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Report on the

5th African Regional Child Survival Implementation Workshop

June 24 - July 1, 1990
Atta, Imo State, Nigeria

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Sponsored by Africare/JHU/USAID in concert with
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"Improving the quality of life in rural Africa through the development of
water resources, increased food production and the delivery of health services"

TABLE OF CONTENTS

	<u>PAGE</u>
PREFACE	ii
EXECUTIVE SUMMARY	iii
LIST OF APPENDICES.	v
I. INTRODUCTION	1
II. PLANNING AND PREPARATION	3
III. THE WORKSHOP	5
A. Opening Ceremony.	5
B. Project Information Matrix.	6
C. Sustainability.	7
D. Community Participation	7
E. Income Generation	9
F. Feedback to Projects on Detailed Implementation Plan	11
G. Writing/Revising Project Objectives and Evaluation.	12
H. Health Information Systems.	15
I. Supervision	21
J. Networking Luncheon	23
K. Resource Center	23
L. Closing Dinner and Variety Night.	24
IV. OUTCOMES	25
V. WORKSHEET BUDGET	27
VI. PARTICIPANTS' EVALUATION	28
VII. COMMENTS AND RECOMMENDATIONS	31
A. Africare Comments	31
B. Africare Recommendations.	32
C. JHU Comments and Recommendations	33

APPENDICES

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PREFACE

For five years USAID has sponsored regional workshops for PVO Child Survival Projects. The workshops provide opportunities for field based project staff to share lessons learned and to strengthen their projects using skills and information acquired through workshop activities.

The early workshops concentrated on helping project staff to understand, develop and target appropriate activities in major intervention areas such as immunization, control of diarrheal disease, nutrition, and child spacing. The focus and content of the workshops has evolved as PVOs have become more skilled in designing and implementing Child Survival interventions.

The Fifth Africa Regional PVO Child Survival Workshop, hosted by the Imo State Ministry of Health/Africare Child Survival Project at the Bishop Cockin Center, Atta, Imo State, Nigeria, focused on the theme "Child Survival: The Challenges We Face...." The workshop addressed recurring concerns of most PVO Child Survival Projects in areas including writing objectives, community participation, supervision, designing and maintaining a health information system, and of course, sustainability. Workshop participants who had attended previous Child Survival Workshops and members of the workshop staff who had organized and facilitated earlier workshops observed some significant differences in the process and content of the Fifth Africa Regional Workshop compared with preceding ones.

The workshop staff found participants to be approaching the major challenges facing PVO Child Survival Projects from a perspective grounded in experience. Participants were able to address critical issues such as supervision and sustainability drawing an increasingly common pool of knowledge. Most striking to participants in previous workshops, was the ability and willingness of everyone to address fundamental issues in a manner that benefited the group. As PVOs become more skilled and more confident in Child Survival, project staff have become more willing to address serious challenges and less inclined to narrate the history of their individual projects.

The workshop participants actively influenced the process and dynamic of the workshop, defining and focusing on the most important issues in each session. The confidence and skills demonstrated by the participants indicate what has been achieved by PVOs in five years of Child Survival Projects. The challenges we face are enormous, but no greater than the commitment and skills of PVOs and their field staffs.

EXECUTIVE SUMMARY

The Imo State Ministry of Health/Africare Child Survival Project hosted the Fifth Africa Regional PVO Child Survival Workshop from June 24 - June 30, 1990 in Atta, Imo State, Nigeria. The workshop was sponsored by the Bureau of Food for Peace and Voluntary Assistance, Office of Private and Voluntary Cooperation, United States Agency for International Development, and planned in coordination with the PVO Child Survival Support Program, Institute for International Programs, Johns Hopkins University. The workshop venue was the Bishop Cockin Center at Atta, a quiet, modest, rural setting that provided a simple but comfortable atmosphere to conduct the workshop.

Workshop participants included project field staff from Adventist Development and Relief Agency, Africare, CARE, International Eye Foundation, Minnesota International Health Volunteers, Rotary, Save the Children, and World Vision. Projects from six countries, including Kenya, Malawi, Nigeria, the Sudan, Uganda and Zimbabwe, were represented.

The theme of the workshop was: "Child Survival: The Challenges We Face...." The goals of the workshop were:

- * To share resources and foster networking among PVO Child Survival field staff.
- * To examine and strengthen activities for effectively involving key segments of the community in Child Survival Project efforts.
- * To share PVO experiences and develop strategies for integrating sustainability in all phases of the project, including developing relationships with the community and the MOH, and income generation activities.
- * To strengthen Child Survival Project management through the selection of appropriate project objectives, indicators and targets.
- * To share lessons learned in data gathering, monitoring, supervision, project evaluation and feedback to the community.

Workshop activities included sessions focusing on sustainability, strengthening community involvement, revising project objectives and benchmarks, building effective health and management information systems, improving supervision, and income generation. The workshop design incorporated adult learning

theory and experiential learning techniques. Sessions were designed to foster maximum participation by all individuals.

In addition to presentations, small group discussions and role plays, two field visits were made to Imo State/Africare Child Survival Project sites. In the first area, the visit focused on community perceptions and involvement in Child Survival. Participants interviewed four segments of the community: mothers, VHWs, traditional rulers, and local government officials. The second visit to another project intervention area focused on income generation activities. Three types of income generation activities were examined and considered, particularly with regard to their viability as mechanisms for sustainability.

Sessions with individual projects were conducted in the evenings to review and discuss comments from the A.I.D. Technical Reviews of Detailed Implementation Plans. Participants unanimously agreed that these sessions made the Technical Review much more useful.

Outcomes of the workshop included: the revision of each project's objectives, indicators and targets, the formulation of 90 Day Sustainability Action Plans, and the formation of Child Survival networks within each country.

The workshop built on the experience and lessons of previous workshops. Participants and workshop staff left the workshop with a sense that the activities and discussions during the week represented a major step forward in PVOs' ability to address the challenges of promoting and sustaining Child Survival.

LIST OF APPENDICES

Description

- Appendix A List of Workshop Participants including: name, title, PVO, country, and address
- Appendix B List of Organizing Team/Resource Persons
- Appendix C Participants/Resource Person Biodata from Opening "Getting to Know Each Other Session"
- Appendix D List of Materials Displayed by the Projects During Workshop
- Appendix E Keynote Address Delivered on the Occasion of the 5th African Regional Child Survival Implementation Workshop on Monday, June 25, 1990 at Owerri, Imo State Nigeria, by Professor J. C. Azubuiké, University of Nigeria, Enugu Campus
- Appendix F Project Information Summary Sheets for Each Project
- Appendix G Sections of Workshop Minutes on Sustainability
1. Project Sustainability Matrix and Examples of Three Types of Sustainability:
 - a. Financial Viability
 - b. Skill and Technical Transfer
 - c. Continued Service Coverage to Maintain Health Behavior Change
 2. List of Participant Comments/Views on Sustainability
 3. Each Project's Sustainability Action Plan

LIST OF APPENDICES
(cont'd)

Description

- Appendix H Sections of Workshop Minutes on Community Participation
1. List of positive and negative beliefs for four intervention groups: ORT, EPI, nutrition, high risk births
 2. Text of interviews of 4 segments of the community (mothers, VHWS, local government officials, traditional leaders) during field visit to Ahiazu Mbaise.
- Appendix I Sections of Workshop Minutes on Income Generation
1. List of Driving and Restraining Forces for each of the three income generation activities discussed by the three groups.
 - a. Drug revolving fund
 - b. Fees for service
 - c. Community fund
 2. Text of interviews with PU and Food Commodities Storage and Marketing Income Generating Projects during field visit to Isiala Ngwa
- Appendix J Sections of Workshop Minutes on HIS
- Appendix K Sections of Workshop Minutes on Supervision
- Appendix L PEN-3 Model

I. INTRODUCTION

In 1985, the Agency for International Development, Bureau for Food for Peace and Voluntary Assistance, Office of Private Voluntary Cooperation (AID/FVA/PVC) established a competitive grants program for private voluntary organizations (PVOs) implementing Child Survival activities in the developing world.

In October 1990, the sixth cycle of Child Survival grants was awarded to PVOs by AID/FVA/PVC. Since 1985, 86 Child Survival grants have been awarded to 26 U.S.-based PVOs to implement activities for EPI, ORT/CDD, nutrition, and prevention of high risk births in 26 countries in Africa, Asia/Pacific, Latin America, and the Caribbean.

On October 1, 1986, AID/FVA/PVC established a cooperative agreement with the PVO Child Survival Support Program, Institute for International Programs, The Johns Hopkins University to provide technical support to the Child Survival PVOs. The major purposes of this agreement are to develop the abilities of PVOs to provide more effective Child Survival activities at the community level, and to enhance professional understanding of the role PVOs can play in the health development process.

PVO Child Survival Support Program efforts include:

1. organizing international and U.S.-based workshops and conferences for PVO Child Survival field and home office staff,
2. sponsoring specialized technical assistance at the request of PVO Child Survival field projects,
3. organizing external technical reviews of Child Survival proposals and detailed technical implementation plans,
4. assisting PVOs with health information systems,
5. initiating special studies,
5. compiling and distributing the quarterly PVO Child Survival Technical Report.

The June 1990 workshop was the seventh regional implementation workshop sponsored by AID/FVA/PVC, organized by the PVO Child Survival Support Program, and hosted by a Child Survival PVO since 1986. Prior to this workshop, similar regional workshops were held in Africa (4), Asia (1), and Latin America (1).

The purpose of the regional workshop strategy is to:

1. strengthen the delivery of Child Survival services and messages at the grass-roots level,

2. exchange lessons learned by PVO Child Survival Programs, and
3. provide networking opportunities for country national staff most directly involved in Child Survival project implementation.

II. PLANNING AND PREPARATION

The number of CSIV and CSV (fourth & fifth cycle) projects working in Anglophone Africa was the stimulus for scheduling a regional workshop. The regional workshop strategy is a cost-effective way to provide training and networking opportunities to country national project staff within specified regions. Twelve PVO Child Survival projects, representing six countries, were represented at the June 1990 workshop.

After AID/FVA/PVC identified a need for an Africa regional workshop in 1990, Africare expressed interest in hosting such an activity at the Imo State-Africare Child Survival Project in Nigeria.

Planning began with a scouting visit by PVO Child Survival Support Program staff in June 1989, in conjunction with a visit to another PVO Child Survival field project in Nigeria.

This one week visit confirmed the Imo State-Africare staff's interest in hosting a workshop. During the visit, possible workshop venues were identified as well as possible sites for field visits.

PVO Child Survival Support Program staff recommended to AID/FVA/PVC that, barring political strife in Nigeria, the Imo State-Africare CS project site would serve as an excellent environment in which to hold the 5th Annual Africa Regional Child Survival Implementation Workshop.

Appropriate agreements were drawn up between AID/FVA/PVC and Africare Headquarters (Washington, DC). At the PVO Child Survival Support Program project profiles and demographic and cost data material were prepared for each participating country project. Relevant background documents and resource materials were also gathered. Africare/Washington distributed a participant needs assessment, which was previously developed and field tested by the PVO Child Survival Support Program.

Appropriate workshop technical resource persons were identified and contracted by the PVO Child Survival Support Program. The AID/FVA/PVC EPI Coordinator for Africa and Haiti was contracted through JSI/REACH and the workshop facilitator was contracted by Africare/Washington.

In April 1990 a 3-day planning meeting was held in Baltimore and Washington, DC and was attended by the Imo State/Africare CS Project Manager, the Africare/Washington Africa Regional Director, AID/FVA/PVC Project Officer for Africare, PVO Child

Survival Support Program Workshop Coordinator, Workshop Resource Persons, and the Facilitator.

At this meeting, the workshop agenda was drafted, based on participant needs assessments and technical review of project documents. Final logistical issues were also discussed. Organizing team members' roles & responsibilities were clarified and "for action items," prior to the June workshop, were identified and assigned to team members.

Africare/Washington accomplished all principal tasks with PVOs to identify host country field staff participants, arrange their air travel, issue letters of invitation, and forward each participant his or her air ticket. Since all participants were travelling from eastern and southern Africa, all were booked into Nairobi to meet up and take the same flight together from Nairobi to Lagos. This greatly simplified customs and immigration formalities, temporary lodging in Lagos, and travel arrangements upcountry.

Final workshop planning took place in-country, one week prior to the workshop.

Appendix A of this report provides a list of workshop participants including name, title, PVO, country and address. Appendix B lists the workshop's organizing team and resource persons. Appendix C provides biodata on participants and resource persons.

III. THE WORKSHOP

A. Opening Ceremony

The Imo State Ministry of Health/Africare Child Survival Project was conceived and has been planned and implemented in close collaboration with the Imo State Ministry of Health. As such, preparations and arrangements for the 5th Africa Regional Child Survival Workshop involved major commitments of personnel and resources by the Ministry. The workshop was officially opened by the Military Governor of Imo State, Commander Amadi Ikwechegh, who emphasized the importance to the state government of child survival activities. Hosting the international child survival workshop strengthened an already deep and extensive commitment to child survival by the Imo State Government.

In addition to the Governor, the participants were addressed by the Imo State Commissioner for Health, Dr. Chigozie Ogbu, the U.S.A.I.D. mission chief, Mr. Henry Merrill (represented by Mrs. Sheeta Bay), and Africare's Country Representative in Nigeria, Dr. Bekki Johnson. The keynote address was delivered by Professor J.C. Azubuiké, the Deputy Vice Chancellor of the University of Nigeria, Enugu Campus. Dr. Azubuiké addressed the progress that has been made in child survival and explored the challenges facing governments and international agencies in sustaining and strengthening health activities, particularly in light of the current economic hardships in Africa and the increasing limitations on and competition for external assistance from donor nations. (A full transcript of Professor Azubuiké's address is reproduced in Appendix E.)

In conjunction with the opening ceremony of the morning, the Ministry of Health organized and sponsored an impressive Cultural Extravaganza later in the evening. The Imo State Dance Troop performed a number of traditional Igbo dances. The Imo State Theatre Company then enacted an amusing drama incorporating major child survival themes such as child spacing, immunization and nutrition.

WORKSHOP SCHEDULE

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Arrival	Opening Ceremony	Field Visit Community Perceptions	Field Visit Income Generation	H.I.S. Networking Groups	Supervision Revising Objectives
Welcome and Orientation	Sustainability Community Participation	Sustainability Update Income Generation	Project Objectives and Evaluation	H.I.S. Revising Objectives	Sustainability Action Plan Objectives Wrap-Up and Evaluation
	Cultural Evening	Project Feedback	Project Feedback	Special Interest Groups Project Feedback	Variety Night

B. Project Information Matrix

During planning and preparation for the workshop, resource persons Mary Harvey and Louis Fazen designed a Project Information Matrix with all of the participating projects on one axis and important areas of information about the project on the other. During the introductory session of the workshop the matrix was explained to participants and each project was asked to fill in all its relevant information. The matrix was then used as a point of reference for many of the ensuing sessions. Information for each project contained in the matrix included: the size of specific target populations (e.g. children < 12 mo., women 15-49, children less than five, etc.), the type(s) of EPI activities and current coverage levels, the types of ORT activities and current coverage levels, the percentage of resources used for each child survival intervention, the number and type of personnel trained, and project sustainability activities.

The entire matrix is too large to be reproduced effectively as one document here, however, the information from the matrix is summarized for each project in Appendix F.

C. Sustainability

Workshop participant needs assessments revealed a common concern related to sustainability of Child Survival activities after PVO projects end.

In past workshops, discussion of sustainability issues was often left to the latter part of the week. For this workshop, the organizers opted to integrate the topic of sustainability throughout the week. Regular "sustainability-stops" were made to review how sustainability related to the sessions being presented. In this way, concerns about, and strategies for, long-term sustainability of CS programs were woven into the workshop agenda.

Discussions on sustainability are therefore reflected throughout this report. They are presented specifically in Section IV and Appendices G.1, G.2 and G.3 which summarize the views and priorities of participants as well as the Action Plans they proposed for their projects.

D. Community Participation Session

Principal Resource Person: Collins Airhihenbuwa

Goal: The goal of the Community Participation session was for participants to be aware of the importance of adapting child survival programs to reflect the knowledge, attitudes and practices of the community.

Objectives:

- * To cite examples of how positive and negative beliefs influence the willingness to use child survival interventions.
- * To identify specific methods for strengthening child survival interventions from the community perspective.
- * To exchange ideas and lessons learned for building effective community participation.

Session Design:

<u>Time</u>	<u>Duration</u>	<u>Step</u>	<u>Method</u>
3:00-3:05	5	Review goal, objectives and Presentation approach to session	
3:05-3:15	10	Describe & define the elements & phases of community participation	Presentation

3:15-3:45	30	Share ideas & experiences on specific interventions using community participation What has been successful? What has been difficult and/or problematic? (Focus on target groups: mothers, community health workers, leaders, government workers)	Small Groups - ORT - Immunization - Nutrition - High Risk
3:45-3:55	10	Draw out common themes & problems	Large Group Discussion
3:55-4:10	15	Describe examples of positive & negative beliefs in relation to child survival interventions	Presentation
4:10-4:35	25	Identify specific beliefs Most important, positive, reinforceable Most important, negative, changeable	Small Groups
4:35-4:50	15	Groups report out	Large Group
4:50-5:00	10	Summary, closing, and introduction/link to field visit	Presentation/ Discussion

Session Report:

The session and the subsequent field visit were designed to provide participants with the experience of identifying perceptions about child survival in four segments of the community --mothers, Village Health Workers, traditional community leaders, and local government representatives. The experience should establish the foundation for involving the community (taking into account their perceptions) in the planning, implementation and evaluation of Child Survival interventions. Each participant was a member of one of four intervention groups -ORT, EPI, nutrition, and High Risk Birth. These groups addressed beliefs and perceptions concerning their interventions. Each group developed a list of reported positive and negative health beliefs related to their interventions. They then categorized the beliefs into important and reinforceable positive health beliefs and important and changeable negative health beliefs.

Given the information generated on positive and negative health beliefs, each intervention group developed a list of questions for interviews with the four segments of the community during the field visit to the Imo State/Africare Child Survival Project area in Ahiazu Mbaise Local Government. Each intervention group (with five members) designated a member to represent them on a team that would interview a particular segment of the community. The fifth member served as a recorder for one of the interview teams. The interviews were conducted and the results processed during the field visit to Ahiazu Mbaise. In processing the field visit after the interviews, members of the interview teams had the opportunity to share some of their questions and answers in different segments of the population. Participants were able to address the perceptions and concerns of different segments of the community in designing particular interventions. The processing ended with the revelation to the participants that they had just completed the application of the PEN-3 Model. Copies of the model (see Appendix L) were distributed to each participant. See Appendix H for workshop minutes on community participation.

E. Income Generation Session

Principal Resource Person: Chibuzo L. Oriuwa

Goal: To enable the participants to examine three types of income generation activities and relate income generation to issues of sustainability and community participation in Child Survival.

Objectives:

- * To identify the driving and restraining forces of a financial viability activity.
- * To prepare questions and guidelines for field interviews at Imo State/Africare Child Survival Project income generating activities.

Session Design:

<u>Duration</u> (minutes)	<u>Step</u>	<u>Method</u>	<u>Materials</u>
10	Introduction and review of session goal & objectives	Presentation	Flip Chart
10	Review list of financial viability activities	Presentation	Sustainability Matrix, Flip Chart

10	Additional activities Participants select three activities from the list	Large group discussion	Flip Chart
30	Identification of driving and restraining forces affecting each financial viability activity	Small groups	Flip Charts
30	Comments/observations about factors identified	Group Pre- sentation, Large	Group Discussion
20	Description of income generation activities of Imo State Child Survival Project	Presentation	Flip Chart
30	Prepare guidelines and questions for field interviews	Small groups	
10	Wrap up/instructions	Presentation/ Discussion	

Session Report:

The session was designed to build on the previous day's session on sustainability of Child Survival programs. A brief introduction to income generation was presented emphasizing how income generation can be linked to Child Survival in an effort to achieve some degree of sustainability of Child Survival programs. Income generating activities provide a viable alternative to finance recurrent costs of Child Survival activities which may not be easily maintained through other means.

Participants were divided into three small groups to address driving and restraining forces affecting different types of activities aimed at achieving financial viability which were identified by different projects. Three of the activities were selected as models to be explored in depth by the three groups. One group was responsible for exploring all the positive and negative factors affecting a drug revolving fund, another group studied fees for service, and the third group looked at a community fund. Following the small group discussions, each group appointed a spckes-person to present their findings to the entire group.

The Project Manager for the Imo State/Africare Child Survival Project, Mrs. Chibuzo Oriuwa, then provided a brief description of three income generating projects being implemented

in conjunction with the Child Survival Project which were to be visited during a field visit. The projects included 1) a small scale food production unit, 2) a community farm, and 3) a food commodities storage and marketing project managed by Village Health Workers.

The same three small groups were each assigned one of the Imo State/Africare income generating activities for which they prepared relevant questions to help them examine the strengths and weaknesses of the activity during the field visit.

The day of the income generation field trip, the skies became cloudy and dark and a very heavy rain fell. Still, one could find three groups of workshop participants exploring a production unit, a community farm, and a food storage/marketing project in Isiala Ngwa. Community members welcomed workshop participants into their homes and honored them by performing the kola nut welcoming ceremony. After the field visits the group returned to the training center to dry off a bit and to process their field experience.

In order to apply in a practical way what the participants had learned, the session facilitator created a scenario in which she was a new PVO child survival project manager interested in developing and implementing an income generation project in the impact area. This inexperienced project manager had come to seek advice from the workshop participants. During the discussions, important advice for starting an income generation project included:

- assure total community involvement from the beginning;
- carry out any needed feasibility study or marketing survey;
- be realistic; determine your source of capital; be certain that the community can sustain the activity;
- plan for training of community members in management skills;
- perform regular monitoring and evaluation.

Appendix I contains minutes of workshop proceedings regarding income generation.

F. Feedback to Projects on Detailed Implementation Plan Technical Reviews

Principal Resource Person: Dr. Louis Fazen III

Goal: To provide individual projects feedback from the A.I.D. Technical Review of DIPs to project staff and initiate steps to address areas of concern.

Objectives:

* To address strengths and concerns identified in Detailed Implementation Plans

* To allow project staff the opportunity to respond to DIP recommendations

* To create climate that will help projects address technical concerns throughout the workshop.

Session Design:

Six individual project review sessions were scheduled with participants from CS IV and CSV(R) projects, to explore step by step the comments and recommendations of the A.I.D. Technical Review team. Dr. Fazen, the facilitator for these sessions, was a member of the A.I.D. technical review team. After discussing the A.I.D. comments and recommendations the participants brainstormed possible strategies to address areas of concern.

Session Report:

In general DIP feedback sessions lasted one to two hours. Notetaking was encouraged and the technical comments were reviewed in order. The DIPs themselves were referenced for additional details related to technical comments. In addition, workshop lessons and the project matrix were used to illustrate the technical reviews.

Discussions were lively and thoughtful. In spite of the late evening hour at which the sessions were conducted, participants were uniformly pleased to be able to respond to the DIP reviews by individual projects in small groups. Most participants had some involvement in writing the DIP and almost all were able to demonstrate a working knowledge of the DIP. At the conclusion, the participants were encouraged individually for their efforts under difficult conditions in the field, and for strengths demonstrated during the workshop.

G. Writing/Revising Project Objectives and Evaluation

Principal Resource Person: Collins Airhihenbuwa

Goal: To strengthen Child Survival Project management through the selection of appropriate project objectives, indicators and evaluation.

Objectives:

* To write measurable objectives for at least one CS intervention area.

* To describe the relationship between objectives and evaluation.

* To identify strengths and weaknesses of the original project objectives submitted to A.I.D.

Session Design:

<u>Time</u> (minutes)	<u>Duration</u>	<u>Step</u>	<u>Method</u>
3:00-3:05	5	Review goal, objectives and approach to session	Presentation
3:05-3:15	10	Describe elements of objectives and evaluation	Presentation
3:15-3:45	30	Share ideas & experiences about writing objectives. Explore perceptions and raise 2 key questions about objectives and evaluation.	Small Groups
3:45-4:05	20	Discuss perceptions about objectives and evaluation. Address key questions raised.	Panel
4:05-4:35	30	Identify + and - in specific project objectives	Small Groups
4:35-4:50	15	Group Report	Discussion
4:50-5:00	10	Summary/Closing	Presentation

Session Report:

The session was designed to provide participants working skills in writing behavioral objectives and indicators and utilizing them to evaluate project outcomes. The criteria established for an objective were:

- * It must be focused on a desired change in behavior of the people for whom the program is intended to benefit.
- * It must have a specific time frame.
- * It must give a specific number in relation to the number in the target population.
- * It must specify the target population (e.g. mother)

- * It must use terms that can be measured (e.g. identify/demonstrate as opposed to know/realize etc.)

The indicators should identify who, how and when the activities will take place as well as benchmarks for tracking progress. Evaluation should describe how the activities will be measured against the objectives in order to determine achievements, strengths and weaknesses.

Participants practiced writing objectives in four intervention groups and progressed to write at least one objective per the interventions in their project.

Initial discussions for the objectives and evaluation sessions were designed to demystify and simplify the writing of objectives, indicators and evaluation. Participants shared their thoughts and beliefs about writing objectives. Criteria were presented for writing objectives and examples were presented and discussed to clarify the presentation of measurable, quantifiable, and sustainable objectives.

Participants were then assigned to their original intervention groups (ORT, immunization, nutrition and high risk birth) from the community participation session. Each group discussed and then drafted one objective and a corresponding indicator and evaluation procedure for their intervention. At the close of the first session, an objective, an indicator, and evaluation procedure was submitted on a worksheet that was provided.

Following this exercise, each project was provided with their original objective that were submitted to A.I.D. and they were asked to critique their objectives and use the worksheet that was provided to write measurable objectives for their project based on the criteria that had been discussed.

The session on objectives, indicators and evaluation spanned over period of three days. During the second day the groups were given the opportunity to make revisions in their objectives for their assigned intervention area. Finally, individual projects were assigned the task of writing one objective for each of the intervention areas in their project. On the final morning of the workshop each project presented one of its revised objectives with indicators and a procedure for evaluation.

Participants expressed a much greater confidence in their understanding of and ability to write objectives. They also expressed an appreciation for their greater awareness of the relationship between objectives and evaluation of project activities. Designing the session to span over three days allowed the participants to learn from and follow up on their experiences.

H. Health Information Systems Session

Principal Resource Persons: Mary Harvey and Dr. James Okuc

Goal: To share lessons learned in data gathering, monitoring, and feedback to the community.

Objectives:

* The participants will be able to describe what is meant by an HIS/MIS and discuss its components.

* Participants will be able to design a data collection instrument for one CS activity objective.

* Participants will be able to prepare descriptive and graphic data analysis report for feedback.

Session Design:

Objective 1. Describe what is meant by an HIS/MIS and discuss its components

Total Time: 1 1/2 hours

<u>Time</u>	<u>Method</u>	<u>Content</u>	<u>Resources</u>
15 min.	lecturette	1. Describe purpose, process, types of info required for HIS/MIS	Chart
15 min.	brainstorm	2. Identify 9 components of an HIS	Flowchart
60 min.	large group discussion	3. Develop sample HIS for one intervention	Flipchart/pens EPI monitoring forms EPI data collection forms, graphs EPI indicators Disease surveillance forms

Objective 2. Identify indicators and design a data collection instrument for one CS intervention

Total Time: 2 hours

<u>Time</u>	<u>Method</u>	<u>Content</u>	<u>Resources</u>
15 min.	lecturette	1. Highlight importance of why dta is collected, importance of form design	Flipchart A.I.D. reptg. forms Community-based forms
1 hr.	4 small groups	2. Designing data collection tool for one intervention	
40 min.	small group	3. Presentation/critique of instruments presentation	Flipchart
5 min.		4. Wrap-up of forms and critique by resource persons	

Objective 3. Prepare descriptive and graphic data analysis report for feedback

Total Time: 1 1/2 hours

<u>Time</u>	<u>Method</u>	<u>Content</u>	<u>Resources</u>
10 min.	lecturette	1. Present examples of graphic and descriptive use of data	Child Survival Report to Congress EPI Monitoring Chart Bar graphs, etc.
60 min.	4 small groups	2. Intro to and small group exercise on preparing report feedback to community, MOH, POV, and A.I.D.	PVO Info Matrix
20 min.		3. Share insights into development of report	Flipchart

Session Report:

1. Introduction

The workshop goal for this session was "To share lessons learned in data gathering, monitoring, and feedback to the community". This six-hour session, presented an overview of steps that should be considered when designing an HIS and provided an opportunity to practice the skills needed to develop effective data collection tools. The final activity of the session offered the participants a chance to analyze the information on project activities which had been recorded on the Project Information Matrix and from that analysis present a report/feedback to the users of this information: the community, the PVO, the MOH, and the donor agency, in this case A.I.D.

2. Presentation Summary

a. HIS Defined

The brief presentation on the purpose of an HIS at the beginning of this session stressed the fact that several concurrent forces have generated a critical need for reliable, timely, and pertinent information:

- * Population-based primary health care programs have made improved managerial effectiveness a priority. The management of information has emerged as a crucial component of such efforts, since effective information management facilitates better informed and timely decision-making for cost-effective program management.
- * The current economic crisis has hit the health sector with devastating force, and cost control and more efficient use of very limited resources have become major concerns.

The need to think of an HIS in terms of a Management Information System was stressed. An MIS was described as a total set of processes, activities, records, and equipment devoted to produce information that assists managers in decision making and enables them to ascertain the progress made by the organization in the achievement of its major use targets and activity targets.

b. The Nine Components of an MIS

The second activity took the participants through a step by step process for designing an MIS. The design of the system, the process for linking inputs to outputs presented is as follows:

- 1. Set Objective - Decide what it is that one hopes to accomplish in a specific project or program.
Ask how much can realistically be done in a given time period.
Choose how you will measure the outcome.
- 2. List Activities - A description of what must be done in order to insure the attainment of a given objective. The activities for a given objective should be sufficiently inclusive that the successful achievement of all activities will necessarily lead to the achievement of one's objective. They should also be measurable.
- 3. Identify Users - In identifying users, the first step is to develop a profile of an organization's information users. They can be community members, personnel of a health facility, MOH personnel, project field staff, project HQ and external donors. Each group will require different information, have a special processing need and use the results differently. To prepare a profile of users, the manager and the other primary health care team members should prepare an initial list of information users. This can be followed by series of short interviews with the persons on the list to determine how they use information and what kind of information they use. Basically the information needed is that which is required to make a decision in order to perform one's work.
- 4. Select Indicators - This step is seen by many as the core of designing a monitoring and evaluation system, since it is the process of defining what it is that will actually be measured during the course of a project's implementation. The process for selecting indicators is difficult since there are many considerations which must be kept in mind for each indicator. The first step is to answer the following questions for each activity:

1. What are the questions we need to answer to know whether we will accomplish our activity?
2. What information do we need to answer these questions? (indicators)

An indicator should satisfy the following requirements:

- * it must be representative of what we are trying to measure;
- * it must be useful to us in making management decision;
- * it must be measurable; and,
- * it must be worth the time and money spent in collecting the necessary data.

5. Set Targets

- Three methods are commonly used for setting interim targets:
 - * Take the final objective or activity output and divide by the number of years in the project for the annual estimate.
 - * Take the previous years result and add 10% for this year's estimate.
 - * Set targets according to some normative standard (i.e standards used in growth monitoring, selecting target populations, estimating how many households a village health worker can see in a week).

6. Collect Data

- Key issues which should be considered:
 - * value vs cost
 - * Health workers workload
 - * Data quality -accuracy check needed

7. Analyze data

- To understand the process of turning the data into information we will need to answer 4 questions:
 - * For what decisions will we need the information
 - * What data will be needed?

* What level of aggregation will be most useful?

* What method of presentation will be most effective?

8. Generate reports - Consider the following:

a. Most people are only able to think about seven items of information at one time. Lists of figures will be difficult to interpret.

b. The problem most managers have is not too little information but too much.

c. Whenever possible information collected on indicators should be presented alongside of the targets for those indicators so that a manager can see at a glance whether a project is on schedule with its plans.

d. Data should be grouped in combination with other indicators so that the picture makes sense to someone scanning a report.

e. A picture is worth a thousand words.

9. Make decisions/take action -

c. Designing a Data Collection Tool

The importance and difficulty of designing a data collection tool was discussed. Project information data collection forms distributed to the participants on the first day as well as the A.I.D. reporting form were used as examples of the difficulties in designing forms and the need to field test them. It was emphasized that forms should be designed in such a way that the data collected is reliable, valid, precise and representative.

Working in four small groups the participants developed forms that could be used for collecting information for and from the community, the MOH, PVO Headquarters and A.I.D. These forms were then critiqued by the resource people who worked at each level.

d. Analyzing Data and Generating Reports

The final session involved the participants in developing reports that could be given to the four levels: community/mothers, MCH, Project, and A.I.D. The data analyzed was that provided on the Project Information Matrix. A brief presentation on how A.I.D. uses the data was made and the participants attention were drawn to the information on their projects presented in the Child Survival Report to Congress and the graphic presentation of the data they provided in their reports.

The session ended with the participants receiving samples of data collection and monitoring forms used for EPI. See Appendix J for minutes of the workshop on health information systems.

I. Supervision

Principle Resource Person: Mary Harvey

Goal: To share lessons learned in data gathering, monitoring, supervision, project evaluation and feedback to the community.

- Objectives: * to develop standards for effective supervision.
- * to identify problems related to supervision and develop solutions to the identified problems.
 - * to understand the importance of supervision to the implementation of effective Child Survival Programs.

Session Design:

Objective 1: Develop standards for effective supervision

Time: 45 minutes

<u>Time</u>	<u>Method</u>	<u>Content</u>	<u>Resources</u>
15 min.	Presentation	1. Intro to supervision - need and importance - objectives and outline of the session plan	Flip chart

30 min.	Brainstorm Group Discussion	2. Functions of supervision list, explain meaning and how it relates to overall CS program	Flip chart
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Objective 2: Identify problems related to supervision and develop solutions to the identified problems

Time: 1 hour 10 minutes

<u>Time</u>	<u>Method</u>	<u>Content</u>	<u>Resources</u>
15 min.	Brainstorm	1. Identify problems programs are having which are affected by supervision	Flip chart
10 min.		2. Describe process of identifying knowledge, attitudes, skills needed to solve problems	
30 min.	Small groups of two	3. Select one problem and apply problem solving method to solve it	
5 min.	Groups of four	4. Request groups to fold into groups of 4 to do role play on how they could use supervision to resolve problem	
30 min.		5. Have group recorder; present observations on role play and problem resolution	
10 min.		6. Process of problem solving in step 3	

Session Report:

This two hour session on supervision took place on the last day of the workshop. It was one in which the participants played a very active role. The focus was on having the participants identify the problems they were facing as supervisors and the types of skills, knowledge, and attitudes they would need to resolve these problems.

The session began with a role play by the workshop facilitator and the resource person focusing on the poor relationship between a supervisor and the supervisee. Following this presentation the participants identified why supervision is important, the functions of a supervisor and the problems they face as supervisors. The participants then identified the knowledge, skills, and attitudes they needed to solve the problems they listed. The majority of the problems were seen to be affected by attitudes and skills. Working in groups of two each participant was asked to discuss with their partner one problem they faced and identify the knowledge, skills, and or attitudes which they would need to resolve this problem. The participants were then asked to form groups of four and conduct a role play based on one of their problems. One person acted as an observer. At the end of this process, the participants presented their observations of the role play and three of the groups presented their role play. The session ended with having the participants record the one knowledge, attitude or skill that they felt they would need to solve their problem.

Refer to Appendix K for minutes on the topic of supervision.

J. Networking Luncheon

On the fourth day of the workshop participants were briefed by resource person Dr. James Okuc about the objectives of a networking luncheon to be held that afternoon. Participants were divided into their respective countries for the luncheon and each country group devised a system by which Child Survival Projects and other related organizations and agencies in each respective country would maintain communication, share information and build on each other's experience to coordinate and strengthen intra-country activities.

K. Resource Center

At the outset of the workshop a resource center was set to provide participants with a wealth of information to support their projects. Resource information came from A.I.D., Johns Hopkins, REACH, UNICEF and other agencies working in Child Survival. There was also a wealth of information from the host

Imo State/Africare Child Survival Project, from the State Ministry of Health, and from each participating project which brought along many of their project materials to be shared with all participants. There was some material for each participant and each project to take back to their respective countries and other material that was available only during the workshop period. Participants found the resource room useful and stimulating, though some felt that the workshop schedule was so busy there was not sufficient time to utilize the available materials. Particular thanks must be extended to Mr. Vincent Obelle from the Imo State Ministry of Health who was in charge of organizing and maintaining the resource center.

L. Closing Dinner and Variety Night

Finally, a report on the workshop activities would not be complete without mentioning the final evening of festivities. Everyone was treated to a sumptuous feast of Nigerian dishes followed by the presentation of certificates and T-shirts to all the participants. Participants from each country then delighted their colleagues presenting songs and dances from their respective nations. The evening closed with dancing and a final sharing of experiences.

IV. OUTCOMES

Participants developed 90 Day Sustainability Action Plans (see Appendix G.4) which they aimed to implement upon returning to their projects. The purpose of these Action Plans was to integrate the lessons and experience from the workshop as soon as possible into the implementation plans of the participating projects. The Action Plans focused specifically on activities that could be undertaken to strengthen sustainability. Activities planned by various projects included 1) arranging meetings to coordinate more effectively with other agencies, 2) integrating project activities with the MOH, 3) establishing mechanisms, such as community health committees, to involve the community more thoroughly in the planning and implementation of project activities, 4) exploring and developing community based income generating activities, 5) simplifying the health information system and involving ministry personnel who would eventually assume responsibility in the design of simplified data collection tools, 6) utilizing existing service delivery mechanisms, and 7) establishing a drug revolving fund. Each project's 90 Day Sustainability Action Plan is reprinted in full in Appendix F.

In addition to developing 90 Day Sustainability Action Plans, each project worked to revise its objectives, indicators and targets to make them measurable, time-limited and focused on a specific population of intended beneficiaries. As well as leaving the workshop with objectives and indicators which were more clearly stated and precisely focused, participants were able to better understand the relationship between objectives, indicators and evaluation, particularly in their role as tools for project management.

Participants returned to their projects with examples designed during small group sessions of health information collection tools specifically targeted for each of the audiences to which information is presented: U.S.A.I.D., the PVO headquarters, internal project management, the MOH/host government, and the beneficiary communities. The exercise heightened awareness with regard to planning health information systems so that they will collect data necessary for specific purposes.

For each country, child survival networks were established so that different projects operating in the same country can share information and build on each other's experience. For each project, specific plans were made to respond, in terms of project implementation, to the comments and recommendations from the A.I.D. Technical Review of Detailed Implementation Plans.

Several participants left the workshop determined to explore and perhaps develop community based income generation activities in an effort to address the financial viability of sustaining project activities after donor funding ceases.

Locally, the major role played in organizing, supporting and implementing the workshop by the Imo State Ministry of Health, and the high visibility of the workshop in the intervention communities, helped to strengthen government and community commitment to child survival.

Finally, one of the most important outcomes is more intangible. The participants left the workshop with a sense of solidarity and purpose, and with a heightened confidence in their ability to manage their projects effectively. This kind of outcome is not easily measured, but is a major benefit of the kind of group activities which the workshop facilitated.

V. WORKSHOP BUDGET

Africare Budget

Fifth Africa PVO Child Survival Implementation Workshop

PERSONNEL

U.S. Hire Consultants	\$5,500
Honoraria for Local Speakers	500
Site Logistics/Clerical/Admin	100
Lagos Logistics	<u>200</u>
Sub-total	\$6,300

TRAVEL/FOOD/LODGING

Travel

Intl Airfares (Intl Consult/Particip)	\$12,000
Incountry Airfares for Staff/Participants	500
Incountry Bus Hire for Staff/Participants	500
Taxi/Vehicle Hire in Imo State	500
Fueling/Repair to Project Vehicles	<u>200</u>
Sub-total	\$13,700

Food/Lodging

U.S. Hire Consultants	\$ 1,500
Participants/Staff	<u>4,000</u>
Sub-total	\$ 5,500

TRAINING MATERIALS

Training & Project Supplies & Equipment	\$ 3,500
Wkshp Bags & T-Shirts (Participants/Staff)	600
Notebook/Stationaries/Pens/Etc.	<u>500</u>
Sub-total	\$ 4,600

OTHER DIRECT

Photos/Video/Workshop Report	\$ 1,500
Phone/Telex/DHL/Postage/Other	<u>3,000</u>
Sub-total	\$ 4,500

AFRICARE ADMINISTRATIVE Sub-total \$10,400

TOTAL \$45,000

VI. PARTICIPANTS' EVALUATION

At the close of the workshop, participants were asked to complete an evaluation that consisted of eleven quantifiable questions and three open-ended questions.

Evaluation results were consistent with other AID/FVA/PVC-sponsored workshops, conducted using the same methodology. Participant evaluations were overwhelmingly positive for content, learning, organization, field visits, and the opportunity to participate. The lowest ratings given related to the workshop training center which experienced water and electricity supply difficulties throughout the week.

Evaluation results are as follows (the mean response is given below each question):

1-2:Very Poor; 3-4:Poor; 5-6:Fair; 7-8:Good; 9-10:Very Good

1. Was the workshop well organized?

8.7

2. Was the training content relevant to the stated goals of the workshop?

9.3

3. Was the training content relevant to your particular needs?

8.4

4. Was the material presented clearly explained?

8.5

5. Was the project background material given useful? (Project profiles & Graphs)

8.4

6. Were the methods used to present the material helpful?

9.0

7. Were participants involved enough in the training?

9.3

8. Were the trainers receptive to suggestions from participants?

8.6

9. Did the trainers provide adequate direction & control of the session?

8.5

10. Was the pre-workshop information adequate?

8.2

11. Was the training site appropriate?

6.8

12. What did you find most useful in the workshop?

- Setting, writing and designing project objectives (13)¹
- Participant involvement and use of role plays (3)
- Networking and information sharing (4)
- Management Information Systems
- Health Information Systems (5)
- Sustainability strategies (11)
- Report writing techniques (2)
- Income Generating Activities
- Community participation (3)
- Project supervision (4)
- Field trips

13. What did you find the least helpful in the workshop?

- No answer or all the topics were very useful (11)
- The lack of people to explain the exhibits in the HIS resource room (3)
- The large number of group activities, some of which were not reviewed
- Networking was not as helpful as it could have been
- There was no scheduled time for sightseeing
- Income Generating Activities
- The field visits (2)

14. How could the workshop have been improved?

- More time should be devoted to each topic which may require an extension of the workshop (3)
- Participant presentations need to be shortened since some detracted from the overall focus
- A more conducive physical environment - the social and welfare facilities were poor (4)

¹ Figures in parentheses indicate number of responses.

- The program needs to be less tight and tiresome and provide time for relaxation (4)
- Have no more than one field visit and process it on the day it is scheduled
- Special interest topics should be covered in mini groups
- More time for resource material demonstration (4)
- Session on individual project presentation (2)
- Projects should be given the chance to present
- Child Survival workshop film (2)
- Review of all group work
- A session on budgeting

VII. COMMENTS AND RECOMMENDATIONS

A. Africare Comments

Hosting the Fifth Africa Regional PVO Child Survival Workshop proved a challenging and enriching endeavor for Africare as an organization and for the Imo State Ministry of Health/Africare Child Survival Project in particular. A great deal of preparation and hard work was required by staff in Washington, in Lagos, and especially in Imo State.

In preparing to host the workshop, project staff became more critically aware of the project with regard to how it would appear to professionals from a dozen other Child Survival Projects. In a sense, hosting the workshop compelled each staff member to look at project activities from the perspective of an external evaluator. This in itself proved to be beneficial to the project.

During the workshop, and particularly during the field visits to two Imo State/Africare project sites, the observations and suggestions offered by participants and resource persons proved insightful and constructive. There was, naturally, some apprehension that comments would be overly critical and perhaps demoralizing. The opposite proved true. Professionals from other projects were positive and provided both reinforcement and encouragement, as well as helpful recommendations. Africare project staff concluded the workshop feeling extremely positive about the accomplishments of the Imo State/Africare project.

Perhaps even more important than the enthusiasm generated among the project staff by hosting the workshop, was the reinforcement and strengthening of the commitment on the part of the Imo State Ministry of Health. From its inception, the Child Survival Project has been implemented in collaboration with the Ministry of Health. It is, in fact, the Imo State Ministry of Health/Africare Child Survival Project, not the Africare Child Survival Project. The Ministry has strongly supported the project throughout its existence. The workshop strengthened that support and enhanced the likelihood that child survival project activities will be sustained by the MOH. State and national publicity, active MOH involvement in planning and preparation for the workshop, and participation by the Governor and all major health policy makers in the state during the launching of the workshop helped solidify child survival as a critical program in Imo State.

In conclusion, Africare, the Imo State Child Survival Project, and the Ministry of Health benefitted tremendously by

hosting the workshop, not only from the workshop itself, but through the entire process of planning and implementation.

B. Africare Recommendations

Numerous recommendations have been made in reports following previous Africa Regional Child Survival Workshops. Many of the recommendations emphasize positive aspects of the workshop process which the reports recommend should be continued. Others focus on suggested modifications. Some of the positive recommendations seem to come up repeatedly. These include:

1. the importance of thorough planning;
2. the need for pre-workshop participant needs assessment;
3. the usefulness of a modest setting;
4. the key role played by a facilitator and appropriate local and international resource persons;
5. the advantages of a small group; and the value of a resource center.

The suggested modifications that have been mentioned include:

1. better integration of the field visits into the workshop as a whole;
2. more realistic assessments of session time and lengths;
3. more strict observance of schedules; and
4. the importance of having a representative from A.I.D. Washington.

In general, the experience of the Fifth Regional Child Survival Workshop supports the above recommendations. Rather than reiterate what has been well expressed in previous workshop reports, a few new and specific recommendations that evolved from this workshop are presented below.

- o Participant evaluations from previous workshops should continue to be used in planning future workshops.
- o The host PVO field staff member who acts as a member of the organizing team has so many responsibilities and duties that it is probably unrealistic and unfair to think that he/she can also serve as a resource person for technical sessions.
- o For projects which collaborate closely with host country Ministries of Health, active involvement of MOH in planning and carrying out the workshop can play invaluable dividends in strengthening commitment to and sustainability of project activities.

- o The AID/FVA/PVC staff member to attend the workshop should be one who previously had taken part in the A.I.D. technical reviews of DIPS for projects participating in the workshop. At the workshop this staff member would be in a position to review and discuss from the Agency's perspective the results of the DIP reviews with the project staff attending the workshop. Also, the FVA/PVC staff member could bring back to A.I.D., for the benefit of the broader child survival program, the insights gained from the discussions and the workshop.
- o During participant evaluations at the end of the workshop, a short segment could be introduced during which participants could express their ideas about what should be included in the Workshop Report. This would give the host PVO a better idea of what would be most useful to PVO field staff.

C. JHU Comments and Recommendations

1. AID/FVA/PVC representation at regional implementation workshops has repeatedly proven to be very important. One important role of the FVA/PVC staff member is to meet with PVO Child Survival Project field staff, individually, to review results of the detailed implementation plan technical review and discuss recommendations made by reviewers. In addition, the networking opportunities and clarification of A.I.D. policy are beneficial to PVO Child Survival project staff. At this workshop, many of the participants expressed disappointment because an AID/FVA/PVC staff member was unable to attend.
2. LESSON LEARNED: The most visible and time-consuming role for PVO Headquarters takes place several months prior to workshop implementation when a workshop budget is developed, invitation letters and needs assessments are mailed, a facilitator is hired, preliminary planning with the organizing team takes place, subsequent mailings of air tickets and workshop information to participants are carried out, technical resource materials are gathered for the workshop Resource Center, and briefing of AID/FVA/PVC takes place. At this workshop it was learned that, although PVO headquarters staff has a less visible in-country role in final planning and implementation, this is also a key role. During final planning and workshop implementation, the PVO headquarters staff, or designated personnel, take a lead role in support of the country national CS project manager-host. Prior to the workshop HQ-designated staff joins other organizing team members in meeting and discussing the workshop with government and local officials, and other appropriate agencies. During the workshop, the major on-site roles of the HQ-designated personnel are manager the Resource

Center, serve as a technical resource persons when appropriate, backstop the country national host, and attend daily organizing team meetings. While the time commitment in-country can range from 11-16 days, depending on the length of the workshop, the benefits of the PVO HQ representation are worth this time commitment.

LIST OF APPENDICES

Description

- Appendix A List of Workshop Participants including: name, title, PVO, country, and address
- Appendix B List of Organizing Team/Resource Persons
- Appendix C Participants/Resource Person Biodata from Opening "Getting to Know Each Other Session"
- Appendix D List of Materials Displayed by the Projects During Workshop
- Appendix E Keynote Address Delivered on the Occasion of the 5th African Regional Child Survival Implementation Workshop on Monday, June 25, 1990 at Owerri, Imo State Nigeria, by Professor J. C. Azubuike, University of Nigeria, Enugu Campus
- Appendix F Project Information Summary Sheets for Each Project
- Appendix G Sections of Workshop Minutes on Sustainability
1. Project Sustainability Matrix and Examples of Three Types of Sustainability:
 - a. Financial Viability
 - b. Skill and Technical Transfer
 - c. Continued Service Coverage to Maintain Health Behavior Change
 2. List of Participant Comments/Views on Sustainability
 3. Each Project's Sustainability Action Plan

LIST OF APPENDICES
(cont'd)

Description

- Appendix H Sections of Workshop Minutes on Community Participation
1. List of positive and negative belief for four intervention groups: ORT, EPI, nutrition, high risk births
 2. Text of interviews of 4 segments of the community (mothers, VHWs, local government officials, traditional leaders) during field visit to Ahiazu Mbaise.
- Appendix I Sections of Workshop Minutes on Income Generation
1. List of Driving and Restraining Forces for each of the three income generation activities discussed by the three groups.
 - a. Drug revolving fund
 - b. Fees for service
 - c. Community fund
 2. Text of interviews with PU and Food Commodities Storage and Marketing Income Generating Projects during field visit to Isiala Ngwa
- Appendix J Sections of Workshop Minutes on HIS
- Appendix K Sections of Workshop Minutes on Supervision
- Appendix L PEN-3 Model

Appendix A - List of Participants & Addresses

LIST OF PARTICIPANTS AND ADDRESSES

KENYA

Ms. Lois Miano
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ZIMBABWE

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Child Survival Coordinator
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Harare, Zimbabwe

Ms. Nonia Temberere
Assistant Child Survival Coordinator
Save The Children Federation
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Harare, Zimbabwe

ORGANIZING TEAM/RESOURCE PERSONS

Mrs. Chibuzo Oriuwa	Workshop Host and Resource Person
Mr. Alan C. Alemian	Africare Washington Regional Director
Ms. Cynthia Carter	Workshop Coordinator and Resource Person
Mr. Dale Flowers	Workshop Facilitator

Additional Workshop Staff Resource Persons:

- Dr. Collins Airhihenbuwa
- Dr. Louis Fazen
- Dr. Mary Harvey
- Dr. James Daniel Okuc

PARTICIPANTS/RESOURCE PERSONS BIODATA

Resource Identification: Name/Organization
Experience/Knowledge/Skills
Personal Interests/Hobbies
Dreams, Hopes & Wishes

Name/Organization: James Okuc Daniel
A Native of Sudan

Experience: Medical Doctor
Community Health Development
Programme Manager Child Survival Projects for 2 1/2 years
Planning & Implementation of PHC Programmes at Provincial
Level

Knowledge/Skills: Working with the Community
Patients Care etc.
Community Organization Skills especially in Health
Information System

Interests/Hobbies: Making friends
Sharing ideas about the world
Listening to music, dancing, watching, soccer and fishing

Dreams/Hopes/Wishes: That the World may be an easy place to live in.
To see the World become an easy place to live in.

Name/Organization: Dan Smith
Africare

Experience: Sociology (Undergraduate, B.A.)
Peace Corps - Community Health Extension Worker
MPH - International Health PVO-CS (Work study)

Knowledge/Skills: Sustainability
Writing Project Proposals

Interests/Hobbies: Sports-Tennis

Dreams/Hopes/Wishes: Someday, everyone would realize that lending a hand
will make their life more fulfilling and worthwhile.

Name/Organization: Lou Fazon
Consultant - John Hopkins University

Knowledge/Skills: Pediatrician - Public Health
International Travel for Health
Russia, China, Afghanistan, Haiti, Liberia

Child Survival Consult for "DIP"

Interest & Hobbies: Bicycle Tour, Sailing, Swimming, recently Golfing

Dreams/Hopes/Wishes: Dream of Wife + Family - Health + Safety
Hope to start new job in Zimbabwe
Peace on Earth

Name/Organization: Cynthia Carter
John Hopkins University/PVO
Child Survival Support Programme

Knowledge/Skills: 3 1/2 years living in Nepal
Peace corps maths and science teacher
worked with UNDP Health Project (material development)
workers for Health out reach

Did a big Community Education for Sanitation Project
(building latrines)

2 1/2 years at J.H.U. - Does workshop planning and
implementation

Co-ordinated technical assistance to the CS field projects
Trying to develop a network of regional technical
resources
Very good at listening, learning and giving feed back

Hobbies: Collect wood carvings, Reading, Tennis

Dreams/Hopes/Wishes: Dreams for more females in politically powerful
positions worldwide.

Name/Organization: Collins Airhihenbuwa
Pennsylvania State University

Experience: Work with State of Tennessee Health Education Specialist 7 years now as a faculty member in Health Education with a specialty in International Health. Working as consultant for USID in Child Survival Projects for 5 years.

Knowledge/Skills: Program Planning in Implementation & Evaluation
Training Health workers
Special Interest in looking at the cultural aspects of health behaviors

Interests/Hobbies: Music, particularly African. Likes travelling, tennis, swimming

Dreams/Hopes/Wishes: To have impact to close the health gap between rich and poor countries

Name/Organization: Frank Imhagwe
Rotary International

Experience: Started with Govt Civil Service - Switched pharmaceutical business, now a partner in MAC Pharmaceutical manufacturing firm. Because of business much travel in Nigeria, Europe and America.

Volunteer - 5 yrs. experience to assist chair of Polio plus as coordinator.

Knowledge/Skills: Has knowledge of Science. Wife is a paediatric nurse. Selected by Rotary to support Polio Polio plus 2005 Program. Much knowledge of Ministry of Health.

Interests/Hobbies: Football player + Tennis with awards + Table Tennis with awards; social golfing

Chief - Village community -stress community development. Belong to many volunteer organizations.

Dreams/Hopes/Wishes: Improved Infrastructure for Health in Nigeria. Hope political stability & economic improvement. Sustain above 2 and live together with the law of God.

Name/Organization: Omoolerun Olupona
World Vision Nigeria

Knowledge & Skills: Community mobilization. Community out reach since 1986
Clinical work in community outreach

Interests: Sharing the love of God as expressed through Christ

Hobbies: Football

Dreams: Making resources for CS project

Hopes: Work as missions in Sierre-leone

Wishes: World vision come to stay permanently in Nigeria

Name/Organization: Dr. Biar Deng Biar
Save The Children Federation/USA - Sudan

Experience: Medical Doctor with clinical experience worked with
community for the last 5 years, with MOH as administrator
for 2 years. All in all 15 years.

Knowledge: Knowledgeable in community medicine and Public relations

Skills: Management and supervision

Personal interest: To work with community

Hobby: Walking

Dreams: Enough funds for Cs projects

Hopes: To see all CS projects in other parts of the world
succeed.

Wishes: For all Children in Sudan, a happy prosperous future.

Name/Organization: Beatrice Muwa
World Vision International, Uganda

Experience: Nurse/Midwife/Public Health Nurse/Tutor for Public Health Nurses - 14 years

Knowledge/Skills: Knowledgeable in Public Health Nursing with training skill (trained four groups since 1986)

Personal Interest: Social interaction (general)

Hobbies: Music

Dreams: Wealth for Uganda

Hopes: To train as many Community Health Workers as possible

Wishes: To live to see my children independent (socially)

Name/Organization: Nonia Temberere
MOH - Zimbabwe - Attached to Save the Children

Experience: Trained Nurse, been with MOH for past 8 years in community medicine with specialty in MCH.

Knowledge & Skills: Community Nursing & Education. Provide EPI & growth monitoring for saving the children. AIDS intervention specialist since 1989. Participated in AIDS education training of trainers workshop in Cameroon in 1989.

Personal Interest: Going to Church, working with community

Hobbies: Knitting, singing

Dreams: Zimbabwe succeeds in the sustainability of SCF/CS program

Name/Organization: Joseph Atuhairwe
MOH staff seconded to World Vision International
Bundibugyo Child Survival Project, Western Uganda
Has worked for ten months with the project
Married with three children

Education: MBCHB

Experience: Medical Officer for ten years; Medical Supt. 3 years
Dist. Med. Officer 2 years

Skills: Cover MCH services in the districts; organize seminars;
train health staff; administration; attend conferences.

Interests: Delivery of health services to Mothers and Children in
rural areas; further education in PHC.

Hobbies: Mountaineering, gardening, baby sitting

Dreams: To see Agencies, Governments and other institutions having
same goals and objectives towards health.

Name/Organization: Herbert Banda
Working with International Eye Foundation, Malawi

Experience/Skills: 9 yrs. worked as Health Inspector, Malawi Health Education
& Communicable Disease Control Office, Queen Elizabeth
Central Hospital, Blantyre. STD control at Blantyre.
Sanitary pit latrine & water project for 3 months.
Attended up-grading course at Howard University. Now
working with IEF/Malawi Blindness Prevention & Training
Program as program training and supervision coordinator.

Interests: Supervision, multi-sectorial collaboration. Continue
working with IEF.

Hobbies: Swimming, watching football, gardening, studying new
information.

Dreams: Improvement of Child Survival in my working area and
project sustainability for the benefit of the community.

Hopes: I hope my dreams come true.

Wishes: Attend more advanced MCH courses/workshops to improve
child survival; reduce morbidity/mortality in my country.

Name/Organization: Gloria Ugochi Nwulu
Rotary International Polio-plus/Nigeria

Experience: Cross-cultural: Pre-Med and Master's of Science in U.S.
Voluntary work in Hospital; National Youth Corps Service,
Nigeria; Community Health Education, Research Program
Assistant, Polio-Plus Program, producing Newsletter.

Knowledge & Skills: Women/Infant Nutrition; Community Based Research
Health Education
Bridging curative/preventive gap

Interests/Hobbies: Travelling, photography, story books
Loves music (can't sing)

Dreams/Hopes/Wishes: Wants to make a difference; return what God has given me.
(e.g. walking after Doctors said no hope because of Polio)
Become a Missionary.

Name/Organization: Regina A. Obiagwu
Imo State/Africare Child Survival Project

Experience: Health management/education with experience in all CSP
interventions and community mobilization.

Knowledge/Skills: Financial management skills and organization skills

Interests/Hobbies: Farming, lawn tennis, shopping

Dreams: To be more involved in financial management and get
absorbed by Ministry of Health.

Name/Organization: Chibuzo Oriuwa (Mrs.)
Seconded by Imo State Ministry of Health to Imo
State/Africare Child Survival Project as Project Manager
Married with 4 children

Education: Masters M.Sc. Nutrition

Experience: After 1st degree worked with MOH trainer, community Health
nutrition. Teaching Nurses & other staff, communities.
Surveys in nutrition. Now 3 1/2 years as CSP Project
Manager.

Interests: Serving & working with needy communities

Ambition: By the year 2000 all Mothers to get messages on Child
Survival, strategies; Health of Mother & family members

Dreams: Needs more specialization; consultancy job.

Name/Organization: Nnenna Ukwoma
Imo State/Africare CS Project, Nigeria

Experience: Programme officer, Nursing and midwifery background.
Business administration. Social welfare activities (group
homes for children aged 6-16 yrs.). Working with
communities especially the targets (women aged 15-45 yrs.;
under-5 yrs. population)

Knowledge/Skills: Interrelated to the experiences

Interests/Hobbies: Net ball play, jogging, swimming and tennis

Dreams: travelling around the world

Hopes: Rural dwellers (especially me) be health oriented.
No more war. Peace on Earth.

Name/Organization: Ethel Kapyepye
Save the Children, Malawi

Experiences: Worked with Ministry of Health and now with Save the Children Federation in community based activities

Knowledge/Skills: Community-based drug revolving fund, child spacing & income generating activities in rural based Infant Health Centers.

Interests/Hobbies: Table tennis, reading, & getting to know people

Dreams/Hopes/Wishes: To improve on my skills so that the communities can benefit.

Name/Organization: Abdel Rahim Ahmed
Care International Sudan (Project Manager)

Experience: Medical Doctor
Has worked in Rural communities (14 years)

Knowledge/Skills: Has worked in Rural communities

Interests/Hobbies: Football, watching movies.

Dreams/Wishes: To see different parts of the world especially Egypt and Ethiopia

Hopes: No more wars.

Name/Organization: Stanley ("Sugar") Jere
Save The Children Federation/Malawi

Experience: 38 years, MOH/Malawi spent Managing Child Health Programs;
since 1987 CS Manager for SCF

Knowledge/Skills: All CS activities. Developed RTH card ORT manual; HIS
Liaising with MOH and NGOs

Interests: Reading current affairs, educational materials, geography,
and adventures - not romance.

Hobbies: Gardening, Horticulture, Animal Husbandry

Wishes: International agencies provide more time to implement
projects

Dream: Every Mother should know and be able to care for her own
health and her Children

Name/Organization: Lois Miano, RN, RM, RPHN
Minnesota International Health Volunteers/Kenya
Community Mobilization; Urban PHC Expertise

Experience: Worked for MOH (1 year), bed-side nursing; Transferred to
Nairobi Local Government - worked for 13 years
implementing EPI and conducting MCH/FP training for
outreach workers; leprosy research

Retired, has worked for private sector (PVOs) for last 5
years doing training for CHWs, TBAs & CBD (comm.-based
distributors for family planning. Community mobilization
activities for increased participation in community-based
health projects. Did health education for AIDS. Does
family-life education to youths.

Hobbies: Reading, walking, public speaking

Dreams/Wishes: Cut down diarrhoea diseases in the community, increase
family planning, reduce child mortality, healthier
children & Mothers

Name/Organization: Mary ("Musician") Harvey
Works for Project R.E.A.C.H.

Experience: Peace Corps Volunteer for 2 1/2 years in Senegal
E.P.I. Programme in Chicago while doing M.P.H.
Inter-country projects in Health especially immunizations
3 1/2 years in Abijan
Worked with WHO/AFRO, Rotary International,
C.D.C./Atlanta, and MOH EPI programmes in the training of
National EPI managers
Worked with Johns Hopkins University and with PVOs in
Haiti in support E.P.I. Programmes to increase coverage.

Interests: All around sports fan and enthusiast; music; ballet

Dreams: For all people to communicate and break any barriers

Hopes: E.P.I. must be extended for all Children

Hobbies: Gardening and cooking.

Name/Organization: Liz Chieza
Save the Children-USA/Zimbabwe

Experience: Nine years with MOH as Nurse-Midwife at all levels of care
(Rural Clinics, District Hospital, Provincial Hospital).
One year with STC, Supervising/Supporting VHWs in EPI,
growth monitoring, ORT, MCH, ARI, Aids Education &
Prevention.

Knowledge/Skills: Community outreach/participation
Nursing/Midwifery
Record Keeping/Data collection
Outreach worker support/Supervision

Personal Interests: Church going
Visiting Places of Interest

Dreams/Hopes/Wishes: To learn more and further my Education

50

Name/Organization: Alan Alemian
Africare, Washington DC, USA

Experience: School teacher/community development
Administrator for development assistance for 20 years.

Knowledge/Skills: Biological Sciences & Public Health

Interests/Hobbies: Billiards, Volley ball & Table Tennis

Dreams/Hopes/Wishes: Child Prosperity & World Peace

Name/Organization: Charity T.N. Iwu (Mrs.)
MOH, Imo State of Nigeria

Experience: Head of Nutrition Unit MOH, Coordinator of training
activities & Imo State/Africare CSP Trainer

Knowledge/Skills: Nutritionist, Teacher Trainer, Education

Interests/Hobbies: Running the Home, Gardening, Bakery Singing, Cooking,
Women & Church meetings

Dreams: See her Children grow-up and brought up well, well
educated, independently well settled.

Hopes: Her dreams come true

Wishes: Long Healthy Life for both Husband and Wife

Name/Organization: Bola Ogunjumo
World Vision International Nigeria
MPH Dundee England (Married with 4 Children)

Experience: 6 years in England as a Staff Nurse;
4 years in teaching Hospital; 6 years with MOH Hospital
State Government as Public Health Tutor and Public Health
Sister; 1 year as PHS with WVRD.

Knowledge/Skills: She can offer advice on questionnaire writing,
immunization, weighing children, family planning child
counselling, treatment of childhood illnesses, training &
supervision of VHC workers and other community health
cadres, report writing.

Personal Interest: Music Adventure, meeting people, reading novels, looking
good

Wishes: To Subscribe for America Public Health Journal

Hopes: Health for all by the year 2000

Name/Organization: Theodore Okoroiwu
Ministry of Health, Imo State - Nigeria

Experience/Skills: Performed Ad-hoc Duties
Advanced Secretarial Administration
Secretary 5th African Regional Child Survival Workshop

Interests: Church; Going places of interest

Hobbies: Football, Travelling and Meeting people

Dreams: Attend similar workshop abroad

Hopes: Dreams will come true.

Appendix D - List of Materials Displayed

Resource persons and workshop participants brought with them materials from their programs, to share with others attending the 5th Africa Regional Child Survival Workshop held at BCCC Atta Ikeduru LGA, Imo State, Nigeria. The materials were displayed in the Resource Room of the workshop.

11

LIST OF MATERIALS DISPLAYED

1. PROJECT: REACH

Materials/Booklets/Handouts

- a. EPI Essentials - A guide for program officers. (Second Edition, August 1989)
- b. Women and Health - information for action issue paper. (March 1986 Edition)
- c. Missed opportunities for immunization - Resources for Child Health, March 1990
- d. Immunizing the World's Children, Series L Number 5 - March-April 1986
- e. Health Basics: Immunization
- f. Mothers and Children, Vol. 9 No.1, 1989
- g. EPI Technical Series, The Cold Chain, Product Information Sheets No1, 1989/1990
- h. Directions on Immunization, PATH. 1989
- i. Outreach - Reach Supports Health Sector in Kenya - Spring 1990
- j. Kenya Expanded Programme on Immunization (KEPI) newsprints, magazines, stickers, appointment sheet
- k. Immunization in Practice - A guide for Health Workers who give vaccines.
 - (i) Trainers guide Series EPI/PHW/84/TCO Rev. 1
 - (ii) Vaccines and How to look after them 1 - EPI/PHW/84/1 Rev. 1
 - (iii) Syringes, Needles and Sterilization 2 - EPI/PHW/84/2 Rev. 1
 - (iv) When and How to give vaccines 3 - EPI/PHW/84/3 Rev. 1
 - (v) Preparing for an immunization Session 4 - EPI/PHW/84/4 Rev. 1
 - (vi) How to conduct an outreach immunization Session 5 - EPI/PHW/84/5 Rev.1
 - (vii) Health Education in an immunization Programme 6 - EPI/PHW/84/6 Rev.1
 - (viii) How to Evaluate your immunization programme 7 - EPI/PHW/84/7 Rev.1
 - (ix) Preventing Neonatal Tetanus 8 EPI/PHW/87/8

56

2. PROJECT: ADRA NIGERIA

Pamphlets on

- a. Primary Health Care (PHC) EPI Supervisors Cold Chain at LGA, Zonal and National levels by the Federal Ministry of Health, Lagos (FMOH)
- b. PHC, A manual on Management of Aente Diarrhoea by the Federal Ministry of Health, Nigeria (FMOH)
- c. PHC Community Education and Mobilization, Working with the Mass Media in promoting Community Health. (FMOH)
- d. PHC - A Vaccination Manual for Health Workers (FMOH)
- e. PHC - Steam Sterilization Logbook (FMOH)
- f. PHC _ How to treat Diarrhoea at Home (FMOH)
- g. PHC- Social Mobilization for Primary Health Care Health Workers Guide for Community Mobilization (FMOH)
- h. PHC - Social Mobilization for Primary Health Care How to help promote EPI and ORT in your Community (FMOH)
- i. PHC - The Cold Chain (FMOH)
- j. PHC - Health Education at the Health Center - Childhood Immunization (FMOH)
- k. PHC - EPI Diseases Fact Sheet (FMOH)

3. PROJECT: Imo State Ministry of Health/Africare Child Survival Project

Materials:

- a. Mid-term evaluation report - June, 1988
- b. Final Evaluation Report, October 1989
- c. 1988 FVA/PVC Project Annual Report Volume I, Main Report
- d. 1988 FVA/PVC Project Annual Report Volume II, Appendices
- e. Africare - Annual Report 1989
- f. The AID Breastfeeding for Child Survival Strategy
- g. Missed opportunities for immunization March, 1990
- h. Mother-Child Health Cards and Referral slip
- i. Breastfeeding - A report on AID Programs
- j. Posters on:
 - (i) Nri Ndu
 - (ii) Balanced diet needs of a child to grow healthy
 - (iii) Weaning: the right way to do it
 - (iv) Basic Hygiene rules in child care
 - (v) Ideal Child Spacing
 - (vi) Baby's weight Progress Chart
- k. Baby weighing scales, Baxket and Boards
- l. Baby spoons
- m. Baby and Adult weighing scales

5

4. PROJECT: John Hopkins University

- a. Facts for life - A communication challenge
- b. A resource book for facts for Life All for Health
- c. Population Communication Services Package of the Johns Hopkins University
- d. Magazine of Women's International Public Health Network News
 - (i) Vol. 5, Spring 1989
 - (ii) Vol. 6, Winter 1989
 - (iii) Vol. 4, Winter 1988
 - (iv) Vol. 2, Summer 1988
- e. How to weigh and measure children - Assessing the nutritional status of young children in Household Surveys. 1986
- f. Improving Infant Feeding Practices to Prevent Diarrhoea and Reduce its Severity. September, 1989
- g. Evaluation of a simplified Method for Evaluation of Early Childhood Mortality in Small Populations. January, 1989
- h. Operations Research findings in four Church Sponsored Programs in Kenya. May, 1988
- i. New Challenges New Opportunities - Ralph H Smuckler and others
- j. Health Workers Find, Treat, Prevent Vitamin A Deficiency
- k. Handout on Weaning
- l. Dialogue on Diarrhoea
- m. PVO Child Survival - Technical Report Series
- n. Population Report Series - family planning programs

5. PROJECT: World Vision - Nigeria

- a. Register of service
- b. Height tape
- c. Children's weighing hanging scale
- d. ORT bottle, spoons, cup, sugar, salt, funnel
- e. Weanimix
- f. Soya Bean Seed
- g. Posters on Guideline for treating Diarrhoea at Home, the Six Immunizeable Diseases, Diet
- h. Basic Hygiene rules in Child Care, Malaria and the Mosquito
- i. Teaching Aids at Low Cost

6. PROJECT: SCF/MALAWI

- a. Posters on AIDS
- b. Time table recommended for immunization
- c. Malawi Malaria treatment guide
- d. Teaching Flash Card

7. PROJECT: IEF MALAWI

- a. Posters on Eye Hygiene
- b. Recorded songs on Health Education

8. PROJECT: SCF ZIMBABWE

- a. Posters on immunization
- b. Child Survival Record Sheet
- c. Manual for the Zimbabwe Expanded programme on Immunization (ZEPI)
- d. Immunization Register

9. PROJECT: MIHV KENYA

- a. Poster, leaflets, on immunization and family planning
- b. A maternity treatment sheet

10. PROJECT: CARE SUDAN

- a. National Diarrhoeal Disease Control Programme - Plan of Operation. 1986-1988
- b. Reference Book for Mid Level Health Workers
- c. Management of the Child with Cough - A Simple Guide
- d. North Korodora Child Health Project Final Evaluation Report - October 1989
- e. Promoting Community Participation for Preventing and treatment of Diarrhoeal diseases.

POSITIVE AND NEGATIVE HEALTH BELIEFS

PERCEPTIONS	Beliefs related to Knowledge, Attitudes and Practices
ENABLERS	Skills and Resources necessary for Health Actions
NURTURERS	Reinforcement for Health beliefs and Actions

At this phase, a table is developed to identify the beliefs that are rooted in the culture as opposed to those that are not rooted in cultural patterns and lifestyle.

PATTERNS OF HEALTH BELIEFS

CULTURAL	NON-CULTURAL
Health beliefs and practices that are historically rooted in cultural patterns and lifestyles.	Health beliefs and practices that are recent and only superficially tied to the cultural patterns and lifestyles.

Following the process outlined above, the following information was obtained from the community on perceptions, enablers and nurturers about child survival interventions. The participants then classified the items into positive, exotic and negative health beliefs and practices so as to appropriately delineate the focus for health promotion and disease prevention in the community. Each beliefs under the three categories are labelled a C for culturally related health beliefs and an NC for non-culturally related health beliefs.

POSITIVE

- C 1. Idea of taking fluids during illness is acceptable
- NC 2. Community noticed decline in diarrhea morbidity/mortality with ORT usage.
- C 3. Community leaders willing and able to take lead as change agents.
- C 4. Giving of plantain porridge to children who have diarrhea
- C 5. Consumption of pap and/or coconut juice during diarrhea
- C 6. Sexual abstinence during pregnancy reduces the incidence of Pelvic Inflammatory Disease

EXOTIC

- C 1. Beads around a child's wrist and/or ankle would ward off evil spirits.
- C 2. Post-partum sexual abstinence prevents semen from mixing with breastmilk.
- C 3. Palm oil and indigo is a good treatment for measles.
- NC 4. Have a lot of children due to high child mortality.

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KEYNOTE ADDRESS DELIVERED ON THE OCCASION OF THE 5TH AFRICAN
REGIONAL CHILD SURVIVAL IMPLEMENTATION WORKSHOP ON MONDAY 25TH
JUNE 1990 AT OWEKRI, IMO STATE NIGERIA, BY PROFESSOR J.C.
AZUBUIKE, UNIVERSITY OF NIGERIA, ENUGU CAMPUS

Ladies and Gentlemen:

I would like to express my gratitude to the organizers of this workshop for the honour done my Institution and myself, through the invitation to deliver the keynote address to this august body.

To all persons who are interested in the welfare of children, the theme of this workshop: Child Survival: the challenge we face: says a lot. To the faint-hearted and easily discouraged individual, the enormity of the perceived problems may be such as to discourage him or her from ever settling down to do what is obvious, simple cheap and yet efficacious. To the undaunted, however, the appearance of challenges in the horizon only recalls to his or her memory the adage, "When the going gets tough, the Tough get going."

That we are talking about challenges today in our Child Survival Implementation Projects, simply means, to me, that we have make some progress, as far as our initial goals are concerned. As a member of the Health Care Delivery profession, I could look at the theme of this workshop from a general overview angle. As a Pediatrician, I could be carried away by my enthusiasm, when I consider the benefits accruing to the children of the world. As a Neonatologist, I might even be forgiven if I wandered into the esoteric and little known world of the tiny babies, who some of us barley regard as mini-toddlers. I shall take refuge in the brevity expected of me, as one of the many speakers you are all eager to listen to.

When in December 1983 James P. Grant, the Executive Director of the United Nations Childrens Fund (UNICEF), in his annual

report - "The State of the World's Children" - launched an initiative which has become known as Child Survival and Development Revolution, it was with good reason. The effect of the world economic recession, especially in the developing countries, had brought about an urgent need for a revolution. Some of these adverse health conditions included:

- (i) the death of over 10,000 children each day from a process which mothers could, and can, prevent at home.
- (ii) the death and disability of many millions of children from preventable diseases.
- (iii) millions of babies being born malnourished because their mothers did not have enough to eat.

This revolution aimed therefore at reducing child death, malnutrition, birth rate and ultimately slowing down of population growth. The strategies for protecting the lives and guaranteeing normal development of the world's children are well known to us -- Growth monitoring, Oral Rehydration Therapy, Breast feeding, Immunization, Female Education, Family spacing and Food Supplements -- commonly referred to as GOBI-FFF. The first four goals apply invariably to all localities and are inexpensive, whilst the three F's, although important health levers, are more expensive and more difficult to achieve.

The success of any Child Survival and Development Programme depends on the commitment of the nation's leadership and the mobilization of the nation's resources to put medical knowledge in the hands of ordinary people, particularly parents. Ladies and Gentlemen, I assume that most of us are parents; and I hope, ordinary people.

The combination of the inputs from International Agencies that sponsor Child Survival activities such as UNICEF, USAID, CCCD, WHO, etc. and of efforts by various Ministries of Health in many developing countries has led to tremendous progress towards the achievement of the goals which were set when these programmes were started.

But there are problems, at local and international levels. I shall not touch on the problems at the grassroots because their multi-faceted nature will become manifest in the course of your deliberations.

The economic hardship in most developing countries, especially those in Africa, presents an even higher and more difficult hurdle. Per capita GDP in sub-Saharan Africa declined by 3.6% in 1980-85, 0.5% in 1986 and by 5.1% in 1987. The World

Bank projections to the year 1995 show zero per capita growth. Between 1985 and 1986, the total debt of the developing world increased by 10% i.e. \$70 billion, that of sub-Saharan Africa increased by 20%, or approximately \$25 billions. By 1995, Africa's debt servicing obligations are likely to reach \$45 billions annually. This vicious cycle of rising debts and falling incomes only leads us one way - to falling standards of living. Every statistical index in the past few years points in that direction. Expenditures on Health, Agriculture, Education etc. are bound to fall further. With the decline in the already poor standard of living, our women-folk will end up producing more babies of low birth weight.

Low birth weight is one of the major causes of perinatal, neonatal and infant mortalities. Over 90% of the 20 million low birth weight babies are born in the developing countries annually. Low birth weight is associated with 30-40% mortality.

I would be doing a disservice to contemporary history if I should fail to mention, at this point, the dramatic turn of socio-political events in the Eastern Block or Warsaw pact countries. Whether we like it or not, the Donor countries are already turning their attention to the area, if only to help them consolidate their newly won democratic reforms. You may want to ask what this has to do with the Child Survival Programmes in the developing countries? The answer is simple. More aid and money will flow to the Eastern Block.

I am aware that the idea of a Development Bank is already being floated in Western Europe for this purpose. So, the sum total of all this is that the financial aid being channeled through the Sponsoring Agencies to us would become even more depleted.

With these prospects, it should become obvious that we face very serious challenges in our Child Survival Implementation programmes. Should we become faint-hearted and want to surrender? We cannot afford that luxury. We should face the challenges squarely, and utilize all peaceful and legal means to attempt to accomplish our goals. Looking back at what has been achieved in the past decade, there is more than ample room for optimism.

As the Chinese saying goes, "A journey of a thousand miles begins with one step." We took the first step for the good of the children of the world, especially those in the developing countries, several years ago. The finishing line of the 1000-mile journey is still a long way off, but we have put a good number of miles behind us already.

Incidentally, China, with one-sixth of the world's children, was expected to achieve the target of Universal Childhood Immunization two years ahead of schedule. Kenya, Malawi, Nigeria, Sudan, Uganda, and Zimbabwe cannot claim to be China. But they can all claim to aim at the same goal in the Child Survival Programme.

I wish you all most fruitful deliberations at this workshop.

J.C. Azubuiké
Professor of Paediatrics & Deputy Vice Chancellor
University of Nigeria, Enugu Campus

Appendix F - Project Information Matrix

A large blank chart, to serve as a matrix, was prepared by workshop staff before the workshop. Participants during the workshop entered certain basic information on their respective projects. That information was later extracted by staff from the matrix chart, and entered into the project summary sheets given in this Appendix.

PROJECT INFORMATION MATRIX

ADRA/Nigeria

TARGET POPULATION: 0-11 mo. = 6,043
 12-59 mo. = 19,132
 15-49 yrs. = 24,179
 pregnant women = 6,043

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. III, 1987-1991

EVALUATION: 1988 Baseline 1989 Midterm Final

HIS: Yes, Working Supervision & Reporting Forms

TRAINING: VHWD, Mothers, Medical Team

EPI:

% of all project activities: 40%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	Yes	Yes	Yes

Target groups:

Coverage:	<u>BCG</u>	<u>DPT1/OPV1</u>	<u>DPT3/OPV3</u>	<u>Measles</u>
	93%	91%	80%	83%
	<u>FIC</u>	<u>TT1</u>	<u>TT2+</u>	
	<1, 70%	56%	51%	

ORT:

% of all project activities: 20%
 Target groups: <5; ORS Clinics, 24,175
 Type of ORT: SSS Home Mix
 Training: No Deliver packets:

Coverage:	<u>Access</u>	<u>Use</u>
	%	%

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
20%	1%	14%	5%
			AIDS, ARI, Malaria

Sustainability Activities:

Strong attachment to existing health care institution
 User fees
 Drug Revolving Fund

PROJECT INFORMATION MATRIX

Africare/Nigeria

TARGET POPULATION: 0-11 mo. = 3,600
 12-59 mo. = 14,400
 15-49 yrs. = 12,000
 pregnant women = 3,600

PROJECT SITE: Rural

LIFE OF PROJECT: C.S.5, '89; R, '89-'90

EVALUATION: Baseline Midterm Final
 1989-1991 6/88 9/89

HIS: Working, VHW-Maintained

TRAINING: CBW-VHW, 160

EPI: % of all project activities: 20%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	Yes	No	Yes No?

Target groups: 0-2, pregnant women

Coverage:	<u>BCG</u>	<u>DPT1/OPV1</u>	<u>DPT3/OPV3</u>	<u>Measles</u>
15%	<1 65%	<1 58%	<1 40%	< 1
	12-23 67%	>1 65%	>1 52%	>1 43%
	<u>FIC</u>	<u>TT1</u>	<u>TT2+</u>	
	<1 13%	55%	49%	
	>1 41%			

ORT: % of all project activities: 20%
 Target groups: <5
 Type of ORT: SSS Home Mix; ORS, Clinic Only
 Training: No Deliver packets: No

Coverage: Access Use
 25%, at home 56%

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
30%	0	15%	15%
			Maternal Health

Sustainability Activities:

MOH-LGA collaboration
 Income generating activities
 Community participation
 Child survival committees

PROJECT INFORMATION MATRIX

CARE/Sudan

TARGET POPULATION: 0-11 mo. = 8,692
 12-59 mo. =
 15-49 yrs. = 42,400
 pregnant women = 9,561

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. V, R, 1989-1992

EVALUATION: 5/90 Baseline 5/91 Midterm 7/92 Final

HIS: Working, Monthly Reports

TRAINING: Health Workers 156
 Mothers 4,250

EPI:

% of all project activities: 40%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>	
<u>Logistics</u>	Yes	Yes	Yes	Yes

Target groups: <1, women

Coverage:	<u>BCG</u> %	<u>DPT1/OPV1</u> %	<u>DPT3/OPV3</u> %	<u>M_rasles</u> %
	<u>FIC</u> <1, 45%	<u>TT1</u> %	<u>TT2+</u> %	

ORT:

% of all project activities: 30%

Target groups: <5

Type of ORT: ORS, Home Mix, Home Avail. Fluids

Training: Deliver packets:

Coverage:	<u>Access</u> 43%	<u>Use</u> 45%
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<u>Growth Monitoring</u> 20%	<u>Vitamin A</u> 3%	<u>Child Spacing</u> 2%	<u>Other</u> ARI - 3% Malaria - 2%
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Sustainability Activities:

MOH collaboration
 Move project office to community
 Train health workers, mothers, village health communities

PROJECT INFORMATION MATRIX

WVRD/Uganda

TARGET POPULATION: 0-11 mo. = 1,200
 12-59 mo. = 4,746
 15-49 yrs. = 6,700
 pregnant women = 1,400

PROJECT SITE:

LIFE OF PROJECT: C.S. IV, 1989-1992

EVALUATION: 4/90 Baseline 1991 Midterm 1992 Final

HIS: Under Development

TRAINING: ?

EPI:

% of all project activities: 35%

Types of activities: Training Vaccination IEC
Logistics Yes

Target groups:

Coverage: BCG DPT1/OPV1 DPT3/OPV3 Measles
 % % % %
FIC TT1 TT2+
 % % %

ORT:

% of all project activities: 25%

Target groups:

Type of ORT: SSS, ORS, Home Mix, Other
 Training: Yes Deliver packets: Yes

Coverage: Access Use
 5.2% <5%

Growth Monitoring Vitamin A Child Spacing Other
 25% 0 15% 0

Sustainability Activities:

Hire local staff
 Use existing infrastructure
 Use MOH structure and local government
 Train CHW and TBA
 Growth monitoring in villages

72

PROJECT INFORMATION MATRIX

IEF/Malawi

TARGET POPULATION: 0-11 mo. = 1,850
 12-59 mo. = 7,290
 15-49 yrs. =
 pregnant women = 8,985 (2 months post partum)

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. I, R, 1981-1991

EVALUATION: 10/89 Baseline Midterm Final
 9/90 9/91

HIS: Developing

TRAINING: 78 VHP, 9 HSA, 3 OMA (Eye)

EPI: (Eye)

% of all project activities: 80%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	No	Provide data	Yes Yes

Target groups: 0-6 Ages, pregnant women

Coverage:	<u>Clin. Diag</u>	<u>Eye Treat</u>	<u>Refer</u>
	<u>Distribute Caps.</u>		
	Yes	Yes	Yes Yes

ORT:

% of all project activities:

Target groups:

Type of ORT:

Training: Deliver packets:

Coverage:	<u>Access</u>	<u>Use</u>
	%	%

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
[SEE EPI SECTION]		20%	Nutritional Education

Sustainability Activities:

Community participation
 Multistoral collaboration with her PVDs
 Close association with MDH

PROJECT INFORMATION MATRIX

MIVH/Kenya

TARGET POPULATION: 0-11 mo. = 4,278
 12-59 mo. = 11,284
 15-49 yrs. = 15,930
 pregnant women =

PROJECT SITE: Urban

LIFE OF PROJECT: C.S. IV, 1988-1992

EVALUATION: Baseline Midterm Final
 Yes 8/90 1992

HIS: Developing

TRAINING: TOT/CAW

EPI:

% of all project activities: 15%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	No	Yes	Yes
Target groups:	<1, pregnant women		
Coverage:	<u>BCG</u> %	<u>DPT1/OPV1</u> %	<u>DPT3/OPV3</u> %
	<u>FIC</u> %	<u>TT1</u> %	<u>TT2+</u> %

ORT:

% of all project activities: 15%

Target groups: <2

Type of ORT: ORS

Training: No Deliver packets: Yes

Coverage: Access Use
% %

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
25%	0	25%	20%
		Curative	Health Education

Sustainability Activities:

Fees for curative service
 Income generation - tent renting
 MOH collaboration

24

PROJECT INFORMATION MATRIX

ROTARY/Nigeria

TARGET POPULATION: 0-11 mo. = }
 12-59 mo. = } 0-24
 15-49 yrs. = } 9,000,000
 pregnant women = }

PROJECT SITE: Mixed (Rural & Urban)

LIFE OF PROJECT: C.S. III, 1987-1992

EVALUATION: Baseline Midterm Final
 No 5/90 5/92

HIS: Working, Check List, Form for Reports

TRAINING: Rotary Family, Volunteers, NGO

EPI:

% of all project activities: 100%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	68%	12%	20%

Target groups: 0-2

Coverage:	<u>BCG</u>	<u>DPT1/OPV1</u>	<u>DPT3/OPV3</u>	<u>Measles</u>
	%	%	%	%
	<u>FIC</u>	<u>TT1</u>	<u>TT2+</u>	
	About 60% by MOH	%	%	

ORT:

% of all project activities:

Target groups:

Type of ORT:

Training: Deliver packets:

Coverage:	<u>Access</u>	<u>Use</u>
	%	%

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
			Begin VITA
			ONCHO
			Ginnea Worm
			Leprosy
			Water Sanitation

Sustainability Activities:

Fund Raising

Donations

Logistic Supplies

PROJECT INFORMATION MATRIX

SCF/Sudan

TARGET POPULATION: 0-11 mo. = 18,333
 12-59 mo. = 54,300
 15-49 yrs. = 99,708
 pregnant women = 22,000

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. V, R, 1989-1992

EVALUATION: Baseline Midterm Final
 KAP, 6/90 1991 1992

HIS: Modify working HIS, Tracking vital events enrollment

TRAINING: Mothers, Health Workers, VHC

EPI:

% of all project activities: 30%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	Tot. Commu.	No	Yes
Yes			

Target groups: <1, women

Coverage:	<u>BCG</u>	<u>DPT1/OPV1</u>	<u>DPT2/OPV3</u>
	<u>Measles</u>		
63.7%	68.3%	64.7%	61%

<u>FIC</u>	<u>TT1</u>	<u>TT2+</u>
%	72%	55%

ORT:

% of all project activities: 20%

Target groups: <5

Type of ORT: ORS, Home Avail., Home Mix

Training: Yes Deliver packets: Yes

Coverage:	<u>Access</u>	<u>Use</u>
	84%	86%

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
20%	1%	2%	Malaria - 10%
			AIDS - 1%
			Water - 1%
			Community Health - 15%

Sustainability Activities:

DMC Village health committees

Community health education and involvement

16

PROJECT INFORMATION MATRIX

SCF/Malawi

TARGET POPULATION: 0-11 mo. = 7,441
 12-59 mo. = 13,976
 15-49 yrs. = 32,335
 pregnant women = 7,500

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. V, R, 1989-1992

EVALUATION: Baseline Midterm Final
 10/87 5/91 6/92

HIS: 5/90: Developing in Mkhota
 Working in Mbalach

TRAINING: CHS

EPI:
 % of all project activities: 35%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>
<u>Logistics</u>	80% Yes	Yes	Yes

Target groups: <1, women

Coverage:	<u>BCG</u> 80%	<u>DPT1/CPV1</u>	<u>DPT3/OPV3</u> 80%	<u>Measles</u> 80%
	<u>FIC</u> %	<u>TT1</u> %	<u>TT2+</u> 80%	

ORT:
 % of all project activities: 20%

Target groups:
 Type of ORT: ORS Home Mix
 Training: Yes Deliver packets: Yes

Coverage: Access Use
 % %

<u>Growth Monitoring</u> 30%	<u>Vitamin A</u> 5%	<u>Child Spacing</u> 10%	<u>Other</u> 15% AIDS, ARI, Malaria, STDS
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Sustainability Activities:

Drug Revolving Fund
 Training of VHC members
 More SCF collaboration

PROJECT INFORMATION MATRIX

SCF/Zimbabwe

TARGET POPULATION: 0-11 mo. = 1,524
 12-59 mo. = 6,096
 15-49 yrs. = 7,612
 pregnant women =

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. V, R, 1990-1991

EVALUATION: None Baseline 2/90 Midterm Final 1991

HIS: Working, Family Enrollment, Birth/Death Records, VHW Monthly Report, Registers

TRAINING: NLO/RN Midwife Training, to be: VCWs/FHWs, Community Leaders

EPI:

% of all project activities: 25%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>	
<u>Logistics</u>	Yes	Yes	Yes	Yes

Target groups: <1, women 15-45

Coverage:	<u>BCG</u>	<u>DPT1/OPV1</u>	<u>DPT3/OPV3</u>	<u>Measles</u>
	<1%	<1%	<1%	<1%

<u>FIC</u>	<u>TT1</u>	<u>TT2+</u>
%	%	%

ORT:

% of all project activities: 25%

Target groups:

Type of ORT:

Training: Deliver packets:

Coverage:	<u>Access</u>	<u>Use</u>
	100%	78%

<u>Growth Monitoring</u>	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
35%	10%	ARI - 2.5%	AIDS - 2.5%

Sustainability Activities:

Activities planned with MOH
 MOH nurses seconded to SAVE
 Likelihood for health coordinator for one of the areas

78

PROJECT INFORMATION MATRIX

WVRD/Nigeria

TARGET POPULATION: 0-11 mo. = 2,954
 12-59 mo. = 10,071
 15-49 yrs. = 13,429
 pregnant women = 3,000

PROJECT SITE: Rural

LIFE OF PROJECT: C.S. IV, 1988-1992

EVALUATION: 6/89 Baseline 10/90 Midterm Final
 10/92

HIS: Working, VHW Reports, Staff Reports

TRAINING: VHW, LGA, Community Health Workers

EPI:
 % of all project activities: 35%

Types of activities:	<u>Training</u>	<u>Vaccination</u>	<u>IEC</u>	
<u>Logistics</u>	Yes	Yes	Yes	Yes

Target groups: Children, 0-23; Women, 15-45

Coverage:	<u>BCG</u>	<u>DPT1/OPV1</u>	<u>DPT3/OPV3</u>	<u>Measles</u>
	%	%	%	%
	<u>FIC</u>	<u>TT1</u>	<u>TT2+</u>	
	%	%	%	

ORT:
 % of all project activities: 20%
 Target groups: <5
 Type of ORT: SSS Home Mix
 Training: No Deliver packets: No

Coverage:	<u>Access</u>	<u>Use</u>
	Good	Fair

<u>Growth Monitoring</u>	0	<u>Vitamin A</u>	<u>Child Spacing</u>	<u>Other</u>
20%		10%	15%	
			ARI - 2%	
			AIDS - 1%	
			Malaria - 5%	
			Water - 4%	
			Other - 3%	

Sustainability Activities:

Drug Revolving Fund
 Strengthening Health Services
 Fund Raising
 Village Health Committee

SUSTAINABILITY MATRIX

During a session on sustainability, the participants identified 26 distinct types of activities which enhance the sustainability of child survival projects they are implementing. They grouped these under three major categories noted by A, B and C below. They then identified in a matrix, by PVO project and sustainability category, the number of activities each project is carrying out.

(A) Financial Viability (6 types of activities)

- Drugs revolving funds
- Funds raising
- Loans
- Income generation (e.g. community farm)
- Contributions of cash or in-kind
- Fees for service and other grants

(B) Skill & Energy Transfer (10 types of activities):

- Health education to women
- Nutrition demonstration at village level
- Primary Health training
- VHWS
- Home visits (e.g. ORT demonstration to families)
- Use of local expertise
- Training village health community
- Document results
- Provide feedback to community
- Recruiting & training community volunteers

(C) Continued Service Coverage to Maintain Health Behavior Change:

- Integrate Child Survival activity with local government
- Strengthen existing services
- Phased handing over of project management
- Supervision by Ministry of Health
- CBIIRD-Community Based Integration of Rural Development
- Document results
- Provide feedback to Ministry of Health
- Collaboration in initial planning stages
- Formal commitment by Federal or State Government (e.g. evidenced by signing of project agreement).
- Joint supervision

SUSTAINABILITY MATRIX

PVO	Financial Viability	Skills Knowledge Transfer	Continued Service Coverage
MIHV/KENYA	5	8	9
IEF/MALAWI	3	9	9
SCF/MALAWI	1	10	6
ADRA/NIGERIA	4	8	3
AFRICARE/NIGERIA	4	9	9
ROTARY POLIO/NIGERIA	5	7	8
WV/NIGERIA	6	10	8
CARE/SUDAN	2	9	10
SCF/SUDAN	5	9	10
WV/ UGANDA	3	2	4
SCF/ZIMBABWE	2	7	10

PARTICIPANT COMMENTS & VIEWS ON
SUSTAINABILITY OF CHILD SURVIVAL

The following thoughts concerning sustainability were shared by the participants:

- Community has to participate and be involved in the project to keep sustained.
- Finance has to be viable and means to revolve funds have to be established.
- There should be knowledge and skills transferred to people who will be running the project.
- There should be proper co-ordination with other agencies and Local Leaders.
- There should be proper supervision and adequate health information system.
- There should be advanced planning with all important levels.
- There should be proper net-working
- It is more than financial viability; it does not mean it must be sustainable for ever, a period of 5 years is adequate.
- Income generating activities do not necessarily have to be a big project.
- Community involvement is very essential to ensure sustainability.
- Income generating activities are the supportive activities to sustain projects.
- Supervisory system is needed with proper feed back.
- Collaboration of different sectors enhances the sustainability process.
- Create awareness in the community and let them realize that the project is theirs and not yours.
- Project should be relevant to the priority need of the community.
- Develop strategy for maximum community participation.
- Prepare technical and support staff to take over when you phase out.
- Government & Communities should get involved in the Planning, Implementation and evaluation of any project.
- Sustainability is the only means that the EPI project is maintained routinely.
- Community Health Workers or volunteers are very vital.
- There should be motivational plans of communities and their Leaders.
- Monitoring and evaluation are key.
- Situation analysis is important.
- Involve local authorities from the beginning, i.e. initial planning.
- Spell out your goals & objectives.
- Create awareness to the local community and work in close liaison with them to realize the project is theirs.
- Ask the community to have our input on the project so that after phase over of the NGO they will be able to sustain the project.
- Sustainability of project should aim at achieving the eventual goal of the project e.g. the reduction of morbidity and mortality of childhood killer diseases.
- Maintain what has been achieved by using local resources.
- Sustainability are processes and procedures put together by the community, the local government authorities, donor agencies and other non-governmental organizations to keep or continue a project beneficial to all parties.

- Is the art of making a venture or project last to yield the desired results.
- Requirements to start a project for sustainability of example the VHWS
- Feasibility study and assessment
- Securing a Bank loan, donations and fund raising
- Adequate staffing and proper management, supervision and evaluation
- PIME - by community
- Fully committed with full participation and use local experts or train them
- Explain the objectives of projects
- Liaise with Ministry of Trade & Industry
- Get consent from community leaders
- Request for land for council use and fertilizers are needed to improve crop

SUSTAINABILITY - For a project to remain sustained it must be financially viable. There must be skill and knowledge transfer, and the service coverage must be continually maintained. This can be achieved through collaboration with the Ministry of Health, Local Government and other organizations. The local government should integrate the activities into its existing structure.



Appendix G.3 - 90-DAY SUSTAINABILITY ACTION PLANS

Participants from each project attending the workshop set out, during the workshop, to develop a 90-day plan to address sustainability needs in their project. The plan was to be:

1. Clear
2. Specific
3. Precise (What, When and How)

Projects then presented their plans to the group as a whole. Presentations they made are set forth over the following pages.

IEF/MALAWI 90-DAY SUSTAINABILITY ACTION PLAN

Activity	TIME								LINE			
	July 1990				August 1990				September 1990			
	1st	2nd	3rd	4th	1st	2nd	3rd	4th	1st	2nd	3rd	
4th Workshop feed back (Report)	X											
Report to Authority		X										
Co-ordination with other Agencies			X			X	X				X	
Community meetings and publicity or Campaigns				X								
VHP Day Orientation Meeting			X	X					X			
TRAINING	X											
Meeting for Extension Workers				X				X				X
Vitamin A Distri. Ophthalmic screening					X	X	X	X				
Nutrition Edu. Cooking Demo.					X	X	X	X				X
Follow-up Supervision	X	X	X	X	X	X	X	X	X	X	X	X
Focus group interviews												X
Mid Term Evaluation									X	X		

89

SCF/US MALAWI 90-DAY SUSTAINABILITY ACTION PLAN

ACTIVITY	OBJECTIVE	MONTHS				
		Jul.	Aug.	Sept.	Oct.	Nov.
<u>Dec.</u>						
1. Hold Feedback/ meetings with field office staff						<-->
2. Report workshop discussions to fellow project staff						<-->
3. Community meetings with MOH and local leaders and VHP's in 13 areas in Mbalachanda	Plan together how the 39 leaders can manage and generate profit from their DRF from K80 to K300 by 1992					<----->
4. Community meetings with MOH, local leaders in 33 areas in Microta	To create awareness on the importance of income generating activities to Ag. leaders e.g. DRF, loans so that they sustain the Child Survival Programs at the end of the project funding (1992)					<----->

SCF/US ZIMBABWE

Feedback on Workshop NGO's, MOH, HQ.	To share knowledge					1st wk. <-----> <--> <-->
Income generating project	For sustainability of program					<---->
Incooperate our activities into other ministries activities	To improve our coverages					<----->
To educate community leaders on Aids	To help educate the community					<-----> <---->

SUPERVISING IN ACTION

- Step 1. List where supervision is most needed.
- Step 2. Review other time-tables.
- Step 3. Make a yearly schedule.

Consider: - minimum needs
- program needs for frequency

ROTARY POLIOPUS/NIGERIA 1-YEAR SUSTAINABILITY ACTION PLAN

ROTARY'S POLIOPUS INTERVENTION: EPI
COMMUNITY BASED VOLUNTEER CORPS

Objective: To raise 20,000 volunteers for Nigeria EPI by the end of December, 1990 to strengthen and sustain routine EPI activities at the LGA. level.

Source of Volunteers: Community leaders, social groups, students, other NGO's, professional peoples.

ROLES:

- P Public Enlightenment
- R Recording/Registration at the Centre
- I Immunization at the Centre
- D Defaulter Tracing
- E Enumeration

Sustainability Strategy:

- 1) Recognition through provision of incentives e.g. Certificates, Badges, Aprons/T-Shirts, locally available medals.
- 2) Training and retraining
- 3) Monitoring tools e.g. Disposition cards and register
- 4) Continued feedback e.g. through Polioplus News.

SCHEDULE OF ACTION: POLIOPUS VOL. CORPS. ESTABLISHMENT

ACTIVITIES	TIME				FRAME				1990			
	1	2	3	4	5	6	7	8	9	10	11	12
1) Identify and Establish PHC Coord. and other functionaries (LGA)												
2) Identify and mobilize volunteers												
3) Identify Resource Persons and Facilitators												
4) Organize Training in line with 6 step approach												

ROTARY POLIOPUS

- Step 1 - Overview on EPI/Polioplus, Update - PHC coord./LVA Coord.
- 2 - Techniques and Logistics of VC area input.
- 3 - Role Play
- 4 - Field Practice
- 5 - Feedback
- 6 - Assign Roles

IMO STATE/AFRICARE NIGERIA 90-DAY SUSTAINABILITY ACTION PLAN

Goal: To sustain the impact of CS activities in the major interventions:
EPI, ORT, Nutrition, Child Spacing and Maternal health.

Areas of Sustainability

A. Financial Viability Delivery		B. Transfer Skills	C. Continued Service
Keys to Services Continued Impact HIS	Support Compensation for VHWS	In-service Trainings. Home Visits Growth Monitoring Sessions	Delivery of Health by MOH, LGA. Supervision Monitoring, Evaluation, by MOH and LGA

Activity	90 DAY PLAN		
	JULY	AUGUST	SEPTEMBER
1) CSP staff meeting(s) to discuss workshop sessions and finalize Action Plan	X		
2) Hire small business consultant to work with the Project and LGA in establishing a marketing strategy and plan		X	
3) Continuing to carry out agricultural/business management training with VHWS	X	X	X
4) Examine Data collection system to consider revising for simplicity/sustainability	X		
5) Identify MOH counterpart to be trained to take over HIS - involve him/her in training	X		
6) Revise training curriculum for Afikpo Pre-service training to reflect simplifications of HIS	X		
7) Train MOH counterpart - HIS		X	X
8) LGA Policy Makers Workshop			X

MIHV/KENYA 90-DAY SUSTAINABILITY ACTION PLAN

<u>ACTIVITIES</u>	<u>JULY</u>	<u>AUGUST</u>	<u>SEPTEMBER</u>
1) Hold a community meeting where - election of CHWs will be done -sell the ideas of IGA (tent renting already mentioned.		
2) Hold meeting with newly elected 90 CHWs - Organize about the training of 90 CHWs -Discuss with village leaders concerning the IGA	-----	-----.....
3) Train CHWs (90) Train 40 CBD officers - Meet with H/community discuss more of IGA	-----	-----
4) Supply 40 CBD officers with 200 condoms each to distribute in the community. - Supervise 40 CBD officers - Supervise 90 CEWs giving each one health topic in each of the 3 communities.	-----	-----
5) Hold community meeting - give feedback of WAWA -Organize a date for fund raising -Raise awareness for fund raising - Community collecting funds for IGA	-----	-----

SESSION AGENDA

Introduction: 10 minutes
Brainstorming, Sustainability Activities 25 minutes
Quantifying, each Project's Sustainability Activities 10 minutes
Wrap-up 15 minutes.

TUESDAY AGENDA

8:00 Community Meeting
8:15 Preparation for Field Visit
9:15 Travel to field sites
10:30 Arrive at field site
10:45 Community interviews
11:45 Return to bus/departure
13:45 Lunch
1:30 Process Community Participation
2:30 Break
2:45 Sustainability Update
3:15 Income Generation
5:30 WAWA

CARE/SUDAN 90-DAY SUSTAINABILITY ACTION PLAN

Sustainability Action Plan SUDAN (Key Charges)

- 1) VDCs members will be able to sustain PHC activities by paying vaccine transportation cost and help in delivering OR's to their Phc units.
- 2) DPHCC members will be most committed to support PHC activities in their district (7R/C in Bara district).

Supporting Forces:

- 1) Committees field staff to C. M. concept.
- 2) Project office within the community.
- 3) Collaboration with other departments at district and village level.

Resisting Forces:

- 1) Non-awareness of some official at the district level to PHC activities.
- 2) Fuel as transportation problems.

Logistics.

MACHI - BARA HEALTH PROJECT OF CARE SUDAN

Key Charge No. I

What to be done: - Orientation and training of VDC about basic managerial processes and help in finding means and money to support the two PHC interventions (CDD, EPI).

How: - Meetings, setting training needs, training.

Who: - Project Manager through his two field coordinators.

When: - August 20th 1990 (5 village D.C> will be trained.).

Key Charge No. II

What to be done:

- Orientation and training of PPHC members in basic managerial aspects, and importance of sustaining PHC activities (CDD or EPI) through their full commitment and participation..

How: - By individual and then group meeting, setting training needs and then training.

Who: - Project Manager through his two field coordinator and a motivated person from another CARE Project in ReNuland District (Hawa) who is C/management task force member.

When: - October - November 1990.

SCF/USA 90-DAY SUSTAINABILITY ACTION PLAN

<u>ACTIVITIES</u>	<u>BY WHOM</u>	<u>WHEN</u>
1. Community workshops in Sherkeila Rural Council re-community transporting vaccines.	District health Committee members	July-August 1990
2. Training of village health committees members in 74 villages of the 5 HIP areas on C/S intervention	Community trainers (2 in each HIP area)	July-Sept. 1990
3. TOT	MOH + SCF staff	August 1990
4. Training of mothers in 16 sponsorship villages on ORT	CHWs + one SCF community trainer	July-Sept. 1990
5. Regional PHC supervisory committee meetings	Project Manager	September 6, 1990
6. Supervisory visits	DHC Tech. committee	5th Monday

SUPPORTING FACTORS:

1. Collaboration with local authorities, local health authorities and communities.
2. Motivated SCF staff
3. Full community participation
4. Equipments available

CONSTRAINTS:

Lack of fuel, Rains, Shortage in supplies.
HIP-High Impact

WORLD VISION NIGERIA 90-DAY SUSTAINABILITY ACTION PLAN

FINANCIAL VIABILITY

Drug revolving fund for six communities - July 22 - 30th. Collect family planning supplies from MOH and sell for minimal charges - August. Help obtain grant from Ministry of Social Development, Youth and Sports, CU.SO to assist one community from July to buy one small cassava grinding machine to generate income - September.

KNOWLEDGE AND SKILL TRANSFER

1. Train ten village health workers in July 2nd - 21 st
2. Train 50 Health/Nutrition Aides. 1st week in July & 2nd wk in August.
3. Form 5 village health committees - 3 in August, 2 in September.
4. Conduct a mid-term evaluation in August.
5. Attend monthly meeting of all the communities, local development associations - 3 meetings July, August, September.

CONTINUES SERVICE FOR MAINTENANCE OF BEHAVIORAL CHANGE:

Provide ORT kit for five communities July. Link up with National Association of NGO's at Federal, State and Local level - July. World vision to sign a formal agreement with Baptist Medical Centre who is the primary partner - August. Conduct a mid-term evaluation in August. Hold a quarterly meeting with Project staffers - MOH, UNICEF, LGA, BMC & CHAN officials - September.

92

WORLD VISION UGANDA BUDIBUGYO 90-DAY SUSTAINABILITY ACTION PLAN

<u>CATEGORIES</u>	<u>JULY</u>	<u>AUGUST</u>	<u>SEPTEMBER</u>
1. Financial Viability	-Meet with community -Support co-operative Society formation -Support IGA Brick making machine	-Acquire loan for Co-operative Society from Co-operative Bank in Fort Partal Visit bank (PM) with comm. leader Contribution by community in cash or kind.	Accountability Buy the brick making machine
2. Knowledge skills	From 15 RC Zone. Training CHWs (15). Retraining MOH and Project staff.	Training CHWs (15) Mobilization of comm. and training on brick making & firing bricks	As in August
3. Continued service	Collaboration with the existing health staff, LGA and PVO in the project area	Monitor response by community survey market for bricks, supervision by community leaders.	<u>Evaluation</u> Number of CHWs trained, Number Comm. members in cooperative. Number of paid Contributors. Number volunteering labour. No. of bricks made. Size of market for brick selling. Supervision.

COMMUNITY INVOLVEMENT - PRIMARY HEALTH CARE

Four small groups (five persons each group) were formed to discuss and share their views with respect to community participation in the implementation of specific child survival interventions:

ORT

WV/Nigeria - Omoolorun
WV/Sudan - Rahim
Imo MOH/Nigeria - Iwu
SCF/Malawi - Ethel
Africare/Nigeria - Dan

EPI

SCF/Malawi - Stanley
ADRA/Nigeria - Samuel
Rotary PP/Nigeria - Frank
WV/Uganda - Beatrice
SCF/Zimbabwe - Liz

High Risk Births

Africare/Nigeria - Regina
MIHV/Kenya - Lois
WV/Uganda - Joseph
ADRA/Nigeria - Ezeigbo
SCF/Zimbabwe - Nonia

Nutrition

IEF/Malawi - Herbert
Africare/Nig. - Nnenna
SCF/Sudan - Deng
WV/Nigeria - Bola
Rotary PP/Nigeria - Gloria

The participants in each group were to:

- a. Identify positive (+) and negative (-) experiences shared in the implementation of the involved child survival intervention.
- b. Present specific (+) and (-) beliefs that should be dealt with in the Child Survival intervention. (Important: a positive belief is one which can and should be reinforced; a negative belief is one which should be changed.)

Each small group was also to decide who within its group would later interview four different types of targeted community representatives concerning child survival interventions (the fifth participant would serve as recorder for the interviews):

- Mothers
- Village Health Workers
- Traditional Leaders of Local Communities
- Government Workers

In this way, four participants across groups (one each from ORT, EPI, HRB and NUTR) could form an interview group to meet with Mothers. A different four participants (again, one each from ORT, EPI, HRB and NUTR) could meet with Village Health Workers. Etc. Etc. Following the interviews, they could summarize, draw linkages and report back upon their findings.

When participants met for their first discussions in their original groupings (i.e. by intervention areas: ORT, EPI, HRE and NUTR), they brainstormed and reported upon (+) and (-) experiences shared. They also identified (+) and (-) beliefs they should attempt to either reinforce or change in carrying out their child survival intervention. Their reports were as follows:

ORT GROUP BRAINSTORMING OF EXPERIENCES AND BELIEFS

(+) POSITIVE EXPERIENCES SHARED

1. Idea of taking fluids during illness is acceptable.
2. Community noticed decline in diarrhoea morbidity/mortality with ORT usage.
3. Community Leaders willing/able to take lead as change agents.

(-) NEGATIVE EXPERIENCES SHARED

1. People unwilling to take fluids during diarrhoea because they believe that fluids prolong diarrhoea
2. Male dominance inhibits necessary female participation.
3. False beliefs that some food items e.g. eggs, meat make the child steal or develop worms.

(+) POSITIVE REINFORCEABLE, IMPORTANT ORT BELIEF

1. Use of fluid during diarrhoea
2. Giving of plaitain porrage to children who have diarrhoea.
3. Traditional use of pap during diarrhoea.

(-) NEGATIVE CHANGEABLE, IMPORTANT ORT BELIEF

1. Belief that sugar (+ other sweet meals) cause diarrhoea
2. Perception that medicine is needed to treat diarrhoea and that ORT is no medicine.
3. Belief that diarrhoea babies must be breast feed.

EPI GROUP BRAINSTORMING OF EXPERIENCES AND BELIEFS

(+) POSITIVE EXPERIENCES SHARED

1. Traditional beliefs
2. Past experience
3. Use of traditional beliefs
4. Favourable attitudes to vaccine
5. Health of children increases

(-) NEGATIVE EXPERIENCES SHARED

1. Ignorance
2. Traditional beliefs
3. Religious beliefs
4. Past experience
5. Bureaucracy

(+) POSITIVE REINFORCEABLE, IMPORTANT EPI BELIEF

1. Traditional Belief
2. Diseases are preventable
3. Use this to introduce immunization

(+) NEGATIVE CHANGEABLE, IMPORTANT EPI BELIEF

1. Ignorance important and can be changed by health educator
2. Traditional belief
3. Encourage what use to prevent disease and introduce immunization.
Question: What is jadi-jadi? Answer: Constipation, Dysentary or Diarrhoea based on belief.

HIGH RISK GROUP BRAINSTORMING OF EXPERIENCES AND BELIEFS

(+) HIGH RISK BIRTH GROUP EXPERIENCES SHARED

1. Awareness from good health
2. Support from government
3. Income generating activity

(-) HIGH RISK BIRTH GROUP EXPERIENCES SHARED

1. Transportation
2. Lack of community support and ownership
3. Low literacy level taboos and beliefs

(+) POSITIVE REINFORCEABLE, IMPORTANT HIGH RISK BIRTH BELIEF

1. High desire/expectation
2. Fear of complications and deaths
3. Post-partum sexual abstinence and prolong breast feeding
4. Sexual abstinence during pregnancy reduces P.I.D.

(-) NEGATIVE CHANGEABLE, IMPORTANT HIGH RISK BIRTH BELIEF

1. Contraceptives & T.T.; cause sterility
2. Taboos on nutrition e.g. eggs, meat, chicken (causes babe to be big to deliver normally.
3. Belief that women should have all children that GOD has given her.
4. Belief to have many children due to child mortality.

NUTRITION GROUP BRAINSTORMING OF EXPERIENCES AND BELIEFS

(+) POSITIVE EXPERIENCES SHARED

1. Prolonged Breast Feeding
2. Traditional Child Survival
3. Extended Family System

(-) NEGATIVE EXPERIENCES SHARED

1. Disease as a curse
2. food taboos and belief
3. Begging as a profession; Deformed either or elders
4. Traditional diet.

(+) POSITIVE REINFORCEABLE, IMPORTANT NUTRITION BELIEF

1. Continued breast feeding
2. Community education
3. Prevention of culture
4. Disease as a curse; Food taboos.

(-) NEGATIVE CHANGEABLE, IMPORTANT NUTRITION BELIEF

1. Affects Child Survival intervention
2. By health education
3. Demonstration & nutrition education

16

VISIT TO INTERVIEW GOVERNMENT LEADERS
AT AHAZU MBAISE ON 26TH JUNE, 1990

Questions posed during the visit to interview government leaders on Imo State/Africare Child Survival Project, and the answers received, were as follows:

ORT INTERVENTION GROUP

- Question: What causes diarrhoea?
Answer: Clinical diseases listed: also bad feeding, bad water and too many oranges.
- Question: What are consequences of diarrhoea?
Answer: Dysentery and ultimately death. Also dehydration growth and mental retardation.
- Question: Recent change in the understanding of diarrhoea?
Answer: Mixing solution is an improvement but on personal level child with diarrhoea may go to hospital instead of mixing up solution.
- Question: What is the role of sugar in Home?
Answer: It is now a part of daily life. Parents are now informed on using sugar properly. Older people don't use it because of diabetes.
- Question: What can be done by Community Leaders?
Answer: Provide healthy environment - clean up homes, use boiled water, and wash fruit and hands. Provide clean water and environmental sanitation.

EPI

- Question: What methods are useful to prevent disease?
Answer: Immunizations for small pox, polio and recently good success with yellow fever vaccine.
- Question: What beliefs or taboos interfere?
Answer: Now 85% will take immunizations. Previously people would wrap joints and forehead to prevent measles. Also old custom systems does not allow different types of people to be immunized together. In emergency native treatments are still used.
- Question: What do people think when child dies from disease sometime after being immunized for that disease?
Answer: If child dies after immunization, it is not parents fault (or government). Other children will still be immunized in that family. We don't change God's work.

97

High Risk Births

- Question: When do women marry?
Answer: Between 16 and 30. Women marry young if they are not going on to school.
- Question: How many children do women have?
Answer: Average 6 but up to 11 or 12. Government and Church support child spacing. Government clinics provide Depopovera and other measures. (Condoms not mentioned). The Catholic Church supports natural family planning.
- Question: What is the role of TBA?
Answer: Only a few are left in remote areas. Now hospitals and maternity homes are available. TBAs are also educated in modern methods.

NUTRITION

- Question: Is breast feeding considered the best?
Answer: Yes, important for infant. No mixing, no infectious diseases. It has proper nutrients also breast milk affects behavior of infant.
- Question: What foods are locally available?
Answer: Cassava, Yams, Plantain, Breadfruit, Corn, Beans, Oil bean seed, many vegetables. But meat, fish, snails are more expensive. Milk is generally used less.
- Question: What is the feeding pattern?
Answer: There is equal sharing of rice and beans for all family members. Animal meat goes to parents, especially father first, There was lively discussion about who eats what at the dinner table (just like home).
- Question: Is there a feeding problem?
Answer: Enlightened family has balanced diet. Other families eat same food each day. There are taboos against eating monkey and if pregnant, certain other foods. Clinic sees very few cases of marasmus or kwashiorkor. No vit. A deficiency noted in clinics.

VISIT INTERVIEW OF VILLAGE HEALTH WORKERS
AT ABIAZU MBRAISE - IMO STATE ON 26TH JUNE 1990

The workshop team was warmly received by about 10 VHWs. A brief introduction of the interviewing team was given by Regina. Explanation that this is not an evaluation. General observation is that VHWs were relaxed and most participate even though 1 or 2 seem to answer questions most of the time.

HIGH RISK

- Question: What problems do you think are associated with high risk birth?
Answer: 1) Given birth more than 4 times by the 5th delivery mother has bleeding.
2) Too many children lead to improper education and underfeeding.
3) After many children i.e. 7, mother does not have strength to work and she is under stress which may lead to hypertension.
4) Some of the children die unnecessarily if they are many.

ORT

- Question: How do you manage a case of diarrhoea?
Answer: We use ORT which we have taught to the community:
1 water (beer bottle full)
1 tea spoon salt
10 tea spoons sugar
We advise that some foods like fried foods should be avoided during diarrhoea but easily digestible food. Surrounding is to be kept clean to prevent. Sent to hospital if ORT does not succeed. Some mothers fear giving water when child has diarrhoea, we try to educate them that ORT is not contraindicated.

- Question: Messages given to mothers apart from ORT
Answer: - Drink clean water
- Keep away flies
- Keep surrounding clean

EPI

- Question: What messages do you give to mothers regarding immunization?
Answer: 1) It is necessary to take child to center against the six killer diseases.
2) Mothers are also advised to get immunized when pregnant.

(No specific comments on side-effects and schedule.)

- Question: Do you have other things you tell them may happen if they do not immunize?
Answer: Some children are deformed and some die.

- Question: What problems do you face in your community regarding immunization?
Answer: Mothers complain that
- Children become sick after immunization and so mother stay back. Attitude change by counselling and health education and home visits.
- When there was a yellow fever epidemic, mothers were worried and felt that immunization would have prevented the illness, therefore this helped to boost immunization. VHW try to educate that disease after immunization will be milder than disease if child was never immunized.

91

Question: What do you think are the things preventing mothers to come for immunization. Why would mothers not want to complete TT.
 Answer: False stories they hear - like child may die, too much fever, child will have abscess or rashes. Financial problem due to transportation money. Some mothers say that since they have successfully had children without tetanus toxoid, they don't need it for future pregnancies. Some bluntly refuse immunization but we persist to educate.

HIGH RISK BIRTHS

Question: At what age should a woman start and stop having children?

Answer:	Age to start	Age to stop
	18 yrs	50 yrs.
	25	40
	10	35-40
	25	46
	20	40
	25	45
	18	35
	16	50
	25	40

Question: What are the major nutrition problems you face in your village and what are the causes?

Answer: Complain of lack of food materials and no money to buy the food and they request us to give them the nutritious food. We advise mothers to use what they have if they do not have money to buy other things. There is general scarcity of food and vegetables.

Question: When did you have training on nutrition and who did it?

Answer: During the courses by Mrs. Charity
 Taught ORT, Nutrition, Breast feeding, Family Planning. Last training was on growth and monitoring. Each training period lasts 1-3 weeks.

GENERAL

Question: What do you regard as the most important Child Spacing intervention?

Answer: 1) Child spacing 2 respondents
 2) Nutrition 6 respondents
 Many children are malnourished. A solution will be to emphasize family planning and to get work to do. Most VHWS think nutrition problem is the major problem.

ORT

Question: How do you get them to remember the way to mix ORT?

Answer: VHW responded with a song in Igbo - they say similar songs exist with other interventions.

TRAINING

Question: How do you feel about the training you get?

Answer: The training has been useful; even for our personal life we still need more knowledge on family planning, growth monitoring and nutrition.

We notice that with the application of the knowledge we get to the villagers less children are dying and there are less unwanted children. This is why the husband/wife relationship has improved.

SUPPORT

Question: What kind of support do you have from MOH, Local community, Africare?

Answer: During training we are given transport money and snacks. We do not get any monetary incentive, but we do have some community donating lands to us for farms. Some community helps to cultivate, some do not. We are supervised by MOH, LG nurse and Africare staff.

Question: What role does the community members play in passing out the information.

Answer: Mobilize people.

CONCLUSION

Question: What motivates you?

Answer: The knowledge we get.

One of the VHW states that there is a need for some remuneration - may be on a monthly basis.

We thanked the VHWs about their participation and promised that there will be a feedback. We also said that we have learnt a lot from them and impressed about their level knowledge.

In conclusion, we expressed our appreciation for their cordial reception.

M

VISIT TO INTERVIEW MOTHERS AT
AHLAZU MBAISE: IMO STATE ON
26TH JUNE, 1990

ORT

- Question: What causes diarrhoea?
Answer: Drinking unboiled water or drinking from uncovered water.
- Question: What do you do when your child has diarrhoea?
Answer: Prepare ORT
- Question: What do you know about ORT?
Answer: Prevents diarrhoea and gives child strength during diarrhoea.
- Question: What do you think is the best way to handle diarrhoea?
Answer: 1) Prepare ORT when child has diarrhoea
2) After 24 hours take child to hospital
- Question: When do you take the child to hospital?
Answer: 1) When the prepared ORT finishes
2) After 24 hours take child to hospital
- Question: Name two benefits of ORT
Answer: 1) Helps to stop diarrhoea and vomiting
2) Gives child strength during diarrhoea.
- Question: Roles of hygiene (personal and environmental) in preventing diarrhoea.
Answer: 1) Prevents flies that help to cause diarrhoea
2) Prevents the breeding of cockroaches

EPI

- Question: What do you think about EPI?
Answer: Helps children to grow well.
Prevents children from getting the 6 deadly diseases or when they get it, it is not serious.
- Question: What information were you given before you children are immunized?
Answer: Immunize children so that they don't get ill and even if they get ill it is not serious.
- Question: Any information given as regards side-effect?
Answer: We were told that the child may have fever and should be given analgesic.
- Question: What preventable diseases do you know?
Answer: 1) Bleeding
2) Tetanus
3) TB Mothers said this after being encouraged by VHWS
4) Measles " " " " " " " "
5) Polio " " " " " " " "
- Question: Are there still some mothers who refuse EPI?
Answer: Yes.
- Question: Are there any traditional beliefs to prevent the mothers from bringing their children?
Answer: Yes - Children still have fewer abscess after immunization.

NUTRITION

- Question: What do you feed your child with?
Answer: Breast milk and pap.
- Question: How many times daily do you feed your children?
Answer: 2 times
3 times
- Question: When do you start introducing other foods to your child?
Answer: 4 months
- Question: When do you finally stop breast feeding?
Answer: 1) 1 year 2 months
2) 1 year
3) 8 months
4) 1 1/2 years
- Question: Who do you feed first in your family?
Answer: If husband is home, he is fed first (3 women answered the same thing).
- Question: What are your food taboos?
Answer: Sweet food causes (diarrhoea and worm)
No milk because this is not good for children it causes (diarrhoea).
- Question: Can you remember what you fed your child with for the past 24 hrs.
Answer: 1) Foo-foo with okro soup
2) Garri with ogbono soup
3) Rice and stes, garri and cocoyam soup
4) Yam porriage, garri and cocyam sour, yam
5) Pap and garri
6) Pap, yam porriage.
- Question: Have you ever heard of Family Planning?
Answer: Yes
- Question: What does it mean?
Answer: Prolongs life and mother can go out to find food for her children.
- Question: What does Child Spacing mean?
Answer: 2-3 years gap before another baby.
- Question: What methods of child spacing do you know?
Answer: 1) Prolong breast feeding and
2) Pills
- Question: What do people say about child spacing?
Answer: That they should stop having children. Government says that they should not have children.
- Question: You as mothers what do you think?
Answer: It is good to have the number you can train.
- Question: Is child spacing helpful in your community?
Answer: Yes
- Question: How?

Answer: Gives the women strength.

Question: Have you ever seen a woman with complications of child birth?

Answer: - Bleeding
- Tetanus
- Eclampsia - mothers didn't use this terminology.

Question: How will the community sustain this project when Africare goes?

Answer: 1) Assist the VHW in her farm since she does not have time to work on her farm.
2) Give VHW food stuff
3) Can not do any thing but are begging Africare to help the women.

Question: Is it possible to supply the VHWs drugs to give them?

Answer: Project staff explained that the Project will look into it and that first of all the project has to write a proposal etc.

Question: Could they be given anything for their children and themselves?

Answer: We lectured them on how they can use locally available food stuff to make balance diet which is the same as if they are given milk, cereals etc. from overseas.

VISIT INTERVIEW OF EZE E.O. NWOGA AT AHIAZU MBAISE:
IMO STATE ON 26TH JUNE, 1990

EPI

- Question: What are the native beliefs of your people if your children are afflicted by any of the EPI diseases? Are there taboos/suspicions?
- Answer: Presently through interaction/contact. By Omen of god/punishment e.g. whooping cough, traditional belief before was to wear something to prevent it. Since EPI, this has reduced; Omen belief has gone now with present EPI. Juju man was the medicine man who made something for children to wear around their neck. By faith it worked.
- Question: How have you officially encouraged EPI in your community especially in the remotest area?
- Answer: Nearness of the Local Government to the people has helped. LGA health workers visit autonomous community for information, education and service. Have health centers. Thanks to Government of Imo State for EPI and ORT program. Information passes through letters and Church announcement and the village town criers. The Church is the dominant group in the community. Also the community leaders help. LGA officials move with their vans and megaphones for information.
- Question: How do you encourage or make sure people bring their children for immunization?
- Answer: By imitation. People do what they see their neighbours do; e.g. last year December outbreak of yellow fever, they scrambled for immunization. When the immunization team arrive, they go to the nearest point.
- Question: Who helps you in immunization? Do Government and other NGO visit you for help?
- Answer: Regular visit is from LGA council health team. Visit of government during outbreaks. Chiefs are the agents of informing the people; presence of Africare in the community. Government is always very slow in reacting to reported cases of outbreaks - management by crisis syndrome.
- Question: What are you doing for continuity after the delivering PVO go?
- Answer: It is early to talk of withdrawal now.

ORT

- Question: What causes diarrhoea in children in your community?
- Answer: Bad water, bad food and unripe fruits.
- Question: Is there any suspicion or taboos in this?
- Answer: No. Children get treatment immediately.
- Question: How do you treat diarrhoea in the family?
- Answer: Mother takes action first; takes child to clinic, maternity, hospital or quacks for treatment.
- Question: What do you do when many children have diarrhoea at the same time?
- Answer: Reported; Health centre informed for control. Referred to nearest hospital.

105

NUTRITION

- Question: What is the food you like best, i.e. staple?
Answer: Garri, Cassava, Akpu with either vegetable, Ugu, Ukazi, ofe Owerri, Egusi or Okro soup.
- Question: Wnen children are born what time do you start to feed them.
Answer: Fathers only provide for the family and mothers feed children. So only mothers can answer best. Breast and water is given. At the age of 4 months feeding of Akamu etc. is started.
- Question: Do you have any special belief about any particular food for children to take?
Answer: None specific. But mothers are careful and take precautions. No taboos about giving particular food to children but poverty could contribute.
- Question: How do you serve food to children in the family? Individual or groups?
Answer: Food is served individually.
- Question: Do your people believe that not eating some kinds of food cause disease like kwashiorkor?
Answer: Yes.
- Question: Are there village health workers working in the community?
Answer: Yes, thirty to forty village health workers are trained and working today doing weighing, home visiting etc.
- Question: What do you assist the village health workers with?
Answer: Through donation. MOH Owerri should continue the VHW services for sustainability until the community is able to take over.
- Question: How long do you think you can be able to take over services?
Answer: Five years to generate funds, budgeting and appreciation by people.

HIGH RISK BIRTHS

- Question: Do you have any way of knowing the number of children born in the community.
Answer: No statistics are kept. But every body aims at having 10 children in order to achieve a certain membership (i.e. Ewu Ukwu) in Mbaïse community. If a women reaches that mark, she belong to an association. In the past it was so, although now some people are still obstinate. But through health education the elites have since been playing down on this practice.
- Question: Do you have any idea of people who cannot support their families?
Answer: Yes so many here and there. They depend on the haves, working and begging for support.
- Question: Do you see having too many children a problem in your community?
Answer: In the recent past it was a blessing because people count on the number of children. But now it has become a reverse, that is, it is now a problem.
- Question: Do people embrace modern Family Planning methods as the old methods?
Answer: It would be nice if they did but such old method may not appeal to modern people today. There could be results of mistakes to child bearing as well.

INCOME GENERATION

Participants formed three small groups to discuss different types of income generation schemes for support of VHVs and other financial needs of projects. The reports back to the main group were as follows:

DRUG REVOLVING FUND (Group.1)

Driving Forces:

- Perception of need for the community
- Willingness of the people to pay (Procurement)
- Proper Management of the DRF
- Consistency in availability of the drugs
- The drug should be affordable
- Strong leadership qualities
- The community should perceive that the drug is effective.

Restraining Forces:

- Lack of Leadership and Capital
- Lack of business management skills
- Misappropriation of funds
- Interruptions in drug supply
- Inconsistent Government Policy (Procurement)
- Insufficient turnover
- High pricing of the drugs
- Inflation
- Transport problems
- Lack of proper supervision and awareness
- Wrong administration of drugs.

FEES FOR SERVICES (Group.2)

Chargeable:

ORT, Growth monitoring card
Family Planning Supplies
Treatment of minor ailments
Control of endemic diseases
Transport family record card

Driving Force:

ORT solution seen as medicine
Mothers pride to own card and see how child grow
Economic situation forcing people to plan family
Immediate relief from ill-health and prevention of complications

Negative Force:

Quacks charge less fee for treatment
Political intervention
No Charges - Immunization, Health Education
If you charge Mothers would not come

Note: A point was made in regard to transport problem. UNICEF typically makes donations of cars, motorcycles and bicycles as its international aid to immunization projects. Locally, funds to meet project vehicle incountry operation costs can be generated by charging token fees.

COMMUNITY FUND (Group 3)

Method: Communal Farm.

Positive Factors:

- Free Land
- Communal Labour
- Capital from Government/NGO or contribution from Community
- Farm implementation from community members
- Seeds from Government donors community
- Storage arranged by community Leaders
- Maintenance of farm by community

Negative Factors:

- Crop Failure
- Pests/animals
- Drought/Flood
- Lack of Market
- Non-commitment
- Poor management
- Insecurity/theft

GROUP 1 VISIT TO THE PRODUCTION UNIT PROJECT AT ISIALA NGWA, IMO STATE
ON 27TH JUNE 1990

The Child Survival Project was started with a trial food processing, packaging and sales activity (Production Unit) that could generate income to support Village Health Workers. Capital was from CS project. The Production Unit needs more funds and is not yet self sustaining. The Unit's manager expects that marketing could be quite good but hasn't had a chance to advertise. The catchment area is about 8 sq.km.

The Child Survival Project is supervised by Child Survival Project Manager. The impact of the overall programme on the nutritional status of community is reported as reaching 80% of malnourished children.

As regards the Production Unit, 32,000 tons were produced and 75% was bought by local community. Plans are for the Local Government to take over the project but its still in the pipeline.

The personnel of the Production Unit are:

- 1 Production Unit Management
- 4 Production staff trained on the job
- 3 Security

Problems faced by the Unit are:

- means of marketing
- selecting who to train

Income Generating Activity:

Advised you get into an activity that people will need under any circumstance. (economic recession, war, natural disasters etc.) A food commodity storage and marketing is worth considering. Steps you may wish to consider

- (1) Budget (capital outlay and overhead costs must be considered).
- (2) Set up an office, recruit staffers, give job descriptions so that everyone knows what is to be done and how it is to be done. Put all other management tools in place
- (3) Do feasibility study/market surveys

Advise to someone who wants to start a project:

- Identify needs
- In choosing your commodities consider types, availability and storage, methods of preservation, marketability etc.
- Have a dialogue with the community
- Need for a set of indicators to monitor progress
- Pick a project you can find capital for
- Need for raw materials - resources
- Create awareness through - training, meetings
- Managerial skills needed - maintenance, operation
- Significant Local Representatives on the committee.

GROUP 2 VISIT TO ISIALA NGWA: IMO STATE ON FOOD
COMMODITIES STORAGE AND MARKETING PROJECT
ON 27TH JUNE 1990

- Question: Are there rules/regulations for operating the project?
Answer: 1) Has a constitution
2) Has officers: President, Vice president, Secretary, Treasurer, Purchasing Officer, Sales Officer, Storekeeper
3) Purchasing Officer does not do the sale.
4) Collective decision to determine sales price and time to sell.
5) Operate bank account.
- Question: What food commodities are you dealing with now and in future?
Answer: Now: Palm oil.
Future: Melon, corn, yam, legumes, ogbonno.
- Question: Do you have any budget plan for executing this project?
Answer: N5480 (N5000 revolving fund from Africare and N40 levy/person).
Did not look elsewhere to raise capital. Heard about Peoples Bank but did not know their potential to get loan from Aba branch of the bank.
- Question: What is the storage capacity and what methods of preservation are you going to use?
Answer: Open yard, can take 500 tins of palm oil. Dry corn and melon in the sun. Keep these items in a room in a bag and on top of oven. Use chemicals to fumigate the grains.
- Question: Is there a ready market for the grains?
Answer: Yes, there is a railway station near the base. Commodities could be sold to people from near and far.
- Question: What safety measures are in place to secure the commodities and the proceeds from them?
Answer: A night security guard. Proceeds kept in bank. 3 signatories with coordinator must sign before money could be withdrawn. Pussy cats and rat poison to discourage rats eating the corn.
- Question: What are your plans for the future?
Answer: Work harder
Being careful
No thought on how profits would be shared yet.

Appendix J - Workshop Minutes on Health Information Systems

The workshop goal for this session was "To share lessons learned in data gathering, monitoring, and feedback to the community". This six-hour session presented an overview of steps that should be considered when designing an HIS and provided an opportunity to practice the skills needed to develop effective data collection tools. The final activity of the session offered the participants a chance to analyze the information on project activities which had been recorded on the Project Information Matrix and from that analysis present a report/feedback to the users of this information: the community, the VHW, the MOH, and the donor agency (in this case USAID).

Objective 1 - Describe what is meant by an HIS/MIS and discuss its components.
(Time 1 hr.)

Activities: Describe purpose, process types of information require for HIS
Identify 9 components of an HIS (Brainstorm)
Develop sample HIS for one intervention.

HIS was defined as the total set of processes, activities, records & equipment devoted to generating transporting and storing information. It is a system designed to produce information that assists managers in decision making and enables them to ascertain progress make. The nine components of a management or health information system were set forth:

1. SET OBJECTIVES

- Decide what you hope to accomplish
- Ask how much can realistically be done in a given period
- Choose how you will measure the out-come

2. LIST ACTIVITIES

Describe the activities which must be done in order to achieve the objective. In listing activities, provide a measurable description of what must be done, an include all major activities needed to achieve objective. For an objective such such as 80% immunization coverage, some activities to describe might have to do with:

1. Logistics in place
2. Manpower - identify given training Budget consideration
3. Identify strategy
4. Monitoring/Supervision
5. Evaluation

3. IDENTIFY USERS (I.E. PERSONS WHO WILL USE THE INFORMATION

1. Prepare list of Information users
2. Interview/Determine how they use information and what they will use

For information needed for decisions, managers may wish to identify users within the context of the following matrix.

	Users for monitoring & supervision	Users for feedback
1. MOH		
2. Community		
3. Project Staff		
4. Donors		
5. Project HQ		

Each group/level of users may require different information, and all may require some of the same pieces of information.

4. SELECT INDICATORS

This is an important step. In selecting indicators, the first step is to answer the following questions:

1. What are the questions to answer to know if activity is accomplished?
2. What information is required to answer these questions?

Indicators: Must be representative of what we are trying to measure
Must be useful to making management decisions
Must be measurable
Must be worth the time and money to collect

5. SET INTERIM TARGETS

Three methods are commonly used for setting interim targets:

Take the Final objective divide by Project Years
Take the previous years target add 10%
Set according to some normative standard (e.g. growth monitoring population)

6. COLLECT DATA

In collecting data, consider:
Value vs. cost
Health workers' work load
Data quality i.e. accuracy check

7. ANALYZE DATA

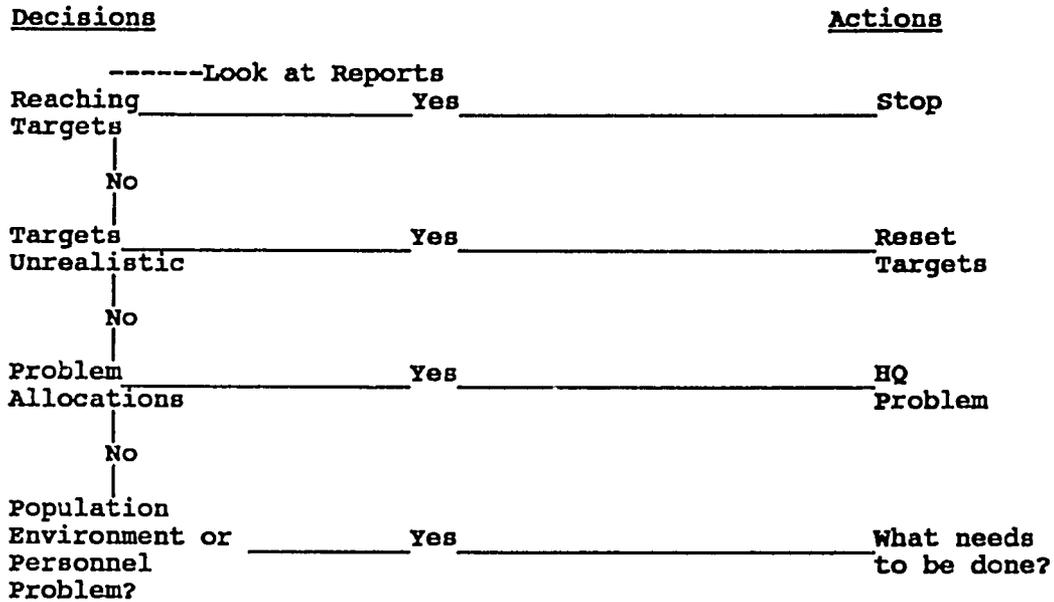
Consider:
For what decisions will we need the information?
What data will be needed?
What level of aggregation will be most useful?
What method of presentation will be most effective?

8. GENERATE REPORTS

Things to keep in mind in preparing reports:
 Most people are only able to think about seven items of information at one time.
 Lists of figures are difficult to interpret/understand.
 Information overload.
 Present information collected on indicators with targets.
 Data should be grouped with indicators for easy scanning.
 A picture is worth a 1000 words.

9. MAKE DECISIONS AND TAKE ACTION

Decision Making Flow-Chart



Objective 2 - Identify indicators and design a data collection instrument for (Time 2 hrs.) one CS intervention for a particular group.

<u>Content</u>	<u>Method</u>	<u>Resource</u>
Highlight	Lecturette	Flip chart
Importance of why data is collected		aid report forms
Importance of form design		Community based forms
(2) Designing data collection tool for one intervention	2.4 small group	-
(3) Presentation	3. small group presentation	Flip charts pens

The importance of collecting data, and the form in which it is collected, were highlighted by the presenter. The participants then moved to their four groups (ORT, EPI, HRB and NUTR) where they designed forms for collecting data destined for use at four different levels: community, MOH, PVO headquarters and USAID. The forms presented were critiqued by the other participants and resource persons. The presentations given below do not include the critiques, and they are not intended to represent final forms. They are simply the first draft of forms as presented by the four groups.

A. ORT REPORTING FORM TO PROVIDE INFORMATION FOR HEADQUARTERS USE

1. State projects'3 ORT objective: _____

2. Reporting period: _____
3. Demographic Information
 - a. Total Population in project Area _____
 - b. of WRAs in project area (15-49) _____
 - c. of child 0-59 months in project Area _____
4. Training Cost Data
 - a. of persons trained in ORT:

Trainers _____	Mothers _____
Clinic staff _____	Others (Specify) _____
VHWS _____	_____
5. What method(s) of ORT preparation is taught?
 - a. Home mix (SSS)
 - b. ORS packets
 - c. Locally available fluids
6. What is the incidence of:
 - a. cases of diarrhoea reported from children 0-59 months during the last 1st days in the project area _____
 - b. of deaths attributed to diarrhoea in the project area during the past months _____
7. Usage:

How many cases of diarrhoea for children 0-59 months during last 14 days were treated with ORT? _____

110

8. Availability:

If project is distributing ORS packets, how many sachets were distributed in the last 14 days _____
1 month _____

If project is teaching home mix, what % of mothers have:
- Salt _____
- Sugar _____
in the home?

B. HIGH RISK BIRTHS REPORTING FORM TO PROVIDE INFORMATION FOR USE BY
IMO STATE CHILD SURVIVAL PROJECT

Child Spacing

Form No. 101

Name: Date of Birth
Sex - (M) (F)

Address:
Village Community LGA

Marital Status Married Divorced
Single Separated

Level of Education (Tick appropriate line)
1. None
2. Primary Level
3. Secondary Level
4. Over Secondary Level

Religion
1. Christian
2. Moslem
3. Traditional
4. Other (Specify)

Pregnancies: -10

Pregnancies	Total	Life births	All deaths	N/D	C/S/Abortion
	10	8	6	2	

Name of Children Under 5	Age	Breastfeed	For how long
1.
2.
3.
4.

Ever used method of contraceptive If Yes State method.....
Are you currently using one: Yes or No.
Source of method/ supply

C. EXPANDED PROGRAMME ON IMMUNIZATION (E.P.I.) REPORTING FORM FOR PROVIDING INFORMATION TO COMMUNITY

Reporting Form/ Data Collection for Community

- 1. Community Date
- 2. Population I.G.A.
- 3. State
- 3. Name of Interviewer Experience
- Name of Interviewee

- Questions:
- 1. Have you heard about EPI?
 - 2. What is it?
 - 3. How many Children have you?
 - 4. Were you vaccinated during Pregnancy?
 - 5. Have your Children been immunized?
 - 6. Do you have the card (can I see it?)
 - 7. How many times should you take your Child to immunization centre to be fully immunized?
 - 8. Do you know of any mother of child in this community not yet immunized?
 - 9. How many Children have been fully immunized for the past 12 months?
 - 10. Do you have regular stock supplies?
 - 11. How often do you sent report to local HQ?
 - 12. How often are you visited by your supervisors?

Comments:

Summary: No. Mothers interviewed
No. Children fully immunized
No. Mothers immunized during pregnancy

Country & Regional Data:- Coverage: by intervention - EPI
Training
Cost per beneficiary
& activity

Uses: - Report to Congress
Workshop (regional & HQ)
Comparisons with country/national data *PVO impact
Impact of interventions - trends, constraints, program issues (TA)
workshop development
A.I.D. \$ cost per project beneficiary (live births)+(0-59)+(15-49)

FEED-BACK TO VHWS

Objective: Train 50% Mothers for coming 3 years.

- Word of thanks
- Presentation of analyzed data to VHWS

No. of trained VHWS on ORT = 156

No. of Mothers to be trained = 24,000

No. of Mothers practically trained = 4,250

Mothers/VHW trained = 4,250/156 = approx 30 mothers per VHW

Mothers remaining to be trained = 24,000 - 4,250 = 20,000 Mothers

Period needed for training = 20,000 mothers/4,000 per year = 5 years

Period of grant = 3 years

Conclusion: Activities to be doubled.

Use Mothers to train other Mothers

Target Group: Mothers

Reporting on the data we collected from their community

Data Analysis:	<u>TTI</u>	<u>TT2</u>	=	<u>Drop out Rate</u>
	55%	49%		6
	<u>OPVI/DPTI</u>	<u>OPU3/DPT3</u>	=	18
	58%	40		
	SSS			
	100% access			
	78% use			

Diagram (1st)

(2nd)

SSS

Feedback:

You have done well so far but we require a little improvement so that everyone will smile.

H.I.S. Report to LGA:

Please note that our project includes 11 village in your region. Our data system shows that the median number of children less than 1 year old is 4278. The median number of women of child bearing age is 13,429. Almost all the projects are in rural areas. Four of the projects will be ending in 1991 and the remainder in 1992. We do immunization from mothers and children in 5 areas. This is 30% of the budget. We teach about control for diarrhoea in 7 areas. This about 20% of our total budget. In addition we spend 20 to 30 % of our budget on nutrition problem, Vit A programs are present in 5 areas. Between 2% and 25% of the budget is spent for child spacing activities. We also do many other worthwhile programs such as malaria control, acute respiratory diseases, leprosy, water improvement and Aids.

We have many strategies for sustaining our activities but our future is mainly related to working closer together with you.

Since you may be taking over these projects in the next year or two, you will need to know the budget. Unfortunately, we did not collect data in the budget in our most recent Health Implementation System.

SUSTAINABILITY

It means the community should be empowered to own the project through training on how to generate income, how to continue the service and to link them to existing services, so that the project continues while you have phased out.

D. NUTRITION REPORTING FORM FOR PROVIDING INFORMATION TO USAID

Objective

Reduce No. of Children N.U/5 in a community (3000) whose weight fall below standard, deviation for age from 60% - 30%. (900) in 4 years (1990-94).
Increase 40% 0 infants/children (12-23 months) who have a weight for age greater than that which is 2 standard deviations below the mean.

A.I.D. FORM

Name of PVO: _____
Country: _____
Impact Area: _____
Supervisor : _____

Name of Child: _____
Sex: _____ Age: _____
Serial No: _____

Breast Feeding? Yes... No...

Date	1st visit	2nd visit	3rd visit	4th visit	5th visit
Weight					
Height					

Growth Falter? Yes.... No....
If Yes: Supplementary feeding? Yes.... No....
Nutrition Demo? Yes.... No....
If Yes, Number of Nutrition Demo: Per Month?....
Per Year?....

115

The remaining three workshop objectives of the HIS Sessions were presented as set forth below:

Objective 3 - Prepare descriptive and graphic data analysis report for (Time 1 hr.) feedback.

- Activities
1. Examples of graphic and descriptive use of data
 2. Intro to small group exercise on preparing feedback
 3. Presentation/discussion of reports

Process:

- Reform Groups
- Distribute sample data set
- Analyze data for user selected in objective 3
- Prepare visual/Descriptive report for user

Objective 4 - Identify at least 6 non-routine methods for data collection (Time 30 min.)

<u>Content</u>	<u>Method</u>	<u>Resources</u>
1. List different methods for collecting information	Brainstorm	Flip chart Missed-Opportunity protocol Household survey protocol.
2. Importance of different methods	Brainstorm	Flip chart
3. Wrap-up	Remarks	-

Notes

Data collection guide/criteria - is data Reliable, Precise, Valid Representative, unbiased?
 KISS (keep it short and simple)
 Relevancy to users - who will use it?
 Are data collection tools effective and precise?
 Are data collection expectations achievable?
 Is the information desired realistically measurable as proposed?
 Design shouldn't interfere with project - Set Objective-
 Are findings consistent? valid?

Objective 5 - Identify at least 3 methods/activities to correct problems (Time 1 hr.) identified by the routine monitoring of the H.I.S.

1. Identify problem; describe method to address it (small group)
2. Present problem resolutions
3. Present Kenyan Child to Child

Process

- Reform small work groups (EPI,ORT,GM. CS)
- Identify 1 problem affecting project activity
- Develop/Describe method/Activity used to address problem e.g. Defaulter tracing

119

Objectives and Evaluation

The overall goals of the 5th Africa Regional workshop are five in number, stated as follows:

1. To share resource materials and foster networking among PVO Child Survival field staff.
2. To examine and strengthen activities for effectively involving key segments of the community in CS project efforts.
3. To share PVO experiences and develop strategies for integrating sustainability in all phases of the project including developing relationships with the community and the MOH and income generation activity.
4. To strengthen CS project management through the selection of appropriate project objectives, indicators and targets.
5. To share lessons learned in data gathering, monitoring, supervision, project evaluation and feed back to the community.

Objectives & Evaluation:

Goal number 3 might be reworded to read:

To strengthen CS project management through the selection of appropriate project objectives, indicators and evaluation.

Objectives: To write measurable objective for at least one CS intervention area.

- To describe the relationship between objectives and evaluation.
- To identify strengths and weaknesses of the original project objectives that were submitted to AID.

Activities:

- Review session
- Criteria for objective
- Small group perception about objectives; discuss perceptions
- Small group write objective, indicators & evaluation on assigned intervention area - use workshop session
- Group report objectives
- Original project objective critique by project participants
- Write project objectives - Summary.

120

SUPERVISION

The minutes taken during the supervision session were recorded as follows:

During the session, the participants will discuss and share their insights and experiences on several important questions regarding supervision:

Why is supervision important?

What are functions of supervision?

What kinds of problems are we having in supervision?

What can we do to solve these problems?

The process to be followed will be:

- Step 1. Brainstorm why supervision is important
- Step 2. Brainstorm the function of the supervisor
- Step 3. Identify the important supervision problems we are faced with today
- Step 4. Identify the knowledge, skills & attitudes needed to solve a particular problem
- Step 5. Role play dealing with a supervision problem
- Step 6. Group discussion and wrap-up

Why is supervision important?

1. Remind supervisee of missing area/problem
2. Problem solving; Supportive too/to supervisee
3. Training; Encouragement/Motivation; Monitoring
4. Problem identification; Keep control of program
"To trust is good to control is better"
5. Changes or amendments
6. Helps to be fair, get work done within scheduled time.
7. Quality control; keeps in right direction and helps achieve objective
8. Evaluation too/of program
9. Continuous restocking/reinforce of resources
10. Helps start working towards sustainability; common understanding of personal behaviors

Supervision Functions:

1. Monitor, Plan, Organize, evaluate performance
2. Task identification
3. Assign task responsibilities; assess project; job description
4. Training; Facilitate; Control/Discipline
5. Verify reports
6. Provide feed back analyze critique
7. Reward
8. Promote networking
9. Make decisions
10. Motivate people

Supervisor Problems:

1. Resistance from supervisee
2. Communication; mobility & Transport
3. Resentment; Execution of changes
4. Conflict - Interpersonal; Lack of technical skill of supervisee
5. Lack of knowledge of doing reporting; Lack of resources - Time

101

Each participant was requested to select one problem to role play in a group of three persons:

Roles - Supervisor
Supervisee
Observer

Problems selected were:

insecurity
weather/environment
turnover
lack of knowledge of supervisor;
political interference
personal interest of supervisee
lack of budget for supervision, for sustainability
distance
time for report writing; Lack of proper scheduling resources
co-ordination/Collaborations
prioritization
implementation of changes
supervisor/supervisee relationship - social distance
budgeting

Instructions were:

- Participants pair up
- Share the problem with your partner
- Identify the KSA You need to solve the problem

Each person selected one - Knowledge, Skills or Attitude that they need in order to be more effective:

<u>Knowledge</u>	<u>Skills</u>	<u>Attitudes</u>
Environmental knowledge	Listening Analytical	Sympathetic Patience
-Knowledge of past & person	Delegation Communication	Understanding Approachable openness considerate
-Train	Train	
-Technical Understanding ORG Policies	Resolving conflicts organizing setting objective with others Evaluation observation Feedback	Discuss Team player sense of humor Diplomacy

THE PEN-3 MODEL

**THE APPLICATION OF A CULTURALLY APPROPRIATE
HEALTH INTERVENTION MODEL FOR CHILD SURVIVAL**

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122

Introduction

Experience in developing countries has shown that their development goals - increased productivity, improved health status, and the enhanced quality of life - are proving frustratingly illusive: The plight of rural peasants and urban poor has become, if anything, somewhat worse than it was in the 1960s (Melkote, 1987). The failure of many social and behavioral programs that were formulated in a "western" construct for implementation in developing nations arise from their cultural inappropriateness (Airhihenbuwa, 1987). The purpose of this paper is to propose a conceptual model (the PEN-3 model) for the planning and development of culturally appropriate health education programs for developing regions of the world.

The PEN-3 Model

A conceptual model for health education programs in developing countries must address cultural sensitivity and cultural appropriateness in program development. This model consists of three dimensions (Health Education, Educational Diagnosis of Health Behavior, and Cultural Appropriateness of Health Behavior) of health beliefs and behavior that are dynamically interrelated and interdependent. This model (Airhihenbuwa, 1989, 1990), known as PEN-3 is illustrated in categories according to the acronym PEN for each of the three dimensions (see Figure 1). The first dimension of the PEN-3 Model is health education.

P - Person. Health education is committed to the health of all. To this end, individuals should be empowered to make informed health decisions, appropriate to their roles in their family and community.

E - Extended Family. Health education is concerned not only with the immediate nuclear family but also with extended kinships. Such a focus on the extended family should also take into account family lineage (e.g., patrilinear or matrilinear). However, when a program

is designed to target a particular member of the family (e.g. the mother), the individual should become the focus of the study and must be so recognized. Such recognition must be noted within the context of the individual's environment.

N - Neighborhood. Health education is committed to promoting health and preventing disease in neighborhoods and communities. Involvement of community members and their leaders becomes critical in providing culturally appropriate health programs. In fact, since community leadership often defines the community boundaries, it is critical for them to define what comprises their community or neighborhood at the beginning of a project.

The second dimension of the PEN-3 model is the educational diagnosis of health behavior. Educational diagnosis has been used by researchers to attempt to determine what factors influence individual, family and/or community health actions. The three models or frameworks that have been used predominately to understand and predict health related behaviors are, Health belief model, Fishbein and Ajzen's theory of reasoned action and the PRECEDE framework (Mullen, Hersey and Iverson, 1987). Influenced by Kurt Lewin's "life Space" notion, the health belief model (Rosenstock, 1974) deals with individual perceptions of their susceptibility to a disease and of the severity of the disease as predictors of their health actions. The Fishbein/Ajzen's theory of reasoned action postulates that behavior intention is a function of attitude toward performance of an impending behavior reinforced by feedback from significant others. The PRECEDE framework (Green, Kreuter, Deeds, Partridge, 1980) deals with how to identify which behaviors (both health related and non-health related) are most important and changeable. Thus this dimension of PEN-3 has evolved

from the confluence of the three aforementioned models in health education. The following are the factors in the second dimension of the PEN-3 model:

P - Perceptions. These are knowledge, attitudes, values and beliefs that may facilitate or hinder personal motivation to change. For example, if there is a cultural belief that consuming sweet items (e.g., sugar) causes diarrhea (a belief held by the Edos and Yorubas and Igbos of Nigeria), it will be a serious challenge to promote home-made oral rehydration solutions (ORS), which contain sugar as a therapy for diarrhea. This means trying to resolve the conflict that might ensue in people's minds, since it would otherwise seem to them as though the causative agent of a disease is also the cure for the disease. An example in child survival is the belief by some mothers in Nigeria that a healthy child does not need to be protected against the utilization of the Expanded Program on Immunization.

E - Enablers. Societal, systematic or structural influence or forces that may enhance or be barriers to change, such as the availability of resources, accessibility, referrals, skills, and types of services (e.g., traditional medicine). At a child survival workshop in Nigeria, several mothers cited being asked to pay for treating abscesses (a side effect of vaccination) as a major reason for not taking their children for EPI, even though they know that EPI is free.

N - Nurturers. These are reinforcing factors that a person may receive from significant others. Examples include attitudes and behavior of health and other personnel, peers, feedback from extended family, kin, employers, government officials, and traditional healers.

This process was operationalized at the African Regional child survival workshop in Nigeria, June-July 1990. Twenty participants representing ten private voluntary organizations with child survival projects were assigned into four intervention groups--ORT, EPI, Nutrition and High Risk Birth. Based on their child survival field experience, each group developed a list of reported positive, exotic and negative health beliefs related to their assigned interventions. These health beliefs reflected the perceptions of members of the communities for whom their child survival projects were designed. Each group then categorized the beliefs into those that are historically rooted in culture and those that are superficially related to the culture. With the information generated on positive, exotic and negative health beliefs each intervention group developed a list of interview questions for one of four preselected segments of the community. The four segments of the community that were interviewed were: 1) mothers; 2) village health workers; 3) traditional leaders; and 4) local government representatives. This was the first phase (health education) of the model.

Each intervention group, consisting of five members, designated one person to represent them on the interview team for each of the four segments of the community. The fifth member of the intervention group was designated as a recorder for one of the interview teams. The interviews were conducted for about one hour in a selected local government area. The questions focused on perceptions, enablers and nurturers concerning the four child survival interventions in the community. This was the second phase (educational diagnosis for health education) of the model. The results of the interview and the information generated by the participants in their respective groups prior to the interview were categorized into Positive, exotic and negative health beliefs and practices. This is the third phase (cultural appropriateness of health behavior) of the model.

NEGATIVE

- NC 1. Male dominance inhibits necessary female participation.
- C 2. Food items such as eggs and meat causes the child to steal or belief that sugar (and other sweet meals) causes diarrhea.
- NC 3. Medicine is needed for diarrhea and ORT is not medicine.
- C 4. Diarrhea babies must not be breastfed.
- C 5. A healthy child does not need health care therefore immunization is deemed unnecessary.
- NC 6. Immunization may cause disability and/or death in a child
- NC 7. Since older, living, healthy siblings were not immunized, there is no reason to immunize the infants.
- NC 8. Contraceptives and Tetanus Toxoid causes sterility.
- C 9. Eggs, meat, chicken causes baby to be too big to deliver normally
- C 10. Taking fluids during diarrhea will prolong diarrhea and/or develop worms.
- C 11. Women should have all the children that God gives them

IMPLICATIONS FOR HEALTH EDUCATION

The challenge for Health Educators is to identify which positive beliefs and practices are supportive of the person, extended family and neighborhood. How are these influenced by predisposing enabling and nurturing factors? How do these health beliefs influence Negative health practices of persons and their extended family. What role does and/or can exotic beliefs and practices play in health promotion and disease prevention. Such information is used to develop health promotion strategies for

maintaining positive health practices and changing negative health practices. The health educator, therefore, must understand the rationale behind stated beliefs and practices. This is necessary for appropriate classification and the selection of health education strategy. For example, when classifying beliefs and practices into positive, exotic and negative beliefs, "having a lot of children due to high child mortality" could be classified as negative beliefs. However, the health team in this case classified it as exotic because this belief, which is logical, is a reality for the women living in this community. Another example is the classification of "immunization as a cause of death" as a non-cultural belief. This belief was recently established when some children who had been immunized through EPI later died, after the mothers were told that immunization will prevent their children from death. Only face-to-face education has been effective in changing some of these beliefs.

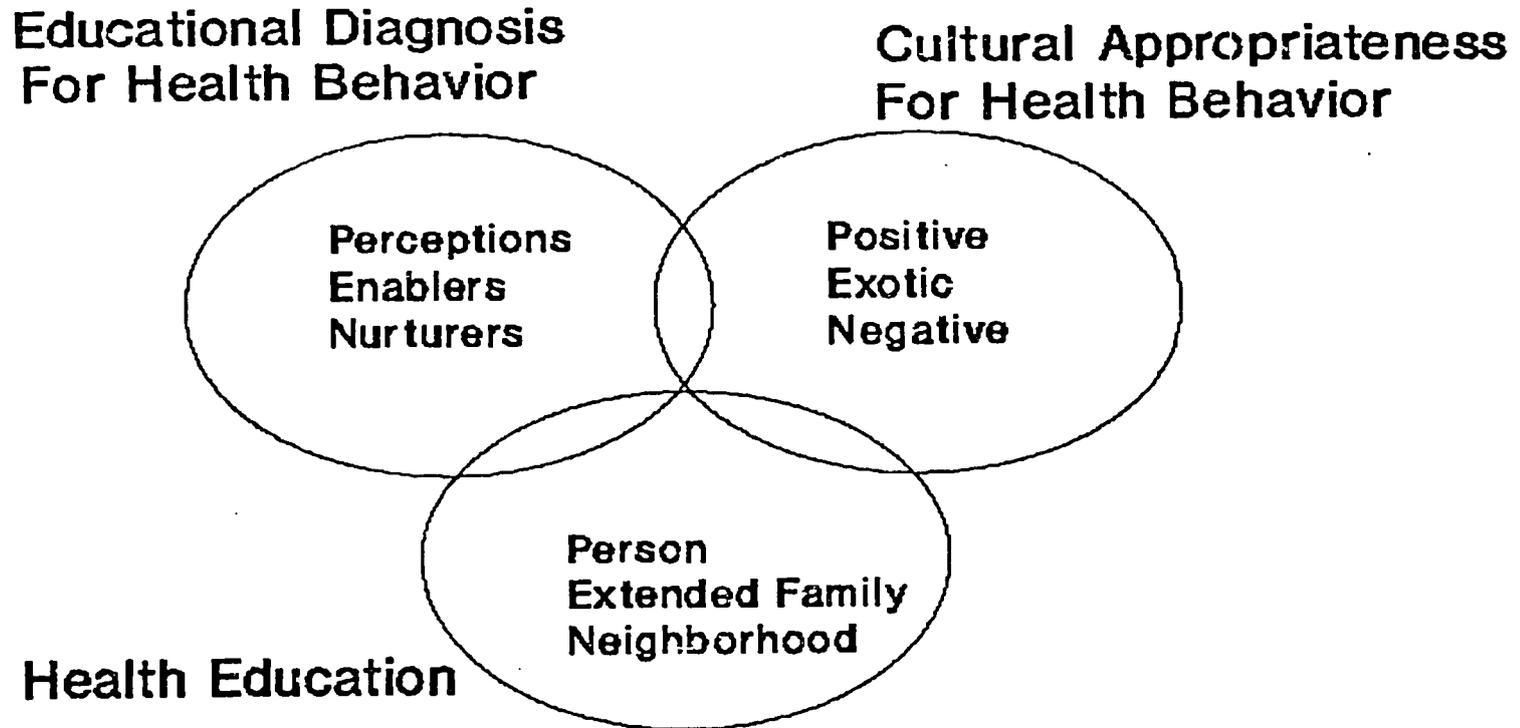
Conclusion

There are several cultural factors that can promote or hinder the success of health education programs in developing countries. The PEN-3 model offers the health educator the opportunity to consider varied behaviors in terms of positive, exotic and negative. The involvement of community members is strongly recommended so as to adequately assess behavior and plan appropriate interventions.

References

1. Airhihenbuwa, C.O. Perspectives on AIDS in Africa: Strategies for Prevention and Control. AIDS Education and Prevention, 1(1), 57-69, 1989.
2. Airhihenbuwa, C.O. A Conceptual Model for Health Education Programs in Developing countries. International Quarterly of Community Health Education, 11(1), 53-62.
3. Airhihenbuwa, C.O. Nigerian Heads of Households' Attitudes Toward Orthodox and Traditional Medicines. The Journal of Rural Health, 3(1), 1987.
4. Green, L.W., Kreuter, M.W., Deeds, S.A., and Partridge, K.B. (1980) Education Planning: A Diagnostic Approach. California: Mayfield Publishing Company.
5. Melkote. S. R. Biases in development support communication. Revealing the comprehension gap. Gazette. The Netherlands. 40, 39-55, 1987.
6. Mullen, P.D., Hersey, J.C. and Iverson, D.C. (1987) Health Models Compared. Social Science and Medicine 24(11), 973-981.
7. Rosenstock, I.M. (1974) "Historical Origins of the Health Belief Model" Health Education Monographs 2(4), 328-35.
8. World Health Organization. (1988) Education for Health: A manual on health education in primary health care. WHO, Geneva. P.9.

FIGURE 1



THE PEN-3 MODEL