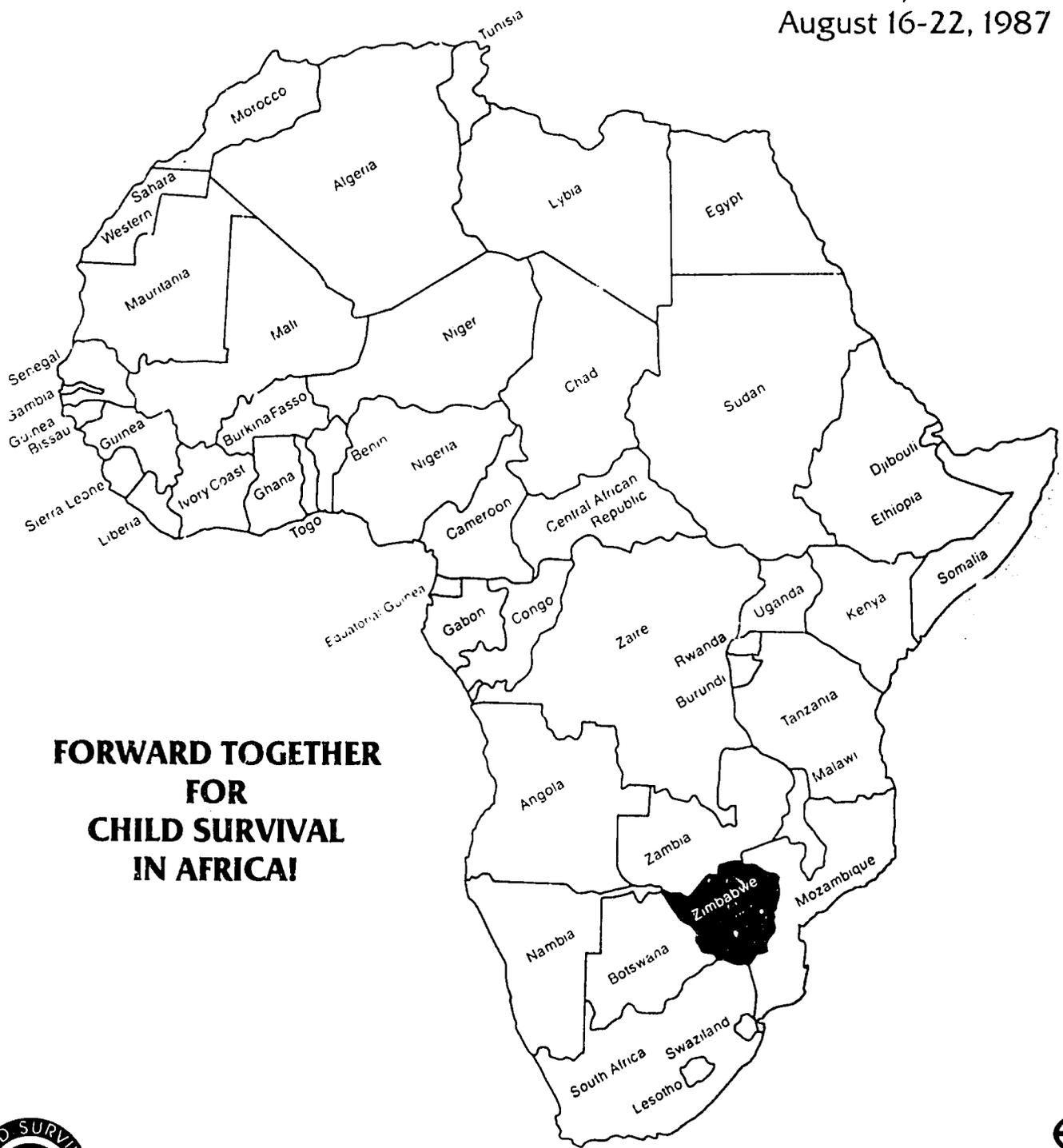


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CHILD SURVIVAL WORKSHOP REPORT

World Vision Zimbabwe Training Workshop
for PVO Child Survival Projects in Africa

Murehwa, Zimbabwe
August 16-22, 1987



**FORWARD TOGETHER
FOR
CHILD SURVIVAL
IN AFRICA!**



United States Agency for International Development/World Vision



**REPORT OF THE ZIMBABWE WORKSHOP:
"FORWARD TOGETHER FOR CHILD SURVIVAL IN AFRICA"
MUREWA, ZIMBABWE
AUGUST 15-22, 1987**

**A Training Workshop for Implementators of Child Survival Projects
Carried Out by Private Voluntary Organizations in Africa**

**Sponsored by
A.L.D./Washington, D.C.**

**Hosted by
World Vision Zimbabwe and World Vision Relief Organization**

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I. EXECUTIVE SUMMARY

Zimbabwe Child Survival Workshop Report

Child Survival is now among the U.S. Agency for International Development's (A.I.D.) top priorities, with more than half of its health budget allocated for child-related activities. In 1985, 13 U.S. organizations were awarded grants for 27 Child Survival projects worldwide, most of which are not in operation. More than \$150 million during FY86 alone going to support Child Survival activities.

World Vision was chosen by A.I.D. to host a training workshop to focus on the improved implementation of A.I.D.-funded Child Survival project which began in 1986 in Anglophone Africa. This workshop was part of a broader A.I.D. strategy to provide technical assistance to projects being implemented by Private Voluntary Organizations (PVOs) throughout Africa. A similar workshop for Francophone Africa was hosted by the Adventist Development and Relief Agency (ADRA) in Rwanda in July 1987. World Vision's Mashonaland East Child Survival project, which was funded by A.I.D. in 1985, was used as a case study for workshop participants.

The overall workshop goal was to improve the survival potential of infants and children in Africa by enhancing the skills and experiences of Child Survival implementors. The theme of the workshop was, "Forward Together for Child Survival."

Murewa (86 kilometers northeast of Harare), Zimbabwe, was chosen as the site of the week-long workshop. It afforded numerous in-country, "grass roots" connections, such as close proximity to the Mashonaland East Child Survival project for in-field, on-site visits by the participants.

Special communications were sent to PVO offices in Africa and the United States to identify their participants. In addition, World Vision Zimbabwe extended an invitation to the Ministry of Health (MOH) of Zimbabwe. The 24 participants of the workshop represented:

- AMREF
- CARE (Kenya, Sudan, and Uganda)
- AFRICARE - Nigeria
- Save the Children (Malawi, Sudan, and Zimbabwe)
- SAWSO - Kenya
- World Vision (Sudan and Zimbabwe)
- Ministry of Health of Zimbabwe
- St. Paul's Mission Hospital

Workshop presentations included:

- Social Mobilization
- Home Management of Diarrheal Diseases
- Nutrition and Growth Monitoring
- Immunization
- Baseline Surveys
- Health Information Systems
- Sustainability
- Supervision and Training
- Linkages

Traditional Health Providers
AIDS/EPI/Malaria
Education/Mass Campaigns
A.I.D. Reporting System
A.I.D. Technical Assistance
Computers in Child Survival Programs
Eye Care and Vitamin A

Highlights of the participants' 90-day action plans were:

- o Determine coverage of EPI in target area
- o Design and implement baseline ORT survey
- o Improve working relationship with other PVOs, Zimbabwe, and MOH (on Child Survival implementation)
- o Conduct seminar on Vitamin A
- o Select and train village health workers
- o Review and improve monetary and evaluation methodologies

ACRONYMS

| | |
|--------------|--|
| A.I.D. | - Agency for International Development |
| AIDS | - Acquired Immunodeficiency Syndrome |
| AMREF | - African Medical and Research Foundation |
| APHA | - American Public Health Association |
| ARC | - AIDS-Related Complex |
| BCG | - Bacille Calmette Guerin (TB vaccine) |
| CBHP | - Community-Based Health Worker |
| CBW | - Community-Based Worker |
| CDD | - Control of Diarrheal Diseases |
| CHA | - Community Health Aide |
| CHC | - Community Health Center |
| CHW | - Community Health Worker |
| CS | - Child Survival |
| CSP | - Child Survival Program |
| DIP | - Detailed Implementation Plan |
| DPT | - Diphtheria/Pertussis/Tetanus |
| HAF | - Home-Available Fluids |
| HC | - Health Center |
| HIS | - Health Information Systems |
| HIV | - Human Immunodeficiency Virus |
| KAP | - Knowledge/Attitude/Practice |
| LAG | - Local Area Government |
| MOH | - Ministry of Health |
| MRDP | - Malawi Rural Development Program |
| MSRDP | - Multi-Sectoral Rural Development Program |
| NCIH | - National Council for International Health |
| NGO | - Non-Governmental Organization |
| NKCHP | - Northern Kordofan Community Health Program |
| OPV | - Oral Polio Vaccine |
| ORS | - Oral Rehydration Salt (Solution) |
| ORT | - Oral Rehydration Therapy |
| PHC | - Primary Health Care |
| PVO | - Private Voluntary Organization |
| REACH | - Resource for Child Health |
| SAWSO | - Salvation Army World Service Organization |
| SCF | - Save the Children Federation |
| SSS | - Sugar/Salt Solution |
| TA | - Technical Assistance/Assistant |
| THP | - Traditional Health Provider |
| TOT | - Training of Trainers |
| TT | - Tetanus Toxoid |
| VHC | - Village Health Center |
| VHP | - Village Health Practitioners |
| VIDEC or VDC | - Village Development Center |
| WHO | - World Health Organization |
| WDC | - Women's Development Center |
| WV | - World Vision |
| WVRO | - World Vision Relief Organization |
| WVZ | - World Vision Zimbabwe |

IL INTRODUCTION

Child Survival is now among A.I.D.'s top priorities, and more than half of A.I.D.'s health budget is allocated for activities that focus on children. More than \$150 million during the fiscal year 1986 alone went to support Child Survival activities all over the world.

Among A.I.D.'s significant moves has been to recognize the role and contribution of private sectors in both the U.S. and the developing world. Private Voluntary Organizations have been given recognition, in particular, because of their proven ability to reach the most needy communities and to mobilize government, private, and local organizations to support the activities which they have carried on for decades.

In 1985, the A.I.D. (Office of Private and Voluntary Cooperation/Bureau of Food for Peace and Voluntary Assistance) initiated a competitive Child Survival grants program. Thirteen U.S. organizations were awarded grants for 27 Child Survival projects all over the world, most of which are now in operation. This same A.I.D. office established a four-year collaborative agreement the following year with Johns Hopkins University to provide technical assistance to PVO Child Survival programs. This agreement consists of four major activities:

1. Implementation support to the field
2. Training workshops (field and headquarters)
3. Assisting A.I.D. in organizing technical reviews of project documents
4. Special problems in monitoring and evaluation

In September 1985, A.I.D. conducted a workshop for PVOs in Airlie, Virginia, to respond to PVO technical assistance requests, particularly on evaluation and monitoring of Child Survival projects. An important follow-up workshop was organized by Meals for Millions in Sierra Leone in April 1986, following a proposal by Dr. Dory Storms, Coordinator of the Collaborative Child Survival Project. Dr. Storms suggested that instead of a high A.I.D. profile meeting, a modest in-country, field-based approach be tried. Due to the serious economic and health situation in Africa, it would be important that the workshop emphasized self-help and local initiative.

A.I.D./Washington determined that a PVO-hosted workshop in Africa would be an appropriate and effective means for transferring specific technical information to PVO projects. As a result of the Sierra Leone workshop, the capabilities of PVOs to carry on Child Survival activities have been reinforced. Furthermore, the workshop brought out the need for people involved in Child Survival projects to know more about each other and learn from one another's experiences.

A. Workshop Objectives

The overall workshop goal was to improve the survival potential of infants and children in Africa by enhancing the skills and experiences of Child Survival implementors.

Specific workshop objectives met were:

1. Promote and actively encourage information, sharing of ideas, experiences and lessons learned by workshop participants during this last year's implementation of Child Survival activities.

2. Enhance participants' understanding of how a Child Survival project works with a community to achieve a sense of "community ownership" for project activities.
3. Improve participants' practical knowledge in the delivery, use and measurement of effectiveness for the key Child Survival interventions of immunization, oral rehydration therapy (ORT), nutrition and social mobilization.
 - Develop critical technical standards for effective interventions in ORT, Expanded Program for Immunization (EPI), and nutrition.
 - Share simple criteria for the definition of high-risk groups; devise practical methods for locating these high-risk children and mothers; devise a practical method for mobilizing each community.
4. Improve participants' practical knowledge of Child Survival information systems, including objectives, project monitoring, Child Survival and PVO reporting requirements, and mid-term and final evaluations.
5. Increase participants' knowledge in communication, coordination, and relation-building among host countries, donor agencies, and other Non-Governmental Organizations (NGOs) working in Child Survival.
6. Help participants to develop a plan of action for identifying and resolving sustainability issues within their projects.
7. Expose participants to an ongoing Child Survival project, observe it critically, and suggest ways to improve the design, implementation, and evaluation systems of their own (participants') Child Survival projects.
8. Promote and actively encourage an Africa regional network among PVO Child Survival project implementors, as started by the Sierra Leone Child Survival Workshop in April 1986.

B. Outcome of the Workshop

1. Participants:
 - a. presented an action plan for monitoring and evaluation that was implemented in the following 90 days,
 - b. presented an action plan for supervision and training that was implemented in the following 90 days,
 - c. presented a networking plan for the benefit of their projects.
2. Participants did have the opportunity to identify critical areas in their Child Survival projects that may require additional technical help. This will be reflected in a technical assistance (T.A.) form.
3. Participants did list what they will do differently in the immunization, nutrition, oral rehydration therapy, and social mobilization components of their projects as a result of participating in this workshop. This will be reflected in the workshop daily evaluation.

4. Participants did have opportunities to obtain feedback on their implementation system from their fellow participants during the workshop and from the resource persons. Sessions between participants and resource persons will be in the form of "clinics" (by appointment) after the evening meal.

III. PLANNING AND PREWORKSHOP ACTIVITIES

In December 1986, World Vision formally accepted the invitation to host the regional workshop for anglophone A.I.D.-funded Child Survival projects in their first year of operation in Africa. At the same time, the Adventist Development and Relief Agency International (ADRA) was initiating plans for a July 1987 workshop for Child Survival workers in francophone countries.

In February 1987, the first planning meeting on the workshop was held at World Vision headquarters in California. Dr. Mary Carnell, M.D., M.P.N., representing Johns Hopkins' PVO Child Survival program, met at A.I.D.'s request with WVRO staff, Dr. Rufi Macagba and Mark Publow, to review A.I.D. guidelines for such workshops. They also agreed to overall standards and goals for the Zimbabwe workshop as well as technical needs for the 1986-funded projects.

Then in March 1987, WVRO appointed Dale Flowers of the Santa Cruz Consultants as workshop facilitator and Dr. George Ngatiri (World Vision/Africa's Senior Regional Primary Health Care Consultant) as the action officer to coordinate all technical activities.

From April 30 to May 1, the second pre-workshop planning meeting was held at A.I.D./Washington. John Grant and Dr. G. van der Vlugt of A.I.D., Dr. Dory Storms and Barbara Johnson of Johns Hopkins, Dr. Mary Carnell, Dr. Rufi Macagba, and Dale Flowers carried out the first workshop needs assessment using project detailed implementation and evaluation plans.

It was agreed that: the workshop venue should be close to an ongoing Child Survival program which would provide an environment to optimize learning; participants from PVOs and the Zimbabwean Ministry of Health should be invited; and resource people should be identified. Workshop objectives were also set to meet the needs and expectations of a diverse group of field people.

A. World Vision Zimbabwe and the Workshop Setting

World Vision Zimbabwe was designated to host the workshop. In May, the workshop site was confirmed by Rev. Max Chigwida (WV Zimbabwe Field Director). Murewa was chosen as the site, about 86 kilometers northeast of Harare. World Vision initiated the Mashonaland East Child Survival project in this area in 1985 in collaboration with the local St. Paul's Mission Hospital and the Ministry of Health. Murewa provided an available facility in the form of a small country hotel which could provide food and accommodations.

B. PVO Participants

In May 1987, Mark Publow, World Vision Headquarters Liaison, communicated with PVO headquarters staff inviting them to send representatives from their Africa Child Survival projects to attend the Murewa workshop. Special communications were sent to World Vision field offices in Zimbabwe and Sudan to identify their participants. In addition, World Vision Zimbabwe decided it was appropriate to extend the invitation to the Ministry of Health. The final workshop participants represented the following organizations:

| | | |
|-----|--|-----------|
| 1. | AMREF (African Medical and Research Foundation) | 2 |
| 2. | CARE - Kenya | 1 |
| 3. | CARE - Sudan | 2 |
| 4. | CARE - Uganda | 2 |
| 5. | AFRICARE - Nigeria | 2 |
| 6. | Save the Children - Malawi | 2 |
| 7. | Save the Children - Sudan | 2 |
| 8. | Save the Children - Zimbabwe | 1 |
| 9. | SAWSO - Kenya (Salvation Army World Service Organization) | 2 |
| 10. | World Vision - Sudan | 2 |
| 11. | World Vision - Zimbabwe | 2 |
| 12. | Zimbabwe Ministry of Health | 3 |
| 13. | St. Paul's Mission Hospital | 1 |
| | TOTAL PARTICIPANTS | 24 |

C. Survey of Participants' Interest Areas

In the earlier part of May 1987, George Ngatiri carried out a survey of participants' expectations, skills, and materials they could bring to the workshop. This formed the second part of the needs assessment. Then in the later part of May, Mark Publow carried out a PVO Headquarters survey on the needs and priorities to be covered by the workshop. This formed the third and fourth part of the needs assessment. Survey results are summarized in the table on the next page. Scoring was from 1 to 13, with 1 as first priority, and 13 as the last priority.

INTEREST AREAS

| | A M R E F KEN YA | W V Z W | W V S U D | S C F MA LA WI | S C F SU DAN KEN YA | S A W S O KEN YA | C A R E KEN YA | C A R E SU DAN | AVERAG SCORE |
|----------------------------------|------------------------------------|------------------|-----------------------|-------------------------------|---------------------------------------|------------------------------------|-------------------------------|-------------------------------|-----------------|
| SUPERVISION | 2 | 4 | 1 | 5 | 11 | 2 | 4 | 1 | 3.75 |
| MONITORING AND REPORTING | 5 | 1 | 3 | 1 | 5 | 1 | 13 | 2 | 3.88 |
| TRAINING (METHODS AND MATERIALS) | 4 | 5 | 5 | 4 | 10 | 6 | 6 | 3 | 5.38 |
| EVALUATION | 8 | 2 | 3 | 2 | 13 | 3 | 5 | 9 | 5.63 |
| COORDINATION WITH THE GOVERNMENT | 3 | 3 | 10 | 3 | 4 | 13 | 3 | 10 | 6.13 |
| BASELINE DATA | 7 | 7 | 6 | 6 | 6 | 10 | 1 | 7 | 6.25 |
| ORAL REHYDRATION THERAPY | 6 | 9 | 7 | 7 | 2 | 7 | 7 | 13 | 7.25 |
| COMMUNITY ORGANIZATION | 12 | 13 | 4 | 13 | 3 | 13 | 2 | 4 | 8.00 |
| TECHNOLOGY OF IMMUNIZATION | 10 | 10 | 9 | 8 | 1 | 13 | 9 | 5 | 8.13 |
| GROWTH MONITORING | 9 | 8 | 8 | 9 | 7 | 8 | 8 | 12 | 8.63 |
| HEALTH AND MONITORING | 1 | 11 | 11 | 10 | 8 | 9 | 10 | 11 | 8.80 |
| PROGRAM DESIGN | 13 | 12 | 2 | 13 | 9 | 5 | 12 | 6 | 9.00 |
| VITAMIN A | 11 | 6 | 12 | 11 | 12 | 4 | 11 | 8 | 9.38 |

D. Key Resource Persons Involved in the Workshop Design and Preparation

As in the Meals for Millions workshop in Sierra Leone, World Vision decided that an experienced facilitator was important to assist with workshop planning and implementation. Mr. Dale Flowers of the Santa Cruz Consultants, facilitator for the Sierra Leone event, was chosen in March. Mr. Flowers is a training expert who has a background in international health, knowledge of program management and rural development, and experience in African development.

Dr. Dory Storms, Coordinator for Johns Hopkins' PVO Child Survival Support project, was a very important technical resource person in the Sierra Leone workshop. Dr. Storms has been involved, working with A.I.D in supporting the PVO Child Survival program since its 1985 inception, and has been a key coordinator.

Mrs. Cynthia Rawn of the Resources for Child Health (REACH) was identified by A.I.D. to become the key resource person on immunization. With a considerable experience in Zaire, Cynthia Rawn is an EPI Technical Associate with REACH.

Dr. Rufi Macagba head of World Vision's International Health Programs, played the key role in coordinating with A.I.D./Washington, D.C., and in structuring the workshop design. Mr. Mark Publow was eventually designated as the World Vision headquarters liaison and Dr. Doug Mendoza as World Vision's technical assistant.

E. Workshop Design

From June 29 to July 2, 1986, a workshop planning and coordinating meeting was held in Monrovia, California. The following people attended: Max Chigwida, Bongi Mushapaidze, George Ngatiri, Dory Storms, Dale Flowers, Rufi Macagba, Mark Publow, and Doug Mendoza. The purpose of the meeting was to do the final planning and design. A workshop standard and strategy document was produced. Also, at this point in the planning, the resource materials to be used in the workshop were designed.

Dale Flowers facilitated this four-day event, helping workshop staff develop agenda for the workshop and ensuring that important areas were covered.

The following were the highlights of the meeting:

1. The workshop design would be participatory in nature with the purpose of training field staff who are directly working in USAID-funded Child Survival projects.
2. A strong emphasis would be placed upon training African staff who anticipate continued involvement in the project area after USAID funding has been completed.
3. The focus of the workshop would be upon improving the delivery and effectiveness of Child Survival technologies, as well as an emphasis upon process issues such as training, evaluating, supervising, monitoring, and reporting.
4. World Vision's Child Survival project would be utilized for site visits and serve as a tool for training and critique.

5. A broad variety of resource materials would be made available to the workshop participants for their future use.
6. During the workshop planning, it was learned that Dr. Gerold van der Vlugt, incoming A.I.D. Health and Child Survival Coordinator, would be available to attend the workshop.

F. Preparation of Project Community Visits

World Vision Zimbabwe Child Survival program staff Ellen Tagwireyi, Zeldi Nhiliziyo, and Bongi Mushapaidze, did considerable preparation for scheduled community visits and community involvement in the workshop. The villages of Zvareva, Musinga, and Pfende were chosen as the sites for community visits. These villages were chosen by WV Zimbabwe staff based on contacts with the leaders and their location. Pre-workshop preparations included the following: briefing the community that groups of visitors would be coming, choosing members of the communities for interviews and demonstrations, and preparing the village development centers (VIDECs) to receive the visitors.

G. Support Activities

1. Resource Materials

It was decided during the workshop planning that participants would be provided with current information on the different areas that would be covered. Contacts were made with Meals for Millions' Kathleen Stack to get copies of materials used in the 1986 Sierra Leone workshop and with ADRA's Lucia Gilkes to request copies of resources being prepared for the Rwanda regional Child Survival meeting in July 1987.

In addition, Doug Mendoza made direct contacts with and obtained recent information/literature from the following: American Public Health Association, Center to Prevent Childhood Malnutrition, Medical Assistance Program International, National Council for International Health, National Research Council, the Population Information Program of the Johns Hopkins University, Resources for Child Health, Save the Children Federation (Connecticut), The Campaign for Child Survival Office in California, World Neighbors, the Pan-American Health Organization, United Nations Children's Fund (UNICEF), and the World Health Organization.

Dr. Rufi Macagba, World Vision's International Health Programs Director, provided additional materials for use in the workshop. World Vision Zimbabwe's Primary Health Care Unit provided 118 printed materials, some films, and video tapes for the resource center. AMREF's participant, Dr. Oirere, came with a number of free health brochures/leaflets and a set of new books for sale at reasonable price.

Looseleaf workshop binders were prepared at WVRO headquarters. Each three-ring binder contained workshop background information, daily objectives and activities, writing materials, participant and staff listings, bibliographies and the bulk of the technical materials.

Each binder was structured according to daily activities and topics. Each major section had a technical summary entitled "Issues and Ideas" for participants to read through briefly before the daily sessions with the

intention that the major texts may be used for future references. The cost per binder and contents was about US\$15.00. World Vision Zimbabwe had ordered satchels to carry workshop materials with World Vision and Child Survival logos printed on them.

A cover page containing the theme "Forward Together for Child Survival in Africa!" was designed and printed in WVRO. A certificate was likewise prepared to be awarded to each participant upon completing the workshop.

Mark Publow and Doug Mendoza took the resource binders to Africa as excess baggage. Other supplies such as pens, transparencies, markers, and writing paper were also transported from the U.S., while World Vision Zimbabwe purchased the rest. The workshop planners anticipated recreational needs for the participants, so chess sets, playing cards, volleyballs, badminton, and table tennis sets were purchased.

2. Travel

Travel to and from Harare via Nairobi for the participants was arranged by Dr. George Ngatiri with the assistance of a Kenya-based travel agency. Tickets were forwarded through the airlines. Per diem allowances were provided.

The participants were met at Nairobi airport by Dr. Ngatiri and other World Vision Large-Scale Development Office staff. Most of the participants left Nairobi for Harare with some of the World Vision workshop staff. World Vision Zimbabwe mobilized some local staff to meet and transport people from the airport to Harare and eventually to Murewa and back. Two World Vision Zimbabwe vehicles and the World Vision-donated Musami Hospital ambulance were utilized for the entire duration of the workshop. Two Sudan participants were, initially, unable to obtain visas. Problems arose at the Harare airport, which were difficult to resolve.

3. Housing and Training Facilities

The participants lodged at Jacaranda Hotel in Nairobi and at Oasis Hotel in Harare. In Murewa, both workshop staff and participants were housed at the Mwamuka Hotel, a modest country lodge.

Arrangements were made to accommodate two persons in each room. There was a large meeting room intended for the sessions, but the open garden in the middle of the building was the preferred place of most. Hot and cold running water, baths, electricity, and indoor toilets were also available. Generally, both lodging and learning facilities were decent.

The hotel staff was excellent: courteous, pleasant, hard-working (going out of their way to please), uncomplaining, well-prepared, and efficient! All these contributed to the workshop during a cool, pleasant Zimbabwean winter.

4. It is important to note that the Mwamuka Hotel provided a number of areas which could be utilized for conducting the workshop. These included:

- Areas for indoor classrooms
- An open garden area for large group sessions
- Space in front of the building for small group sessions
- Adequate area for a separate Resource Center

H. Final Preparations

Due to the National Holiday in Zimbabwe, final planning had to be divided into two parts: Nairobi and Harare. Dr. Dory Storms, Cynthia Rawn, Dale Flowers, and Doug Mendoza arrived in Nairobi on August 9 and met with George Ngatiri to review the workshop design and make final preparations. Some changes were made to include local resource people in some sessions.

Dory Storms, Dale Flowers, and Cynthia Rawn went on to Harare mid-week to review the final plans with Bongi Mushapaidze, Jelda Nhliziyo, Ellen Tagwireyi, and Max Chigwida. Planning activities in Harare included:

- Reviewing respective roles
- Finalizing daily schedules
- Meeting with Susan Chidyamatamba for workshop administrative support
- Establishing a Resource Center
- Field visits to ensure expertise and understanding of the process
- Finalizing the week's schedule of events
- Meeting in-country resource people and clarifying their respective roles
- Deciding on the process of workshop evaluation
- Reviewing and revising the participants list

During the process of identifying in-country resource people, Dr. Storms, Mr. Flowers, and Mrs. Rawn visited the workshop venue, the local St. Paul's Mission Hospital, Dr. Zvandasara, MOH Provincial Medical Director, and Dr. Serima, MOH EPI specialist. Since Mr. Steve Bergen of the Office of Private and Voluntary Cooperation (FVA/PVC) was visiting USAID Zimbabwe at that time, he provided briefings to the Mission, since he was familiar with workshop plans. Dr. Jake van der Vlugt and Mark Publow arrived Saturday morning and participated in a summary briefing session with all workshop staff that same afternoon.

IV. THE WORKSHOP

A. The People Attending the Workshop

1. The Workshop Team

There was a total of 41 people in the workshop: 24 participants from the PVOs of the MOH, 9 workshop staff, 5 resource people from Zimbabwe, and 3 observers.

The final workshop team included Dr. George Ngatiri, overall coordinator; Rev. Max Chigwida, World Vision (Host Country) Field Director; Dr. Jake van der Vlugt, Health and Child Survival Coordinator (A.I.D./PVC); Dr. Dory Storms, Coordinator (A.I.D. reporting systems, D.I.P. review feedback, Collaborative Child Survival Project); Mrs. Cynthia Rawn, Resource Person in EPI (REACH); Mrs. Bongi Mushapaidze, World Vision Zimbabwe PHC Unit Head/Child Survival Project Manager; Dale Flowers, Health and Management Training Consultant (Facilitator); Mark Publow, World Vision Relief Organization Headquarters Liaison; and Dr. Doug Mendoza, technical assistant from World Vision Relief Organization.

2. The Participants

All of the 24 participants had key roles in ongoing Child Survival and most had health-related training and/or considerable experience in health. The PVO participants were as follows:

- a. Margaret Okello (Mrs.), AMREF - Kenya, Coordinator for Community-Based Health Care and Child Survival (Urban Nairobi)
- b. B. O. N. Oirere (Dr.), AMREF - Kenya project. Leader of the Kibwezi R.H.S.
- c. Kate Burns (Ms.), CARE. Regional Technical Advisor for PHC in East Africa
- d. Osheria Mohammed Elamin (Miss), CARE, Administrative Assistant/Extensionist, CSP
- e. Catharine McKaig (Ms.) CARE - Sudan, CjP Project Manager
- f. Lovisa Marion K. Ayazika (Mrs.), CARE - Uganda, Senior Nursing Officer
- g. Israel Kalyesubula (Dr.), CARE - Uganda, Head of Health Sector
- h. Charles W. Oliver (Mr.), AFRICARE - Nigeria, Project Advisor, IMO CSP
- i. Regina A. Obiagwu (Mrs.), AFRICARE - Nigeria, Administrative Assistant, IMO CSP
- j. Rosellyn Chiwaya (Ms.), Save the Children, Medical Health/Nutrition Projects Assistant

- k. Stanley Jere (Mr.), Save the Children, Medical Health/Nutrition/CSP Coordinator
- l. Biar Deng Biar (Dr.), Save the Children - Sudan, Health Sectoral Deputy Manager
- m. James Okuc Daniel (Dr.), Save the Children - Sudan, Health Sectoral Deputy Manager
- n. I. A. Bani (Dr.), World Vision - Sudan, Project Advisor
- o. Nel den Boer (Ms.), World Vision - Sudan, Project Manager
- p. Beatrice Mutua (Mrs.), SAWSO - Kenya, Project Coordinator/Supervisor
- q. Ruth Simiyu (Mrs.), SAWSO - Kenya, Women's Group Leader
- r. Ellen Tagwireyi (Mrs.), WV Zimbabwe, Health Associate
- s. Jelda Nhliziyo (Mrs.), WV Zimbabwe, Training Officer
- t. Emily Shoko (Mrs.), Zimbabwe MOH, Community Nurse
- u. Lawrence Mubaiwa (Mr.), Zimbabwe - MOH, Community Nurse
- v. Ruth Muka..yangi (Miss), Zimbabwe - MOH, Community Health Nursing Sister
- w. Sr. Florence Chipango, Matron, St. Paul's Mission
- x. Richard Kudhanda (Mr.), Save the Children - Zimbabwe, Health Program Coordinator

3. Resource People/Observers/Support Staff

Although the workshop team provided the major technical support, participants, nationals, and expatriates working in Murewa were enlisted as resource persons. They were:

- a. Dr. M.O. Alli, UNICEF, Adira, Harare (EPI)
- b. Mrs. E. Serima, Zimbabwe - MOH (EPI)
- c. Dr. Van Nueton, District Medical Officer (Murewa - Health System)
- d. Dr. Zvand'asara, Provincial Medical Officer (ORS)
- e. Mrs. Jelda Nhliziyo, WV Zimbabwe (Social Mobilization)
- f. Dr. Hasha Hove, Zimbabwe - MOH

World Vision Zimbabwe designated people to support the workshop staff in important duties.

The observers who stayed on for most of the workshop sessions were Dr. and Mrs. (Dr.) Liebert Agnes Van Nueton and Dr. Teresa Matuszewska (Medical Officer, Musami Hospital).

Eventually, participants with observers numbered 35, larger than originally planned. Thus, design and teaching activities had to be adapted accordingly.

B. The Workshop Approach and Format

As in the Sierra Leone workshop, the approach was to integrate adult learning theory, reflection, and experimental learning processes. The workshop was geared toward providing actual experiences that would strengthen technical information and optimize participation so that everybody would learn from each other.

Planners endeavored to create a setting where each one, staff and participant, would be a potential resource person with experiences and information to share. Time slots were appropriated at the start to enable everybody to know each other's background.

World Vision's Child Survival program in Murewa district was chosen as the "laboratory" where staff and participants interacted with each other, with the villagers, and with the project implementors.

There were many sessions provided for small groups to meet and discuss issues and concerns. Groups then chose speakers to present the contents of their discussions. This process proved to be very effective.

The combination of indoor and field activities helped participants to identify strengths, weaknesses, and areas of concern in their respective programs. Everybody was encouraged to come up with ideas on how to improve the implementation of Child Survival interventions in their own programs.

The staff structured the workshop in such a way that objectives were set for each day and activities linked in a logical sequence. The overall program is contained in a subsequent page.

Dale Flowers, as facilitator, handled the challenging task of seeing that the workshop was on the mainstream and that daily objectives were followed and participant needs were met. The staff met after dinner to review the day's events and prepare for the following day.

Although limited activities were scheduled in the evenings, participants organized small "clinics" to share common interests and issues that could not be covered in the workshop. Some chose to meet with workshop staff to discuss other concerns.

C. Opening Sessions

On Sunday, August 16, 1987, participants arriving in the afternoon at the workshop site from Harare, were assigned their rooms, and given their workshop binders. An official welcome was given by Rev. Max Chigwida, host country field director. This was followed by introductions, participant interviews, and an opportunity for everybody to know each other. Then a review of the overall

workshop was scheduled by Dr. Ngatiri. After dinner, Doug Mendoza briefed the group on the workshop binder and resource center. An opportunity for the participants to express their expectations was provided, and these were considered by the staff to modify the activities for the subsequent days.

The workshop was formally opened on Monday, August 17, with speeches and remarks delivered by Rev. Max Chigwida, Dr. Godfried Sikipa (Zimbabwe-MOH), and Dr. Gerold van der Vlugt (A.I.D.). Dr. Van Nueton, district medical officer, gave an outline of the health services in Murewa district. Other highlights of the day were participant presentations of projects and poster displays, "ice-breaking" exercises that introduced participants to one another, sharing of expectations, and an orientation for site visit.

D. Participants' Expectations

The following expectations were raised in the evening of August 16, 1987.

1. Topics with emphasis on:
 - a. Child survival in relation to development programs
 - b. Monitoring
 - c. The role of traditional healers/birth attendants in Child Survival
 - d. Role of information/education in Child Survival communication
 - e. Linkages/coordination communication between projects, the ministries, and A.I.D.
 - f. Monitoring information on EPI services
 - g. Computers and baseline studies
2. Formation of small-group discussions to facilitate sharing of experiences.
3. Identify resource people within the group for specific topics, and other issues such as computers.
4. Others expected participants to present program profiles.
5. Everybody expected a cultural night at the end of the workshop.

E. Community Activities

The indoor workshop sessions on social mobilization and oral rehydration therapy were complemented by visits to three villages: Zvareva, Musinga, and Pfende. These visits gave an opportunity for the participants to experience these two processes right on site.

The first visit was on August 19, 1987. The participants (divided into three groups) left the workshop site at 9:30 a.m. after the WV Zimbabwe case study presentation. The groups were back at the hotel at about 2:30 p.m. and were given time to prepare their comments, critique, and recommendations on the WV Zimbabwe social mobilization experience.

The second visit was on August 20, 1987. This time it was to conduct interviews with mothers on knowledge and practical demonstration of oral rehydration therapy. The participants spent about four hours in the communities and were back by 2 p.m. Time was allocated to receive feedbacks on the visit and interviews.

A third visit intended for the immunization session had to be canceled due to time constraints. On the whole, the two visits were effective learning processes for the participants. While giving comments and recommendations, the participants likewise learned lessons from the Murewa experience that would be useful in their own projects.

World Vision and MOH-Zimbabwe exerted considerable efforts to organize these visits, not to mention the tremendous input contributed by the people.

WORLD VISION ZIMBABWE CHILD SURVIVAL TRAINING WORKSHOP SCHEDULE - AUGUST 15-22, 1987

Final Schedule

| Time | Saturday August 15 | Sunday August 16 | Monday August 17 | Tuesday August 18 | Wednesday August 19 | Thursday August 20 | Friday August 21 | Saturday August 22 |
|-------------|-----------------------|---|---|--------------------------|--------------------------------------|---|-----------------------------------|--|
| 7:00-7:45 | B R E A K F A S T | | | | | | | |
| 8:00-9:00 | ARRIVAL IN | WORKSHOP STAFF LEAVE FOR WORKSHOP SITE | ANNOUNCEMENTS | SOCIAL MOBILIZATION | CONTROL OF DIARRHEAL DISEASES | IMMUNIZATIONS | PREPARATION OF ACTION PLANS | PARTICIPANTS LEAVE FOR HARARE |
| 9:00-10:00 | | | POSTER DISPLAY PRESENTATIONS | TEA BREAK | TEA BREAK | TEA BREAK | TEA BREAK | |
| 10:00-11:00 | HARARE | | TEA BREAK | BRIEFING | TEA BREAK | | TEA BREAK | WORKSHOP STAFF WRAP- UP MEETING AND DEPART FOR HARARE |
| 11:00-12:00 | | OPENING CEREMONIES | SITE VISITS (LUNCH SERVED IN THE COMMUNITY) | BRIEFING | HOME VISITS/ ORT INTERVIEWS | A.I.D. REPORT- ING SYSTEM | ACTION PLAN PRESENTATIONS | |
| 12:00-13:00 | | LUNCH | LUNCH | | | LUNCH | FINAL EVALUATION | |
| 13:00-14:00 | | PARTICIPANTS ARRIVE IN MUREWA | POSTER PRESENTATIONS CONTINUED | | LUNCH | HEALTH INFORMATION SYSTEMS | LUNCH | |
| 14:00-15:00 | | REGISTRATION | | REFLECTIONS ON VISITS | REFLECTIONS ON VISITS | | PHOTO SESSION | |
| 15:00-16:00 | | DISTRIBUTION OF BINDERS | TEA BREAK | TEA BREAK | TEA BREAK | SMALL GROUP SESSIONS/ PRESENTATIONS | CULTURAL PRESENTATION | |
| 16:00-17:00 | | WELCOME | SURVEY REVIEWED | PRESENTATIONS | PRESENTATIONS | | | |
| 17:00-18:00 | | INTRODUCTION | GROUP SESSIONS | EVALUATION | CASE STUDIES | EVALUATION | | |
| 18:00-19:00 | | PARTICIPANT INTERVIEWS | ORIENTATION FOR NEXT DAY AND EVALUATION | REVIEW OF NEXT DAY | EVALUATION | | | |
| 19:00-20:00 | | ORIENTATION | | | | | FELLOWSHIP DINNER | |
| 20:00-21:00 | | DINNER | DINNER | DINNER | DINNER | DINNER | | |
| | | REVIEW OF RESOURCES | WORKSHOP STAFF MEETING | STAFF MEETING | EPI MEETING/ STAFF MEETING | STAFF MEETING | CLOSING | |

F. The Resource Center

There was a room reserved for the resource materials which was also used as office space. The room eventually became a multi-purpose room where participants not only could read materials, but also could view health-related video tapes or listen to a Vitamin A cassette in the evenings. Likewise, participants and staff could type, make photocopies, prepare audiovisuals, obtain learning materials, and borrow recreational games. World Vision designated a workshop secretary who not only handled typing and photocopying chores but also took messages, handled travel booking reservations/confirmations, telephone calls, and even looked after the first-aid kit.

Though busy and needing more organization, the resource center proved to be a very important place in the Murewa workshop.

G. Workshop Presentations

I. Social Mobilization

Social mobilization was the subject for August 18, 1987. An indoor session in the morning was highlighted by the presentation of the case study on social mobilization in the World Vision Zimbabwe Child Survival project by Mrs. Jelda Nhliziyo. The full text of the paper is included in the appendix. Among the lessons learned from the experience were:

- a. A community-based health program recognizes the political context and works with the objective of evolving a structure which responds to the needs and priorities of the total community.
- b. The most important felt need of the community is to control the programs that affect them.
- c. The program should develop a careful analysis of problems in the context of the socio-political and economic structures and potentials, and use a range of methods to cope with inherent struggles of power.
- d. The WV Zimbabwe CSP recognized the tension between flexibility and replicability, and tries, as far as possible, to keep a balance between the two.

Community visits were scheduled for the day to give the participants the opportunity to observe the WV Zimbabwe program in action. Three villages were chosen: Zvareva, Musinga, and Pfende. Participants were briefed to make observations and suggestions to be presented in the afternoon. Notes on these are included in the appendices.

In summary, the participants were generally impressed on how effective the implementors had been in mobilizing the community. This was seen in the interaction between the staff and the people. It became evident that singing and dancing are very much a way of expression by the Zimbabweans, reflecting oneness as a community. The VIDECS (village development centers), water wells and Blair toilets were major features that were noted in each of the sites.

After the visits, the groups presented their impressions. While pointing out the strengths and concerns, the participants made a number of suggestions to further improve the World Vision Zimbabwe CS^D, such as planting more trees for fuel and shade, using run-off water from the wells for gardening, and implementing other income-generating activities.

2. Control of Diarrheal Diseases

This was the major topic for the workshop. Dr. George Ngatiri introduced the session. CARE Regional Director Kate Burns, who has considerable experience in Africa, became the major resource person for the day's event. Kate emphasized the importance of EPI and ORT as key CS interventions. The following components were discussed: ORS, SSS, HAF, continuing feeding during diarrhea and referrals. In addition, management of diarrheal diseases issues was raised, such as various approaches in ORT implementation, training of CHWs and mothers, quality of home management (such as adequate use and time of referring a child based on severity recognition), and evaluation of interventions based on success/failure of knowledge versus practice.

Case studies were presented by CARE-Uganda and Save The Children-Sudan. The Uganda case study focused on the strategies implemented by the Multi-Sectoral Rural Development Program (MSRDP) which CARE joined in July 1986. Village Health workers were selected and trained to work in oral rehydration corners in aid posts. All three ORT techniques (ready packets, salt-sugar solution, and homemade solutions like light tea, porridge, and banana juice) were promoted. The VHWs provided teaching to individual mothers at home, immunization sessions, women groups, and schools. The home-aid post-health center/hospital referral system was elaborated.

The Save the Children (SCF) Sudan case study revealed that the ORS (UNICEF packet) is the number one intervention being promoted, but both SSS and home-based solutions are being introduced. The CHWs, VHWs, and the Community Health Aid (CHA, usually a volunteer) deliver the interventions at village, health post, and hospital levels. Demonstrations are provided for preparing the three solutions. The number of packets dispensed through the health posts and health workers is used for monitoring. While training and evaluation of health workers are already being done, efforts on community training are being initiated. Supervision of ORT activities is being conducted through the pre-school health infrastructure.

After the case studies, Dr. Zvandasara, Provincial Medical Officer, gave his observations. He strongly stated that the Murewa experience has shown the salt-sugar solution to be the intervention that has been promoted and highly accepted by the community. It has been found that most households in Murewa have the ingredients readily available and efforts will continue to reinforce this intervention.

Home visits were conducted after the above sessions. The participants were divided into three groups again. A structured interview for diarrhea and ORT was carried out by every participant. This was designed by Dr. Carl Kendall, medical anthropologist from the Johns Hopkins University. After the home visits, the participants presented results of the

interviews. There was a general impression that the mother-interviewees had a good literacy level, knew what diarrhea was all about, identified causes and how to mix the salt-sugar solution. Although most of the mothers knew how to administer the solution, there were some that considered it as a "medicine" to be dispensed, e.g., three to four times a day.

3. Nutrition and Growth Monitoring

This topic was taken up in the afternoon of August 19 after the diarrhea and ORT sessions. Three case studies were presented: World Vision Sudan, SCF Malawi, and AFRICARE Nigeria.

The nutrition component of World Vision Sudan was part of a country-wide program during the 1984-85 famine with concentration in the Central Region. The following messages were conveyed: breastfeeding at least up to 18 months and introduction of foods at four to six months; gradual weaning from three to six months, even if mothers were pregnant; and promotion of local balanced diet. To determine the extent of coverage, the following were used as indicators: proportion of registration of under-threes (rather than the usual under-fives), proportion of cards issued, and attendance in clinics. Success in meeting objectives of program was evaluated through knowledge and skills of mothers, and decreases in malnutrition cases.

The SCF-Malawi group elaborated on the rural development linkage program in which the SCF tied up closely with the Ministry of Health/Public Health Association of Malawi (MOH/PHAM) and the Ministry of Agriculture. Among the major objectives pointed out were regular growth monitoring for at least 85 percent of the 0-5 year olds in impact areas, installation and periodic calibration of Salter scales at all delivery points, village-level growth monitoring every two to three months, and development of referral system.

The IMO/AFRICARE CSP project overview was presented. It was pointed out that the nutritional status of the community was part of the baseline survey. The Women's Development Center was cited as a very important feature of the program. Nutrition components primarily included agricultural demonstration gardens and alternative income-generating activities to sustain nutrition.

4. Immunization

A pre-immunization meeting was conducted by Cynthia Rawn with the participants on the evening of August 19, 1987, to determine the areas of concern on EPI coverage surveys. A list, which includes survey methodologies to the role of computers is included in the appendix.

A large table was prepared for participants to fill in information on different EPI components. The completed table is included herein. A full report prepared by Cindy Rawn is likewise included in the appendix.

Save the Children Federation - Sudan presented the case study on the EPI in the El Obeid and Northern Kordofan regions. This project has low target figures due to logistical difficulties and the fledgling stage of the Sudan

project itself: 4.5 percent or 19,000 children under one year and 3 percent or 12,500 pregnant mothers. As a long-term objective, a challenging 70 percent vaccination coverage was set. Strategies to achieve this included: giving more support to CHWs, improving district-level EPI management and working towards sustainability of EPI activities.

After the Sudan case study, Mrs. E. Serima of the Zimbabwe Ministry of Health delivered her paper on the country's expanded programme on immunization. In summary, she emphasized the EPI planning and the multi-sectoral EPI Task Force aspects. She raised some important issues with which both the government and non-government were concerned. "Awareness" activities to promote the program were also mentioned. She concluded by stating that there is a need to consider the role of private voluntary organizations in primary health care--will the role diminish or become institutionalized? Or, will there always be unmet needs that call for outside assistance?

Dr. M. O. Alli, Advisor to UNICEF in Zimbabwe, followed Mrs. Serima's presentation. Dr. Alli discussed identifying and maintaining satisfactory levels of immunization.

The texts of both papers are included in the appendix.

5. Baseline Surveys

This topic was taken up by two small group discussions in the afternoon sessions of August 20, 1987.

One group raised the following:

- a. What is the most effective, practical, and cost-effective way to baseline information?
- b. How much time is required for collection?
- c. What is "representative?"
- d. How many personnel are necessary to do the baseline?

The Uganda "100-house survey" was quoted as a practical cost-effective method that would meet the above criteria. In addition, a more comprehensive method may be utilized to cover different demographic characteristics of a population.

A second group discussed other components such as the community's knowledge, attitude and practices; resources; maps; and family enrollment as survey tools.

6. Health Information Systems

Dr. Dory Storms was the key resource person for health information systems. She detailed four issues: uses, problems, personnel, and time constraints in health information systems. Dr. Storms pointed out that no component of Child Survival programming has been more difficult for field staff than information systems. The different issues were outlined with

their corresponding approaches. She then discussed the major problems identified by PVOs, with their suggestions for dealing with them. The notes in the appendix should benefit anyone involved in CSP health information systems.

7. Sustainability

Even though this was a formal session on the third day, sustainability was a constant issue in practically all the Child Survival topics addressed during the workshop. It was emphasized that while the USAID is funding the projects during the first few years, PVOs are challenged to work out measures with the communities to sustain the Child Survival activities after the funding has been completed. Strategies like fee-for-service, attempts to reduce costs, resources generating activities, and seeking other funding sources have been proposed to fully or partially sustain program activities.

8. Supervision and Training

These topics were taken up during the small-group sessions on August 20, 1987. While "top down" supervision was mentioned, the group pointed out that many areas (such as Sudan and Malawi) have been adopting the grass-root or the "bottom-up" approach. The following were suggested:

- a. Communities become actively involved at the planning, implementing, monitoring and evaluating stages.
- b. That supervision be shared between the health workers and community leaders.
- c. That supervision, though critical, be supportive of the CHWs.
- d. A more participative style of supervision should be used to allow a two-way evaluation process.

In terms of training, supervisors should be afforded training on technical know-hows, supervisory processes, and refresher courses.

9. Linkages

- a. Linkages between PVOs and the MOH:

Private Voluntary Organizations' activities are incorporated into the existing MOH infrastructure, and both MOH and PVO staff workers are often members of committees at varying levels. Concerns mentioned were that MOH is often too slow; MOH lacks interest in following up with PVO activities; MOH lacks feedback; MOH has shortage of staff; and MOH has divided responsibilities among its various levels.

The following were recommended: Private Voluntary Organizations should act as model of integrated PHC components, have coordinators at various MOH levels to facilitate efforts and influence policies/strategies, avoid conflicts among themselves, and consider and respect community and government inputs. On the other hand,

the MOH should develop more interest in PVOs' activities, provide feedback to PVOs, and monitor/follow up PVOs' programs.

b. **Linkages among PVOs:**

The Kenya and Uganda participants met to discuss linkages among themselves. Linkages are important to exchange ideas on CSP and development projects, to exchange reports, to visit each other's projects, and to meet and consult with each other. In this manner, PVOs can learn and benefit from each other. The group identified projects with strong component(s) and came up with a local technical inventory.

The Sudan group also agreed on the need to meet and share with each other. The participants were more specific in setting up dates and places for regional meetings/workshops and coordinating PVOs/personnel.

Everyone agreed that each PVO had something to contribute in terms of experience and technical know-how that would definitely benefit others.

10. Traditional Health Providers

The issue on traditional health providers (THP) was also discussed by a small group. It was commented that traditional health providers are already being utilized in some countries as with the traditional birth attendants or "hilots" of the Philippines. The THPs in CSPs do have their strengths; many of them have already been integrated, are respected members of the community, and have reasonably acceptable practices. On the other hand, some THPs do not want to work with "modern medicine" providers, they often work in secrecy, and they may still have some harmful practices. Likewise, THPs are often "despised" by modern health providers; this situation should change.

11. AIDS/EPI/Malaria:

Transmission was discussed, and it was pointed out that there is no evidence yet that AIDS has been transmitted through expanded programs on immunization. Recommendations were to promote sterile techniques and use of one-needle-one-patient policy; train EPI workers to educate the community and help dispel rumors; educate health care providers that AIDS is evolving; realize the government has a major role in AIDS education; and consider measures to support AIDS patients such as increased social/family sympathy, establishment of hospices, AIDS-anonymous, and labor certification support.

Malaria was briefly discussed. This mosquito-borne protozoan disease has been one of the major causes of fetal wastage, prematurity, and low-birth weight neonates. The target, then, of a malaria intervention in a Child Survival program (chloroquine prophylaxis) should be on pregnant mothers and children under two years old. Appropriate environmental interventions should be implemented. The incidence and prevalence of malaria were also pointed out as appropriate indicators of the health status of the community. These may be considered in surveys and in providing technical assistance.

12. Education/Mass Campaigns

In a small-group discussion, five strategies for mass campaigns were proposed. Mass campaigns should be seen not as an end in themselves but rather as a means of developing and refining implementation schemes. There is a need to develop short-term and long-term strategies towards reaching goals and maintaining sustainability. Mass campaign strategies cannot be sustained over the long-term in a vacuum; inter-sectoral linkages are important. Mass campaign strategies require a comprehensive foundation as baseline surveys and KAP focus interviews.

13. A.I.D. Reporting System: Monitoring, Reporting, and Evaluation

Dr. Dory Storms elaborated on the recent guidelines for private voluntary organizational reporting to A.I.D. Both qualitative and quantitative reporting were explained in detail and participants had the opportunity to raise questions.

14. A.I.D. Technical Assistance

The participants from Zimbabwe and Malawi programs discussed technical assistance as a group. They pointed out that TAs should have knowledge and familiarity with the country's health policy, should have good background information about the country, and a TA should be someone able to share his own expertise with the receiving country rather than learn from the people. Likewise, TAs are important in the start-up, middle, and concluding phases of CSPs. Technical assistance should be made available from international (PVO headquarters), national, regional, and local levels with the possibility of tapping project workers to act as TAs to other PVOs.

It was acknowledged that TAs will definitely help in the coordination among PVOs within one country, give a considerable input in the planning stages, and should save PVOs a lot of money.

It was during this session that the USAID announced the availability of TAs from Washington, D.C. A technical assistance request form was explained, and questions from participants were addressed.

15. Computers in Child Survival Programs

A number of participants convened in a computer "clinic" in the evening of August 18, 1987. Experiences were shared by participants who have been using computers in their projects. Most have found computers useful in baseline studies, statistical analysis, reporting, communications, and logistics. Different programs were shared. Repair and maintenance were also discussed. World Vision Sudan participants, having recently received a computer, spent extra time with other participants who already have considerable experience with computers in the field.

16. Eye Care and Vitamin A

It was a privilege to have Dr. Larry Schwab address the participants on this subject on the last day of the workshop. Dr. Schwab, an ophthalmologist, is the author of the book Primary Eye Care in Developing Nations, which was recently published. He briefly discussed that 1 percent of the world's

population is blind by World Health Organization's criteria and two-thirds of these cases are preventable and treatable. There is a global effort to reach about 5 million affected people. Dr. Schwab elaborated on the chapter on malnutrition and external diseases in which Vitamin A was discussed as an important intervention. Dr. Schwab gave copies of his book to the participants.

H. Ninety-Day Action Plans and Closing Sessions:

On the final day of the workshop, participants from all the PVOs were given the task of developing an action plan for the next ninety days to implement an idea or ideas gained in the workshop in monitoring, evaluating, supervising, training, networking and others. The participants had the opportunity to present their plan.

These action plans are detailed in the Appendix. They will actually be used by both PVO participants and USAID to determine how they have been accomplished after the stated period.

Picture-taking sessions were held in the afternoon. As scheduled, a cultural presentation was held at the Murewa Culture Center. The Zimbabweans honored the participants and staff with traditional numbers. Participants from other countries were invited to perform. The Murewa Culture House, being the first of its kind outside Harare, also impressed the group in terms of providing the opportunity to view traditional treasures and artifacts. Appreciation was expressed for what the local people are doing to preserve these, not to mention the efforts to build a center to promote culture and education for the people.

A candlelight dinner was organized during the last evening. The final ceremonies followed the fellowship dinner with the delivery of closing speeches. The participants were awarded their certificates for completing the workshop. There were presentations of gifts, recognition and awards to individuals. Then, each one had the time to express thanks and farewells. The atmosphere of the evening seemed to further reinforce the spirit of commitment to child survival as well as camaraderie among both participants and staff.

V. BUDGET

CHILD SURVIVAL PROGRAM ZIMBABWE WORKSHOP

| Line Items | A.L.D. Budget | A.L.D. Actual | Over/ (Under) | Percent Variance | WVRO Match |
|-----------------------------|------------------|------------------|------------------|---------------------|-----------------|
| 1. Consultants & Evaluation | \$ 5,300 | \$ 5,300 | \$ 0 | 0.0% | \$ 1,700 |
| 2. Supplies/Materials | 2,000 | 1,853 | (147) | (7.3%) | |
| 3. Other Direct Costs | 3,700 | 3,847 | 147 | 4.0% | 2,812 |
| 4. Indirect Costs | 4,000 | 4,000 | 0 | 0.0% | 0 |
| 5. Travel | <u>25,000</u> | <u>25,000</u> | <u>0</u> | <u>0.0%</u> | <u>3,793</u> |
| WORKSHOP TOTAL | \$ 40,000 | \$ 40,000 | \$ 0 | 0.0% | \$ 8,305 |

Budget Detail

Each line item is made up of the following:

Consultants & Evaluation

- o Costs and fees attributable to the time and efforts of Dale Flowers and Douglas Mendoza.
- o Costs and fees for:
 - Printed materials
 - Transport of supplies
 - Transport of materials

Other Direct Costs

- o Costs and fees for:
 - Cab service
 - Related auto expenses (gasoline, etc.)
 - Airport taxes
 - Cost of staff assigned to production of workshop reporting
 - Food and lodging at Murewa, Harare, and Nairobi for participants

Indirect Costs

- o Costs attributable to, but not definable for, a specific line item in the Zimbabwe Child Survival Workshop budget.

Travel

- o Costs and fees attributable to air fare of 20 workshop participants from Kenya, Malawi, Nigeria, Sudan, and Uganda, as well as workshop facilitator and World Vision staff.

VI. EVALUATION OF THE WORKSHOP

A. Workshop Evaluation: By the Participants

"The most important things I have learned in this workshop and would like to apply in my project."

- o Encourage intersectoral collaboration with all the PVOs, WHO, UNICEF, and MOH. This can increase country/regional networking and technical assistance.
- o How to prepare an action plan and how to evaluate my project better.
- o Communicate more, work and live together with the people to be more effective.
- o I will get more technical assistance especially during the middle and final phases of my project.
- o Consider the strategies demonstrated in the workshop and explore other methods to sustain Child Survival activities after funding has been exhausted.
- o Traditional health providers will definitely be tapped in my community.
- o I need to reevaluate my project objectives, have better baseline studies, improve reporting system, work with comparable standards, and keep close linkages with other PVOs.
- o Improve on the health information systems of my project.
- o Develop a simple message and make sure mothers understand well.
- o We should rely more on African manpower resources and less on expatriates.
- o In mobilizing the community, we should start by asking the community's most felt need: water? food (in famine conditions)?
- o Learning is difficult and should be a continuing process. Reminding them constantly will be a strategy that I will consider seriously.
- o This workshop has prepared me to host a future workshop.
- o Take advantage of the technical assistance being offered by A.I.D./ Washington, D.C.

"My suggestions for future workshops of newly funded Child Survival projects in Africa."

- o Plan on a longer workshop.
- o Involve experienced and qualified field workers as resource persons.

- Give other countries the chance to host future workshops.
- Inform participants months ahead to be able to prepare better.
- Workshop materials should be sent in advance.
- Limit number of participants.
- Plan to have back-up facilities in case of electricity cuts.
- Limit community visits. Consider observing more than one intervention per visit.
- The following topics should be addressed (or discussed more) in future workshops:
 - Birth-spacing
 - Maternal health
 - Growth monitoring and sustainability

Participants listed 32 potential resource people for future workshops. Some suggested that CDC-epidemiology type of people, project staff from impact areas, regional staff, and headquarter staff should likewise be invited as resource persons. A list is included in the appendix of the full report.

B. Workshop Evaluation: By World Vision Zimbabwe

The Zimbabwe Child Survival Workshop was the first international effort of its kind to be held at district level in a remote area. This "grass roots" approach served to foster a deeper identity and oneness with the local people.

Organizational skills of the Child Survival team were enhanced by arranging just such an international workshop. The workshop provided a learning exercise for the Child Survival team, as well as the country as a whole.

The Child Survival projects benefitted from contributions made by workshop participants from Kenya, Malawi, Nigeria, Sudan, Uganda, and Zimbabwe.

The participation of NGOs at the workshop is widely held to be the beginning of the ultimate goal of interagency coordination.

Ministry of Health officials expressed their appreciation of the week-long effort to World Vision Zimbabwe.

C. Workshop Evaluation: By WVRO (Headquarters)

The organization and facilitation of this training workshop represented a significant degree of collaboration, coordination, and cooperation between the World Vision Relief Organization (WVRO) headquarters in Monrovia, California, and the World Vision Zimbabwe (WVZ) field office in Harare, Zimbabwe. While WVZ served as the host to the actual workshop, WVRO served in a facilitation and coordination capacity with A.I.D./Washington and the headquarters of other PVOs invited to participate in the workshop.

The following observations represent the highlights of WVRO's evaluation of the workshop planning and preparation process:

1. The successful preparation and planning for this workshop required a close and intentional coordination between WVRO (headquarters) and WVZ. WVRO determined from the point of inception that the primary responsibility and authority in the hosting of the workshop would be with the field office hosting the event, and not with headquarters. While both WVRO and WVZ by necessity undertook specific roles in the planning process, the ultimate point of approval for all decisions impacting the workshop was with the WVZ field director, Max Chigwida, and his team.
2. Coordination efforts by WVRO required the continued recognition of and sensitivity to appropriate organizational protocol, both between the headquarters and fields of other PVOs invited to participate, and between WVRO and WVZ.
3. Successful workshop preparation required the significant attention of at least one mid- to senior-level staff person within WVRO headquarters for at least six months prior to the workshop. During the three months immediately prior to the workshop, the time requirements for preparation incrementally grew from approximately 25 percent of one person's time to a full-time equivalency for the last six weeks of preparation.
4. Based upon WVRO's experience, the process of the workshop design must include the field office (for content, as well as structure and format). Moreover, the process of workshop design will, by necessity, need to be flexible throughout the planning process, including the flexibility to adjust after the workshop itself has already begun. Of particular significance in this regard is the need to allow opportunity for small group interaction by the participants for both predesignated and participant-determined topics of discussion.
5. Feedback by both A.I.D. officials and World Vision staff who attended both the Sierra Leone workshop in 1986 and the Zimbabwe workshop in 1987 concluded that the technical capability and degree of project-level experience was notably higher in the area of primary health care with the Zimbabwe workshop. Speculation on the reasons for this included the fact that the A.I.D. Child Survival program was at a greater point of maturity than in 1986, when it was first beginning, and the strong perception that the PVO projects represented at the workshop were further along due to increased PVO capability than were the projects at the first workshop.
6. Relatedly, the workshop design appeared to be more successful when sufficient unprogrammed time was allowed for the schedule. This greater level of experience seemed to generate a significant degree of self-motivation among the participants to learn from the resources available from one another.
7. The role of workshop facilitator was critical to the ongoing flow and effective progress of the Zimbabwe workshop. In WVRO's estimation, it was particularly important that this role be carried out by a person external to both A.I.D. and the host PVO to allow the facilitation to be carried out with effective authority and objectivity. Moreover, while the facilitator should be generally conversant with the overall topics being

discussed, in WVRO's estimation, it is more important for the facilitator to have a training background than it is for the person to have a technical background in Child Survival issues. In his role as facilitator at this workshop, Dale Flowers performed exceptionally well; A.I.D., WVRO, and WVZ officials each recognized and noted Dale's strong personal performance, as well as the value that this role played. Thus, in WVRO's estimation, this function is also worth the cost involved for the consultant's time and travel, if the person is well selected.

8. While it should not be an ongoing issue, WVRO's experience indicated the importance of role clarification at critical mileposts in the workshop preparation, planning, and implementation process. For the Zimbabwe workshop, these mileposts included the point of WVZ and WVRO first accepting the responsibility to host; the initial stages of workshop planning, beginning six months prior to the workshop; a point approximately three months before the workshop, when detailed planning and preparation began in earnest, both with WVZ and WVRO; and the point just prior to the workshop's beginning. With workshop staff and resource persons, including PVO field and headquarters' representatives, as well as A.I.D. representatives, the process of role clarification was very helpful to the overall flow of the workshop itself.
9. Relatedly, daily coordination and review meetings at the end of each workshop day for all workshop staff proved to be very helpful, particularly in adjusting schedules and training processes.
10. Two days of detailed site visits seemed to be a good level for this workshop. Originally, three days of site visits were included in the design, but each site visit required so much time for the participants, as well as time in coordination with the area communities and MOH staff, that more than two would have diminished the ability of the workshop to address several key issues due to a simple lack of time.
11. While the financial allocation by A.I.D. for the workshop appeared at first to be significantly under the required costs, WVRO's experience was that actual costs were able to be minimized due to the lowered costs of lodging and food for a workshop held in a more rural area. Moreover, the workshop setting proved to be very adequate and allowed participants to focus on the workshop without significant distractions (e.g., shopping). In agreeing to host a workshop like this, however, the PVO headquarters and field office will need to recognize the substantial contribution in staff time and related impact on other work loads that this requires.
12. While the experience of hosting this workshop held many valuable lessons for World Vision generally, in retrospect, one critical component of the workshop design was the close coordination and involvement with the MOH in its planning. MOH officials at the national, provincial, district, and local levels were included in both the planning process and the workshop itself. This involvement provided a critical and complementary resource point for workshop participants, as well as lasting goodwill for the ongoing work of WVZ in the implementation of the Mashonaland East Child Survival project.
13. Finally, a critical component to the lasting effectiveness of this workshop was the intentional focus on training for enhanced ability to implement

existing Child Survival projects. The focus of the workshop participants from the start, much less the focus of the workshop design, was upon obtaining tools and learning new information based upon the experience of one another and the resource persons utilized in the workshop which would enable them to improve the successful implementation of their own projects.

D. Workshop Evaluation: By A.L.D.

(Letter from Dr. Dory Storms on the following page.)



THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF HYGIENE AND PUBLIC HEALTH

INSTITUTE FOR INTERNATIONAL PROGRAMS

November 11, 1987

Dr. Rufino Macagba
World Vision Relief Organization
919 West Huntington Drive
Monrovia, CA 91016

Dear Rufi,

I congratulate World Vision for the successful workshop in Murewa. You made manifest the values on which we have built the Child Survival Implementation workshop strategy -- field-based, shared experiences, exchange of ideas, and dissemination of practical information to help project managers do a better job. Indeed, in the opinion of some, the group dynamics and the feelings of solidarity were the most prominent outcome of the workshop. As one letter from a PVO staff member expressed, "Participants now feel that they are not alone in the struggle to implement the child survival interventions."

We believe the participants who came to Murewa will be more effective in their work in the Africa region because of that experience. It was a very worthwhile experience for me personally, and I am deeply appreciative of the tremendous amount of hard work which those at World Vision gave to the effort.

The success of the WV workshop, (and that of the earlier workshop for the CS projects in francophone Africa), has convinced A.I.D. to continue their support of additional implementation workshops in the Africa region in 1988. Based upon his direct experience of the WV workshop, Dr. Gerold van der Vlugt, PVO Health and Child Survival Coordinator, FVA/PVC, has encouraged further field-based workshops in Africa. He has directed the PVO Support Program at Johns Hopkins to work with AMREF in Kenya, to design a workshop for Child Survival III project implementors. You will be excited to learn that we are working with Dr. B.O.N. Oirere, who attended the WV Zimbabwe, to incorporate the lessons learned in Murewa.

I look forward to continued contact with you, Mark Publow, George Ngatiri, Max Chigwida, Bongsi Mushapaidze, Doug Mendoza, and all the wonderful WV field staff who accomplished so much through this workshop.

Sincere regards,

Dr. Doris Storms
Coordinator, PVO Child Survival Support Program

WORLD VISION/ZIMBABWE TRAINING WORKSHOP
FOR PVO CHILD SURVIVAL PROJECTS IN AFRICA

August 16-22, 1987

Murewa, Zimbabwe

List of Participants (Final)

APPENDIX A

| COUNTRY | POSITION | ADDRESS |
|-------------------------------------|---|---|
| 1. Margaret Okello (Mrs.) | CBHC CSD Coordinator (Urban Nairobi) | Africa Medical and Research Foundation P.O. Box 30125 Nairobi, Kenya Tel. 301301 Tlx. 23254 |
| 2. B.O.N. Oirere (Dr.) | Project Leader, Kibwezi, R.H.S. | |
| 3. Kate Burns (Ms.) | Regional Technical Advisor for PHC in East Africa | CARE - Kenya P.O. Box 43864 Nairobi, Kenya Tel. 724674 Tlx. 25430 |
| 4. Osheria Mohanmed Elamin (Miss) | Administrative Assistant/Extensionist Child Survival Project | CARE - Sudan P.O. Box 2752 Khartoum, Sudan Tel. 45521 Tlx. 24242 CARE SD |
| 5. Catharine McKaig (Ms.) | Project Manager | |
| 6. Lovisa Marrion K. Ayazika (Mrs.) | Senior Nursing Officer | CARE - Uganda P.O. Box 7280 Kampala, Uganda Tel. 58568/69 Tlx. 61128 |
| 7. Israel Kalyesubula (Dr.) | Head of Health Sector | |
| 8. Charles W. Oliver (Mr.) | Project Advisor | Imo Africare Child Survival Project P.O. Box 3545, Oweri Imo State, Nigeria Tel. (083) 232314 Tlx. 21670 (Attn. Dr. Haider, c/o USAID Mission) |
| 9. Regina A. Obiagwu (Mrs.) | Administrative Assistant | |
| 10. Rosellyn Chiwaya (Ms.) | Health/Nutrition Projects Assistant | Save the Children Federation (SCF) P.O. Box 30374 Lilongwe 3, Malawi Tel. 733-777 Tlx. 4487 CBS MI |
| 11. Stanley Jere (Mr.) | Health/Nutrition/Child Survival Coordinator | |

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| COUNTRY | POSITION | ADDRESS |
|------------------------------|--|---|
| 12. Biar Deng Biar (Dr.) | Health Sectoral Deputy Manager | Save the Children Federation (SCF) P.O. Box 3896 Khartoum, Sudan Tel. 46550 Tlx. 970-2409: SATCH SD |
| 13. James Okuc Daniel (Dr.) | Health Sectoral Deputy Manager (Showak) | |
| 14. I. A. Bani (Dr.) | Project Advisor | World Vision - Sudan P.O. Box 3180 Khartoum, Sudan Tel. 47587 Tlx. 22190 ACROP SD |
| 15. Nel den Boer (Ms.) | Project Manager | |
| 16. Beatrice Mutua (Mrs.) | Project Coordinator/Supervisor | SAWSO - Kenya P.O. Box 10822, Machakos, Kenya Tel. MKS 21708 P.O. Box 160, Machakos, Kenya |
| 17. Major Ruth Simiyu (Mrs.) | Women's Group Leader | |
| 18. Ellen Tagwireyi (Mrs.) | Health Associate | World Vision - Zimbabwe P.O. Box 2420 Harare, Zimbabwe Tel. 726788 Tlx. 4686 WORVIS |
| 19. Jelda Nhiliziyo (Mrs.) | Training Officer | |
| 20. Emily Shoko (Mrs.) | Community Nurse | Ministry of Health Chitate Rural Health Centre Box 129 Murewa, Zimbabwe |
| 21. Lawrence Mubaiwa (Mr.) | Community Nurse | Ministry of Health Madamombe Rural Health Centre Box 60 Murewa, Zimbabwe |
| 22. Sr. Florence Chipango | Matron | St. Paul's Mission P.B. 633E Harare, Zimbabwe |
| 23. Ruth Mukanyangi (Miss) | Community Health Nursing Sister | Ministry of Health Chinhoyi Hospital Box 17 Chinhoyi, Zimbabwe |
| 24. Richard Kudhanda (Mr.) | Health Program Coordinator | Save the Children (USA) Box 2908 Harare, Zimbabwe |

WORLD VISION/ZIMBABWE TRAINING WORKSHOP
FOR PVO CHILD SURVIVAL PROJECTS IN AFRICA

APPENDIX B

August 16-22, 1987

List of Workshop Staff and Resource People (Final)

| NAMES | POSITION | ADDRESS |
|---------------------------|--|---|
| 1. Mr. Dale Flowers | Workshop Facilitator | Santa Cruz Consultants 492 Corralitos Road Corralitos, California 95076 Tel. (408) 728-4694 |
| 2. Rev. Max Chigwida | Field Director, World Vision Zimbabwe | Box 3576 Harare, ZIMBABWE Tel. 726788 Tlx. 4686 WORVIS |
| 3. Mrs. Bongi Mushapaidze | Child Survival Project Manager World Vision Zimbabwe | Box 3576 Harare, ZIMBABWE Tel. 726788 Tlx. 4686 WORVIS |
| 4. Dr. George Ngatiri | Workshop Coordinator Regional Health Advisor | World Vision P.O. Box 58379 Nairobi, KENYA Tel. 24266 Tlx. 25311 WORVIS |
| 5. Dr. Dory Storms | A.I.D. Technical Liaison | The Johns Hopkins University School of Hygiene and Public Health Institute for International Programs 615 North Wolfe Street Baltimore, Maryland 21205 Tel. (301) 955-125110 |
| 6. Mrs. Cynthia Rawn | EPI Technical Associate for PVO Child Survival Projects in Africa | REACH Resources for Child Health 9th Floor 1100 Wilson Blvd. Arlington, VA 22009 Tel. (703) 528-7474 |

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NAMES**POSITION****ADDRESS**

7. Dr. Gerold van der Vlugt

Health and Child Survival Coordinator

Office of Private and Voluntary Cooperation
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8. Dr. Rufi Macagba

Head International Health Programs

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9. Mr. Mark Publow

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APPENDIX C

"FORWARD TOGETHER FOR CHILD SURVIVAL IN AFRICA!" WORLD VISION ZIMBABWE TRAINING WORKSHOP FOR PVO CHILD SURVIVAL PROJECTS IN AFRICA MUREWA, ZIMBABWE, AUGUST 15-22, 1987

Daily Objectives and Schedule

August 15, 1987--Saturday

Arrival in Harare, Zimbabwe--all participants lodge at the Oasis Hotel in Harare.

August 16, 1987--Sunday

Objectives of the Day:

1. To get people acquainted with each other and with the hosts.
2. To get people comfortable and ready to learn.

Schedule:

| | |
|------------|---|
| Morning: | Workshop staff arrive in Murewa |
| Afternoon: | Participants' arrive in Murewa (workshop site one hour from Harare, about 86 kms). Participants and staff lodge at Mwamuka Hotel. |
| 1500-1545: | Registration/distribution of workshop binders. Poster displays set up according to country and projects. |
| 1545-1700: | Welcome and introduction to Zimbabwe and World Vision by Reverend Max Chigwida, Host Country Director; Dr. George Ngatiri, Workshop Coordinator; and Mrs. Bongi Mushapaidze, Project Manager. Introduction of workshop facilitator, Mr. Dale Flowers. |
| 1700-1730: | Participant interviews and introductions |
| 1730-1845: | Review of workshop goals, objectives, and outcome: Dr. Ngatiri |
| 1900-1930: | Participants' expectations |
| 1930-2030: | Dinner |
| 2030-2100: | Orientation to resource materials (Dr. Doug Mendoza) |
| 2100-2130: | Workshop staff meeting: reaction to the day's events; discussion of participant expectations; keeping workshop clinics optional; guidelines; final workshop report format; wrap-up session. |

August 17, 1987--Monday

Objectives of the Day:

1. To set the stage for learning, acquaintance, collaboration, participation, and evaluation in the workshop.
2. To understand the context in which Child Survival project activities take place in the countries represented in the workshop.
3. To prepare the participants for the project visits to be made during the workshop: understand the political, governmental, cultural, and community structures within which the project functions.

Schedule:

- 0700-0745: Breakfast
- 0800-0815: Reverend Max Chigwida announced the arrival of the participants from Sudan (Dr. Biar and Dr. Bani) who were held at Harare Airport because of visa problems.
- 0815-1015: Participant presentation of project poster displays from AFRICARE (Nigeria), AMREF (Kenya), SAWSO (Kenya), SCF (Malawi)
- 1015-1030: Tea Break
- 1030-1200: Opening ceremonies:
- Introduction by Reverend Max Chigwida
 - Official opening by Dr. Godfried Sikipa, Acting Deputy Secretary for Rural Development, Ministry of Health, Zimbabwe
 - Remarks by Dr. Gerold van der Vlugt, PVO Health and Child Survival Coordinator, Agency for International Development, Washington D.C.
 - Comments by Mr. Magunda, Murewa District Administrator
 - Brief outline of District Health Services as they relate to Child Survival interventions by Dr. Van Nueton, District Medical Officer, Murewa District
- 1200-1300: Lunch
- 1330-1430: Continuation of participant presentation of project poster displays-- WV (Zimbabwe) and CARE (Uganda)
- 1430-1500: Dr. George Ngatiri gave outline for PVO participants' presentation of strengths and areas of concern in their projects/raise issues that relate to monitoring and evaluation of these concerns over time.
- 1500-1515: Tea Break
- 1515-1530: Review of participants' survey results by Dr. George Ngatiri
- 1530-1700: Small group tasks; small group presentations
- 1700-1730: Orientation to community visits by Mrs. Bongi Mushapaidze
- 1700-1745: The day's evaluation
- 1900-2000: Dinner
- 2030-2100: Workshop staff meeting

August 18, 1987--Tuesday

Objectives of the Day:

1. To understand the process of social mobilization as an important medium for accomplishing Child Survival goals.
2. To observe and share experiences on the integration of Child Survival activities into community development.

Schedule:

- 0700-0745: Breakfast
- 0800-0900: Case study on social mobilization: World Vision Zimbabwe Child Survival Project. Dr. Dory Storms, Mrs. Bongi Mushapaidze, Miss Nyanyiwa and Mrs. Jelda Nhliziyo to present the case study.
- 0900-0915: Tea Break
- 0915-0930: Introduction to the community visit--Mrs. Bongi Mushapaidze
- 0930-1430: Site visits by group to Village Development Centers (VIDECs)
- Group I: Zvareva
Group II: Musinga
Group III: Pfende
(Lunch served in the community)
- 1430-1530: Reflections on site visits by the three groups. Group task:
- To identify the experience
 - What happened?
 - What did you learn?
 - Give comments on the World Vision Child Survival program visited
- 1530-1600: Tea Break
- 1600-1700: Presentations by three groups
- 1700-1730: The day's evaluation; preview of the next day's activities
- 1900-2000: Dinner
- 2030-2100: Workshop staff meeting
Computer clinic held

August 19, 1987--Wednesday

Objectives of the Day:

1. To share effective approaches for educating families to use ORT to protect children from dehydration.
2. To discuss ways to evaluate the quality of home management of childhood diarrhea in each CS project.
3. To share effective approaches to educating and motivating families to improve on their nutritional health, even where there is little food and money.

Schedule:

- 0700-0745: Breakfast
- 0800-0815: Housekeeping
- 0815-1000: Home management of childhood diarrhea:
- Fluids, Feeding, and Referral (Control of Diarrheal Diseases)--
Dr. George Ngatiri
 - Resource person: Ms. Kate Burns (CARE)
 - Case Studies in ORT Programming--Save the Children Federation (Sudan)
 - CARE/Uganda
 - Observations by Dr. Zvandasara, PMD Office, Zimbabwe, MOH, Provincial Medical Officer
- 1000-1015: Tea Break
- 1015-1030: Orientation to home visits--Mrs. Bongzi Mushapaize
- 1030-1400: Home visits in three villages--Zvareva, Musinga, Pfende. Observations/interviews with mothers and community leaders about the problem of childhood diarrhea, ORT home management, and ways to prevent diarrheal diseases (snacks actually served by the communities).
- 1400-1500: Lunch at the hotel
- 1500-1600: Small group reflections on home visits
- 1600-1615: Tea Break
- 1615-1700: Small group presentations
- 1700-1800: Case studies in motivating families to improve their nutritional health--World Vision/Sudan, Save the Children/Malawi, AFRICARE/Nigeria
- 1900-2000: Dinner
- 2030-2100: EPI meeting with Cynthia Rawn; workshop staff meeting

August 20, 1987--Thursday

Objectives of the Day:

1. To share and learn ways to attain satisfactory levels of immunization coverage and how to maintain these levels.
2. To talk about other issues related to immunization (e.g., nutrition, AIDS, etc.).
3. To describe obstacles encountered in developing the project's health information system and share strategies used to overcome these barriers.
4. To clarify revised A.I.D. Child Survival reporting schedule and other reporting requirements.
5. To come out with a working definition of "sustainability" in projects.

Schedule:

- 0700-0745: Breakfast
- 0745-0800: Housekeeping
- 0800-1100: Session on immunization--Cynthia Rawn
- Project EPI components
 - Case study--Sudan
 - Perspective of the Zimbabwe MOH: Mrs. Serima
 - Satisfactory levels of immunization and how to maintain these levels: Dr. Alli, UNICEF
- (Tea break from 0945-1000)
- 1100-1200: A.I.D. reporting systems--Dr. Dory Storms
- 1200-1300: Lunch
- 1300-1330: Break
- 1300-1530: Session on health information systems--Dr. Dory Storms
- 1530-1545: Tea Break
- 1600-1700: Special small groups, followed by brief presentations:
- Family enrollment/baseline surveys (Cindy and Doug)
 - Sustainability (Kate B. and Sr. Nasha Hove)
 - Tropical Diseases/AIDS/Malaria (Dr. Jake van der Vlugt)
 - Supervision and Training (Bongi)
 - MOH and PVO linkages
 - Traditional healers/traditional birth attendants/safe motherhood (Chip)
 - Strategies for mass campaigns
 - Technical assistance
- 1700-1730: The day's evaluation
- 1900-2000: Dinner
- 2030-2100: Workshop staff meeting

August 21, 1987--Friday

Objective of the Day:

1. To encourage commitment to a plan of action for monitoring and evaluation to be implemented in the next 90 days.

Schedule:

- 0700-0745: Breakfast
- 0745-0800: Housekeeping
- 0800-0830: Guest: Dr. Larry Schwab, ophthalmologist and author of "Primary Eye Care in Developing Nations"
- 0830-1000: Preparation of action plans--each PVO will develop an action plan for the next 90 days to implement an idea gained in the workshop in monitoring and evaluation, supervision and training, networking, and others
- 1000-1030: Tea Break
- 1030-1230: Presentation of highlights of action plans by each PVO project
- 1230-1300: Final evaluation
- 1300-1400: Lunch
- 1400-1500: Group photo
- 1500-1700: Cultural presentation at the Murewa Culture Centre
- 1900-2000: Fellowship dinner; closing ceremonies; awarding of certificates; farewells

August 22, 1987--Saturday

Morning: Participants leave for Harare; workshop staff meet for wrap-up session and depart for Harare

WORKSHOP SONGS COMPOSED BY ZIMBABWEAN PARTICIPANTS

1. PAMBERI !!!!! (FORWARD TOGETHER . . .)

WE PROMOTE HEALTH IN AFRICA
BY PREVENTING DISEASES
COME EVERYBODY
PREVENT DISEASES WITH US

2. PREGNANT WOMEN
COME TO THE CENTER
TO BE WEIGHED
TO AVOID PROBLEMS
WE LEARN ABOUT DISEASES
WE CAN PREVENT
MEASLES!
TUBERCULOSIS!
TETANUS!
POLIO!
DIPHThERIA!
PERTUSSIS!
SOME CHILDREN LEFT US
BECAUSE THEY DIDN'T
HAVE THE CHANCE FOR PREVENTION

APPENDIX D

Opening Speech by
Dr. G. Sikipa, Representing the
Secretary for Health, MOH
Child Survival Workshop at Murewa
August 17, 1987

Mr. Chairman, Dr. Van der Vlugt, Provincial Medical Director Mashonaland East, distinguished guests, Murewa District Health Executive, ladies and gentlemen.

I am highly honored to be invited to come and open this five-day Child Survival Workshop. This international workshop has drawn participants from the Ministries of Health and non-government organizations in Africa and abroad. The non-governmental organizations are playing a vital supportive role to the governments' efforts in providing better health services to our children. This workshop has brought together people of different experiences, thus creating an excellent opportunity to exchange ideas and experiences.

This workshop is unique in that it is being held in a rural setting. To date, most international workshops are being held in the splendid surroundings of Harare hotels. I would like to congratulate the workshop organizers for bringing such international expertise closer to the people. The success or failure of health programs depend on the District Management Team. It is my hope that Murewa District Health Management Team will take full advantage of this workshop and improve the delivery of health services to the people.

The theme of this workshop is in concordance with the Ministry of Health's thrust in providing health services to mothers and children. Mothers and children are the silent majority in our country, making up to 70 percent of Zimbabwe's total population. Furthermore, they bear the brunt of most of the morbidity and mortality in our country and, I am sure, in other countries where some of the participants are coming from. The bulk of this morbidity and mortality is largely avoidable or preventable. Preventable by very simple and cheap technologies which are now, or could be made, easily available. I believe the promotion of these technologies is the reason for your gathering here.

Although strides have been made in promoting immunization, nutrition and oral rehydration therapy (ORT) in Zimbabwe, a lot more still needs to be done. Oral Rehydration Solution (homemade or prepared) is probably one of the greatest scientific discoveries this century. Its ability to reduce morbidity and mortality of children suffering from diarrhea makes it a miracle solution within easy reach of all mothers. Parents cannot make vaccines but can make sugar and salt solution from commodities available in their own houses. We have the simple technology, what is left is to bring this technology to every household in our country and encourage mothers to use it on the first sign of diarrhea.

I cannot tell you in terms of figures of how many children have been saved by sugar and salt solution (SSS), but I can inform you that we have seen a 30 percent reduction in outpatient attendance at clinics due to diarrhea.

This year is the Africa year of immunization during which we will redouble our efforts to increase our immunization coverages. We again call on the non-governmental organizations to help the Ministry of Health in ensuring that every child in our country is immunized.

The masses should be mobilized to participate in the planning and implementation of these programs. Methods should be found on how to sustain and maintain the enthusiasm of communities mobilized. I note with satisfaction that on your program you will be addressing yourselves to this very important subject of social mobilization.

The state of the children's health is probably the best indicator of a country's development. Since Independence, Zimbabwe has managed to reduce the infant morbidity and mortality rates through appropriate policy decisions which emphasize the central role of a healthy nation in the development process.

The field visits organized for you will cement the theoretical deliberations in this conference room with the realities of delivering health services to the people.

During your visits, feel free to talk to the villagers, community leaders, and peripheral health workers. We want you to be critical of the projects you will see so that we can learn from our mistakes and improve our health services.

On behalf of the Secretary for Health, let me extend our Zimbabwean hospitality to you all. The workshop facilitators and the hotel management will certainly make your workshop and visit a memorable one.

Ladies and gentlemen, we shall anxiously await the results of your deliberations and findings which I have no doubt will be fruitful.

It is now my pleasure to declare the Child Survival Workshop officially open.

Thank you.

APPENDIX E
CASE STUDY (CSP - ZIMBABWE)
HOW SOCIAL MOBILIZATION WAS ACHIEVED IN MUSAMI
By Mrs. Jelda Nhiliziyo, WV CSP Training Officer

INTRODUCTION

Definition

Social mobilization is a process by which communities are motivated to participate in project implementation. Hence, social mobilization was used as the main strategy in the implementation of the Musami Child Survival project. Social mobilization tremendously impacts children's ability to survive due to parents' participation. This peoples' empowering approach enhances the very sense of self and one's role in society.

Staffing at Field Office

Before implementing the program, World Vision examined and reviewed staffing needs to suit project implementation and future sustainability. They employed a few more people to enable them to have the following:

| | |
|--------------------|----------------------------|
| Field Director | |
| Project Manager | H.E.D. and Adult Education |
| Training Officer | Public Health Nurse |
| Evaluation Officer | Social Worker |
| Health Officer | Public Health Officer |
| Technical Support | From Regional Office |

At the project level, they were lucky to team up with a hospital administrator who is working as the field officer and hospital matron. The training officer, hospital inatron, and administrator form a very strong social mobilization team because all of them have been trained in the social mobilization process.

The Implementation Process Promotion with the Government

To gain official approval and support for the proposed project, the field director, the regional consultant, and the program manager held six meetings with different officials in the Ministry of Health at the national level. These were the permanent secretary, the Expanded Program on Immunization manager, and the Non-Government Organizations Liaison officer.

These meetings also intended to gain insight on the current government health policy; recruit government resource, including technical advice, facilities, and funds; gain support from other disciplines at the same or higher levels to develop a comprehensive project; and integrate the project and prevent overlapping and competition from government projects.

At the provincial level, the consultant, project manager, and evaluation officer held seven meetings with the provincial health authorities to gain approval and support for the project and to discuss the proposed implementation plan. At these meetings, a number of suggestions and recommendations were added to the original plan.

At the district level, the field director, project manager, evaluation officer, training officer, and the matron of the St. Paul's Mission Hospital held about five different meetings with the district administrator, district medical officer, and district nursing officer to discuss the proposed project. Negotiations with all government departments took four months before the actual project implementation started.

Establish a Partner Agency

The area where the project was to be implemented was identified. In 1978, World Vision helped St. Paul's Musami Hospital with an ambulance for outreach work. Once again, Musami was identified and found in need of assistance to run such a program. Since Musami is a mission hospital which is a member of the Zimbabwe Association of Church Related Hospitals (ZACH), discussions were also held with this administrative board. These discussions were between World Vision, Ministry of Health, and ZACH.

Consolidation of Health Staff

The Musami Hospital was given some in-service training to prepare it for a project oriented to the community and to provide staff with skills required for community work. There was need to increase the number of staff, so a nurse's aide was employed. The health staff involved were the hospital nurse, the nurses aides, and the village health workers, according to their level of basic training.

The courses' content included:

1. Proof of project approval by the government.
2. Reinforcement on skills in:
 - a. Communicating with the community
 - b. Working together with the community
 - c. Project planning
 - d. Maintaining and developing a program
 - e. Simple administrative skills
3. The training methods included:
 - a. Group discussions
 - b. Exposure to situations, followed by reflection on the situations
 - c. Role playing

Social Preparation of the Community

A health committee, chosen by the people, was established. The committee members coordinate the community with the project staff. The Musami Hospital administrator and matron held a meeting with this committee to introduce the Child Survival project. These committee members, who represented about six villages, went back to discuss the project with their respective village leaders.

The second meeting between the World Vision training officer, the Musami team, and the health committee ended with the training officer and the Musami team being invited to address respective communities within the villages. This was to enable the whole community to be involved, as opposed to the leaders only. At least three meetings were held per cluster of villagers under one health committee member.

The stages of the meetings were as follows:

1. Group discussions involved community problems and needs and the proposed Child Survival project. These discussions were between the World Vision training officer, Musami staff, and the local leaders, including any extension workers in the area.
2. Community leaders, assisted by the Child Survival training officer and Musami staff, then introduced the ideas informally to the community members.
3. A final meeting was held among the World Vision training officer, Musami staff, and a wide representation of community leaders and community people to work out an implementation strategy.

NOTE: At all the above meetings a multi-sectoral approach was used when time permitted.

Implementation

During the awareness-raising sessions, the communities had identified the lack of preschools as their priority need. In conjunction with the Child Survival activities, the project integrated the preschool into Child Survival. The communities were then mobilized towards Child Survival activities and construction of preschool centers. These preschool centers were turned into Village Development Centers where activities such as the following were carried out: immunizations, growth monitoring, nutritional demonstrations, family planning activities, agricultural meetings, women's club meetings, and oral rehydration therapy.

The village development center comprises a hail for all immunization and development activities, a demonstration kitchen, a protected well for safe water, a blair toilet, and a demonstration nutrition garden.

Collecting of Data About the Community

Besides the baseline survey, there is a need to enable local leaders to become more aware of conditions in their community and increase awareness of the community's problems facing them. The idea was discussed at a community gathering and a decision was reached that the first information gathering was to be done by the village chairman and his secretary. He would record the mother's name, children's names, date of birth, any deaths in the family, and the causes of the deaths. The chairman would, in turn, report to the Village Health Worker (VHW), who would then record this information in their own record book. Every three months, the VHWs and chairman meet to discuss problems or progress in the health of the people. This feedback is shared every three months at village meetings. In this manner, the community is involved in monitoring and supervising the program. For any problems or recommendations about the program from the community, the health committee member coordinates this communication with the project staff. At the village meetings, it is encouraged that all developmental structures and extension workers be represented since they are all involved in implementing the program.

Community Awareness

In order to encourage the community to utilize its own strengths and resources, community leaders, health committee members, and the project workers meet every

month to discuss implementation, including steps, timetable, division of tasks, and technical assistance. The pace of implementation depends on the community's degree of motivation.

CONCLUSION

Community participation in the project was achieved through contributions of many agents of development--the Ministry of Health, the District Council, the Ministry of Community Development, the Family Planning Council, the dedication of the Musami staff, VHWs, and the community leaders and members in particular.

Lessons Learned

- A community-based health program recognizes the political context and works with the objective of evolving a structure which responds to the needs and priorities of the total community.
- The most important felt need of the community is to control the programs that affect them.
- The program should develop a careful analysis of problems in the context of the socio-political and economic structures, potentials, and use a range of methods to cope with inherent struggles for power.
- The Child Survival program recognized the tension between flexibility and replicability and tries as far as possible to keep a balance between the two.
- Improved health is a means of improving the community's life-style, but is not the only entry for community participation in programs.
- Professionals should teach what they know and others can acquire that knowledge and spread it through the informal sector.
- By having the community take responsibility for its own health, the program played an important role in restoring human values, dignity, and pride in realizing that the people have the ability to carry out their own development with the aid of external funding.
- Evaluation on the part of education and growth processes of the community and community programs recognize their success in how people judge the program and in the evidence of responsible community leadership, which reflects improvements for all groups within the community. The project staff realized that health and development is about people, so they tried hard to find ways of giving people the priority.

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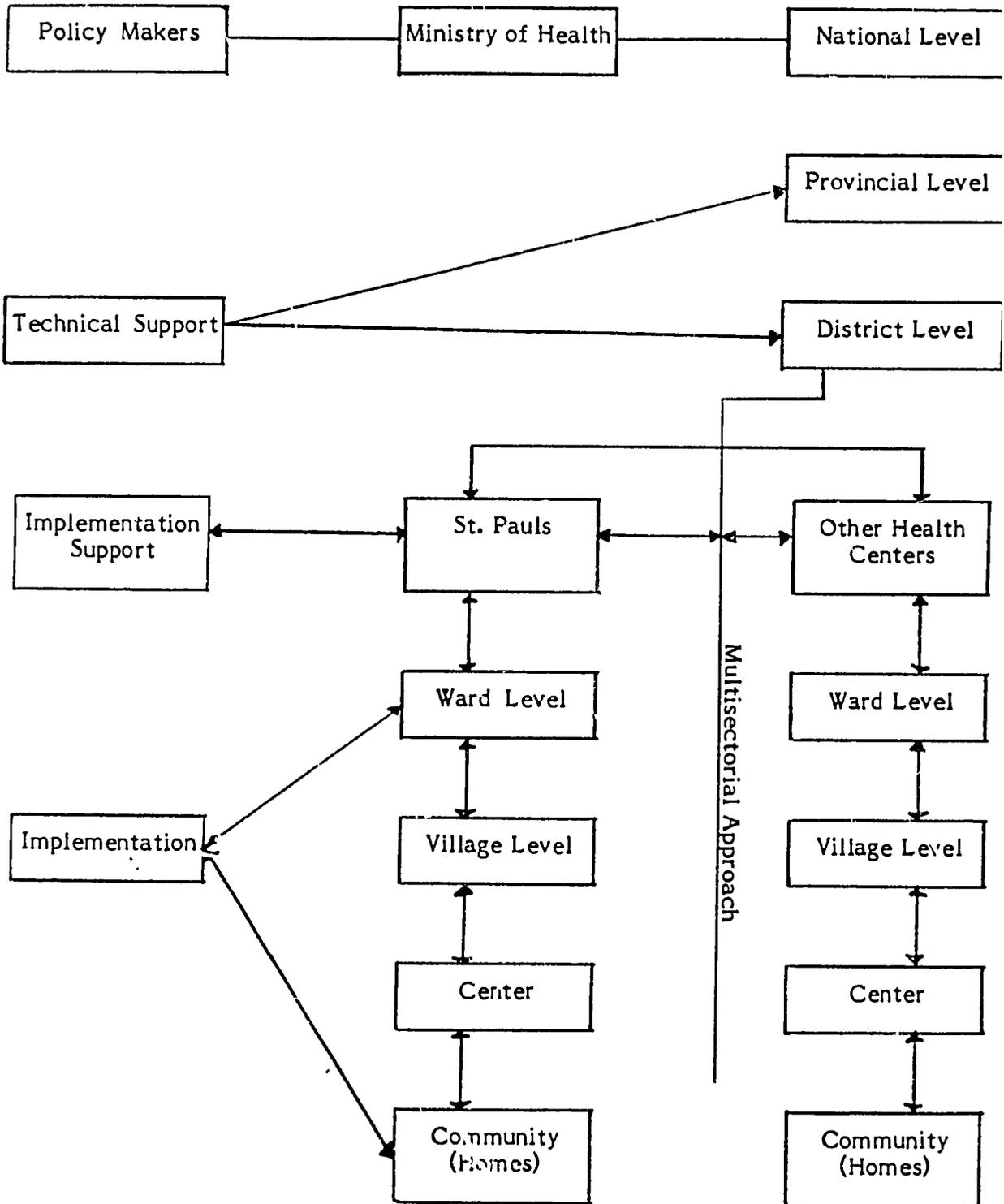
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Annex

Diagram to illustrate structures involved in implementation of the Child Survival project.

DIAGRAM TO ILLUSTRATE STRUCTURES INVOLVED
IN IMPLEMENTATION OF SOCIAL MOBILIZATION



APPENDIX F
PVO STRATEGIES FOR ORT PROGRAMMING, ZIMBABWE WORKSHOP, AUGUST 1987

| Question | AFRICARE Nigeria | AMREF Kenya | SAWSO Kenya | CARE Uganda | WVRO Zimbabwe | WV Sudan | CARE Sudan | SCF Malawi | SCF Sudan | SCF Zimbabwe |
|---|-------------------------|---|--|--|---------------------------------|---|---|--|--|---|
| What are traditional practices for diarrhoea? | Herbal medicine | - Stop feeding - Stop breast-feeding - Give herbs | Roots, leaves of tree, traditional foods | No acceptable single practice known in the country, stop feeding | Herbal drinks, continue feeding | Use of herbs in smoke, stop feeding | - Give local fluids - Soft foods--custard - Smoking - Herb infusions | Use herbs to stop diarrhoea, continue normal feeding | - Stop breast-milk and/or milk - Reduce food - Give rice water, porridge, tea, and lemonade - Caution | Herb mixture for oral administration |
| Total number of mothers you plan to teach? | 15,000 | 5,000 per year | 10,000 | 6,000/year for 3 years | Information not available | 10,000 in 3 years | 10,000 | 3,600 1st year 3,000 2nd year 2,400 3rd year | At least one member from each family be competent in ORS preparation | Total trained by project, about 8,000 mothers |
| Use packet, etc.? Yes/No | Maybe, project produced | Yes (clinic) | Yes | Yes | No packets | Packet, plus homemade | Yes | Both | Yes | No |
| Distributed home and/or clinic | Home/CBW | Clinic | Home & health education sessions | (Aid Post) Clinic | n/a | Clinic sachets in home and clinic | Both | Packets at clinics | Both | n/a |
| Sold/Cost | Do not know yet | -- | Ave: Ks. 2.85; 2.00 for 1 litre; 1.00 for 3.00 m/s | No | n/a | No | No | No | No | n/a |
| Who demonstrates use to mother? | CBW | Community health workers | Health Leader and home league members | V.H.W. & practicing nurses at Aid Post | n/a | MOH nurses, CHW, VHW, volunteers, WV team | Health workers village volunteers, midwives | SCF/project and MOH staff | Health worker, village health agent | V.H. workers |
| Home mix SSS? | Yes | X | Yes | Yes | Yes | X | No | Yes | Yes and No | Yes |

| Question | AFRICARE Nigeria | AMREF Kenya | SAWSO Kenya | CARE Uganda | WVRO Zimbabwe | WV Sudan | CARE Sudan | SCF Malawi | SCF Sudan | SCF Zimbabwe |
|-----------------------------------|--|----------------------|---|--|---|--|--|---|---|---|
| Measuring equipment and formula | Yes | Home available | Kimbo can, 1/2 litre, special spoon, 3 level of side A & B level of salt B side | Tumpeco beer bottles, Rimbo cowboy cup, spoons and fingers | 750ml bottles full of water plus 6 level tsp sugar and 1/2 tsp salt | Tea cup, spoons, hand | Standard measure marked in the home plus packet, six Osman Hussin tea glasses and packet | 10 level Fanta bottle tops, sugar, 1 level top salt, 1 plastic ltr. cont. or 3 full Fanta bottles | 6 Osman Hussin tea cups; small, second & middle finger twice for sugar; 2 pinches of thumb, ring, and middle fingers for salt | 6 level tsp. sugar, 1/2 level tsp. salt, 750 mls boiled water |
| Scarcity of salt, sugar, or water | Scarcity of sugar | No | No scarcity | Yes | Not very scarce | Sugar infrequent, water infrequent | Sugar and water scarcities | Salt - No Sugar - 50% Water - No | Water is scarce in UR district; sugar and salt are available in more than 75% of houses | Less than 5% of population |
| Who demonstrates how to mix? | CBW | CHWs/VHWs | Home league leaders and league members | VHW & nurses | VHW, pre-school teachers | MOH workers, teachers, WV team | Health workers, village volunteers, nurses, midwives | Village health promoters and supervisors | Health worker and village health agent | Village health workers |
| Demonstrated home and/or clinic? | Home and at women's development center | Home & clinic | Home & health education in sessions | Clinic & home | Home clinic | Home & clinic | Both | Packets in clinics, SS in home & craft shelters | Prepared at home | |
| Number of households to a visit | To be determined | 2,500 | 4 in scattered areas, 6-10 in highly populated areas | 4-5 | Varies | 10 houses per visit per day | 5 (projected) | 7,000 | Not yet started | All enrolled families in IA |
| Media/Radio Campaign | Radio | As national exercise | Mass media | Word of mouth from VHW | Not yet common, but by media during special health days | MOH and pilot project by UNICEF using mass media in the project area | Local media posters, flip-charts, loud-speakers, fairs | By Ministry of Health | Radio and face-to-face contact | Yes, by MOH |

Resources for Child Health



A John Snow Foundation Project

REACH

APPENDIX G

ZIMBABWE P.V.O. CHILD SURVIVAL WORKSHOP

August 17-21, 1987

P.V.O. IMMUNIZATION ACTIVITIES

Ten PVO Child Survival Projects participated in the World Vision Zimbabwe 1987 P.V.O. Child Survival Workshop. All of the participating projects were familiar with the basics of EPI; this paper further elaborates on some of the major issues discussed at the workshop.

EPI SESSION DESIGN AND OBJECTIVES

One morning session was scheduled initially to be devoted to EPI, and later a special evening session on immunization coverage surveys was also held at the request of some of the participants. As with other sessions, one of the main goals of the EPI session was to facilitate exchanges between projects and individuals so that they could learn from each other.

There were two major objectives for the E.P.I. session:

- 1) To share and learn ways to attain satisfactory levels of immunization coverage and how to maintain these levels.
- 2) To talk about other issues related to immunization: e.g. nutrition, AIDS.

The morning session, held on Thursday, August 20, began with a rundown on what all the projects were doing in EPI, based on a general EPI activities information chart the projects had filled out. (See annex I.) A special case study was presented by CARE/Sudan, and presentations were then given by the Zimbabwe EPI National Manager and the UNICEF EPI Project Manager on PVO collaboration with Ministries of Health and other donor organizations. The participants then split into small groups to discuss different topics including AIDS and immunization programs; collaboration with national Ministry of Health programs; coverage surveys; and delivery strategies. The respective groups then presented their findings to the larger group, giving them a chance for discussion.

RELATIONS BETWEEN PVOs AND NATIONAL MOHS AND OTHER DONOR GROUPS

The participating PVO projects described a variety of collaborative relationships with national Ministries of Health. As all of the participating projects are involved in some way or another with EPI, coordination of immunization-related activities with national MOHS was a common concern. The need for coordination extends, of course, to other

donor groups, such as UNICEF, and other PVO projects.

As has been stressed before by AID, if a PVO has not already done so, it should establish contacts with MOH programs at the district, regional, and, if possible, the national level. PVOs should establish with the MOH their respective commitments - what will the PVO do, what will the MOH do, when will the MOH begin to take over the activities the PVO is carrying out, etc. This should help to allay some of the concerns that both PVOs and MOHs have about the regularity and sustainability of services provided by the other.

One example of such concerns is the problem of irregular stocks of vaccine. PVOs may complain that the national EPI is not able to supply them with the amounts of vaccine they need when they request it; the MOH may see the problem as one of insufficient lead time in orders from PVOs. Ultimately, the PVO may be able to solve the problem by more advanced planning of vaccine needs.

In some cases, Ministries of Health themselves may have policies for immunization that are different than established international norms. Some national programs are still using DPT and Polio vaccine administration schedules beginning at three months rather than six weeks. Other countries may have, as a national policy immunizing all children under five, rather than the highest risk group of under-ones or under-twos.

PVOs should discuss with national EPIs the use of strategies or schedules different than national norms. In most cases, PVOs will be obliged to adhere to national policies. However, in the case of a country with a target age groups of all under-fives, for example, PVOs may concentrate their communication efforts on getting mothers to bring in under-ones, but vaccinate other children under five years old who come to the vaccination sessions.

PVO projects have unique qualities that enable them to try innovative approaches in delivering vaccinations: they serve relatively small populations and have technical and financial resources available to them that Ministries of Health may not have. As such, they may serve important functions as "testing grounds" for new approaches for national EPIs, provided they operate on a scale that is reproducible.

MONITORING AND EVALUATION

All of the PVOs have to deal with monitoring and evaluation early on in their projects as part of their baseline surveys. Many PVOs will find that their evaluation needs change as their projects mature: once a project is well-established they will want to ascertain whether target disease incidence is falling as would be expected, rather than simply knowing how many doses of vaccine they have delivered.

AID REPORTING REQUIREMENTS FOR EPI

PVO projects are currently only required to supply AID with "Tier I"

data on their projects. However, it is hoped that they will also recognize the usefulness for their own EPI activities of collecting information that fall into "Tier II" and "Tier III" levels, following international EPI norms.

Tier I data includes information on the level of services provided -- how many doses of DPT delivered, how many staff trained, etc., in addition to general project strategy information. The Tier I reporting requirements shouldn't be problematic for PVOs as specific data requirements can be calculated simply by keeping accurate inventory records and vaccination administration tally sheets.

It is very important for all immunization reporting that vaccine doses delivered be categorized according to:

- o the specific vaccine;
- o the number of the dose (ex: DPT I,II, or III,) for DPT, Polio, and TT; and
- o the age group (specifically, <9 months, 9-11 months, 12-23 months, 24-36 months, and so on up to five years old if the target group is that large).

The most important indicators for Tier II in EPI are coverage rates for the vaccines included in the program. The Tier III indicators used most for EPI are morbidity and mortality rates from the target diseases. Most projects will not be able to determine exactly how many children are becoming ill with or dying from the diseases, but they can get a good idea of what these trends are over time if they develop solid disease surveillance systems.

IMMUNIZATION COVERAGE LEVELS

Coverage levels can be estimated both by comparison of doses delivered to total target population and by survey. Both methods are discussed briefly here. Coverage should be determined according to the four criteria noted above for reporting. Also, when doing coverage surveys, information should be collected on the proportion of children who have received the complete series of all the vaccines.

The choice of methods to be used for determining coverage should depend upon the expected level of coverage and the size of the population in question. If a PVO knows that it could not have covered over 10% of a given population, it is not worthwhile for it to do a 30-cluster survey to confirm this. Equally, elaborate survey mechanisms are not needed for relatively small, (under about 30,000 - 50,000) populations.

CALCULATION OF COVERAGE BY DOSES DELIVERED

If a PVO has a family enrollment system, it can calculate relatively easily the the proportion of children in the target age group immunized

| Information | AFRICARE Nigeria | AMREF Kenya | SAWSO Kenya | CARE Uganda | WVRO Zimbabwe | WVRO Sudan | CARE Sudan | SCF-USA Sudan | SCF-USA Malawi |
|--------------------------------------|-------------------------------|----------------------------------|------------------------------|--------------------------------------|------------------|------------------------------|--|--|---------------------|
| Coverage Levels If Known | | | | | | | | | |
| BCG | 7.7% | -- | -- | -- | -- | -- | -- | -- | -- |
| Polio | 4.2% | 70% | -- | 60% | 65% | 50% | 1% | 42% | -- |
| Measles | 5.0% | 50% | -- | 50% | 70% | -- | at base line | 62% | -- |
| DPT | 4.9% | 70% | -- | 60% | 65% | 50% | for all | 42% | -- |
| TT | 74.3% (?) (no card avail.) | only clinic cards held | -- | 70% | 45% | 22% | vaccines | 76% | -- |
| Coverage Determined by | | | | | | | | | |
| Tally Data | -- | Yes | -- | Yes | Yes | -- | -- | Yes | -- |
| Survey | Yes | Yes | -- | -- | n/a | Yes | Yes | Yes (MOH) | -- |
| If Survey Done, What Type? | Stratified cluster survey | Cluster samples | -- | n/a | n/a | Random sample | -- | Sample survey (MOH) | Family enrollment |
| Any Charge for Immunizations? | No | No | No | -- | No | No | No | No | No |
| Training Carried Out? | For survey | For TOFs, TOPs, CHWs, VHWs, RHWs | On immunization and diseases | VHWs staff at Aid Post; CW | Yes | For mothers, VHW, MOH nurses | EPI training for CHWs | Yes | For baseline survey |
| If So, By Whom? | Enumerators, supervisors | AMREF | Coordinators, and trainers | MS RDP staff | MOH | WV staff | MOH | MOH and SCF | Enumerators |
| Media Campaigns Used? | Not yet, but will use radio | Posters, public meetings | Mass media by government | Posters, church, face-to-face by VHW | Posters, radio | Posters | Flip charts, posters, booklets, loud speakers, public meetings | Radio cassettes, posters, community mobilization | MOH |

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APPENDIX H

COORDINATION OF GOVERNMENT, ZEPI AND PRIVATE VOLUNTARY ORGANIZATION

Presented by Mrs. E. Serima, September 20, 1987
Zimbabwe Child Survival Workshop, Murewa

In 1981, the National Health Policy was presented in a document entitled "Planning for Equity in Health." A detailed plan was formulated to establish the Primary Health Care (PHC) system throughout the country. In order to achieve the objective of the plan, the management and administration of health services were decentralized to Provincial and District levels, and re-allocation of resources were made within the health budget. The previously fragmented curative and preventive services were integrated into a health care delivery system, with a focus on the primary level. In recognition of the fact that provision of PHC extends beyond the responsibility of Ministry of Health, intersectoral collaboration was promoted. Popular mobilization, which was part and parcel of the community participation process during the struggle for independence, was advocated and used in the delivery of PHC. Reorientation of health and other staff concerned with the provision of PHC received attention through workshops and reorientation of the pre- and in-service training courses.

Training Centers for Village Health Workers (VHWs) were established in all 55 districts of the country. The training of traditional midwives was also initiated.

Zimbabwe Expanded Program on Immunization (ZEPI)

As an integral part of the Primary Health Care programs, ZEPI was launched in 1982.

The framework of its plan of operation followed the global objectives of reducing illness, disability and death associated with the six target diseases and to improve the overall health of children in Zimbabwe by the year 1990.

The plan called for among the various other issues:

- The improvement in the awareness for immunization requirements by the mothers.
- Integrating ZEPI with other MCH services to provide a "package" to the mother.
- Bringing services closer by increasing outreach services.
- Mobilization of additional resources both within and outside country and from members of the international community, Private Voluntary Organizations, international.

The ZEPI Task Force

To maximize the impact of ZEPI, a broadly based multi-sectoral approach is used to ensure for effective mobilization of political structures; the public service; religious; non-governmental and international organizations; and, particularly, of communities, including leaders and parents themselves. Accordingly, the Intersectoral Task Force was established.

The overall functions of the Task Force are:

- To ensure that the goals, objectives and activities of ZEPI and other Child Survival actions are understood and widely known throughout each member organization's structures.
- To determine how each organization can best support the work of ZEPI and other Child Survival actions.
- To lobby on international, national, provincial, district and local levels, as appropriate, for full participation and support of ZEPI and other Child Survival actions.
- To review the progress of ZEPI and Child Survival programs and to advise on needed adjustments in order to strengthen and improve activities.

Composition of the Task Force:

Government:

Ministry of Health:

MCH Unit
EPI Unit
Health Education Unit
Nutrition Unit
Nursing Services
Epidemiology and Statistics Unit

Ministry of Community Development and Women's Affairs
Ministry of Youth, Sport and Culture
Ministry of Education
Ministry of Information: Zimpapers and ZBC

Local Authorities:

Harare City Health
Chitungwiza City Health

Non-Governmental Organizations:

Red Cross Society
Zimbabwe Association of Church-Related Hospitals (ZACH)
VOICE
Rotary Clubs of Harare

Donor Agencies:

Save the Children Fund (UK)
Save the Children Fund (USA)
SIDA
UNICEF
World Health Organization
World Vision International
AFRICARE

The Task Force is divided into three subcommittees as follows:

Subcommittee on Program Management, Funding and Assessment
Subcommittee on Mass Media, Mobilization of Leaders and Special Events
Subcommittee on the Education and Mobilization of Communities

Functions of the Subcommittees are as follows:

Subcommittee I:

Subcommittee on Program Management, Funding and Assessment:

Task 1

To review and make recommendations on the managerial aspects of ZEPI and its integration with other Child Survival programs to ensure that services are available to all children and women by 1990.

Aspects to review include:

- Vaccination requirements
- The cold chain and logistical system
- Training and deployment of health staff

Task 2

To review the funding requirements of ZEPI and other Child Survival activities to ensure adequate resources are available for all required programs through the following sources:

- Government, at all levels
- Non-Governmental Organizations
- International bodies

Task 3

To ensure that ZEPI and other Child Survival programs are monitored and evaluated with regard to:

- Program management and implementation
- Disease surveillance
- Immunization coverage
- Quality control

Subcommittee II:

Subcommittee on Mass Media, Mobilization of Leaders and Special Events:

Task 1

To review how ZEPI and other Child Survival programs can be given maximum and appropriate coverage in the mass media, and to ensure regular coverage on television, radio, and in national and local newspapers.

Task 2

To identify those leaders who can/need to be coopted to support ZEPI and other Child Survival programs and to ensure their appropriate participation in the activities. Leaders to be considered include:

- Political figures
- Religious personalities
- Traditional and community leaders
- Society and other organization figures
- Union leaders
- Entertainers
- Sportsmen

Task 3

To advise on which special events might best be used to promote ZEPI and other Child Survival programs and what activities are most appropriate. Events to be considered include:

- Fairs
- Internationally and nationally designated days, e.g., World Health Day, International Children's Day, national holidays, etc. . .
- Competitions, such as art, drama, writing, etc. . .

Subcommittee III

Subcommittee on the Education and Mobilization of Communities

Task 1

To review how children and youth can be mobilized to be aware of and to participate in the activities of ZEPI and other Child Survival programs, particularly through organized school activities and youth groups.

Task 2

To review how communities, including mothers and fathers, can best be mobilized in Child Survival measures. The activities of the subcommittee should include recommendations on:

- Appropriate health education
- How to overcome resistance of specific groups, such as fathers, religious groups, etc. . .
- How communities can actively participate in ZEPI and other Child Survival programs

In conclusion, the concerted efforts of a wide range of individuals and organizations are needed to achieve Health for All by the year 2000.

While Ministries of Health can devise plans and strategies and are the mainstay of health services, in practice much activity takes place outside government:

- Aid Agencies
- Private Voluntary Agencies
- Religious bodies
- Charities, etc. . .

. . . are all keen to demonstrate their support by funding Primary Health Care/Child Survival development projects.

The main issue is to ensure coordinated efforts so as to avoid duplication of efforts. Coordination also allows for strengthening and better allocating available resources.

It ensures the beneficiaries full participation and involvement, and enables better appreciation of government policy.

Issues:

1. How necessary is the concept of voluntarism to the success of Primary Health Care?
2. Is the voluntary contribution something unique or can it be reproduced in government and official health systems?
3. Can voluntarism perpetuate existing injustices in society and encourage paternalism, and dependency?
4. Governments are unable to take the risks involved in new and untried approaches. Once developed, however, it will take them over from their pioneers.
5. Governments find it difficult to reproduce some innovative approaches. In generating public sympathy, they may project a distorted picture of the real problem.
6. Once the programs have started, there are pressures to continue them even when they have outlived their usefulness.
7. Ambivalent relationships may develop with non-governmental organizations urging governments to take on new responsibilities, while trying to maintain support for their own activities.
8. Governments can build on the innovative capacities of private voluntary organizations.
9. Facilities of private voluntary organizations need to be integrated at implementation level with those of governments.
10. Governments also have problems:
 - There may be few controls over activities of non-governmental organizations.
 - Their reliability may be in doubt if they do not have long-term plans.
 - Religious bodies may be accused of ulterior motives in promoting health care.

Other coverage survey methods and issues

PVOs should try to assess whether their data collection will need to give them information on their populations that is statistically valid or operationally useful. That is, there are methods other than the 30-cluster method that will give less specific estimates of coverage levels that can still be useful for purposes of project supervision and evaluation.

One project had done a survey of coverage by systematically sampling every seventh household on their target population roster. While the limits of statistical precision aren't well defined for this method, it does take a good cross-section of the population covered and gives a reasonable idea of what coverage is.

Supervisors may use other methods that are even less formal to evaluate if the vaccination system is working as it should. The methods noted below may reveal problems with vaccine delivery, such as whether kids far outside of the target age group are being immunized, or whether abscesses are occurring as a result of vaccinations given.

- o The 100-household survey. This method, developed first in Uganda, simply surveys vaccination status (other health indicators can be included also) of children in the 100 households closest to a health center. It is useful in areas that have been poorly covered by health services, and operates on the presumption that the households closest to a health center are likely to have the best vaccination status. If coverage is poor in these households, one can guess that it may be even worse in areas further away from services. If the health worker from the center participates in the survey, it will also give him a good chance to become better acquainted with conditions in the area he's serving.
- o While visiting health centers under their jurisdiction, supervisors can make systematic spot checks of the vaccination cards of children being brought in not only for vaccinations but for curative care as well. One subgroup of children which can be examined, sometimes with revealing results, are the children of the health workers themselves, who one would expect to be vaccinated. This method is not very useful, however, for getting an idea of coverage levels.

PVOs will need to determine individually what proof of vaccination will be required. Often cards need to be presented as proof; however, it is usually worthwhile getting an oral history of immunization from the child's mother as well. While women may not know the names of specific vaccines, they can often which vaccines a child has received when they are described by site of administration.

The frequency with which coverage surveys are conducted will equally depend upon the individual circumstances of each project. Normally, cluster-sampling surveys are not conducted more often than every year. However, a supervisor may wish to do some sort of spot-check of vaccination cards at most of the sessions he visits.

DISEASE REPORTING SYSTEMS

Because of their strong local presence and often their emphasis on individual registration, PVOs are well positioned to assist Ministries of Health with disease surveillance. Excellent information on establishing "sentinel" disease surveillance systems can be found in the WHO Mid-level Manager course module "Conduct Disease Surveillance".

It is most important to conduct surveillance of measles, polio, and neonatal tetanus cases. Establishing disease surveillance systems will allow PVOs to determine trends for cases and outbreaks of these diseases. This knowledge, in turn, will help them determine if the vaccinations they are giving are actually effective. If outbreaks are occurring in areas thought to be well covered, PVOs will want to conduct simple outbreak investigations to determine if a large proportion of the cases were occurring in children who had been vaccinated, and presumably protected against the disease.

AIDS AND IMMUNIZATION PROGRAMS

African PVO projects need to recognize the implications that the potential presence of the AIDS virus (HIV, or Human Immunodeficiency Virus) has for their immunization activities.

First, to be certain that there is no chance that the disease may be spread through the injection equipment used in their programs, the PVOs need to assure that all injection equipment is sterile. In countries that use disposable syringes and needles, this means using a new needle and syringe for every child, and using each syringe and needle once only. For countries using reusable equipment, this means adequately steam sterilizing or boiling injection equipment for between each use, using the same rule of one sterile needle and syringe for each child.

Secondly, PVOs need to know what current recommendations are for immunizing children who may have clinical AIDS or be infected with HIV, because of the concerns that children infected with the virus should not receive live vaccines. WHO now recommends that the only vaccine which children with clinical AIDS disease should not be given is BCG. All other vaccines should continue to be given to children with the disease, and all vaccines should be given to any children who may be found to be infected with HIV who have not developed clinical AIDS.

These recommendations are different from those for the United States and Europe. The EPI target diseases, because they are so prevalent, pose a

against the different diseases. If a registration system is not used, estimates can be made by determining the total number of doses of each antigen administered by age (by compiling the totals of daily tally sheets used in areas where the coverage will be calculated) and comparing this to the estimated target population for the same time period. As a rule of thumb, under-ones make up about 4% of the total population in developing countries with high birth rates.

There are two main difficulties with this method. First, the target population estimates may not be accurate, particularly if a census has not been conducted in many years. A second problem is knowing the ages at which children received their vaccinations. If this information is not available, for example, in an area where all children under two years old are vaccinated, one will not be able to determine what proportion of the vaccinations had been given to children three months compared to those given to children 23 months old.

This method works best in rural areas where the population live in discreet village units, and tend to be vaccinated near where they live. It is less applicable to crowded urban areas where mothers may take their children to be vaccinated in clinics outside of the administrative unit that they live in.

COVERAGE SURVEYS

Coverage evaluations were a major area of concern and thus are covered in some detail here. During the workshop evening session on coverage surveys the issues raised by participants showed that they were clearly tuned to the issues that district-level programs are struggling with everywhere: appropriate sampling methodologies and questionnaire design; frequency with which surveys should be conducted; analysis of results and computerization; determining tetanus toxoid coverage; and reconciling differences with national immunization coverage evaluation practices.

The first time many of the projects will have to deal with coverage surveys is when they develop their baseline surveys. Most PVO projects will want to evaluate what baseline coverage levels are in the areas where they will be working so they can assess the contribution of their efforts. One exception might be if a PVO planned to vaccinate in an area not previously served by any vaccination services. In such a case, the PVO might reasonably assume that coverage was close to zero to avoid the expense and effort of doing a survey to confirm it.

As part of their collaborative efforts with national Ministries, PVOs should be aware of their EPI evaluation activities, if any, going on at the regional or national level.

Questionnaire forms

In designing their general survey questionnaires PVOs should keep in mind that no piece of information should be collected unless it is going to be used. A PVO may wish to have a two-stage survey strategy, where most mothers interviewed would answer a few questions determined to be most important, and every 10th mother would be selected for a more detailed

questionnaire concerning, for example, her attitudes towards immunization.

Cluster sampling surveys

Several of the participants knew about or had used the standard E.P.I. cluster sampling method. It is important to know when this method is useful and what its limitations are. When used correctly, it can estimate the coverage in an area to within ten percentage points above or below the actual rate.

Cluster surveys can also yield a wealth of information on the ages that children are vaccinated at, the length of time that passes between doses, and so on. While summarizing such information by hand is very tedious, computer programs are being developed which will perform these calculations automatically.

A 30-cluster survey usually takes 3-4 surveyors at least 2 weeks to complete. This should be taken into consideration when determining whether or not it should be used.

It is designed to be used for relatively large populations, say, over 50,000 and is used most efficiently for populations over 200,000. While it can be used for smaller population groups, it is somewhat inefficient because of the large numbers of children that have to be interviewed.

This can be illustrated by taking a hypothetical example of a population of 20,000. We can assume that about 4%, or 800, of the population will be children under one, the main target age group. A 30-cluster survey reviews the vaccination status of 210 children. If children 12-23 months were interviewed (with a population of slightly less than 800), this means that over one out of every four children in the target population (210/800) would be interviewed. If a smaller age group were interviewed, say 12-17 months, over half of those in that age group would have to be interviewed.

Doing a standard EPI cluster-sampling survey gives a good estimate of what coverage is for the children of that total population. It will not allow projects to compare coverage levels between areas surveyed for the different clusters. Also, the cluster-sampling method is only designed to be used for dichotomous data, meaning questions that can only be answered by one of two possible answers. Thus, it will allow PVOs to determine by a statistically valid method only if, for example, more children have been vaccinated at an outreach post than have not been vaccinated at an outreach post. It does not permit the statistical comparison of numbers of children vaccinated at an outreach post versus an MCH center versus a hospital versus not vaccinated at all.

Tetanus toxoid coverage has often not been conducted along with evaluation of childhood immunizations, but it should be included in cluster-sampling surveys by interviewing the mothers of children in the age group interviewed. Of course, there may be other women of childbearing age that won't be interviewed simply because they don't have children in that age group - but it will should a reasonable estimate of T.T. coverage nevertheless.

- Private voluntary organizations may flourish, or seem to flourish, while government services struggle to gain credibility.
- Establishment of coordinating bodies (VOICE) for joint planning is crucial.
- There can be conflicts between the real needs of the people and health workers and those of private voluntary organizations.

Finally, there is a need to consider the role of private voluntary organizations in primary health. Will they diminish, become institutionalized, or will there always be unmet needs that call for outside assistance.

Some Community Awareness Activities in ZEPI

1. Mass media channels
 - Radio programs
 - Television programs (features and interviews)
 - Newspapers and magazine articles
2. Use of community leaders
 - Politicians
 - Religious leaders
 - Associations and organizations
 - Others
3. Production of literature
 - Pamphlets
 - Posters
 - Calendars
 - Slogan discs
4. Production of ZEPI Film/Videos, etc.
5. Use of school children
 - Quizzes
 - Competitions in:
 - Drama
 - Music
 - Poetry
6. Use of community theatre groups for drama and song.
7. Legislation of immunizations as requirement into preschool/schools.
8. Immunizations awareness weeks.
9. Information stands at agricultural shows, international trade fairs and other major community events.

APPENDIX I

HOW TO ACHIEVE A SATISFACTORY LEVEL OF IMMUNIZATION COVERAGE AND SUSTAIN IT

Paper prepared by Dr. M. O. Alli, Project Officer EPI/CSD
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1.0 INTRODUCTION

The "UCI 1990 goal UN Banner" is being adopted by most NGOs under the umbrella of Child Survival and Development program. Through CSD, it will be ensured that it is not only the childhood deaths from immunizable diseases that will be prevented, but also deaths that would have occurred due to diarrhoeal diseases, acute respiratory infections, malaria and malnutrition. For most developing countries, real progress has been made in immunizing the children. For example, WHO July 1986 data has shown that the following deaths from EPI target diseases have been prevented: Of 2,110,000 deaths from measles, 371,000 were prevented, i.e., 17 percent; of 839,000 deaths from tetanus, 132,000 were prevented, i.e., 16 percent; of 599,000 child deaths from pertussis, 228,000 were prevented, i.e., 38 percent; and of a total of 3,548,000 deaths from vaccine-preventable diseases, 731,000 were prevented by immunization, i.e., 21 percent. But there is a lot more to be done to reach the goal; for example, recent lameness surveys in developing countries have revealed previously unsuspected high levels of crippling polio comparable to those of the worst epidemics in industrialized countries before the development of vaccines. **The challenge is to raise immunization coverage levels to the point where significant reduction in morbidity and mortality can be sustained. This is the UCI goal.**

2.0 FACING THE CHALLENGE OF UCI 1990

2.1 Intensive mobilization.

2.2 Political will.

2.3 Application of new techniques of Communication and Social Mobilization

2.4 Sustained application of the management support required to transform that mobilization into effective programs. The provision of management support remains a high priority objective and a frequently difficult problem. However, the recognition of the problems and opportunities presented by accelerated or intensified immunization activities is itself a useful tool in the provision of management support and should be explored.

3.0 ACCELERATED PROGRAMMING FOR IMMUNIZATION

3.1 The objective should be national fiscal and technical self-sufficiency beyond 1990. The initial efforts should be successful enough and lead to a sustained improvement in immunization services. The planning should be based on what you need, not what you have, e.g., using police cars to distribute vaccines where there are no EPI vehicles.

3.2 Campaigns should be used as a means, not an end. Therefore, one campaign may not be enough. There should be plans for follow-up campaigns up to 1990 and beyond. As a matter of fact, a year-to-year sustained campaign, e.g., in the form of an Annual EPI Awareness Week should be complementary to what is going on. It serves as a "kick" or "boost" once a year to routine services. But it should have a measurable objective. For example:

- * To get at measles morbidity and ensure more nine-month olds receive measles vaccination.
- * To correct constraints why field staff are not functioning properly.
- * To reduce risk of injection, associated with AIDS transmission, through emphasis on steam sterilization.

Also, for a campaign to effectively contribute to an increase in vaccination coverage and ultimately a reduction in disease and death levels, there may be a need to establish extra temporary immunization sites and make use of "extra vaccinators" during the period. After the campaign, it may become necessary for such temporary sites to become permanent, depending on the work load achieved during the campaign.

Every country program should be able to determine under what circumstances a campaign is not an appropriate strategy. For example, KAP surveys on choice of communication channels by population strata should be done, including focus group discussions before messages are developed. Audience habit surveys should be done so that broadcast is at the right time. Messages should also be transmitted through the right media by rural, semi-urban, and urban groups.

During a campaign week, the program should be able to match supply with demand and be able to document that demand has actually increased based on how the supply was used. A Social Mobilization Analysis survey is mandatory for each country. The survey includes a KAP, Focus Group Research (FGR), audience stratification, and a media habit survey. The results of the survey will be used to determine messages and delivery channels. Also, through the results of a Social Mobilization Analysis Survey, it will be possible to stratify the society to identify sub-group specific knowledge, attitudes and practices and deeply held beliefs in relation to EPI. For each belief, knowledge gap etc., a specific message is prepared. The message is then delivered through a source of credible health information for each sub-group.

Education is a tool for sustaining immunization coverage. It helps mothers seek immunization voluntarily.

Pretesting messages is essential before they are disseminated. It may be advisable to impact Pretest messages while preparing them FGR. Based on results of the FGR, it may be necessary to revise and pretest again. The advice to never mass produce messages, until successfully pretested, has not been heeded by most programs.

4.0 NON-MEDIA SOCIAL MOBILIZATION

4.1 Channeling for Acceleration

This strategy sorts out the denominator for each vaccine through house-to-house enumeration of the target group. It provides a good introduction of the program. However, immunization progresses slowly without an occasional "boost," like a campaign.

5.0 FOLLOW-UP TO THE EPI WEEK/CAMPAIGN

Programs should concentrate on the need for sustainability. Other CSD interventions should be addressed with emphasis on PREVENTION.

Health workers continuously should stress the specific and concrete actions that parents themselves can take to promote the survival and development of their children.

The Inter-relationship between malnutrition, diarrhoea and vaccine preventable diseases should be highlighted. The MCH-PHC staff in charge of immunization should contribute further to the development of community-based nutrition surveillance and growth monitoring, e.g., through provision of VHWs with scales and by their training. Also efforts for the identification of high-risk groups should be intensified, e.g., through community inquiries and by regular weighings.

6.0 WAYS TO ACHIEVE SATISFACTORY LEVELS

6.1 On the Supply Side: Improvement of Routine Services

6.1.1 Identification of personnel (MCH/PHC workers).

6.1.2 Training (EPI-PHC Integrated Workshops).

Training workshops should address the identified training needs as to why field staff are not working well.

6.1.3 Supervision and support for Peripheral staff.

Important prerequisite to supervision is Communication i.e. wherever there are problems, the solutions, in the form of information or supplies, must be given immediately.

Exercise: EPI Acceleration on the Field (List the Problems and Possible Solutions)

Problem

(from the field)

Solution

(from the supervisory level)

6.2 On the Demand Side: Improvement of Consumption of Public Demand

6.2.1 Meticulous Planning

6.2.2 Ample lead time

6.2.3 Evaluation of Effectiveness of Social Mobilization Activities

7.0 EXERCISE

7.1 Questionnaire to Mothers Attending Vaccination Session

Question: How did you know about Immunization?

Channels of Communication

| Sub-group | Non-Health worker (specify) | Radio | TV | Agric Show | Health Worker at home | Health Facility | Health worker in community |
|---------------------------------|-----------------------------|-------|----|------------|-----------------------|-----------------|----------------------------|
| Mothers Attending | | | | | | | |
| Mothers Not Attending (control) | | | | | | | |

7.2 Men have been identified as a group whose support is needed to assure participation of women in Family Planning.

- What are the information needs? (i.e. messages)
- What are the most effective ways of presenting that message to this group (i.e., the means)
- What is the medium for providing that message (i.e., the materials).

7.3 How to use Social Mobilization to cause a measurable change.

7.4 Non-media Social Mobilization

8.0 ROLE OF NGOS IN ACCELERATING IMMUNIZATION

8.1 Where NGOs have impacted areas, it provides a learning ground. Appropriate technologies and strategies can be implemented quickly and successes spelled out. Experiences can be shared quickly and suggestions for corrections tried out. This positive aspect of impact areas are seen when sustainability is assured.

8.2 Selective and Comprehensive Health Care:

Through NGOs it can be illustrated how selective health care complements comprehensive health care, and that they are not alternatives. This positive aspect of selective health care is seen where there are prospects of expansion.

It has been suggested to compare surveys of districts where NGOs are, with districts where there are no NGOs, to highlight the positivity of selective health care.

8.3 Monitoring and Evaluation

Many NGOs have assisted with the development of a more accurate health information system in their impact areas e.g. family enrollments have been used to establish an accurate denominator.

3.4 Community-based Growth Monitoring and Nutrition Surveillance

NGOs have used VHWs/CHWs for weighing children and have acquired much experience in this area which should be shared for universal use.

3.5 ORT

There is a dire need to improve ORT at home, community and health facility levels, especially where SSS is used as an alternative to the complete ORS formula for the management of diarrhea. Mothers, community health workers, and the rest of the health team need to be retrained to correctly manage a child with diarrhoea by using the WHO Diarrhoea Treatment Plans A,B, and C.

REFERENCES

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2. "Analysis of Social Mobilization as it relates to achieving national UCI/ORT targets in Zimbabwe towards the development of a Regional Framework for Program Communication/Social Mobilization 1987-90", Paper by UNICEF, Harare, February, 1987.

APPENDIX J

**90-DAY ACTION PLANS
OF PARTICIPANTS**

**CARE - SUDAN
90-DAY PLAN OF ACTION
August 21, 1987**

MONITORING AND EVALUATION

- Objectives:**
1. Determine coverage of EPI in target area operational for six months.
 2. Baseline ORT survey.

Field Teams

Who: NKCHP/EPI (CARE personnel from other projects)
Two teams of three: two males and one female

| When: | | Person Responsible: |
|---|----------------------|-------------------------------------|
| 1. Development of survey tools and MOH checking | Sept./Beginning Oct. | Cat & Osheria Carol (Consultant) |
| 2. Training of surveyors | October | MOH Cat & Osheria |
| 3. Survey | Two weeks in October | NKCHP/EPI |
| 4. Analysis & Reporting | November | Cat, Osheria & New PM |
| 5. Feedback to MOH & Communities | | |

SAVE THE CHILDREN FEDERATION - ZIMBABWE
90-DAY PLAN OF ACTION
August 21, 1987

| <u>Objective</u> | <u>Task/What</u> | <u>Activity</u> | <u>When</u> |
|---|--|---|----------------|
| Develop working relationship with other PVOs Zimbabwe & MOH (On CS implementation). | 1. Explain need for liaison with other PVOs to SCF FOD and Headquarters. | Request for permission from SCF ZimSave and Headquarters. | September 1987 |
| | 2. Communicate plan of action to PVOs concerned. | Plan together with other PVOs for a MOH meeting. | October 1987 |
| | 3. Plan regular meeting for CS staff. | Other meetings | November 1987 |

**AMREF - KENYA
90-DAY PLAN OF ACTION
August 21, 1987**

**MONITORING AND EVALUATION
Urban Nairobi: Basic Survey**

Problem: Basic survey to lay basis for monitoring and evaluation.

What to Do:

Sample survey of project area covering all the indicators stated in CSD project.

- Immunization coverage
- Nutritional status of the under fives
- Diarrhoeal morbidity among under fives
- Child spacing

Tasks: Time Plan

Planning:

- Week 1-4 (a) Develop questionnaire and pre-test it.
(b) Prepare the community
(c) Arrange for funds
(d) Arrange for transport
- Week 5-6 Plan and train personnel (enumerators)
- Week 7-8 Carry out survey
- Week 9-12 Carry out analysis and reporting
- Week 13 Feedback workshop to the community

Budget

| | | |
|-------------------------|------|-----------------------------|
| Printing questionnaire | Ksh. | 5,000 |
| Training of enumerators | Ksh. | 10,000 |
| Preparing community | Ksh. | 3,000 |
| The survey | Ksh. | 15,000 |
| Analysis | Ksh. | 30,000 |
| Reporting | Ksh. | 1,000 |
| Feedback workshop | Ksh. | <u>12,000</u> |
| Total Cost | | <u><u>76,000</u></u> |

SAWSO - KENYA
90-DAY PLAN OF ACTION
August 21, 1987

THREE MONTH CALENDAR

August

- 26th, 27th - Seminar Vitamin A
- 31st - Preparation for training

September

- 4th - Growth Monitoring Training Leaders
- 8th-11th - CoRat Workshop NRBI
- (Ukalaani, Mitaboni Mikono)
- 14th-18th - Supervision and Monitoring office work
- 21st-26th - Office work and report evaluation
- 28th-
- 2nd Oct. - Preparations for family planning leaders

October

- 2nd-11th - Making contacts NCKK, APAK, MOH, USAID, AMREF (training starts October 11th)

- 17th - Leaders training FP and ANC
- 19th-26th - Training report writing
- 30th - Monthly report writing

**CARE - UGANDA
90-DAY PLAN OF ACTION
August 21, 1987**

| <u>Activity</u> | <u>By</u> | <u>Indicator</u> |
|--|--|--|
| Selection of VHW and CWs in ten project areas | Communities | - Get names of selected people |
| Baseline survey | The selected VHWs and CW supervised by MSRDP staff | - Results from all ten project areas |
| Train 20 VHW & 10 CW in in project areas | MSRDP staff | - 20 VHW, 10 CW (people trained) |
| Immunizations/ | MSRDP staff | - No. of children |
| Nutrition education/ | Nurses in charge of aid/ Post CW & VHW | - No. of mothers receiving nutrition education |
| Oral Rehydration Therapy | | - No. of mothers who know and use ORS correctly. |
| Acquire EPI equipment (cold chain and immunization kits) | DMOs from UNICEF | - Equipment acquired - Equipment delivered |
| Distribute EPI equipment | MSRDP | - Equipment delivered |
| Supervise work of VHW & CW | Staff Aid Pos | - Monthly reports |
| Supervise work of nurses | Community Development Committee | - Report written monthly - Number of monthly meetings |
| Monthly meetings with other PVOs & MOH | MSRDP & PVO & MOH (DMOs) | |

CARE - UGANDA
 90-DAY PLAN OF ACTION GANTT CHART
 August 21, 1987

CARE/Uganda Summary of Work Plan

| Tasks | September | | | | | October | | | | | November | | | | | | |
|---|----------------------|-------|--|--------|----------------------|----------------------|--|--|--|--|----------|--|--|--|--|--|--|
| Selection of CWs & VHWs | XXXXXX | | | | | | | | | | | | | | | | |
| Baseline Survey (level of immunization ORS KAP) | | XXXXX | | | | | | | | | | | | | | | |
| Training VHW & CW | | | | XXXXXX | | | | | | | | | | | | | |
| Acquire equipment | XXXXXXXXXXXXXXXXXXXX | | | | | | | | | | | | | | | | |
| Distribute equipment | | | | | XXXXXXXXXXXX | | | | | | | | | | | | |
| Immunize & HEd. | | | | | | XXXXXXXXXXXXXXXXXXXX | | | | | | | | | | | |
| Supervise CWs | | | | XXXXX | XXXXXXXXXXXXXXXXXXXX | | | | | | | | | | | | |
| Supervise Nurses | XXXXXXXXXXXXXXXXXXXX | | | | XXXXXXXXXXXXXXXXXXXX | | | | | | | | | | | | |

9-C

AFRICARE - NIGERIA
90-DAY PLAN OF ACTION
August 21, 1987

| October | November | December |
|--|---|---|
| 1. Training CBWs/ PU staff (A, B, C, F, G, L, N) | Finance/Accounting system transferred locally (A, B, C) (A, B, C, D, E, L, T) Liaison for measles campaign (A, B, C, L) | Measles campaign conducted in four intervention communities |
| 2. • Training CBWs/PU staff (A, B, C, F, G, L, N) • CBW kit boxes, growth monitor ring charts distributed (M, Q, L) • Training and evaluation (A, B, G, L) | Planning week for measles campaign (A, B, C, G, M, L) | |
| 3. Trial production on license (A, P, L) Agreement signed with WA (A, K, S, T) | Logistic/media development for measles campaign (A, B, C, I, O, K, T) CBWs EPI promotion (I) | Tabulation/analysis of measles campaign (A, B, C, L) |
| 4. CBW begin activities: distribute/ promote (D, E, I) CBPS continue promotion Financial reporting (A, B, C) | Data collection from CBWs (D, E, J) This activity carried on to December | Prepare report on campaign (B, A) Review acceptability of WS (C, D, E) |

Persons Responsible

| | | | |
|--------------------------------|------------------------|--------------|--------------|
| A. Project Manager | F. Trainer | K. CCC | P. FI |
| B. Project Advisor | G. Consultants (local) | L. SMOH | Q. AFR/WASH |
| C. Administrative Assistant | H. Consultants (Int'l) | M. UNICEF | R. AFR/Lagos |
| D. Site Manager | I. CBWs | N. MA/ISADAP | S. W.A. |
| E. Assistant Site Manager | J. CBPs | O. MI | T. LGA |

SAVE THE CHILDREN FEDERATION (USA) - MALAWI
90-DAY PLAN OF ACTION
August 21, 1987

Data Collection on Time

- Reviewing daily completed family enrollment forms
- Number of villages covered by four weeks

Evaluation

- Quality of data
- Methods used to analyze the data

Training of Trainers (Supervisors)

- Methods of training of VH promoters, families and H. committee
- Supervision techniques
- Growth monitoring, ORT (control of diarrhoeal diseases)
- Identification of malaria management and treatment
- E.T.C.

Work Out Supervision Schedule

- Supervision of enumerators
- Supervision of supervisors and VH promoters
- Supervision and discussions with area development committee and H. committee

Networking

- Further discussions with MOH and PHAM regarding program implementation
- Areas of concerns and switch sustainability of program activities
- Discussions at regional level on improvement of vaccine delivery and other supplies
- Discussions with health centre staff
- Discussions with community services and party officials on improvement of community mobilization
- Discussions & Ministry of Agriculture

Others

- Data analysis
- Developing and monitoring of tools, rosters and other records
- Distribution of bicycles, equipment for growth monitoring, simple drugs (e.g., chloroquine, eye ointment, etc.)

WORLD VISION - ZIMBABWE
90-DAY PLAN OF ACTION
August 21, 1987

| Who | When | What |
|--|----------------------------|--|
| Child Survival staff S.M. J.N. E.T. S.R.F. | 1/9/87 to 4/9/87 | Review monitoring and evaluation tool FRB |
| CSP Staff S.M. J.N. E.T. S.R.F. | 7/9/87 to 14/9/87 | Analyze data from one village |
| CSP Staff | 21/9/87 | Review results |
| CSP Staff S.M. J.N. E.T. S.R.F. | 28/9/87 to 9/10/87 | Planning for reimple- mentation training |
| CSP Staff J.N. E.T. S.R.F. Others | 12/10/87 to 6/11/87 | Re-implementation |
| CSP Staff | 10/11/87 to 13/11/87 | Come back and analyze |
| CSP Staff | 17/11/87 to 20/11/87 | Plan to implement in whole project area |
| CSP Staff | 23 to 25/11/87 | Train implementors |
| CSP Staff to Sr. Hove and MOH staff | 30/11/87 | Implement in whole pro- ject area |

**WORLD VISION - SUDAN
90-DAY PLAN OF ACTION
August 21, 1987**

| CSP World Vision Sudan | Activities | Accountability | Schedule |
|------------------------|--|------------------------------------|------------|
| September | - Information System: Using VH volunteers | Senior area coordinator | Sept. 1-14 |
| | - Weekly events information/birth/deaths, etc. | | |
| | - Annual report | All tech staff | 1-30 |
| | - Monitoring home visitors "drop-outs" | Area coordinator/nurse | 1-30 |
| | - Visit WHO centre (T.O.T.) to gain information on curriculum | All tech staff | 25-30 |
| | - Introduce microcomputer | PR manager | 1-30 |
| 3-10 October | - Develop special messages for all interventions | Medical consultant Nutritionist | 1-14 |
| | - Child Survival Training Manual for Health Educators | Medical consultant (PR Manager) | 14-30 |
| | - Meeting with MOH Topics: sustainability sharing DIP (detailed implementation plan) | All medical staff | 1-3 |
| November | - Interagency meeting - SCF/CARE/WVI | PR manager | 10-14 |
| | - Review evaluation methodologies | Medical consultants SAC | 14-25 |
| | - Health day for increasing awareness Tanbone Town | Medical consultant | 14-25 |
| | - Rural hospital est. ORT coverage | All staff All area coordinators | 14-25 |

APPENDIX K

ZIMBABWE CHILD SURVIVAL DAILY EVALUATION

The following are notes from the participants' actual evaluation forms.

AUGUST 17, 1987 - EVALUATION

What I learned today:

1. That the majority of the participant countries use and prefer to use SSS instead of the UNICEF sachet (ORS). Zimbabwe has a very strong SSS strategy.
2. Activities of various PVOs in other countries; concerns on problems related to Child Survival are more or less the same everywhere, such as monitoring and evaluation, sustainability, logistics, supervision, follow-up, and community participation.
3. Need for coordination between PVOs and MOH to ensure program sustainability; other tools for monitoring and evaluating program activities; concepts related to ORT (preparation and administration); concerns in a CS program and ways of monitoring them.
4. My Zimbabwean friends have managed to do without UNICEF packets and have done well with just SSS; there is a missing link in supervision of village health workers and nurses in our program; in planning projects, everybody, especially the communities and MOH, should be involved early.
5. Child Survival programs can be sustainable if they are designed to operate within the PHC of the government; involving the government in project design will ensure its continuation; project supervision forms a continuous monitoring system; supervision checklist can assist on feedback.
6. ORT in different measures.
7. Different immunization schedules; promotion of home-available solutions for ORT; differences in information depicted in CHC of the different countries; skills of mobilizing and motivating the community.

Things I will therefore do differently in the project:

1. Making the flip-chart posters into small booklets or leaflets, having the same sequence as the health education story.
2. Work hand-in-hand with the MOH and the PVOs; meet the committee members in the community and make them advisers in implementing plans; know the priorities; involve the MOH when starting a project.
3. Develop and strengthen monitoring and evaluation system.
4. Reassess marketing system before implementation; redefine organizational management roles within projects; collaborate more intimately with MOH during implementation phase; adjust monitoring instrument based on overall project objectives.

5. Still too early at this point in my project to suggest changes.
6. Will try to use SSS exclusively in some project areas and compare with where both SSS and UNICEF packets will be used; we will try to get a representative from our level in every community development committee to provide the missing link; keep ears and eyes open to acquire useful knowledge that will help us achieve a reasonable degree of acceptable supervision; evaluating and monitoring our program.
7. Continue using non-health team for close supervision.
8. Foster closer liaison with MOH and other agencies at all levels of program activities.
9. CS in urban Nairobi is a new project, so what I learned will help me in planning, organizing, and implementing my strategies better; I have involved MOH and Nairobi City Commission staff of all levels in all the stages of the program implementation.
10. Encourage community to go to MOH for follow-up; make sure link with MOH and other management lines are going to be improved; review home-mixed solution approach.
11. Evaluation of ORS effectiveness.

I would like to receive follow-up information on:

1. Monitoring and evaluation, principles of social mobilization, principles of growth monitoring, ways of assessing quality of ORT in the home, monitoring and maintaining of cold chain system.
2. Sustainability of projects; planning, implementation and monitoring of Child Survival programs.
3. Attend similar workshops in other countries to be kept up-to-date with latest concepts, ideas, and experiences in community-base health projects.
4. The relation of monitoring and evaluation system in CS projects.
5. Sustainability of the program in the urban set-up; how to keep urban communities motivated.
6. What steps other NGO-operated programs are taking to ensure post-funding, uninterrupted sustainability.
7. Outcomes of problem-solving process in other Child Survival projects.
8. The exclusive use of SSS in Zimbabwe as their program advances.
9. More income-generating schemes for financing CS interventions.
10. Immunization coverage from VHW using baseline survey; maintenance of cold chain.
11. ORT strategies in other countries.

12. What to do with impossible noncompliance of partners, e.g., MOH reaction to participants' (and self) request on workshops and experience visits.

AUGUST 18, 1987

What I learned today:

1. A case study of social mobilization in Zimbabwe; learned about the intervention that goes on in the country; how organized the community is; and all the qualities that we can take back to our projects.
2. Music/songs and dance as communicative media; strong relationship of project to the community; potential/concerns for sustainability of project at Mushinga.
3. Social mobilization develops gradually and evolves mainly based on the felt need; each country has "chances" to start and strengthen social mobilization. It is a matter of looking for them; baseline survey helps communities to view themselves and thus easily grasp the need for the program being introduced to them.
4. Community participation and togetherness--structure network; awareness of preschool children's needs.
5. Visited the Pfende Center; the community was well motivated; role plays from the community concerning health; community participation and togetherness.
6. Not to have other plans after visiting a project; fish farming and nutrition gardens in projects; to plant fast-growing trees as potential sources of firewood.
7. Social mobilization, a tool for Child Survival projects' sustainability; integration of CS activities into community development; involvement of PVO in order to achieve CS goals.
8. Shared ways and methods of community mobilization; observed outcomes of community mobilization and participation; linkages in Child Survival.
9. Active community interaction and participation in doing activities together; strong feel of commitment and feeling of ownership; active participation and involvement of PVOs, the community and the MOH.
10. Good working relationship exists between World Vision and existing local authorities (VIDECS) and other relevant ministry bodies. It is important to involve communities--participation from the planning stage of programs to the end including monitoring and evaluation.
11. Historical factors can have far-reaching effects on mobilizing and motivating the people to do something for themselves.
12. Working together with social, political, and religious groups; high motivation shown by the community; integration of different sectors; appropriate technology.
13. Zimbabwe's love for song; communities similar to other countries in their organizational skills--women playing greater role.

14. Planned integration of sectorial development: HW automatically member of village committees; involvement of community in baseline; Blair or VIP toilets and hand pumps; enthusiastic use of slogans and songs about health.
15. The more the community knows about health messages and policy of work, the more they will be involved in project planning and implementation.
16. Achievements seen in enthusiastic community; importance of political system in mobilization; cultural factors play a role in mobilization.
17. A well-motivated community; encouraging to see community participation working; importance of community involvement in monitoring and evaluating; relationship between political support and health services (very well organized in Zimbabwe); computer system sharing.
18. Community activities and cooperation; their devotion for knowing what they are doing; plans of their future.
19. Process of social mobilization in Zimbabwe; shared in a discussion on a study case of Musami mission; structure of MOH in Zimbabwe and how it functions and integrates with NGOs and WV.

Things I will therefore do differently in the project:

1. Will involve agricultural extension offices more to increase food yields in the project area.
2. Using masses' language to understand; to allow my community or project members to go home in time; to have a short program aimed only at the goal.
3. Encourage community participation in one project; think about ways to involve community in monitoring and evaluation.
4. Supervision; coordination of community structure.
5. Strengthening the health education system to achieve more involvement and more knowledge about the project.
6. Follow up suggestions to MOH about planned regional health committee; may try to have communities do self-assessment/baseline.
7. Conduct some more meetings with MOH from headquarters/regional/district level; socialize with the community---be part of the community.
8. Adequate water supply; technical support of the techniques to some; motivation of the CHW.
9. Strengthen the existing committees so that they can take on more responsibilities and activities.
10. Increase level of village health officers (MOH).
11. Continuously be available to dialogue with the community until we achieve such a high level of motivation; will persistently involve other PVOs and MOH more than before.

12. Strengthen community mobilization and organization; strengthen linkages in Child Survival.
13. Involve the community; committees for development for the success of my project.
14. Involve as many preschools on center; build health center near project.
15. Motive the community and foster the relationship with World Vision; make community share responsibility for the development process; involve school children as much as possible.
16. I hope to be patient with the communities whenever they appear to be "disinterested"; be on the lookout for a chance to woo the communities into social cooperation; encourage village health workers to do a survey relating to their "own interest" other than "our own interest."
17. Consider other appropriate technology, e.g., earth cook stoves, income-generating cottage industries as soap making, fish ponds, etc.
18. Increase my mobilization techniques; include preschool education or childcare center to my project if funds permit.

I would like to receive follow-up information on other comments:

1. How World Vision supplements the salaries of VHWs.
2. Mushinga VDC should have access to information on the alternatives proposed by World Vision.
3. Baseline surveys.
4. The MOH to put curative services nearer to the people; planting fruit trees; and improve cooking facilities.
5. MOH to provide curative center near CSP area.
6. How to sustain community motivation for participation and how to ensure project sustainability.
7. More information on urban mobilization.
8. All the information written down on newsprint paper must be typed and given to all participants every morning or before the end of the workshop.
9. The effects on people's enthusiasm for the activities when the WVI assistance phases out.
10. Who supervises whom? Village committees meetings; how the village committees solve their problems.
11. Principles on social mobilization.
12. Income generating incentives for "motivation of communities" and payment of CHWs.

13. The field trip took a long time--can we manage two more this week?
14. Identification of weakness should be in relation to what aspect in the project?
15. Mass media and social mobilization.
16. Using computers.
17. This is difficult because it involves individual countries and a lot of traditions and beliefs and political set-ups. I suggest that what has been tried elsewhere and seen to work may be given preference.

AUGUST 19, 1987 EVALUATION

What I learned today:

1. Growth monitoring, i.e., height for weight, weight for age; men should be more involved in nutrition.
2. Community involvement and enthusiasm; working relationship between community and staff; usage and importance of VHW in preparing ORS and to involve fathers.
3. Ideas about sustainability; more about health information system social mobilization.
4. There is much in Child Survival to be learned; SSS can be practically and widely used.
5. The different practices used for ORT (mixing of SSS) and the high level of community awareness is very encouraging.
6. Home management of childhood diarrhea--fluids; observation of interviews with mothers and community leaders about childhood diarrhea.
7. Making of SSS (theory and practical); nutrition and health information.
8. Diarrhea experience from CARE, KAP of ORT by the local women and men; case studies on nutrition in Sudan and Malawi.
9. The different opinions of ORT; focus on training--how to get the message to the mother; check up home visitors/spot checks/supervision; involvement of anthropologist to look at behaviors/how mothers learn.
10. Knowledge/attitude/practice in ORT management; awareness of the families in ORT in villages; case studies were stimulating.
11. The importance of promoting good nutrition in Child Survival projects.
12. The importance of nutrition education in Child Survival projects.
13. To put more emphasis on usage and competence in preparing ORT; other growth monitoring methods; other project implementation methods.

14. I appreciated that teaching skills to adults needs patience and constant contact with your "students" in order to remind them of what they are taught. Most people we talked to did not appear to have many episodes of diarrhea in their homes.
15. Components which ensure success of CDD program; principles of nutrition and growth monitoring.
16. Interesting to see such a well-developed program; especially people so versed on causes and prevention.
17. Shared experiences and activities in other projects; ORT and nutrition.
18. Women who attended the diarrhea interviews held key posts in the village; ORT (SSS) preparation was up to date; amount of fluids to be given is not yet clear to some mothers.
19. The people know the advantages of ORT, but its details and correct management should be improved.
20. Importance/concerns/limitations of mass campaign strategies; importance of linkages between project/MOH/other PVOs; importance of small-group discussions in mutual problem-solving and support.

Things I will therefore do differently in the project

1. Initiate measles immunization campaign; initiate monthly meetings between project, MOH and other agencies involved.
2. Try to improve community mobilization for action in CSP.
3. Not boil water (unnecessary).
4. Improve on my project's activities in nutrition, ORT and monitoring.
5. More emphasis on HAF and continued feeding . . . it seems that message needs to be given equal emphasis; also that ORS does not stop diarrhea.
6. Nutrition and growth monitoring target be from 0-3 rather than 0-5 years old.
7. I will impress upon my VHW and nurses the need to ask mothers to tell them what they know about ORS, with the view of correcting any mistakes they might be making.
8. Emphasis on practical demonstrations.
9. Promotion of good nutrition in Child Survival projects.
10. Value of "checklist" for ORT practices by the mother.
11. To discuss ORT again; make curriculum for health trainers; system developed for better supervision of VHW.
12. Improve my home management of childhood diarrhea by getting down to the level of the users.

13. Supervising, monitoring and encouraging of teams; take an example to my people from Zimbabwe; the community to do a review about SSS.
14. Supervise and encourage mothers/community to know more about SSS.
15. Try my best to make the messages of ORT very clear so that we can achieve the objectives of the intervention more easily.
16. To educate the mother first why we are doing what we are doing before practical training; community mobilization as foundation to obtain community approval.
17. How to mobilize the community; how to approach sustainability issue.
18. Improve community approach/working relationship/staff and community; close supervision.
19. I will use one ORT method only.

I would like to receive follow-up information on other comments:

1. ORS preparation in different settings; involve mothers to participate in community activities to achieve our goal in Child Survival.
2. More ideas about sustainability; health information system baseline studies.
3. I appreciate the increased use of ORT in other projects; it will be more useful to sit with those who apply the interventions and learn more from their experiences.
4. Follow-ups on home management on childhood diarrheas.
5. Management and evaluation about ORT/SSS.
6. Training of trainers techniques and materials.
7. Case studies of projects which had been sustained after the withdrawal of funds; KAP in EPI, family planning, nutrition.
8. How to conduct survey on the use of ORT/SSS.
9. Prevention of diarrheal diseases; use of ORT and home available fluids in the treatment of diarrhea.
10. More information on TOT.
11. More about interventions/Vitamin A/Rotavirus Vaccine.
12. More from those using computer in data collection and analysis.
13. Mothers' KAP on diarrheal disease management; passing of ORT knowledge from one mother to another.
14. How can we shorten the methods of educating mothers so that correct messages are easy to retain and implement?

15. Earliest possible time when vaccine can be given (there was some debate on this at the A.I.D. Child Survival last summer at George Mason University).

AUGUST 20, 1987 EVALUATION

What I learned today:

1. Importance of having or educating traditional healers; strategies for mass campaigns.
2. Importance of traditional healers; linkages among PVOs.
3. More on EPIs.
4. The importance of interagency collaboration in trying to increase immunization coverage of the target population; frequent liaison with donor agencies about their roles in EPI.
5. Coverage survey issues, baseline surveys; information systems; EPI; supervision/training; tropical diseases/AIDS.
6. Participants liked small groups; sharing networking very important; solidarity important for stress relief.
7. Inherent difficulty of implementation of ORT intervention---particularly the proper administration; difficulties inherent in workshops meeting participant needs when the individual project activities and problems are so different. However, the resolution of these difficulties appears now to have a framework.
8. Small group discussions were fruitful; Dory's illustration of information and reporting systems was beneficial and supportive; good, knowledgeable presentations; EPI approaches good; action plans, though prepared in a short time, were meaningful.
9. About how PVOs work with MOH; some information on AIDS; TA assistance for nutritional surveillance; malarial control and prophylaxis.
10. The ways to attain satisfactory levels of immunization coverage and how to maintain these levels.
11. The time to look for a TA; the importance of a traditional midwife.
12. We have a lot of resources in Africa and we should tap them; immunization should take precedent over the fear of AIDS.
13. Much information about other projects, especially those concerned with traditional ways of treating diseases compared to people trained in PHC.
14. Learned a lot about AIDS, tropical diseases; immunizations; supervision.
15. EPI in Child Survival; mobilization for EPI; AIDS in CS; requirements for reporting to headquarters.

16. Group discussion was the best; sharing and exchanging some of the experiences from other countries; knowing others' problems and getting new ideas from others.
17. Learning from other people; addition to VIDECS structures as fishponds, etc.

Things I will therefore do differently in the project:

1. Encourage income-generating projects to help sustain CSP.
2. Pay attention to live vaccines; strengthen group participation at the member's level and community; open discussion with MOH staff on better techniques of immunization and treating infections in relation to AIDS.
3. Supervision--not only to look for mistakes.
4. Trend is to make use of knowledge of the traditional healers and try to involve them in the PHC system so as to benefit from their experience and strengths.
5. Continue looking for people to help in our projects from my own country; not make a big issue out of AIDS.
6. To involve the traditional midwife in the CSP.
7. Coordinate more closely with other PVOs; request TA for nutritional surveillance; may investigate malarial control as possible intervention.
8. Not give polio, BCG vaccines to children who are HIV positive.
9. Try to encourage frequent meetings among PVOs, government and donors about the best way to utilize the inputs in EPI and other activities.
10. Do random surveys frequently and put more effort on the family registration.
11. Incorporating traditional healers into our Child Survival strategies.

I would like to receive follow-up information on/comments:

1. Supervision, follow-ups.
2. Income-making activities in CSPs.
3. Baseline survey; new ideas on monitoring and evaluation.
4. Any information which I can use to make rural mothers more conscious of the need for getting children fully immunized. *I think today's discussions have revealed a lot of areas which require further discussions. I wish the workshop lasted a little longer than five days.
5. Supervision/training; coverage survey issues; baseline surveys.
6. Comments: outside speakers--not appropriate--took too much time; too much input by host country; noise from kitchen interfered with concentration; schedule for today too ambitious; group too big, being in smaller classroom better even though crowded.

7. Comments: An interesting idea came out of a formative tea-time meeting--that a resource bank be established among the participants' projects whereby funding could be made available by Jake's office. Participants with resource expertise could visit and consult other projects at their request. A compendium of participants and their respective resource areas should be compiled along with other contact information. It would also be helpful to this end to have "up-to-date" project summaries along with areas of strength and weaknesses.
8. Comments: Washington D.C. requirements and comments should be studied and noted properly; NGOs working in CSPs should design a system where they can come together; action plans should be strictly followed unless there is a good reason for flexibility.
9. AIDS in Africa ---recent epidemiologic work; would like some information on other vaccines to be included.
10. AIDS and AIDS-related complex.
11. How to choose a TA.
12. Literature on AIDS; get a list of all possible TAs in Africa.
13. Comments: good, clear, interesting topics today.
14. Nursing care of AIDS patient; supervision.
15. AIDS in children.
16. Involve health workers in discussion, know their problems and problems from the community. Comments: supervision and monitoring are the source of everything.
17. Appropriate technology.

AUGUST 21, 1987 EVALUATION

The most important things I have learned in this workshop and would like to apply in my project:

Participant 1:

- Intersectoral collaboration with all the PVOs, MOHs, WHO and UNICEF. That is, network at an in-country level.
- Community mobilization, motivation and supervision
- Monitoring and Evaluating
- Regional networking and technical assistance
- Project sustainability
- Training and supervision
- Different methods of surveys
- Community organization - structures for participation

Participant 2:

- How to prepare an action plan
- How to plan and implement Child Survival projects in my area
- How to motivate the community to improve their nutrition and health

- To evaluate a project

Participant 3:

- Communicating, working, and living together with people
- The importance of networking
- Suggestions for the improvement of CSP in Zimbabwe
- The importance of field supervision
- Methods of facilitating group discussion
- How to keep learners on track during a session
- Be prepared for emergencies in a workshop (e.g., when the lights went off, people had to cope somehow)

Participant 4:

- Suggestions from the group on how CSP can be improved especially on planning, implementing, monitoring and evaluating with sustainability strategies.
- Improve networking

Participant 5:

- Increase coverage on immunization and growth monitoring; strengthen linkage and network with other NGOs and MOH. Need for TA at mid and end-project.

Participant 6:

- Community mobilization at Musami
- Nutrition and growth monitoring promotion and other measures to promote maternal and child health.
- Oral rehydration management: fluids, feedings & referrals.

Participant 7:

- Sustainability and collaboration with the ministries such as the MOH, PVOs, to ensure proper monitoring and community mobilization.
- Sharing ideas and integration of CS in community development
- Supervision of all activities in the project (EPI, ORT prepared by mothers, etc.)
- Involvement of community in all activities to accomplish goals.

Participant 8:

- Role of constant liaison between PVOs, government and donor agencies.
- Work out methods of sustaining the activities which will be implemented during the life of the project at the end of the project.

Participant 9:

- Importance of traditional healers in Child Survival.
- Learned a lot on Zimbabwe's and other countries' health services.
- Social mobilization.
- USAID form completion.

Participant 10:

- Need to: have project objectives
work with implementation plan
keep time schedule
have good baseline
keep good reports
work with comparable standards
keep linkages with other projects

Participant 11:

- Approach to sustainability
- Social mobilization and community participation
- Goal-oriented implementation plan
- Health information systems

Participant 12:

- Sharing all experiences with individual people
- Networking most important
- Sustainability needs continuous attention
- New ideas/new methods on baseline/evaluation surveys
- Health information systems/use of microcomputers
- Training: develop simple messages/make sure mothers understand the message
- Involve community in monitoring and evaluation
- ORT - all different views/new developments
- Presentations from other projects
- Input from USAID/Johns Hopkins - excellent!

Participant 13:

- EPI coverage surveys recommended for 100,000 population
- Eye disorders - potential survey questions
- AIDS: concerns with Child Survival
- Availability of technical assistance from USAID
- Health Information Systems

Participant 14:

- Nutrition and growth monitoring promotion and other measures to promote maternal and child health especially for the high-risk groups.
- Importance of social mobilization in accomplishing Child Survival goals.

Participant 15:

- Social mobilization; integration of activities; coordination with MOH/MOH/NGOs and other ministries.
- Monitoring and evaluation of activities
- Supervision techniques

Participant 16:

- In planning projects for Child Survival, everyone should be involved from the start.
- Projects which are built on a National Plan may be easier to sustain.
- Baseline surveys help communities to view their needs and we may win the communities' cooperation by involving them in the survey activities or give them feedback on their own findings.
- We have a lot of manpower resources in Africa; we should rely on other than expatriates whose knowledge of our needs may be lacking.
- In trying to mobilize the community, we should do so gradually starting with their biggest need, e.g., supplying foods in a famine-stricken country.
- Learning skill is difficult. People taught in any health intervention should be constantly reminded of what is taught.
- Good supervision will be achieved if the project is built on the existing structure.

Participant 17:

- Community mobilization
- Discuss sustainability issues with MOH
- Case studies from other projects
- Monitoring of village health workers
- Role of computers in Child Survival projects
- Sharing practical issues in CSPs
- Survey coverage in EPI
- Marketing supplements in nutrition programs
- Computer programs in CSPs

Participant 18:

- Going very deep in explaining the project to the community with whom we are working gives very good reflections of community involvement and social participation: very important for project success.
- Creating linkages between the different CS projects in the same country can be of great importance, as mini-workshops, can be conducted to share experiences in the same country among CS programs.

Participant 19:

- I have learned so many things that I cannot count them, but I know where I am going to apply them in our area.

Participant 20:

- Process/interactions between different participants and trainers.
- Best way to learn is from colleagues
- Participants are only able to incorporate or truly learn a very small amount of the total workshop content
- Process of learning may be more important than content
- Prepared me (Kate B. of CARE) for potentially running the next CS workshop

Participant 21:

- The need for a continuing dialogue at all levels as often as possible between the project, the MOH, the women's association and local leaders toward maintaining perspectives with regard to objectives and goals to deepen commitment and mutuality in partnership.

Participant 22:

- Community, once organized and mobilized, is a key to the success of its projects.
- Technical, political support is essential for CS activities
- Sharing of experience among PVOs builds up confidence in their approach to CS activities
- A.I.D./Washington D.C. consultants are ready to support CS projects once requested to do so.
- Reliance on locally available resources is important for sustainability
- Good monitoring, supervisory approaches yield good results towards objectives/evaluation

Participant 23:

- Community mobilization
- Linkages with other departments (NGOs, ministries, local people, etc.)

- EPI in Child Survival
- Sustainability of programs--its importance
- Reporting forms and techniques
- AIDS in Child Survival
- Growth monitoring in Child Survival
- Supervising, monitoring and evaluating
- ORT-home management of childhood diarrheas
- Case studies on social mobilization

Things I did not like in the workshop:

1. I liked everything because organizers were flexible.
2. Group discussions should have begun with the start of the workshop.
3. Too much of a good thing, i.e., field visits may have been counterproductive to group/individual needs.
4. Participation of local project and national staff too much; group too large; noise disrupted concentration; could have been more skills building, especially in baseline surveys.
5. Workshop design too ambitious . . . too many topics, depth not always achieved.
6. The sessions were too long at the beginning.
7. Nothing. Everything was organized and useful.
8. Short breaks, tight schedule; lack of social programs on day-to-day basis.
9. The evaluation sheet was too limiting, since it assumed that participants learned only five things per day and/or had to learn them.
10. Time was too short and other activities were not well taken due to lack of time (e.g., the evening group discussion clinics). Other participants were busy with other things or tired due to the day's pressure of work.
11. The pace seemed poor. The first two days were slow; Day Three was okay; the 4th day too fast; too many participants from Zimbabwe; not enough time allowed for discussion during presentations; often tasks were not explained clearly enough; we did not keep to our schedule very well; logistics problems.
12. First day too much discussion in one group; overloaded program workshop should be longer; no time for other activities besides Child Survival; that Dr. Rufi Macagba was not there.
13. Water supply and electricity limitations; continuous session from 8 a.m. to after 5 p.m. and even up to 7 p.m.
14. Generally, all went well and is commended. Time too short in some cases.
15. First two days were better organized.
16. There was not enough time to present the materials; the schedule was too tight.

17. Traveling daily from Harare to Murewa and back (for some Zimbabwe participants); missed some important discussions and sessions.
18. I liked everything about the workshop.
19. The attitude of some participants who found it difficult to adjust to local situations.
20. The sessions were too long at times; the day was not long enough.
21. Plenary discussion in the first two days.

Things I liked most in the workshop:

1. Going into clinics; group sharing and discussion; organization and facilitating methods; site visits.
2. Organization of the workshop; full attendance; openness and best chairmanship; services rendered by the hotel staff.
3. The talent/patience/good nature of the group; the flexibility and commitment of the staff; the warmth of the Zimbabweans; it was also a nice change to be in a cold climate again.
4. People very warm and enjoyed sharing; most all members participated and were encouraged to do so; organizers flexible, responded well to participants' requests.
5. Sharing of ideas among participants/groups; giving constructive comments; commitment to go and put into practice things learned in the workshop.
6. The group discussions which were held in the workshop were very interesting and gave important information about other Child Survival projects by sharing ideas.
7. Sharing experiences with other fellows; site visits of the Zimbabwe workshop.
8. The set-up, i.e., where the workshop was held was ideal; every participant was given a chance to participate fully; the discussion groups were very helpful.
9. The community visits; the video tapes; the discussion on immunization.
10. Group discussions and presentations; community visits.
11. Active interaction among participants and level of interest; participation of MOH (however, it might have been limited to bit more); clinic design for after hours work.
12. Sharing with other colleagues about program; good harmony in the group/highly motivated; that the workshop was at the community level; excellent ideas; room service at 6 a.m.
13. The organizers and participants; the location of the workshop; the small group discussions and presentations.
14. Everybody freely participated and all expressed their concerns and abilities; all seemed to recognize their areas of concern & needs; a rural setting for the workshop brought all at home.

15. Linkages/network developed among the participants/resource persons.
16. Group meetings and discussions; spirit of oneness in purpose for the survival of children.
17. Group discussions and presentations; visiting countries and sharing their problems.
18. The way everybody was sharing ideas; the community visits.
19. Tea and field visits; friendly people; shared program experiences.
20. The adult teaching methods used--mostly discussions; small group work.
21. The presentations and group discussions; the integration.
22. Sharing of ideas among participants; giving each other constructive comments; group discussions.
23. Small group discussions and presentations in the plenary; facilitators' and participants' warm relationships; commitment and the seriousness during all the sessions; good self-discipline.

My suggestions for future workshops for newly funded Child Survival projects in Africa

Other Comments:

1. There were a lot of things to learn from this workshop: venue, participants' contributions, the resources available.
2. To have community participation; to have TA when starting a project and mid-project phase/evaluation.
3. Plans to have longer workshop days; involve experienced and qualified field workers as resource people.
4. Extend life span of project to 5-10 years; regional workshops and make groups smaller than this.
5. Subsequent workshops should be held in a different country.
6. There were a lot of new ideas to learn and I would encourage such organization of workshops to continue.
7. To try and develop a broader linkage approach to avoid developing single activity-program as money may not always be available.
8. The workshop should be for two weeks to allow for spread-detailed topics.
9. If all would be done when all projects are starting; it would be easy for all of them to work towards common goals using similar, possible ways and enable inter-project comparisons.
10. Emphasis on sustainability; break up the workshop in the morning and evening sessions; field visits should be at the end of the first or morning sessions and reports at the beginning of evening sessions.

11. More group discussions; at least once a year, a need for up-to-date information on CS developments.
12. Keep the field visit schedule reasonable; need more technical update information; what about mothers? Maternal health needs to be addressed.
13. Should still be held at project sites if possible; length of time should be increased if funds allow.
14. This workshop may be simulated. I suggest MSRD/CARE project may be used for this purpose; more time should be given or else number of participants cut to 10-12.
15. Planning ahead, i.e., informing participants three months ahead; using slides, videos, overhead projectors; sessions on management in PHC.
16. Coming CS workshops can be for longer duration (10-15 days) so that the participants can find more time for discussing each other's projects using resource center.
17. To include the community involved in decision-making to achieve or ensure sustainability.
18. Do needs assessment, if possible, by visiting projects beforehand; try to distinguish different levels and allow groups to choose subject/topic areas which they want to be involved in; different balance of host country project in overall workshop.
19. Include birth-spacing and maternal health as topic areas.
20. Should be alternating and accompanied with slides; literature could be sent to the participants a month before the start of the workshop to give time for reading.
21. Be done every year in rotation so that each country MOH can share with PVO about CS.

Potential resource people I recommend for workshops

1. Penina Ochola - AMREF Kenya
2. Dr. Ali of the Zimbabwean MOH
3. Ms. Mona Moore of SAWSO-Washington D.C.
4. Dr. George Ngatiri
5. Miss Wendy-SCF-USA-Sudan Field Office
6. Dr. Bani of World Vision, Sudan
7. Dr. Henry Elkins (MSH) - Health Information Systems
8. Dr. Len Singerman (AFRICARE) - Pediatrics/Family Planning

9. Mr. Chip Oliver - alternative approaches to sustainability; income generation/ appropriate technology/traditional health providers as PHC workers.
10. CDC epidemiologist type of person working on CCCD.
11. Mrs. Jeld Nhiliziya - WV Zimbabwe
12. Dr. Doug Mendoza of WVRO - USA
13. Kate Burns of CARE Kenya
14. Dr. I. Bani of World Vision Sudan
15. Professor Nambooge Josephine of Public Health Department, Makere University
16. Professor Ndugwa, Professor of Pediatrics, Makere University, Uganda
17. Dr. Jake van der Vlugt
18. Mrs. Bongzi Mushapaidze
19. Mr. Stanley Jere - SCF/USA Malawi
20. Dr. Rufi Macagba - WVRO
22. Dr. Jane Vella - SCF/USA Westport, USA
23. Mr. Dale Flowers
24. Mrs. Cindy Rawn
25. AMREF's Victor Masbayi
26. AMREF's Petre Narcheson
27. AMREF's Dr. B.O.N. Oirere
28. Aga Khan's Dr. Dan Kaseje
29. MAP's Dr. Roy Schaeffer
30. Mrs. Regina Obiagwu - Nigeria
31. Project staff within or from impact areas.
32. Regional staff
33. Headquarter staff for support and policy, directives on funding, etc.
34. Dr. Israel Kalyesukula, CARE - Uganda
35. Professor Kakkemde, Uganda
36. Why not invite Dr. David Morley?

37. Dr. John Alwar, Pediatrics, University of Nairobi
38. Use of experts in TOT may be of great importance in CS workshops to understand more about training (very important part in project implementation).

I would like to take this opportunity to thank all the organizers for this workshop and to express how much I appreciated their integrated efforts which made the workshop very successful and useful.

APPENDIX L

CHILD SURVIVAL . . . THE WORLD'S SILENT EMERGENCY ISSUES AND IDEAS

- Even in the least developed parts of the world, there is hope. With the knowledge and technology we have at hand today, we can save the lives of at least half the children who otherwise would die, more than 20,000 children saved each day, every day! To achieve this, PARENTS MUST BE GIVEN SUPPORT AND THE KNOWLEDGE UPON WHICH TO ACT, FOR SAVING THESE CHILDREN IS ESSENTIALLY DEPENDENT ON EDUCATION AND SELF-HEALTH. Though identification of most health and growth problems is rather simple, the solutions are complex and long-term . . . but it is already happening. One-and-a-half million children are now kept alive each year because of the recent increased use of two easy, inexpensive techniques: IMMUNIZATION AND ORT.
- The CHILD SURVIVAL REVOLUTION will succeed because international organizations, national and local governments, private voluntary and religious groups, and tens and thousands of individuals are joining forces in an effort of global magnitude. Self-health becomes a more powerful concept if it is supported by all, not just taught to those in need.
- Within each developing country, governments officials, the health ministry, the military, religious institutions, the business sector, the media, hospitals and private organizations are focusing the efforts and resources of a concerned world on the education of parents and care for their children. Local efforts are of vital importance, for it is in cities, towns and small villages that Child Survival must succeed.
- COMMITMENT to Child Survival is essential. The global eradication of smallpox is one great example where commitment by governments and other concerned sectors was a major key to its success.
- GROWTH MONITORING: Recording a child's weight gain even just once a month on a 10¢ growth chart can indicate malnutrition before it has caused serious damage to a child's health. Likewise, a community worker can give the mother up-to-date information on how and when to wean young children as well the ways to improve their nutritional health, even when there is little food and money.
- ORAL REHYDRATION THERAPY (ORT) could save the lives of most of the 5 million children who die every year from diarrheal dehydration, the number one killer of young children in the world today. A "single drink" made from a pre-packaged 10¢ mix or a mixture of sugar, salt, and water in the correct proportion can enable a child's body to absorb 25 times more water and salt than it was capable of before.
- BREAST-FEEDING, particularly in poorer communities, is crucial to a baby's chances of survival and normal growth. In underdeveloped areas, bottle-feeding often means over-diluting milk powders with unclean water in an unsterile container--all of which would increase the risk of infant death two to three times that of breast-fed babies. These infants receive the best possible nutrition

and possess a high degree of natural immunity against common childhood infections during the first six months of life.

- IMMUNIZATION against the six diseases (tetanus, whooping cough, measles, diphtheria, tuberculosis, and polio) that threaten a child's health costs only \$5 per child, but could prevent deaths of 3.5 million children each year and spare many more from life-long crippling handicaps. If parents can understand the where, when, and why of vaccinations, then the number of children immunized could be tripled.
- FEMALE EDUCATION has a strong impact on children's health, particularly in poorer communities. The more educated the mother, the more exposure she gets to new information, thus the more willing and able she will be to take advantage of new thinking and innovations. The level of a mother's education is, in short, the single most influential factor in the health of her children.
- FOOD SUPPLEMENTS of just a few hundred calories a day for chronically malnourished pregnant women can reduce low-birth-weight deaths by more than 50 percent. According to the WHO, about one-third of the world's poor children are malnourished, simply because there is a critical shortage of food in the house. Food supplements can make the difference between health, life-long debility or death. A 2¢ Vitamin A megadose every six months or a daily handful of the cheapest leafy green vegetables can prevent the deficiency that causes various impairments in 10 million young children and causes blindness in up to half a million children every year, along with high rates of illness and death. ADEQUATE FOOD is the only means to normal growth, and neither medical nor health intervention can compensate for its absence.
- FAMILY SPACING allows couples to determine beforehand the number of children they will have, the age at which they will have them, and the interval between births. It affects, in large measure, the health and chance of survival for each child.
- THESE CHILD SURVIVAL TECHNIQUES AND PRACTICES depend upon the education and motivation of the family itself. These are self-health methods that do not require major additional input from doctors or medical instructors. Teaching mothers and fathers how to protect their children's lives will pave the way for a revolution in child health. **THE WHOLE SOCIETY MUST JOIN FORCES BECAUSE PARENTS CANNOT ACT WITHOUT SUPPORT!**
- WORLD BANK STUDIES indicate that investment in basic health care and primary education can lead to significant increases in productivity and economic growth. In India, a long-term study found that adults who were malnourished in childhood had a 30 percent lower work capacity than those with a healthy early childhood.
- Supporting basic services like immunization can result in appreciable savings for the industrialized nations. To look at the question of cost-effectiveness another way:
 - \$5 can immunize a child against six life-threatening diseases.
 - 10 cents can buy a chart on which to plot a child's growth progress, thereby pinpointing any problems before they become a serious health threat.

- 10 cents provides a dehydrated child with a full dose of ORT salt that treats deadly diarrhea.
- A mother can give her child the overwhelming benefits of breast-feeding--
for free.

DO WE LOSE A CHILD'S LIFE FOR SO LITTLE? FORWARD TOGETHER FOR CHILD SURVIVAL IN AFRICA!!!

ISSUES AND IDEAS ON IMMUNIZATION

- UNIVERSAL IMMUNIZATION IS A WORLD IMPERATIVE! Without an increase in the number of children immunized, in the next ten years, 20 million children will die from measles, 10 million children will die from tetanus, 6 million will die from whooping cough, and nearly 3 million will be paralyzed for life by polio. Yet, the annual cost of fully immunizing every child born into the world (at US\$5 per child) would be less than the price of three advanced fighter planes.
- One objective of Child Survival--the commitment to vaccinate all the world's children against six deadly diseases by 1990--is making drastic impacts. Already, 40 nations are sharply accelerating immunization programs in their efforts to reach the goal of "Universal Child Immunization by 1990," and recently the world's two largest nations made a public commitment to that goal.
- In India, where 3,000 children die each day from measles and the five other target diseases, Prime Minister Rajiv Gandhi announced that the immunization of all children would be a living memorial to his mother, the late Indira Gandhi. From China, President Li Xian-Nian announced that immunization levels would reach at least 85 percent in all provinces by the end of 1988.
- In El Salvador, three daring day-long truces between government and guerrilla forces enabled some quarter of a million young children to be vaccinated against measles, whooping cough, tetanus, diphtheria and polio. Twenty thousand health workers and volunteers staffed 2,000 vaccination centers across the country.
- In Nigeria, all 19 states are taking up the challenge of the Owo area where the immunization coverage was pushed from less than 10 percent to more than 80 percent in less than a year.
- In Sri Lanka, millions of TV viewers throughout the subcontinent read the message "IMMUNIZE YOUR CHILD TODAY" printed in giant white letters in three languages across the field of the Sri Lanka-India cricket match. The advertisement helped launch Sri Lanka's campaign to immunize all its children by the end of 1986.
- Other intensive campaigns have immunized many children quickly. SPECIAL VACCINATION DAYS widely publicized by mass media and even door-to-door visits have proved effective in countries like Brazil, Burkina Faso, Colombia, Ecuador, and Turkey.
- A surge of progress is bringing many nations within striking distance of the 1990 goal, spurred by TWO BREAKTHROUGHS:
 - The development of more heat-stable vaccines supplied through more reliable cold chains (refrigeration controlled from manufacture to delivery).
 - The training of many thousands of immunizing teams that are mobilizing to answer the demand for immunization in practice, and not just theory.
- Newborns can be protected against neonatal tetanus if their mothers are vaccinated with tetanus toxoids even as late as during pregnancy.

- Other vaccines--against hepatitis B, cholera, and other forms of diarrheal diseases (as rotavirus), typhoid, malaria, and leprosy--are in various stages of development. More than 3 million lives could be saved if all children (and women of childbearing age) were vaccinated just with the vaccines that are readily available today.
- A MAJOR CONCERN: AIDS! A vaccine against the AIDS virus is years away. A vaccine for general use is not anticipated before the next decade, and its use would not affect the number of persons already infected by that time.
- A major logistical problem is keeping vaccines cold to protect their potency. Careless handling, a broken refrigerator, or electric failure can break the cold chain and leave children unprotected.
- Common problems that immunization programs face:
 - Limited surveillance of disease cases and immunization coverage.
 - Inadequate supervision.
 - Insufficient communication efforts.
- Child Survival programs need to set targets and move toward full immunization of 80 percent of a nation's children by the end of the decade, as well as develop the capacity to sustain that level of coverage into the future. At this level, transmission of disease is greatly lessened.
- Child Survival projects should monitor the effectiveness of their immunizations coverage efforts. Special emphasis is being given to measles vaccine for infants and tetanus toxoid for women, the two vaccines that could do most to lower infant mortality rates and the two that have been most neglected in the past.
- Programs with immunization components need a clear, precise definition of organizational structure for administering vaccines and for supervision.

Considerations:

- Who will actually immunize and when that will take place.
- Who will supervise and when.
- Who will tabulate number of doses given and when.
- Who will calculate the acts, plot trends, prepare reports and when.
- IMMUNIZATION IS TRULY A CHANCE FOR EVERY CHILD!!!

ISSUES AND IDEAS ON NUTRITION AND BREAST-FEEDING

- BREAST-FEEDING IS THE BEST FORM OF NUTRITION FOR THE YOUNG INFANT AND AN IMPORTANT MEANS OF SPACING BIRTHS.
- Breast milk has special properties that make it superior to even the most carefully homemade or commercial preparations:
 - Immunological protection against common childhood diseases such as diarrhea and respiratory diseases.
 - Helps to maintain a protective environment within the intestine
- INFANTS MAY FACE SPECIAL HAZARDS WHEN BREAST-FEEDING IS CURTAILED. THE HIGH COST OF PROPER BOTTLE FEEDING (US\$200-300 IN THE FIRST YEAR) MAY LEAD PARENTS TO DILUTE COMMERCIAL OR HOME PREPARATIONS.
- Studies of infant feeding and nutrition among several hundreds of children indicate that breast-fed children are less likely to be malnourished than bottle-fed children. There is a lower incidence of infections, including diarrhea among breast-fed children.
- OTHER POSSIBLE BENEFITS OF BREAST-FEEDING:
 - BETTER BONDING BETWEEN MOTHER AND CHILD
 - AVOIDING DENTAL CARIES USUALLY FOUND IN CHILDREN SLEEPING WITH BOTTLES
 - PROMOTING NORMAL FACIAL DEVELOPMENT
 - AVOIDING INFANT OBESITY
 - PROTECTION AGAINST VARIOUS DISEASES LIKE CORONARY HEART DISEASE, ULCERATIVE COLITIS, SUDDEN INFANT DEATH SYNDROME, ACUTE NECROTIZING ENTEROCOLITIS
 - IMPROVING SPEECH DEVELOPMENT
 - PROMOTING GREATER INTELLECTUAL ABILITY
- A study of breast-feeding promotion in Honduras shows that the duration of breast-feeding can be extended when hospital practices are changed and health professionals are trained in appropriate breast-feeding techniques. Changes, such as eliminating the routine use of supplemental formula and encouraging rooming-in, resulted in successful initiation of breast-feeding within the hospital.
- SEVERAL STUDIES SHOW THAT EXCLUSIVELY BREAST-FED INFANTS DO NOT NEED TO CONSUME ANY LIQUIDS OTHER THAN BREAST MILK TO MEET THEIR WATER NEEDS. BREAST MILK MEETS ALL THE NUTRIENT AND WATER NEEDS OF INFANTS FOR THE FIRST FOUR TO SIX MONTHS OF LIFE.
- Studies do link Vitamin A deficiency, even in mild form, with increased childhood morbidity and mortality due to diarrheal and respiratory diseases. Preliminary findings from two Indonesian studies suggest that programs to prevent and control Vitamin A deficiency may be cost-effective interventions for Child Survival in countries where severe Vitamin A deficiency is prevalent.

- LONG-TERM VITAMIN A PROGRAM OBJECTIVES CENTER ON CHANGING THE FAMILY DIET TO INCLUDE MORE FOODS RICH IN VITAMIN A AND IMPROVING INTRAFAMILIAL FOOD DISTRIBUTION TO FAVOR PREGNANT/LACTATING WOMEN AND CHILDREN OF WEANING OR PRESCHOOL AGE.
- Medium-term Vitamin A program objectives are to fortify appropriate foods with Vitamin A like Monosodium Glutamate in the Philippines, tea in Pakistan, sugar and margarine in Guatemala.
- SHORT-TERM VITAMIN A PROGRAM OBJECTIVES AIM AT UNIVERSAL OR TARGETED DISTRIBUTION OF VITAMIN A SUPPLEMENTS, THE MOST COMMON OF WHICH IS A GELATINOUS CAPSULE OF 200,000 IU PROVIDED BY UNICEF.

ISSUES AND IDEAS ON ORAL REHYDRATION THERAPY

- FOR THE VAST MAJORITY OF PEOPLE WITH DIARRHEAL DISEASES, INTRAVENOUS THERAPY MEANS LITTLE. THEY HAVE NO ACCESS TO FACILITIES FOR IV THERAPY, AND IN ANY CASE, THEIR NUMBERS WOULD OVERWHELM FACILITIES. THE ONLY POSSIBLE MEANS OF SERVING LARGE NUMBERS OF PEOPLE IS ORAL REHYDRATION THERAPY!
- To reach millions of mothers who actually provide care for children with diarrhea, community-based programs that do not depend on doctors and clinic facilities are essential. Every family in every village should have supplies available and be carefully taught and encouraged to use them.
- NATIONAL COMMUNITY-BASED ORAL REHYDRATION THERAPY NOW STANDS APPROXIMATELY WHERE COMMUNITY-BASED FAMILY PLANNING DID SOME YEARS AGO. THE NEED IS RECOGNIZED, THE TECHNOLOGY IS AT HAND. WHETHER SERVICES, SUPPLIES, AND KNOWLEDGE WILL IN FACT REACH THE PEOPLE DEPENDS ON GOVERNMENT OFFICIALS, HEALTH PROFESSIONALS, PRIVATE ENTREPRENEURS, AND COMMUNITY LEADERS.
- Oral rehydration therapy needs to emphasize continued feeding during diarrhea. Frequent episodes of diarrhea contribute to malnutrition because appetite diminishes, feeding is interrupted, and absorption of nutrients is reduced.
- ORT PROGRAMS NEED TO EMPHASIZE CONTINUED FEEDING DURING DIARRHEA.
- On a longer term, sanitation, clean water and food, better nutrition, and improved living conditions can reduce the incidence of diarrhea. But on a short term, the scientific knowledge and the practical technology embodied in oral rehydration therapy already exist to prevent most deaths from diarrhea.
- MANY FAMILIES HAVE TOO LITTLE FUEL OR ARE UNWILLING TO TAKE THE TIME TO BOIL WATER AND LET IT COOL JUST TO PREPARE THE ORAL FLUID. BECAUSE OF THE OVERRIDING NEED TO ADMINISTER WATER AND ELECTROLYTES QUICKLY TO A SICK CHILD, DIARRHEA CONTROL PROGRAMS USUALLY RECOMMEND USING THE CLEANEST WATER IMMEDIATELY AVAILABLE.
- Families should certainly not be told to boil oral rehydration solution after it is mixed since this will increase the concentrations of electrolytes and sugar.
- EVEN WITH CLEAN OR BOILED WATER, ORAL REHYDRATION SOLUTION IS A GOOD MEDIUM FOR BACTERIAL GROWTH. BACTERIA MULTIPLY RAPIDLY WITHIN 24 HOURS. HENCE, FLUIDS SHOULD BE PREPARED FRESH DAILY, AND VILLAGE WORKERS AND FAMILY MEMBERS SHOULD BE TOLD TO DISCARD ANY UNUSED FLUID AFTER 24 HOURS.
- Each oral rehydration therapy program, while drawing as much as possible on the experience of others, needs to identify appropriate local teaching methods as an integral part of planning.

- MANY COMMUNITY-BASED ORT PROGRAMS ENCOURAGE FAMILIES TO BEGIN ORT SOLUTIONS--EITHER COMPLETE FORMULA OR SUGAR AND SALT--ON THEIR OWN INITIATIVE AS SOON AS A CHILD DEVELOPS DIARRHEA, RATHER THAN WAITING UNTIL SIGNS OF DEHYDRATION APPEAR AND THEN TAKING THE CHILD TO A CLINIC.

ISSUES AND IDEAS ON COMMUNITY PARTICIPATION IN CHILD SURVIVAL

- Community participation, stimulated by private voluntary organizations in charismatically directed small-scale PHC projects, has yielded exciting positive results that demonstrate community members' involvement in their own care.
- COMMUNITY PARTICIPATION PROMOTES SOCIOECONOMIC DEVELOPMENT. After starting out as a charitable medical clinic, Peoples' Foundation Health Program in the Philippines evolved into a medical cooperative.
- COMMUNITY PARTICIPATION INCREASES SELF-RELIANCE. It is considered a necessary step toward the release of creative ideas to allow communities and their constituent families and individuals to begin taking more responsibility in resolving community health problems.
- COMMUNITY PARTICIPATION LOWERS COSTS. Community contributions of human and material resources will almost always be required to ensure SUSTAINABILITY of PHC programs, especially those begun with external assistance.
- In the Basic Health Sources project in Afghanistan, the use of unsalaried part-time health workers from the community made possible a total cost for patient visits of only 43 cents. Clients defrayed half this amount by paying service and drug fees.
- In the Rural Community Health Services project in Nicaragua, local contributions for such community projects as small water systems and latrines were four times higher than anticipated by the end of the project's first year and covered about 10 percent of total program costs.
- COMMUNITY PARTICIPATION INCREASES SERVICE UTILIZATION. In the Colombia research project, a controlled comparison between the communities incorporating community participation in promotion and education and the ones using only traditional health education by staff showed much better results in communities with participation.
- COMMUNITY PARTICIPATION FACILITATES BEHAVIORAL CHANGE.
 - In Guatemala, Panama, Zaire, and Sierra Leone, communities have helped construct latrines, water systems, and garbage disposal areas, and have then adopted the improvements into their daily life.
- COMMUNITY PARTICIPATION ENCOURAGES GOVERNMENT SUPPORT.
 - In Nepal, community political leaders are involved in selecting CHWs, which has created mutual loyalties and given politicians a vested interest in the program. At the legislative level, such political interest has been manifested in villagers to provide the program with adequate resources.
- COMMUNITY PARTICIPATION CONTRIBUTES UNIQUE KNOWLEDGE AND RESOURCES. In Honduras, failure to consult the community resulted in an unused health post.

- COMMUNITY PARTICIPATION CREATES MORE CULTURALLY APPROPRIATE SOURCES. Interviews with villagers in Niger revealed that they preferred health sources from village workers, in whom they had confidence, to sources offered at health centers outside the village.
- Community involvement needs fundamental changes in people's attitudes, especially in areas where people have long been apathetic, dependent on outside directives, or resistant to new ideas. Cultural beliefs and taboos, or a plain lack of money, may keep them from adopting new habits that could improve their health. Merely imparting information about better health does not solve the problem. Hence, programs in developing countries need to try other means such as demonstration, hands-on experiences, and nonformal education, thereby increasing the people's understanding of health needs and developing in them a genuine sense of commitment to find solutions.
- Even the best of methods will not work unless field staff and supervisors are suitably trained. If staff are expected to conduct participatory learning for adults, then they themselves need to experience participatory learning.
- VILLAGE VISITS are ways of learning about the people's ideas, customs, and problems in the community.
- "Johari's Window," a method successfully used in Indonesia, is an excellent way of beginning to appreciate the importance of understanding and considering other people's perceptions. Thus, it is useful for planning a project with the people to help solve problems.
- Role-playing provides excellent exercise to demonstrate the differences between lectures and approaches that promote more participation by the people.
- When community members are sensitive to each other's perceptions and actions, it is more likely that they will discuss their problems and participate in resolving them.
- Drawing a map involves people in the creation of a visual picture of their community. This map could be put up in a community center for people to look at and learn about the community.
- The DISCUSSION STARTER is an excellent activity that helps the village health worker and the community gain insights on the views that community members have with respect to nutrition, health, sanitation, and agricultural practices.
- PUPPETS and THEATER have been used to entertain and communicate in many cultures. They are good to use since they have no ego and can say things to an audience and get away with it. They are adaptable, and scripts can be changed for different groups.
- PEOPLE ENJOY ANALYZING THEIR EATING HABITS. This discussion may lead to growing new foods, trying new recipes, or beginning nutrition education classes. Let the community how you can promote good health and nutrition and tell you about their food habits.
- Child weighing can be a community activity. This activity, repeated every six months, as done in Indonesia, can assist villagers in recognizing the extent of

nutrition problems in their community and encourages mothers to weigh their children as a means of knowing whether the children are healthy.

- Comics and photo novels can be enjoyed by those who cannot read as well as by literates. The stories are read and discussed in group sessions and the pictures serve as a reminder of the story when the book is brought home.
- Comparative posters can stimulate good discussions on issues related to health and nutrition. A discussion of the differences perceived by the community members can be used in an analysis of why they exist and what the community members can do to modify the situation. This learning activity may motivate community members to plan projects to resolve the causes of the problem presented.
- Card games created a great deal of enthusiasm among trainees and villagers in the Dominican Republic. The people also modified games to create awareness of the factors that influence children's health.

ISSUES AND IDEAS ON AIDS AND CHILD SURVIVAL

- "AIDS, the syndrome, is only the tip of the iceberg; for every AIDS case, there are three to five cases of the less severe AIDS-related complex and anything between 50 and 100 silent carriers, giving a cumulative total of 5-10 million infected persons, capable of transmitting the virus."

- Halfden Mahler, Director-General, WHO
- "... a minimum of 10,000 AIDS cases annually may be occurring in Africa."

- WHO
- There has been much fear, misinformation, and rumor about AIDS. EVERYONE NEEDS THE FACTS. These are sever. basic points.
 1. AIDS is a fatal disease that cannot now be cured.
 2. AIDS is not spread by casual contact.
 3. AIDS is spread by sexual intercourse, by contaminated blood, and by contaminated needles.
 4. An infected woman can give AIDS to her child during pregnancy.
 5. A stable, faithful relationship with another uninfected person is safest. In any case, reducing the number of sexual partners reduces the chances of getting AIDS.
 6. For the sexually active, always using condoms is good protection against AIDS.

Recall this:

Son to father: "Dad, what did you wear in your days to have safe sex?"
Father to son: "A wedding ring."
 7. A person can look and feel healthy and still be able to spread the infection that causes AIDS.
- AIDS can be transmitted from mother to fetus during pregnancy or childbirth. In any area where AIDS has been reported, women who have had many sexual partners, or women whose partners have had many partners, face a high risk. These women should be told that they may be risking their future children's lives and perhaps their own by childbearing. Family planning workers need to carry out some of this counseling.
- AIDS can be transmitted by blood transfusion (in places where blood samples are not adequately screened or not tested at all) or by use of contaminated needles. Maternal and child health personnel need to avoid unnecessary transfusions and to maintain scrupulously the sterility of needles and syringes.
- AIDS is a fatal disease that cannot now be cured. The vaccine against AIDS is years away. A vaccine for general use is not anticipated before the next decade,

and its use would not affect the number of persons already infected by that time. With no cure or vaccine in sight, the only real hope for controlling AIDS now is EDUCATION THAT CHANGES PEOPLE'S BEHAVIOR.

- o Family planning workers and other health workers must lead, but the mass media, community, and national leaders, parents, and teachers also must help. The basic messages are simple, but they must be heard and heeded.
- o From June 1981 to September 1986, U.S. health authorities have reported 24,420 cases of AIDS to the centers for disease control; of these, 1 percent or 345 cases were children. Over 60 percent of these children have since died.
- o Little is yet known about the prevalence of HIV (human immunodeficiency virus or the virus causing AIDS) infection among children in both the U.S. and less developed countries.
- o Two reports from the Mama Yemo Hospital in Zaire show that 10 to 12 percent of hospitalized children were infected with HIV in 1984 and 1985 compared with 1 to 2 percent of two health control groups.
- o Diagnosing AIDS in children is difficult because the major manifestations of diarrhea and failure to thrive are very common and not specific.
- o The immunologic abnormalities associated with symptomatic HIV infections have raised concerns on immunizing infected children.
- o Immunization risks are not known with certainty, but there are potential risks if HIV-infected children are not immunized.
- o If there are local measles outbreaks in areas where there is a cluster of non-immunized children and a high prevalence of HIV infection, the risk of measles of HIV-infected children may be high. Measles in children with immune deficiency may be severe, protracted, and fatal.
- o SOME RECOMMENDATIONS:
 - Children with symptomatic HIV infection:

Live virus and live bacterial vaccines (mumps, measles, rubella, oral polio, BCG for example) should not be given to children and young adults who are immunosuppressed in association with AIDS. For routine immunizations, these individuals should receive inactivated polio vaccine (IPV) and should be excused for medical reasons from regulations requiring measles, rubella and/or mumps immunization. DTP is recommended.
 - Children with previously diagnosed asymptomatic HIV-infection:

Existing data show that OPV can be given without adverse reactions to HIV-infected children without overt clinical manifestations of immunosuppression. DTP is recommended.
 - Children not known to be infected with HIV should be immunized.
 - Child living in the household of a patient with AIDS or other HIV infections should not receive OPV because vaccine viruses are excreted by the vaccine recipient and may be communicable to their immuno-compromised contacts.

APPENDIX M

AFRICA RESOURCES/CONSULTANTS (Information Provided by Workshop Participant, Charles Oliver of AFRICARE, Nigeria)

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- * Kola Oluwatuyi, Tel: 611180(H)
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- * Mr. Remi (Protocol Officer)
- * Dr. Funke Bogunjoko (Nutrition)
- * Professor G. B. Makinjuola (Appropriate Technology)
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- * Dr. Sulaiman (Health Planning), Tel: 684491
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- * Mrs. Adedeji - PHC Coordinator, WID

UNICEF/Lagos: 11A Osborne Road, P.O. Box 1282, Ikoyi, Lagos, Tel: 603540 to 44

- * Mr. Revelans Tuluhangwa - Nigeria Rep
- * David Bassiuni - Deputy Rep, Tel: 680934(H)
- * Dr. Ahmed Magan, (EPI), Tel: 684996(H)
- * Lloyd (Bill) Clayton, Tel: 684993(H)/Okusan/Nkwonta(Logsts)
- * Mrs. M. W. (Reona) Aig-Ojehomon (Home Nutrition/Women in Development Program)
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- * Khadijat L. Mojidi (PHN)
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- * Dr. Princeton Lynman (Ambassador), Embassy Guest House, 16 Queen's Drive, Ikoyi, Tel: 680813
- * Dr. Keys McManus, Director of Mission, Tel: 613825(O), Residence: House B, 1162 Saka Tinubu (off Adeola Odeku by Post Office), Victoria Island, Tel: 614369(H)
- * Lawrence R. Eicher, Health Development Officer
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- * FP Coordinator, Ms. Veronica Nwosu/Celine Anosike (Dep.)
- * Dr. Njemanze (ORT)
- * Dr. Obiribe/Mr. R. Ude (EPI)
- * Mrs. Njoku (PHC Program)
- * Mrs. Florence Ekeada (World Bank)

- * Dr. Ugoji (Director, Health Services), World Bank Project
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- * Mrs. Emezi (CNO), Tel: 234307

UNICEF/Owerri: 26/28 Anokwu Street, Owerri

- * May Anyabulu, Tel: 233064
- * Nelson Atunonwu (Hydrology)
- * Mr. Robert Emeh (Water/Sanitation Project), Tel: 231601
- * Mr. Ohanuma, Sanitation

Ministry of Information:

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- * Mr. Ugwunegbo, Tel: 233480

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- * Project Manager, Dr. O. Nduaka

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Planned Parenthood Federation/Nigeria: 38 Old Market Road, Owerri

- * Ms. Rose Nzeako, Tel: 232646

Isiala-Ngwa LGA:

- * Chairman, Mr. F. I. N. Ekwueme, call operator, Tel: 230769 (ask for Nbawsi Post Office)

Nitel:

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- * Mr. Anumadu, Tel: 230500(O) (for direct line)

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- * President Sackley/Elder Oberg, Tel: (082) 225-360

Bishop Cockin Church Centre: Box 34, Atta, Ikedur

- * Rev. E. E. Osuegbu, Tel: (083) 230784

Chris Dure Consortium: (Small Business Consultants), Tel: 232323

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- * Umezuruike Hospital, Dr. E. M. Umez/Eronini, 21 Orlu Street, Owerri, Tel: 230161/231022

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- * Ekwonwa Madu (Sales Rep), Tel: 233-927

DATATEC: 138 Telow Road, Owerri

- * Larry Osuagwu, Tel: 234-240

DHL/OWERRI: 103 Wetheral Road, Owerri

- * E. M. Awulonu, Tel: 234610
- * Rev. T. N. A. Odoemela, Tel: 230219 JSC
- * Raymond Mbina (LDS) Aboh Mbaise
- * Sister Tiritita, Owerri Orphanage 1-3 pm/W/Th
- * Siter Pat, Tel: 680411

KADUNA STATE

AFRICARE/Kaduna Office: 3A Gwani Mouktar Road (near Capital School, north near Bureau of Customs Mess)

- * Landlord, Alh. A. Dangana (Tel: Abubakar)
Nightwatchman: Abu Isa

U.S. Consulate/Kaduna: Tel: (062) 201070/072/073/074

Kaduna State Ministry of Agriculture: KS Secretariat, Independence Way

- * Commissioner, Arc. Mohammed N. Sambo, Tel: (062) 242465/217432

Kaduna State Ministry of Health: Lugard Hall, P.M.B. 2014

- * Commissioner, Dr. Musa Shok, Tel: (062) 212501(O)/214429(H)

Kaduna State Ministry of Works and Transport: P.M.B. 2023, Kaduna

- * Commissioner/Engineer, Usman Abubakar, Tel: 212052(O)/215735(H)
- * Chief Engineer, Mr. Byoma

Kaduna State Water Board:

- * General Manager, Yusulu M. Sada
- * Assistant General Manager (Projects), Mohammed H. Iliyas
- * Chief Borehole Engineer, G. G. Donladdi

ALH, Abdulahi Abubakar: Tel: (062) 216781

KANO

La Locanda: 40 Sultan Road, Kano, Tel: (064) 628-269

Castle Restaurant: Lebanese

Maramara Clinic: * Maryam Bayero

NSUKKA

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- * Professor Ngoddy, Department of Food Science Technology (Food Science Engineering), Tel: (042) 770482

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- * Dr. Obionu, CHO, Anambra State MOH, Tel: (042) 333179

RIVERS STATE

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- * Dr. Tuburu, Chief Health Officer

American International Insurance Co.:

- * A. A. Adeseye, P.O. Box 8843, Port Harcourt

Port Harcourt International Hotel: P.O. box 4411, P.H.

- * S. Klein, Manager, Cables: AIRPORTEL-PORT HARCOURT

COMPUTER CONSULTANTS

NIB:

- * Mageed Khawam
- * Dadson Nwakalor, Tel: 610840

Tara Consulting Nigeria Ltd.:

- * Seni Williams, Tel: 619053

Chams (Nig.) Ltd.: 4, Akerele Road, Surulere, Lagos

- * Aladekomo, B. A. (Chief Engineer), Tel: (01) 843153/843502/833769/802546 through 802548

IT Systems:

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- * Mrs. Bernadette Orefo, Family Planning/Training, Onitsha, 1A Tasia Road, P.O. Box 4132, Onitsha, Tel: (046) 212343 (sister), 214407 (neighbor)
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- * Dr. Mark Mitchell (Survey Analyst)
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- * Denis J. Hynes (Rural Development/Project Design), 7 Rue Farah, Kodjovia Kope, Lome, Togo, Tel: 21-28-89, Telex: c/o World Bank, 5009 TO/, c/o Sid Bliss, B.P. 852, USIS/Lome
- * J. Timothy Johnson (Demographer), U.S. Public Health Service Program Evaluation Branch, Division of Reproduction Health, CDC, Atlanta, Georgia 30333, Tel: (404) 329-3056(O), 634-5858(H)

- * Dr. Kandiah Kanagaratnam (Population/Family Planning), Population Reference Bureau Inc., 777 14th Street, N.W., Washington, D.C., 20005, Tel: (202) 639-8040
- * Carol Kazi (PATH/PIACT), 1800 M Street, N.W., Washington, D.C., 20036, Tel: (202) 822-0033, Telex: 4740049 PATH UI
- * Gomeje Legesse (Media/Communications), 2637 16th Street, #705, N.W., Washington, D.C., 2009
- * Dr. Adetokumbo Lucas, Carnegie Corporation of New York, 437 Madison Avenue, New York, New York 10022, Tel: (212) 371-3200, Telex: CARNEGIE 166776
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- * Jason B. Smith (Project Coordinator), CEDPA, 1717 Massachusetts Avenue, N.W., Suite 202, Washington, D.C., 20036, Tel: (202) 667-1142
- * Kim E. Winnard (Senior Program Officer), Population Communication Services (PCS), Johns Hopkins University (SH&PH), Population Information Program, 624 North Broadway, Baltimore, Maryland 21205, Tel: (301) 955-7666

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- * Dr. P. Neuenschwander (Entomologist), Tel: 413244/413315/413440, Telex: 31417 TROPB NG and TDS IBA NG 20311 (Box 015)
- * Mr. A. A. Ayorinde, Building 400, Room 148C, IITA, c/o TRIP (Tubor/Root Crop/Improvement Program), Tel: 400300/2853

Appropriate Technology/Cottage Industries

- * Chris Dure Consortium (small business consultants), Tel: 232323
- * Mr. F. W. Lukey, MASDAR UK Ltd., Rural Agricultural Industrial Scheme (RAID), Ibadan, Tel: 412002, Telex: 31417
- * Adam Platt (Appropriate Technology), Intermediate Technology Group Ltd., Myson House, Railway Terrace, Rugby CV21 3HT, United Kingdom, Tel: RUGBY (0788)60631, Telex: 317466 ITDG G

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- * Mr. Ahmed Magan, UNICEF, Tel: 684996(i.)

- * Dr. Obiribe/Mr. R. Ude (ISMOH)

ORT

- * Dr. Njemanze (ISMOH)
- * Dr. Okiahalam, University of Nigeria Teaching Hospital, Enugu, Department of Pediatrics, Tel: (042) 332161/332022, ext. 170

Communication/Training Media

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Computer/Information Systems

- * John Nelson, CCD/FMOH-Lagos (Computer Systems)
- * Janet Patenaude/Brady Prieam, Software Mark, 925 17th Street, N.W., Washington, D.C. 20006, Tel: (202) 775-8188/569-2525
- * Leo Hool, Bureau of Census, Tel: 684-5584
- * Maged Khawam/Dadson Nwakalor (NIB), Tel: 610840
- * Seni Williams, Tara Consulting Nigeria Ltd., Tel: 619053
- * Aladekomo B. A. (Chief Engineer), CHAMS (Nigeria) Ltd., 4 Akerele Road, Surulere, Lagos, Tel: (01) 843153/843502/833769/802546 through 802548
- * David Ikwue, IT Systems (IBM), c/o NIB

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- * J. Timothy Johnson, Demographer, U.S. Public Health Service Program Evaluation Branch, Division of Reproduction Health, CDC, Atlanta, Georgia 30333, Tel: (404)329-3056(O), 634-5858(H)
- * Jose F. Mas-Jordon, Pathfinder, Director of Commodities Department, 9 Galen Street, Watertown, Massachusetts 02172, Tel: (617) 924-7200, Telex: 681-7095 PFBOS
- * Dr. Benson Morah, Statistics, National Population Commission
- * Debra A. Schumann, Population Dynamics, Johns Hopkins University School of Hygiene and Public Health, 615 North Wolfe Street, Baltimore, Maryland 21205, Tel: (301) 955-7983

Epidemiology

- * Dr. Robert S. Desowitz, Department of Tropical Medicine, University of Hawaii (Leahi Hospital), 3675 Kilauea Avenue, Honolulu, Hawaii, Tel: (808) 732-1477
- * Dr. Walter P. Kipp, GTZ, 37 Talstrasse, 744 Nuertigen 8, West Germany
- * Dr. Adetokumbo Lucas, Carnegie Corporation of New York, 437 Madison Avenue, New York, New York 10022, Tel: (212) 371-3200, Telex: CARNEGIE 166776
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- * Dr. Surungbi (FMOH)
- * Dr. Jason Weisfeld, CCCD, Epidemiology, Kaduna
- * Matt Lynch, 3634A Hakekipa Place, Honolulu, Hawaii 96816, Tel: (808) 948-8894

- * Sam Oni, Surveys, Project Plowshares, Lagos

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- * Moses Agoha, 31 Oronna Street, Oshodi, Lagos
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- * Mrs. Bernadette Orefo, Family Planning/Training, Onitsha 1A Tasia Road, P.O. Box 4132, Onitsha, Tel: (046) 212343 (sister), 214407 (neighbor)
- * Dr. Francesca Osegbue-Obasi, Health/FP/Surveys, Falamo Police Clinic, Ikoyii, Tel: 683241(O), 615283(H)
- * Dr. Len and Gloria Singerman, Child Survival/FP Training, 5300 Hamilton Avenue, #19D, Cincinnati, Ohio 45224, Tel: (513) 541-5773
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Food Science Technology

- * Dr. Enoch Akobundu, Food Processing Technology, Federal University of Technology, Owerri
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- * Dr. Osei Boeh-Ocansey, Food Processing Technology, Federal University of Technology, Owerri, Tel: 230-974

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- * Dr. Dickson Nnanyelugo, Department of Nutrition, University of Nigeria/Nsukka,
Tel: (042) 771911, ext. 130 (O), (042) 771897(H)
- * Dr. Patrick Okungbowa (Medical Nutritionist, Federal Nutrition Division,
Tel: 862419(O), 618141(H)
- * Mrs. V. I. Nnatuanya, F.M.H.

Rural Development

- * Denis J. Hynes, Rural Development/Project Design, 7 Rue Farah, Kodjovia Kope, Lome,
Togo, Tel: 21-28-29, Telex: c/o World Bank: 5009 TO/ c/o Sid Bliss, B.P. 852,
USIS/Lome

APPENDIX N

STRUCTURED INTERVIEW TO ASSESS THE KNOWLEDGE/ATTITUDE/PRACTICES REGARDING HOME MANAGEMENT OF CHILDHOOD DIARRHEA

Date: _____
Village: _____
Interviewer: _____
Interviewee: _____
Role in Community: _____

1. What is diarrhea?

2. Can you tell me what you know about diarrhea in children?

3. Do you think diarrhea is dangerous to a child? If yes, in what way?

4. Do you have a child under the age of five? If so, when was the last time your child had an episode of diarrhea?

5. What did you do then?

6. Have you ever heard of the solution you can make in your home to treat diarrhea?

No _____ Yes _____ Not Sure _____

7. What do you call it?

8. Do you think this solution is useful? If yes, how?

9. Tell me how you mix it?

| | | | |
|-------|-------|--------------|-------|
| Water | _____ | Container | _____ |
| Sugar | _____ | Spoon | _____ |
| Salt | _____ | Doesn't Know | _____ |
| Other | _____ | | |

10. Will you mix it for me? Describe in detail the process of collecting ingredients and utensils and mixing performance.

11. How much will you give each day of this solution to a sick child who is:

6 months old? _____
1 year old? _____
2 years old? _____

12. How long can you keep this solution?

13. Do you think a child would like this solution?

Yes _____ No _____
(If no, ask why) _____

14. What do you think are the causes of diarrhea? How can you prevent each of these causes?

| <u>Causes</u> | <u>Actions to Prevent</u> |
|---------------|---------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Structured by Dr. Carl Kendall
Medical Anthropologist
Johns Hopkins University
School of Hygiene and Public Health

APPENDIX O

ASSIGNMENT # _____
CONSULTANT _____
DATES _____

TA REQUEST: FVA/PVC PVO Child Survival Grants Program

To: Dr. D. Storms, Coordinator
PVO Project Technical Support

From:

Subject: Request for Consultation and/or Technical Assistance

1. Purpose and Scope of Work (Attach relevant documentation.)

2. Geographical Location (Please give each city/country; and number of days desirable in each location. If field travel is involved, please indicate distance and mode of travel to remote area.)

3. Rationale -- Indicate why TA is important to success of project, and why the resource can't be obtained in-house.

4. Estimated duration of work schedule _____

5. Desirable dates for commencement of services: _____

6. Dates when a consultant visit would not be feasible

7. Expertise and special skills required: _____

8. Special working conditions (e.g., temporary office space, typing assistance, other)

9. Special requirements for content and distribution of final report.

10. Contact person and phone number for additional assignment details:

Approved for action under PVO Child
Survival Technical Support Project _____

Source of funds for assignment: _____

APPENDIX P
HEALTH AND CHILD SURVIVAL PROJECT REPORTING SCHEDULE
REFERENCE GUIDE FY87

The Health and Child Survival Project Reporting Schedule is used to track Agency health and child survival project activities. It also forms the basis for the annual report to Congress describing the child survival program. The enclosed schedule refers to the reporting period October 1, 1986 - September 30, 1987. Reports are due in AID/W no later than October 30, 1987 and should be addressed to S&T/Health, SA-18 Room 709, Attn: Health Information System.

The schedule is designed to minimize duplicative information and the need for detailed instructions. For example, whenever possible, codes or words are provided on the schedule and need only be circled. For other items, blanks are provided for you to write in numbers or names. However, as with any questionnaire, some items may be ambiguous. The purpose of this guide is to define those items which may not be clear.

If data are to be useful, it is essential that they be as timely, accurate and reliable as possible. Such data are not always available from data collection systems. If such data are not available, we request that you (or a person who has participated in implementing the project) provide your best estimate based on your personal knowledge of the project and mark the source as "Best Guess." If a REASONABLE "BEST GUESS" can not be made, please mark the item "Don't Know." Throughout the schedule, you will be asked to identify the source of your information. Circle DC if your information came from a data collection system; BG if it is a best guess; or, DK if you don't know.

Although A.I.D. project managers or officers are responsible for insuring that the reporting schedules are completed and submitted to AID/W, we encourage you to ask those persons responsible for implementing the projects to assist in completing or verifying the schedules. Accurate spelling, and careful printing or typing - especially of foreign names - is important since these forms are used as a source of information for many printed materials such as the Report to Congress and Country Fact Sheets.

Please note that Schedules 2 - 6 are to be completed ONLY IF the project contains a child survival component as determined by the attributions reported in item 11, page 2. As noted in the transmittal letter, this reporting schedule refers only to Tier One information. If your project is collecting coverage (Tier II) surveys and/or special (Tier III) studies we ask that you to provide these data.

We appreciate your efforts to provide these data. Thank you in advance.

DEFINITIONS

PROJECT NUMBER: The number assigned to the A.I.D.-funded projects.

2. SUBPROJECT NUMBER: The number assigned to a sub-activity of the larger project.
3. COUNTRY: Country location of project activity. If regional or multi-country please indicate.
4. PROJECT TITLE: Title of the A.I.D.-funded project.
5. PROJECT BEGINNING DATE: The initial fiscal year in which project funds are/were obligated. Generally, this will be the initial date the agreement or contract is/was signed.
6. PROJECT ACTIVITY COMPLETION DATE: The actual date all project activities have ceased or will cease.
7. PROJECT STATUS: Indicate whether the project is "Proposed," "Ongoing," "Discontinued," or "Completed" as of September 30, 1987.
8. PRINCIPAL CONTRACTOR/GRANTEE: The name of the contractor or grantee which has the principal or primary responsibility for implementing the project.

Principle Implementing Agent/Organization: Name of cooperating host country agency or organization responsible for the project.

Contract/Grant Number: The number assigned by A.I.D. to a contract or grant through which the project is implemented. Include the number on the line with the name of the contractor.

Type of Organization: See codes 1 - 9.

NOTE: (3) "Non-Profit: Other" includes any non-profit organization which is not a Private Voluntary Organization.

(7) "Multilateral Agency" includes any international, quasi-governmental organization, primarily the UN and UN-related organizations.

(9) "Host Country: Other" includes any organization in the participating or "host" country which has responsibility for the project but is not an official agency of the government.

LIFE OF PROJECT BUDGET: The total dollar amount of all A.I.D. funds shown in the budget for the LIFE OF THE PROJECT.

10. OTHER FUNDING SOURCES: If the project receives support from PL 480 accounts or from other sources (e.g., host country, UNICEF, or other donors), please report the US Dollar equivalent and identify the source of such funds.
11. PROGRAM FUNCTIONS: All projects will involve one or more of the program functions identified under either "Child Survival" or "Other" Functions. Estimate the percentage of PROJECT ACTIVITIES (including administrative support) during the LIFE OF THE PROJECT that is attributable to each of the listed functions. You must account for all PROJECT ACTIVITIES during the LIFE OF THE PROJECT. That is, the sum of the percentages should total 100%.

CHILD SURVIVAL FUNCTIONS: FOR ANY PROJECT WHICH REPORTS A CHILD SURVIVAL FUNCTION, THE APPROPRIATE SCHEDULE (1 through 6) MUST ALSO BE COMPLETED. All projects funded from the Child Survival Fund account must attribute 100% of project activity among the five Child Survival functions listed:

- o Oral Rehydration Therapy/Diarrheal Diseases,
- o Immunization/Vaccination,
- o Nutrition,
- o High Risk Births (see definition "a" below);
- o Other Child Survival Activities (see definition "b" below).

- (1) High Risk Births (Child Spacing): It is generally recognized that the spacing of births -- the length of the interval between each birth -- directly affects fetal wastage and neonatal and infant mortality. That is, closely spaced births are associated with significantly higher levels of low birth weight, related health complications and mortality than long birth intervals. Research shows that when birth intervals are at least two years, the chances that the child will survive are much greater than when the interval is less than two years. However, child spacing is not the only factor that affects child survival. Also important are the mother's age -- whether she is reproductively very young or very old -- and parity (or birth order). Children born to mothers who are reproductively very young (i.e., under 20) or who are reproductively very old (i.e., 35 and older) are much more likely to have health complications which lead to death than mothers who are in their prime reproductive years. High parity births are more likely to encounter health complications which lead to death than low parity births.

In summary, high risk births are defined as those which occur too soon, are too many and occur to mothers who are reproductively too young or too old. Projects which educate and deliver services targeted to these issues are defined as "HIGH RISK BIRTH" projects.

- (2) Other Child Survival Activities: The list of child survival interventions given in Item 11 under "OTHER CHILD SURVIVAL" is meant to be illustrative of some of the types of project activities which should be included in this residual category. It is not meant to be an exclusive or comprehensive list. This category or function includes any project activity or intervention which directly affects child survival and does not fall within Oral Rehydration, Immunization, Nutrition or High Risk Births interventions. It may include activities which are designed specifically to reduce child mortality such as presumptive treatment of malaria in children or treatment of acute respiratory disease. It also may include "Other Health" activities such as disease control or water and sanitation. Attributions of these types of activities can be divided between "Other Child Survival Activities" and "Other Functions" according to the proportion of children under 5 years in the population. In projects directed to the general population, the percentage of activities under "Other Functions" attributed to child survival should not exceed the percentage of children under five in the population of the project area.

OTHER FUNCTIONS: The non-child survival functions listed include those health activities which do not have a direct impact on child survival goals.

13. TRAINING: Number of Health Workers and Others Trained: If the project has a training component, please indicate the numbers trained during the reporting period by group. TRAINING is defined as any formal course of instruction which lasts four hours or more and is attended by two or more participants. "Other Health Workers" includes any para-professionals, non-professionals, or allied health workers (e.g., technicians, etc.) of the public or private health system. "All Others" is a residual category which includes anyone not assignable to the "Health Workers" category (e.g., mothers, other family members, school teachers, community leaders, etc.).
14. NUMBER OF PERSON MONTHS OF LONG TERM EXPATRIATE ADVISORS: Report the number of person months of technical assistance provided for each type of long-term advisor listed. LONG TERM is defined as in-country assignments of 12 months or more. Include only expatriate advisors (i.e., advisors from countries other than the one in which the work is being performed).

HIGHLIGHTS: Include any qualitative or anecdotal information that describes significant project activities or accomplishments during the reporting period. We are particularly interested in information on progress towards achieving project targets and other significant reportable data.

16. PHOTOGRAPHS: Where available, please include good quality, clear, action photographs directly related to child survival interventions. For example, we use black and white or color photos of mothers and infants, training sessions, immunization sessions, growth monitoring, administration of ORS, breastfeeding, child spacing, etc. Please include credit and caption information. Do not write on photos with ballpoint pen. Also, please indicate if photos are to be returned.

Name and Title of Person Preparing Report: Name and title of the person who is responsible for completing the Health and Child Survival Reporting Schedule. If more than one person prepares the schedule, please list the name and title of each person.

Date: Date the schedule was completed.

SCHEDULE 1: DEMOGRAPHIC CHARACTERISTICS: [To be Completed for ALL Projects]

Item 1-1.1. This section applies to projects whose overall purpose includes service delivery.

Item 1-1.3. NATIONWIDE PROJECTS: To encourage comparability and to reduce reporting burdens, the Health Information System obtains demographic estimates for nationwide projects from the U.N. Population Division. The Health Information System will make these estimates available to any mission or project manager requesting them. Project Managers are also welcome to provide nationwide demographic estimates if a better local source is available. For projects serving a defined geographic area, please complete Item 1-1.4.

Items 1-1.4 - 1-5.1. In many cases, projects will need to obtain estimates for demographic data for management as well as reporting purposes. Such data are seldom available for small areas or for periods other than that for which a census is conducted. Project managers or officers are encouraged to consult the national (or regional, if any) Statistics Office to determine if estimates or projections have been or can be prepared. Other sources of such information include local universities with a demography program or private companies with demographic expertise. If reasonable estimates cannot be made, you should mark the data element "Don't know." Please note that all estimates refer to the "REPORTING PERIOD" which in this case is October 1, 1986 through September 30, 1987. Ordinarily, such estimates are made as of the middle of the period. For this report, it is preferable that the estimate refer to mid-year 1987.

SCHEDULE 2: ORAL REHYDRATION/DIARRHEAL DISEASES: [To be Completed for Projects with ORT/Diarrheal Disease Activities]

Item 2-1.2. Number of ORS Packets Imported and/or Locally Produced by the Project by Size of Packet.
The number of ORS packets PURCHASED with A.I.D. project funds or PURCHASED or DONATED by other governments or organizations during the reporting period. Distinguish between packets imported into the host country and those locally produced. If more than one size of packet is purchased, please provide this information for each packet size.

SCHEDULE 3: IMMUNIZATION: [To be Completed for Projects with Immunization Activities]

Item 3-1.2. Number of Vaccine Doses Purchased or Donated.
The number of vaccine doses PURCHASED with A.I.D. project funds or PURCHASED OR DONATED by other government or donor organizations during the reporting period. If you purchase vaccines other than those listed, provide the requested information in SCHEDULE 6.

Items 3.2.1. - 3-2.3. Immunization Training. (See definitions under Item 13, Page 4.)

SCHEDULE 4: NUTRITION: [To be Completed for Projects with Nutrition Activities]

Item 4-1.4. Number of Persons Given Nutrition Counseling During the Reporting Period.
The number of persons who participated in a counseling session or program which was presented or sponsored by the project.

Items 4-2.1. - 4-2.6. Nutrition Training. (See definitions under Item 13, Page 4.)

Item 4-3.2. Targets for Supplementary Feeding Activities.
Circle all that apply.

SCHEDULE 5: HIGH RISK BIRTHS: [To be Completed for Projects with High Risk Births Activities]

Item 5-1.2. Units of Contraceptives Purchased with A.I.D. project funds.
The number of units of the listed contraceptives PURCHASED with A.I.D. project funds, or PURCHASED or DONATED by other organizations during the reporting period.

Items 5-2.1. - 5-2.3. High Risk Births Training. (See definitions under Item 13, Page 4.)

SCHEDULE 6: OTHER CHILD SURVIVAL PROJECTS: [See Definitions, page 4:(b).]

Items 6-3.1. - 6-3.3. Training. (See definitions under Item 13, page 4.)

1987 HEALTH AND CHILD SURVIVAL PROJECT REPORTING SCHEDULE

1. Project Number: _____ 2. Subproject Number: _____ 3. COUNTRY: _____
4. Project Title: _____
5. Project Beginning Date: / / 6. Project Activity Completion Date (PACD): / /
7. Current Project Status: (Circle One) 1 - Proposed 2 - Ongoing 3 - Discontinued 4 - Completed
8. For each contract or grant, please provide the A.I.D. contract (or grant) number, the COMPLETE name of the contractor (or grantee), the name of the implementing agency/organization and the type of organization for each. SEE CODES BELOW. USE ADDITIONAL SHEETS IF NECESSARY. PLEASE PRINT OR TYPE.

| | Type of Organization |
|--|-------------------------|
| Principal Contractor/ Grantee: _____ | _____ |
| Principal Implementing Agency/Organization: _____ | _____ |
| Other Contractors/Grantees/Implementing Agencies/Organizations: | |
| Contractor/Grantee: _____ | _____ |
| Implementing Agency/ Organization: _____ | _____ |
| Contractor/Grantee: _____ | _____ |
| Implementing Agency/ Organization: _____ | _____ |

Codes for Type of Contractor/Grantee/Implementing Agent: (Place Appropriate Code on Lines Provided Above)

| | | |
|--|---------------------------------|-----------------------------|
| 1 - Non-Profit/Private Voluntary Organizations/US | 4 - University | 7 - Multilateral Agency |
| 2 - Non-Profit/Private Voluntary Organizations/LOCAL | 5 - Private Sector (For Profit) | 8 - Host Country/Government |
| 3 - Non-Profit/Other (Includes NGOs) | 6 - U.S. Government | 9 - Host Country/Other |

9. Life of Project Budget: (A.I.D. Funds from ALL funding accounts) \$ _____

10. Other Funding Sources:

| ACCOUNT | | LIFE OF PROJECT BUDGET (in Thousands) |
|--|----|--|
| PL-480/Title I | \$ | _____ |
| PL-480/Title II (Including Value of Feed and Monetization) | \$ | _____ |
| PL-480/Title III | \$ | _____ |
| HOST GOVERNMENT: (US \$ Equivalent) | \$ | _____ |
| OTHER DONORS: (Identify) | | |
| A. UNICEF Funds: | \$ | _____ |
| B. _____ | \$ | _____ |
| C. _____ | \$ | _____ |
| <hr/> | | |
| TOTAL, ALL SOURCES | \$ | _____ |

1987 HEALTH AND CHILD SURVIVAL PROJECT REPORTING SCHEDULE

11. Program Functions:

(Life of Project Attributions From ALL Funding Accounts)

| | PER CENT ATTRIBUTION | COMPLETE SCHEDULES |
|--|----------------------|--|
| CHILD SURVIVAL: | | |
| Oral Rehydration/Diarrheal Diseases | _____ % | ➔ 1 AND 2 |
| Immunization/Vaccination | _____ % | ➔ 1 AND 3 |
| Nutrition | _____ % | ➔ 1 AND 4 |
| Includes: | | |
| 1 - Breastfeeding | | |
| 2 - Growth Monitoring | | |
| 3 - Infant/Child Feeding Practices | | |
| 4 - Vitamin A | | |
| High Risk Births (e.g., Birth Intervals, Maternal Age, High Parity) | _____ % | ➔ 1 AND 5 |
| Other Child Survival Activities | _____ % | ➔ 1 AND 6 |
| Are Any of the Following Types of Activity Included? | | |
| 1 - Acute Respiratory Infection | | |
| 2 - Water & Sanitation | | |
| 3 - Disease Control/Malaria | | |
| 4 - Disease Control/AIDS | | |
| 5 - Disease Control/All Other | | |
| PORTION OF "OTHER FUNCTIONS" LISTED BELOW ATTRIBUTABLE TO CHILD SURVIVAL | ➔ | |
| Circle All That Apply | ➔ | |
| OTHER FUNCTIONS: | | |
| DO NOT INCLUDE CHILD SURVIVAL PORTION | ➔ | |
| Health Care Financing | _____ % | ➔ COMPLETE SCHEDULE 1 |
| Water & Sanitation | _____ % | |
| Medical Education (Academic Only) | _____ % | |
| Disease Control/Malaria | _____ % | |
| Disease Control/AIDS | _____ % | |
| Disease Control/All Other | _____ % | |
| Other, Non-Child Survival | _____ % | |
| TOTAL, ALL PROGRAM FUNCTIONS | 1 0 0 % | |

12. Types of Health Workers and Others Trained Under the Project During the Reporting Period. (10/1/86 - 9/30/87)

| | | | |
|----------------|----------------------------------|--------------------------|----------------------------|
| 1 - Physicians | 3 - Community Health Workers | 5 - Pharmacists | 9 - School Teachers |
| 2 - Nurses | 4 - Traditional Birth Attendants | 6 - Other Health Workers | 10 - Religious Leaders |
| | | 7 - Mothers | 11 - Community Leaders |
| | | 8 - Other Family Members | 12 - Other (Specify) _____ |

Circle All That Apply

13. Number of Health Workers and Others Trained Under the Project During the Reporting Period. (10/1/86 - 9/30/87)

| | In-Country | Third Country | U.S. |
|--|------------|---------------|----------|
| Physicians/Nurses/All Other Health Workers | _____ | _____ | _____ |
| All Others | _____ | _____ | _____ |
| TOTAL TRAINED DURING THE REPORTING PERIOD | _____ | _____ | _____ |
| Source of Information: | DC BG DK | DC BG DK | DC BG DK |

14. Number of Person Months of Long-Term Expatriate Advisors Supported By the Project During the 1987 Reporting Period.

| | | | |
|---|---|---|--|
| Long-Term = Assigned to Country for 12 Months or Longer | _____ Health Administrator _____ Communications Specialist _____ Demographer/Statistician _____ Economist _____ Epidemiologist _____ Health Educator | _____ Health Planner _____ Logistics Specialist _____ Malaria Advisor _____ Physician _____ Medical Educator _____ Other (Specify) _____ | _____ Management Specialist _____ Midwife _____ Nurse _____ Nutritionist _____ Sanitary Engineer |
|---|---|---|--|

SOURCE CODE: DC - Data Collection System BG - Best Guess DK - Don't Know

1987 HEALTH AND CHILD SURVIVAL PROJECT REPORTING SCHEDULE

Project Number: _____

Subproject Number: _____

15. HIGHLIGHTS (Include statements regarding significant project activities/accomplishments during the reporting period.)

Lined area for writing highlights, consisting of approximately 25 horizontal lines.

16. Photographs Included? Yes No
* Please include credit/caption information. Do not write on photos with ballpoint pens.

NAME OF PERSON PREPARING REPORT: _____

DATE: _____

TITLE: _____

SCHEDULE 1: DEMOGRAPHIC CHARACTERISTICS

Project Number: _____

Subproject Number: _____

NO. ITEM ** IF YOU DO NOT KNOW THE ANSWER TO A QUESTION, PUT IN A "DK" **

1-1.1 Is the project involved in the delivery of health and child survival services? 1 - YES, SUBSTANTIAL ACTIVITY
2 - YES, MINOR ACTIVITY
3 - NO
9 - DC'NT KNOW

1-1.2 Which of the following groups does this project serve? GO TO NEXT SCHEDULE

Children:

| | |
|--------------------|-------------------------|
| 1 - < 12 Mos. | 7 - Lactating Mothers |
| 2 - 12-23 Mos. | 8 - Pregnant Women |
| 3 - 24-35 Mos. | 9 - Other Women |
| 4 - 36-47 Mos. | Specify: _____ |
| 5 - 48-59 Mos. | 10 - Men |
| 6 - Other Children | 11 - Aged (65 or Older) |
| Specify: _____ | 12 - Other |
| | Specify: _____ |

Circle
All That
Apply

1-1.3 Is the project involved in the delivery of health and child survival services within a defined geographic area? 1 - YES, NATIONWIDE
2 - YES, LESS THAN NATIONWIDE
3 - NO
9 - DON'T KNOW

GO TO ITEM 1-1.4

GO TO NEXT SCHEDULE

1-1.4 If this area is less than nationwide, what is (are) the name(s) of the PROVINCE(S), STATE(S), or DEPARTMENT(S) (i.e., the MAJOR or FIRST LEVEL POLITICAL SUBDIVISION(S)) in which project activities are being carried out?

| | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

1-1.5 Is this area (Are these areas) primarily URBAN, primarily RURAL, or mixed? 1 - Primarily Urban
2 - Primarily Rural
3 - Mixed
4 - Don't Know

| | NUMBER (Use Actual Numbers) | SOURCE OF INFORMATION (Circle One) |
|--|--------------------------------|---------------------------------------|
| 1-2.1 How many people live in the geographic area served by the project? | _____ | DC BG DK |
| 1-3.1 Of all the people living in the project area, how many are under 12 months of age? | _____ | DC BG DK |
| 1-3.2 How many are at least 12 months old, BUT are not yet 60 months old? | _____ | DC BG DK |
| 1-3.3 Of the children in this 12 - 59 month age group, how many are aged 12 - 23 months? | _____ | DC BG DK |
| 1-4.1 Of all the people living in the project area, how many are women of REPRODUCTIVE AGE (i.e., ages 15 - 49)? | _____ | DC BG DK |
| 1-4.2 How many of these women of reproductive age are in the HIGHER RISK age group 15 - 19 years? | _____ | DC BG DK |
| 1-4.3 How many of these women of reproductive age are in the HIGHER RISK age group 35 - 49 years? | _____ | DC BG DK |
| 1-5.1 How many babies are born alive each year in the project area? | _____ | DC BG DK |

SOURCE CODE: DC - Data Collection System BG - Best Guess DK - Don't Know

SCHEDULE 3: IMMUNIZATION

PROJECT NUMBER: _____

SUBPROJECT NUMBER: _____

•• IF YOU DO NOT KNOW THE ANSWER TO A QUESTION, PUT IN A "DK" ••
 SOURCE CODE: DC - Data Collection System BG - Best Guess DK - Don't Know

NO. ITEM

3-1.1 During the 1987 reporting period, did the project distribute vaccines or participate in vaccination programs in the project area?

1 - YES, SUBSTANTIAL ACTIVITY 3 - NO
 2 - YES, MINOR ACTIVITY 8 - DON'T KNOW

SKIP TO ITEM 3-2.1

3-1.2 How many doses of the following vaccines were:
 Purchased With A.I.D. Funds
 Purchased or Donated by Other Governments or Organizations
 Source of Information

| Measles | | | Polio | | | DPT | | | BCG | | | Tetanus 2 | | |
|---------|----|----|-------|----|----|-----|----|----|-----|----|----|-----------|----|----|
| DC | BC | DK | DC | BC | DK | DC | BC | DK | DC | BC | DK | DC | BC | DK |

3-1.3 How many children (or women in the case of tetanus toxoid) were immunized as part of project activities with the following vaccines?

Number of Children Under Age 5 Immunized
 Number Immunized Who Were Under Age 1
 Source of Information

| Children Only | | | | | | Women 15-49 | | | | | | | | |
|---------------|---------|---------|-------|-------|-----|-------------|----|----|----|----|----|----|----|----|
| Measles | Polio 1 | Polio 3 | DPT 1 | DPT 3 | BCG | Tetanus 2 | | | | | | | | |
| DC | BC | DK | DC | BC | DK | DC | BC | DK | DC | BC | DK | DC | BC | DK |

3-1.4 At any time during the reporting period, was a fee charged for immunizations?

1 - YES → Please describe in Item 3-5.1
 2 - NO 8 - DON'T KNOW

3-2.1 During the reporting period, did the project sponsor training sessions on immunization in the project area?

1 - YES, SUBSTANTIAL ACTIVITY 3 - NO
 2 - YES, MINOR ACTIVITY 8 - DON'T KNOW

SKIP TO ITEM 3-3.1

3-2.2 Which of the following types of HEALTH WORKERS and OTHERS completed these immunization training sessions?

- 1 - Physicians
- 2 - Nurses
- 3 - Community Health Workers
- 4 - Traditional Birth Attendants
- 5 - Pharmacists
- 6 - Other Health Workers
- 7 - Mothers
- 8 - Other Family Members
- 9 - School Teachers
- 10 - Religious Leaders
- 11 - Community Leaders
- 12 - Other (Specify)

Circle As That Apply

3-2.3 How many health workers and others in the project area completed these immunization training sessions?

| Physicians/Nurses/All Other Health Workers | All Others | Information Source | | | | | | |
|--|------------|--------------------|----|----|----|----|----|----|
| DC | BC | DK | DC | BC | DK | DC | BC | DK |

3-3.1 During the 1987 reporting period, did the project sponsor or participate in activities designed to promote or market immunization services through PRIVATE or COMMERCIAL OUTLETS? (includes serial marketing, advertising, etc.)

1 - YES, SUBSTANTIAL ACTIVITY 3 - NO
 2 - YES, MINOR ACTIVITY 8 - DON'T KNOW

3-3.2 Did the project sponsor any of the following in the project area?

- Mass Immunization Campaign →
- Fixed Immunization Center(s) →
- Mobile Vaccination Team(s) →

1 - YES, SUBSTANTIAL ACTIVITY 3 - NO
 2 - YES, MINOR ACTIVITY 8 - DON'T KNOW

3-4.1 Did the project provide technical assistance for improving the MANAGEMENT of immunization programs? (including logistic support)

1 - YES, SUBSTANTIAL ACTIVITY 3 - NO
 2 - YES, MINOR ACTIVITY 8 - DON'T KNOW

3-5.1 Please describe ANY other immunization activity in which the project engaged not identified above.

Please describe any ACCOMPLISHMENTS/SUCCESSSES in the "Highlights" section of the main schedule.

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SCHEDULE 4. NUTRITION

PROJECT NUMBER: _____

SUBPROJECT NUMBER: _____

NO.

ITEM

IF YOU DO NOT KNOW THE ANSWER TO A QUESTION, PUT IN A "DK"
SOURCE CODE: DC - Data Collection System BG - Best Guess DK - Don't Know

| | |
|--|---|
| <p>4-1.1 During the 1987 reporting period, did the project distribute or provide equipment or commodities for use in participating countries?</p> <p>4-1.2 Which of the following did the project distribute or provide?</p> <p>4-1.3 During the reporting period, did the project sponsor or provide counseling on proper INFANT AND CHILD FEEDING PRACTICES?</p> <p>4-1.4 How many persons received such counseling?</p> <p>4-1.5 During the reporting period, did the project sponsor GROWTH MONITORING PROGRAMS in the project area?</p> <p>4-1.6 How many children under age five were enrolled in such programs during the reporting period?</p> | <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>1 - Food 4 - Other Nutritional Supplements 7 - Other (Specify) 2 - Vitamin A 5 - Scales 3 - Iron 6 - Growth Monitoring Charts</p> <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>Information Source: DC BG DK</p> <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>Information Source: DC BG DK</p> |
| <p>4-2.1 During the reporting period, did the project sponsor training sessions on INFANT AND CHILD FEEDING PRACTICES in the project area?</p> <p>4-2.2 Which of the following types of HEALTH WORKERS and OTHERS completed these training sessions on INFANT AND CHILD FEEDING PRACTICES? Circle All That Apply</p> <p>4-2.3 How many health workers and others in the project area completed the training sessions on INFANT AND CHILD FEEDING PRACTICES? (Including breastfeeding)</p> <p>4-2.4 During the reporting period, did the project sponsor training sessions on GROWTH MONITORING in the project area?</p> <p>4-2.5 Which of the following types of HEALTH WORKERS and OTHERS completed these training sessions on GROWTH MONITORING? Circle All That Apply</p> <p>4-2.6 How many health workers and others in the project area completed the training sessions on GROWTH MONITORING?</p> | <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>1 - Physidone 7 - Mothers 2 - Nurses 8 - Other Family Members 3 - Community Health Workers 9 - School Teachers 4 - Traditional Birth Attendants 10 - Religious Leaders 5 - Pharmacists 11 - Community Leaders 6 - Other Health Workers 12 - Other (Specify)</p> <p>Physidone/Nurses/All Other Health Workers All Others Information Source DC BG DK</p> <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>1 - Physidone 7 - Mothers 2 - Nurses 8 - Other Family Members 3 - Community Health Workers 9 - School Teachers 4 - Traditional Birth Attendants 10 - Religious Leaders 5 - Pharmacists 11 - Community Leaders 6 - Other Health Workers 12 - Other (Specify)</p> <p>Physidone/Nurses/All Other Health Workers All Others Information Source DC BG DK</p> |
| <p>4-3.1 During the 1987 reporting period, did the project sponsor SUPPLEMENTARY FEEDING ACTIVITIES in the project area? (Please describe VITAMIN A activities in No. 4-6.1)</p> <p>4-3.2 Were these SUPPLEMENTARY FEEDING ACTIVITIES designed for CHILDREN, for LACTATING MOTHERS, for PREGNANT WOMEN, or for OTHER groups?</p> | <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>Children: 1 - < 12 Mos. 2 - 12-23 Mos. 3 - 24-35 Mos. 4 - Other (Specify)</p> <p>5 - Lactating Mothers 6 - Pregnant Women 7 - Other Groups (Specify) 8 - Don't Know</p> |
| <p>4-4.1 During the 1987 reporting period, did the project sponsor or participate in activities designed to promote breastfeeding?</p> <p>4-4.2 During the 1987 reporting period, did the project sponsor or participate in activities designed to promote nutritional interventions via mass media, social marketing, etc.?</p> | <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> <p>If YES, please describe under item 4-6.1 on separate sheet.</p> |
| <p>4-5.1 Did the project provide technical assistance for improving the MANAGEMENT of nutrition programs? (Including logistics support)</p> <p>4-6.1 Please describe ANY other nutrition activities in which the project engaged not identified above.</p> | <p>1 - YES, SUBSTANTIAL ACTIVITY 3 - NO 2 - YES, MINOR ACTIVITY 9 - DON'T KNOW</p> |

Please describe any ACCOMPLISHMENTS/SUCCESSSES in the "Highlights" section of the main schedule.

APPENDIX Q
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- . Syringes, Needles and Sterilization
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- . How to Evaluate Your Immunization Program Trainer's Guide

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- . Conduct Disease Surveillance
- . Evaluate Vaccination Coverage
- . Provide Training
- . Supervise Performance

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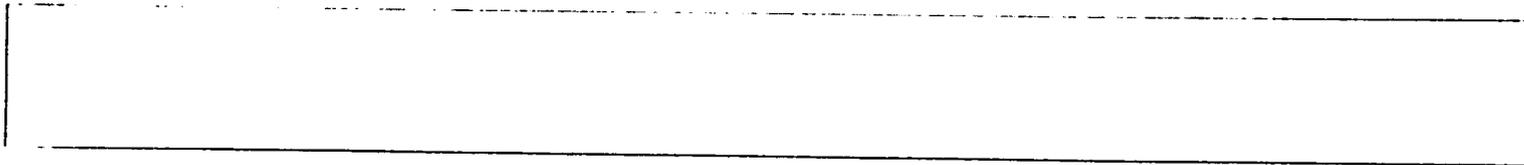
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WORLD VISION and the
UNITED STATES AGENCY FOR
INTERNATIONAL DEVELOPMENT

Award this certificate to



For successful completion of the workshop:

**“FORWARD TOGETHER FOR
CHILD SURVIVAL IN AFRICA”**



Held at Murehwa, Zimbabwe
August 16-22, 1987



Dr. Gerold van der Vlugt, Coordinator
PVO Child Survival Program
Child Survival Coordinator for FVA/PVC
U.S. Agency for International Development

Paul B. Thompson
Executive Director
World Vision Relief Organization

Max Chigwida
Field Director
World Vision Zimbabwe

APPENDIX S

Child Survival Workshop
Murewa, Zimbabwe
August 16-21, 1987



Left to Right: Mr. Banda; Doug Mendoza, Sr.; Florence Chipango; Osheria Mohammed Elamin; Ruth Simiyu; Ellen Tagwireyi; Nel den Boer; Beatrice Mutua; Bongzi Mushapaidze; James Okuc; George Ngatiri; Richard Kudhanda; Max Chigwida; Jake van der Vlugt; Chip Oliver; Israel Kalyesubula; Emily Shoko; Catharine McCaig; Susan Chidyamatamba; Ruth Mukanyangi; I. Bani; Jelda Nhiliziyo; B. D. Biar; Lawrence Mubaiwa; Lovisa Ayazika; Dory Storms; Dale Flowers; Regina Obiagwu; B. Oirere; Cindy Rawn; Rosellyn Chiwaya; Kate Burns; Stanley Jere; Mark Publow.



Dr. Jake van der Vlugt



Mark Publow, Dr. Dory Storms
Rev. Max Chigwida



Dr. George Ngatiri



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Margaret Okello



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Dale Flowers, James Okuc

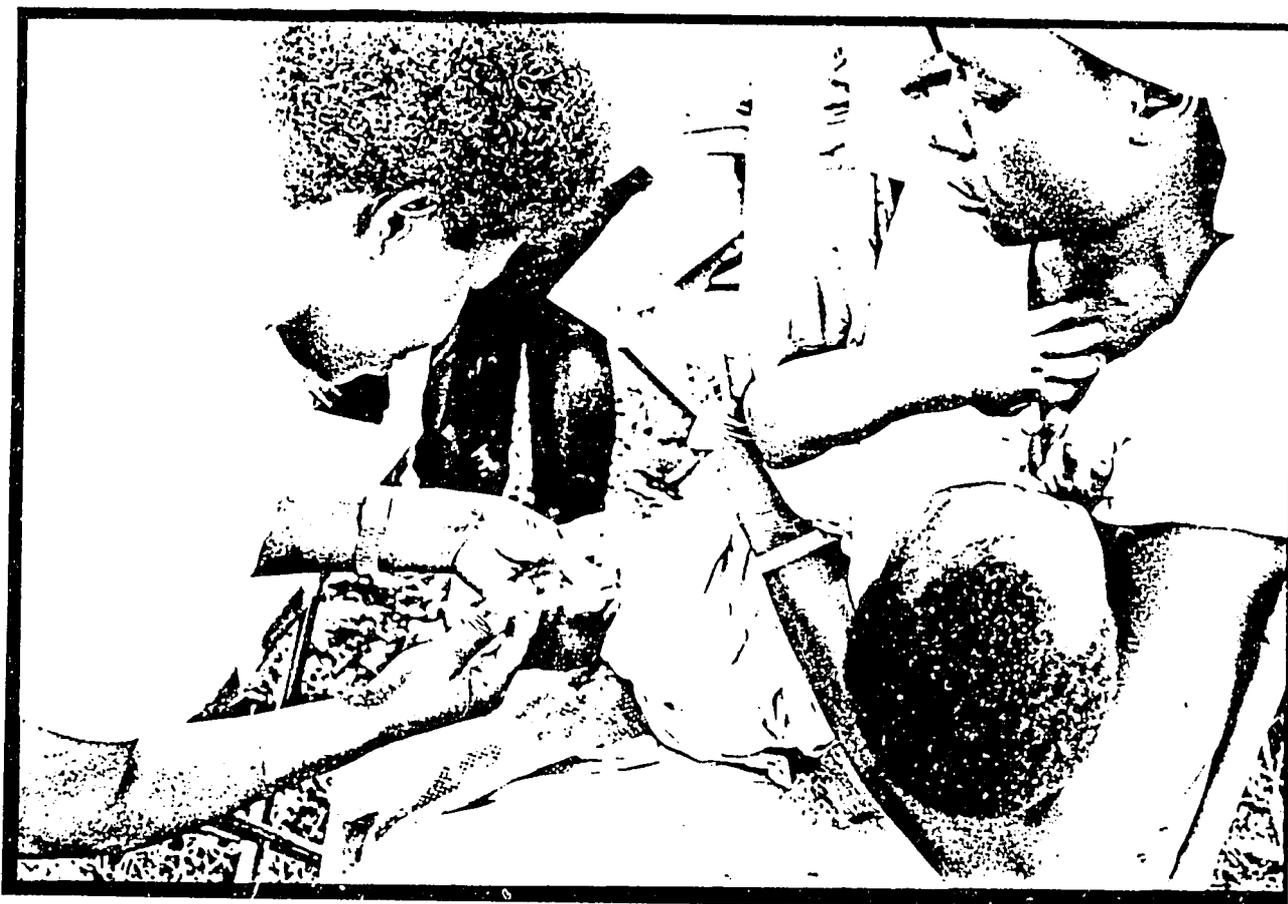


Stanley Jere



BALANCING ROCKS OF ZIMBABWE

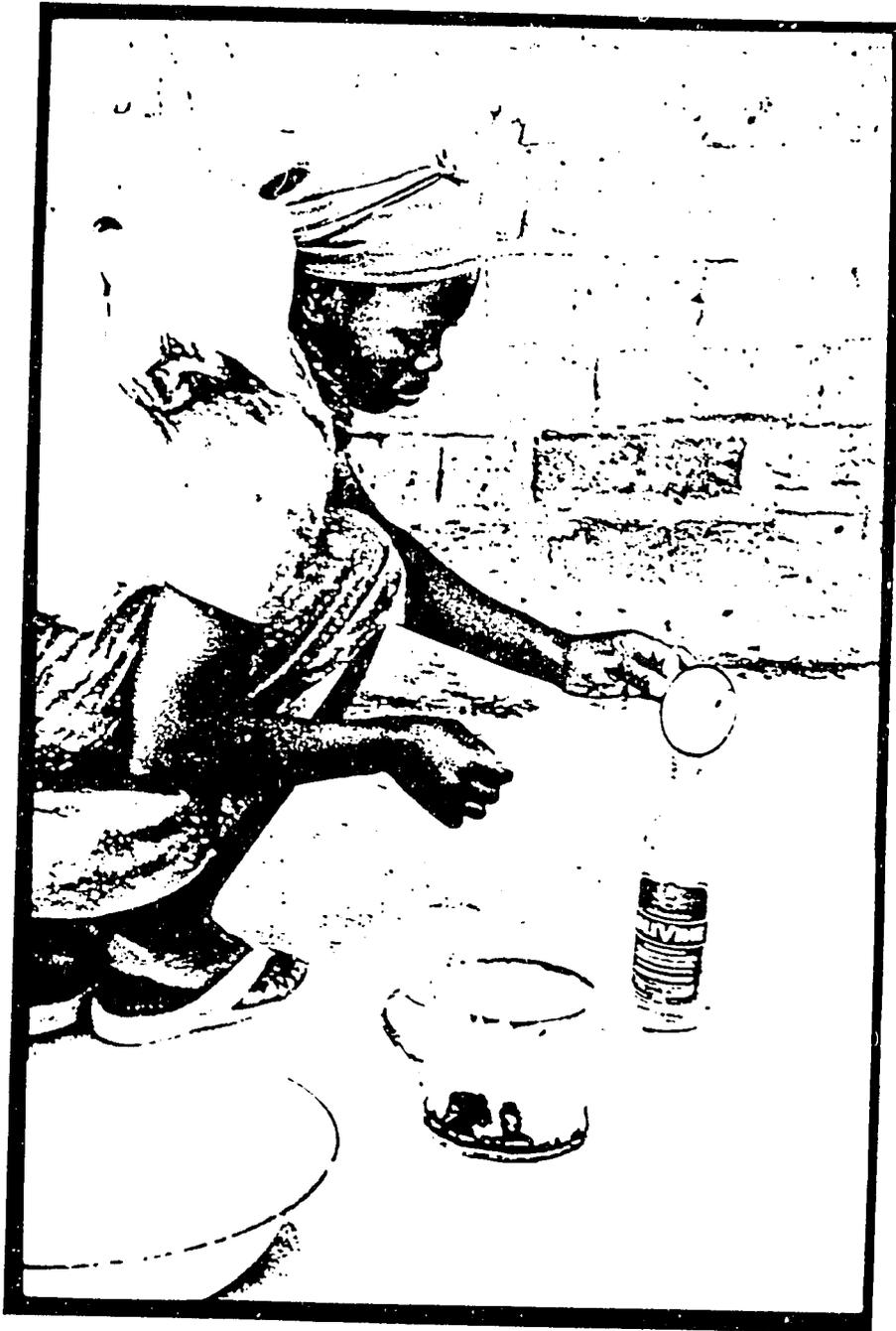
Child Survival is a precarious balance of key interventions that must be maintained if the Africa of today is ever to have a tomorrow.



"I learned the importance of interagency collaboration in trying to increase immunization coverage."



"I've learned the importance of promoting good nutrition and nutrition education in Child Survival projects."



"Improve home management of childhood diarrhea by getting down to the level of the users."



"Group discussion was the best; sharing and exchanging some of the experiences from other countries; knowing others' problems and getting new ideas from others."

APPENDIX T

POST SCRIPT: A MESSAGE

This final report is not merely a compendium nor a tool to help planners of future workshops. May it come with a message to people all over the world involved in Child Survival. The crusade to reduce morbidity and mortality of children and give them a decent start in life is now going on. We need to reinforce the commitment in people, organizations, and governments involved in this global crusade and to encourage dedication among those who will join the campaign. May the Zimbabwe and future workshops serve as catalysts in realizing this dream for the world's future leaders. As the slogan goes . . .

FORWARD TOGETHER FOR CHILD SURVIVAL !!!