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FINAL REPORT

NGO INITIATIVES FOR COMMUNITY-BASED CONTROL OF DIARRHOEAL DISEASES

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ACRONYMS

AID	Agency for International Development
AKHS	Aga Khan Health Service
CBD	Community-based Distribution
CDD	Control of Diarrhoeal Diseases
CEDPA	The Centre for Development and Population Activities
CESA	Central Eastern and Southern African
CHAM	Christian Health Association of Malawi
CHW	Community Health Worker
CORPS	Community's Own Resource Persons
FEMEC	Federation des Eglises Et Missions Evangeliques Du Cameroun
FP	Family Planning
HAF	Home Available Fluids
IEC	Information, Education, and Communication
MCH	Maternal Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PRITECH	Technologies for Primary Health Care
PVO	Private Voluntary Organization
SSS	Sugar-salt Solution
TBA	Traditional Birth Attendant
TOT	Training of Trainers
VHC	Village Health Committee
VHW	Village Health Worker
VM	Village Motivator

EXECUTIVE SUMMARY

CEDPA and PRITECH have been involved in a collaborative effort to strengthen Control of Diarrhoeal Diseases Programs of Community-based Non-Governmental Organizations (NGOs) in Anglophone African countries. CEDPA took the lead in designing, implementing, and managing this initiative, while PRITECH provided technical inputs. The activity encompassed three phases:

(1) Development of a regional pool of African consultants able to provide assistance to NGOs in designing, implementing, and evaluating CDD activities;
(2) Updating/training of selected NGOs in technical issues and implementation strategies for the improvement of CDD activities in communities; and,
(3) Provision of small start-up grants and technical assistance to selected NGOs to ensure CDD activities are broadened and strengthened within the organization and extended to a larger population.

In March 1992, PRITECH and CEDPA held a regional workshop entitled "Extending ORT Services Through Community-based NGOs" in Nairobi, Kenya, for 23 participants from twelve NGOs from nine Anglophone African countries. The workshop covered the integration and implementation of CDD activities in NGO community-based programs, and was divided into four major components or content areas: technical updates on diarrhoeal diseases; community participation and IEC planning; designing training activities; and intervention planning and implementation. During the workshop, participating NGOs developed proposals for community-based projects aimed at: (1) changing behavior of mothers/caretakers through outreach programs; and (2) providing support to existing facilities in order to improve CDD delivery. Under the initiative, seed money had been allocated to fund a selected number of the proposals.

Five African professionals representing various countries and disciplines were selected to assist in the workshop and serve as regional consultants during the project implementation phase. Individuals with both technical and community development experience were chosen. These consultants participated in a training of trainers workshop and planning meeting in the week prior to the initiation of the workshop. The TOT aimed to strengthen their consulting skills in order to provide a full range of technical assistance services to NGOs. The trained consultants participated in the two-week NGO workshop as members of the training team.

Immediately following the Nairobi workshop, CEDPA, PRITECH, and the five Regional consultants met to review the NGO proposals developed during the workshop, decide which NGOs would receive "seed" money under the CEDPA/PRITECH mechanism, decide on technical assistance needs for each NGO, and prepare an action plan for the four month follow-up period (April - July, 1992). Four proposals were selected to receive seed funding: Aga Khan Health Service, Kenya; Uganda Red Cross; the Christian Health Association of Malawi (CHAM), and the Federation of Churches and Evangelical Missions in Cameroon (FEMEC).

Written comments were provided by CEDPA/PRITECH to each of the twelve NGOs on the plans developed during the workshop. The regional consultants provided technical assistance to the NGOs selected to receive seed money in revising their proposals and during project implementation in the area of needs assessment and training.

At the completion of the project, a follow-up meeting was held for representatives of the NGOs that had received funding and the regional consultants to share lessons learned, discuss strategies for sustainability of the projects, evaluate the CEDPA/PRITECH process utilized to extend CDD services to communities through NGOs, and to consolidate project curricula in order to develop a generic curriculum outline for training community-level workers in home-based management of diarrhoeal diseases.

A. LESSONS LEARNED: WORKING WITH NGOS

Workshop

1. **Participant selection process.** Applications were sent through CEDPA alumni and PRITECH country representatives. Several hundred were sent out, and nearly 100 were returned. While this indicated a large demand for this type of workshop, it falsely raised expectations as only twelve NGOs could be selected. Participants from nine countries were selected, four from countries with PRITECH programs. Given the financial and time constraints of this initiative, it might have been more appropriate to limit the number of countries involved and increase the number of NGOs from each country. This would allow for greater ease in follow-up as well as a multiplier effect in a given country.
   Recommendation: Future workshops of this type should limit participant selection to fewer countries. Selection should be based on knowledge of the country setting and which NGOs have the greatest potential to achieve the workshop goals.

2. **Workshop Preparation.** The following factors influenced the overall outcome of the training: 1) It is difficult to prepare a workshop in Washington with limited training needs assessment information; 2) African trainers were brought into the process for only one week prior to starting the workshop; also, the African trainers changed at the last minute due to factors beyond the control of CEDPA; 3) The time frame between participant selection and start-up of the workshop was too short to allow for inputs by participants and trainers into the curriculum content; 4) CDD technical knowledge of trainers was not standardized prior to starting to plan for training.
   Recommendation: Adequate time needs to be allocated for planning of training with a well selected training team responding to a training needs assessment of potential participants.

3. **Prevention Strategies in Diarrheal Disease Control.** Prevention of diarrhea was of keen interest to participants as most of their community-based work is targeted towards prevention. The workshop curriculum did not provide a detailed breakdown of prevention strategies or critique which ones might be more effective, easier to implement, more cost effective, etc. No research data was available to support emphasizing particular aspects of prevention.
   Recommendation: A future workshop of this nature should provide more time for exploring prevention strategies. Available research should be compiled to provide the data necessary to direct appropriate intervention planning and message selection.

Workshop Follow-up: Technical Assistance and Seed Grants

4. **Ensuring Adequate Time for Administrative Procedures and Project Implementation.** The administrative procedures required for managing the seed grants took more time than anticipated. In order to carry out a technical assistance visit, the NGO had to develop a

scope of work which was then reviewed by CEDPA. If modifications were required the scope would be returned to the NGO for revision. Once the scope was finalized, the consultant needed to be identified, and mutually agreeable dates decided upon; travel and rate concurrences needed to be obtained, and travel advances processed. While all of this is fairly standard procedure for fielding consultants, it was difficult to carry out given the short time frame for the three projects (after revision and finalization of the proposals and development of the subcontracts, all of the NGOs had less than one year to utilize the seed money and the technical assistance). The constrained time frame also did not allow for any of the usual delays that occur during project implementation, especially when donors and ministries are involved.

Recommendation: Given the realities of implementation of community-based projects in developing countries and donor requirements, the time period for project implementation should be a minimum of two years.

5. **Strategies for Sustainability.** The concept of seed grants was not well accepted by the NGOs. Although it had been made clear from the start of these projects that only a small amount of seed money would be provided, it became obvious during the follow-up meeting that the NGOs had believed at some level that if their projects succeeded, they would somehow be able to obtain additional funds. The organization providing funding is perceived as a "donor", and NGOs depend upon donors for their survival. The perception existed that the project was being "terminated in the middle", despite their very successful implementation efforts to date. The expectation of the organizers had been that the project would continue within the existing structure of the NGO; however, NGO representatives felt that the projects would have more impact and more potential to influence policy if external technical assistance was available throughout the entire implementation process.

   Recommendation: The concept of seed money for community-based projects needs to be carefully considered. The issue of what will happen after the seed money runs out needs to be directly and specifically addressed during the project planning phase. As mentioned above, the time period for implementation needs to be adequate to allow the project to progress to a stage where it can be sustained.

6. **Follow-up with Workshop Participants**. Except for the comments provided to the NGOs on their written proposals, follow-up with the participants from the initial workshop in Nairobi was limited to those NGOs receiving seed grants. Maintaining contact with **all** of the NGOs would have provided a unique opportunity to evaluate the impact of the training workshop, as well as to further cultivate the establishment of a network of NGOs.

   Recommendation: A system for follow-up with all the workshop participants should be built into the project design, possibly through a follow-up survey, telephone interviews, etc.

Other lessons learned in relation to the process included the following:

- **needs assessments/baseline surveys** were instrumental in project design, planning, and implementation; while the regional consultants provided technical assistance in implementing the needs assessments in this initiative, future workshops could cover the process and methodology for conducting needs assessments in-depth, to develop this capability within the NGO itself;

- ongoing **external technical assistance** must be provided in order to enhance the credibility of the project, motivate NGO staff, and increase project visibility and thus the potential for influencing policy; the technical assistance provided with the CEDPA funding was essential to the project implementation process; when it wasn't provided, as happened in Malawi because of logistical difficulties, project implementation slowed significantly.

- **technical updates** of the NGO staff and others such as MOH workers occurred in the project implementation process -- thus, a **multiplier effect** from the original workshop was experienced;

- the process allowed for **comprehension and assimilation of technical information** at a variety of levels; NGOs at various stages in their ability to implement community-based CDD projects were able to benefit from the workshop experience;

- resource mobilization can result from **networking and partnership**; a tremendous amount was accomplished with only a small amount of "seed" money and from the sharing of experiences during the workshop and follow-up;

B. LESSONS LEARNED: IMPLEMENTATION OF COMMUNITY-BASED PROJECTS

Several common themes emerged as key elements in the successful implementation of community-based CDD projects. These themes reflect the lessons learned during this activity. Most of the lessons are applicable not only to CDD programmes and thus can be treated as guidelines for an approach to successfully implementing community-based programs:

1. **Collaboration/Networking** - The NGOs worked with a multitude of groups at a variety of levels to implement their CDD projects, including child caretakers, community members, teachers, public health officers, agriculturalists, Ministry of Education staff, and Ministry of Health personnel including District-level staff, health centre staff, national programme managers, outreach workers, and divisional level workers. In all the projects, careful attention was paid to protocol, sensitization in order to generate support, and involvement of the appropriate people at appropriate stages. This type of collaboration, while time consuming, provided the foundation on which to build a successful programme.

2. **Community Involvement/Participation** - Adequate time must be allowed to ensure full involvement of the community in the project. All of the seed projects fully involved the communities from the initiation of the project throughout the implementation process. The communities participated in the projects in a variety of ways, including problem prioritization, needs assessment, baseline surveys, selection of community workers, and sharing of cultural beliefs and practices. A variety of methodologies were used to facilitate participation including focus and small group discussions, individual interviews, and surveys. This type of involvement results in true ownership of both problems and their solutions and is empowering to the communities as they discover their own capacities. Flexibility and patience are required by the implementing organization in order to truly allow the communities to exercise some control over project implementation.

3. **Development of Counselling Skills** - Training of health workers in counselling skills resulted in improved attitudes in their relationships with community members, thus increasing the effectiveness of their interactions. Effective communication is central to the success or failure of this type of community-based programme.

4. **Looking Beyond "Community Health Workers"** - All of the projects looked beyond the CHW to fully utilize a wide variety of resource people within the community - teachers, school children, TBAs, young mothers, men, intersectoral outreach workers; this effort to avoid overburdening the CHWs will increase the potential for sustainability and may reduce the drop-out rate.

5. **Use of appropriate technology: Home Available Fluids** - The use of HAF as an approach is empowering and sustainable because it does not create reliance on external resources or technology -- people realize that they have the resources they need to address the problem in their own homes. It is a sound alternative to ORS and SSS, and not subject to either logistical breakdowns or lack of appropriate supplies. At the same time, the concept of use of HAFs is new to both health workers and communities; while ORS and even SSS were perceived as medicines, by definition HAFs are not medicines. Project implementors should be prepared to face some initial skepticism and doubt about the effectiveness of the use of HAFs.

6. **Decentralization in implementation** - Decentralization in order to place responsibility and authority in the hands of those working closely with the communities is essential in enabling the projects to understand and respond to identified needs and problems in timely and effective ways. All of the projects allowed decision-making authority and responsibility to lie at the appropriate level - health centre public health team, divisional level health facilities, a core training team, etc.

7. **Integration into existing structures** - All of the CDD projects were integrated into existing infrastructures, broader Primary Health Care (PHC) programmes, or ongoing projects. This "piggybacking" resulted in a mutually beneficial relationship, as it

facilitated CDD project implementation and also resulted in the strengthening of the existing programmes, especially in terms of technical knowledge and the establishment/strengthening of collaborative relationships within and outside the community.

8. **Ministry of Health collaboration** - A good working relationship with the Ministry of Health is a challenge, but is also essential to the success of the project. Ministries are beginning, in some cases, to recognize that NGOs can fill the gap between government facilities and the communities. NGOs have the flexibility and experience in working with communities to try out innovative approaches, and look beyond constraining, static, and/or impractical policies.

9. **Utilization of experiential learning** - The projects demonstrated the need to allow the experiential learning process to work, rather than simply giving the "answers" to the community. For example, project implementors disagreed with the community's established criteria for selection of village workers which included literacy; however, the criteria was allowed to stand, and the community to make adjustments as they determined necessary. Such an approach requires time, patience, and flexibility, but is an essential element of community ownership of the project.

10. **Technically sound solutions that are responsive to practical needs** - The projects have demonstrated a shift in paradigm from "hard science" towards practicality and utilization of what actually works on the ground and can be sustained over the long term. For example, ORS, though effective, is subject to logistical and economic constraints and thus is more difficult to sustain. Sustainable alternatives such as HAF are needed at the community level.

Recommendations for Future Programming are included at the end of this report.

PRITECH FINAL REPORT

I. INTRODUCTION

A. Background

In February, 1990, The Centre for Development and Population Activities (CEDPA), a subcontractor of Technologies for Primary Health Care (PRITECH), submitted a concept paper to PRITECH proposing the use of its subcontract funds for an activity to strengthen Control of Diarrhoeal Diseases (CDD) activities of non-governmental organizations (NGOs). The Agency for International Development (AID) gave its approval for the collaborative effort between CEDPA and PRITECH targeting and supporting Anglophone African community-based NGOs. CEDPA took the lead in designing, implementing, and managing this initiative, while PRITECH provided technical inputs. The activity encompassed three phases:

(1) Development of a regional pool of African consultants able to provide assistance to NGOs in designing, implementing, and evaluating CDD activities;

(2) Updating/training of selected NGOs in technical issues and implementation strategies for the improvement of CDD activities in communities; and,

(3) Provision of small start-up grants and technical assistance to selected NGOs to ensure CDD activities are broadened and strengthened within the organization and extended to a larger population.

B. Rationale for Project

The contribution that NGOs can make to development efforts is becoming widely recognized. NGOs working at the community level often have the flexibility and versatility to quickly implement innovative strategies that are responsive to community needs. Increasingly, NGOs are being called upon to fill in the gaps where public services cannot adequately meet the needs of the population. In the health sector, community-based programs of the type implemented by NGOs are vital for meeting the health needs of communities that are not adequately served by overburdened public or private health facilities. Diarrhoeal disease is one of the leading causes of morbidity and mortality among the under-five population in developing countries. Prevention of dehydration and timely referral through proper home case management of diarrhoea may prove effective in reducing morbidity and mortality rates. The use of Home Available Fluids (HAFs) for home-based management of diarrhoeal disease is an effective intervention that can easily be carried out at the community level.

Under an AID-funded cooperative agreement with the Office of Population, CEDPA developed and is utilizing a methodology to assist NGOs who are active at the community level in adding or strengthening technical components such as family planning. The methodology was designed

to enlist CEDPA alumni in designing and delivering family planning services through community-based distribution networks. The methodology includes implementation of regional project design and development workshops in family planning; over one half of all agencies involved in such workshops now have family planning services in place and are showing good results.

It was felt that with minor modifications, this methodology could be used to quickly activate NGOs to undertake the technically competent delivery of diarrhoeal disease control programs at low costs. NGOs known to CEDPA and/or PRITECH that were already working at the grassroots level would be provided with updated information on the management and control of diarrhoeal diseases, and skills in effective training, project implementation, and planning. During an intensive two-week workshop, NGO participants would be assisted in designing interventions to improve the home case management and control of diarrhoeal diseases utilizing their existing NGO infrastructures. Financial support in the form of seed grants and technical assistance would be provided to a limited number of NGOs to implement the interventions. The program was conceived to be implemented on a regional basis in order to enlist agencies of significant size, coverage, and capabilities, which could then act as models for similar country-level agencies, provide in-country technical assistance to groups who wish to replicate the CDD component, and participate in evaluation activities designed to show the effectiveness of this approach.

The underlying objective of the activity is to develop local capacity and self-sufficiency. In keeping with this objective, the initiative would develop a group of African facilitators/consultants who would serve as trainers during the workshop and provide technical assistance to the NGOs in the design and implementation of the CDD interventions. These consultants would receive CDD technical information training, and training in project design, implementation, and evaluation.

The building of institutional capacity in NGOs is essential if they are to play a sustainable role in development activities. The approach used here was designed to develop the capabilities of NGOs to implement projects across a broad range of areas, in addition to increasing their technical competency in the area of CDD.

(NOTE: The reports referred to in this document are kept on file by both CEDPA and PRITECH; copies can be obtained by contacting either organization.)

II. DESCRIPTION OF ACTIVITIES

A. Phases 1 and 2:

(1) Development of a Regional pool of African consultants able to provide assistance to NGOs in designing, implementing, and evaluating CDD activities;

(2) Updating/training of selected NGOs in technical issues and implementation strategies for the improvement of CDD activities in communities.

In the preparatory phase, CEDPA and PRITECH sent out brochures to their network of community-based NGOs and CEDPA alumni to announce a two-week project design workshop on the control of diarrhoeal diseases through community-based programs. (See Appendix 1, Workshop Brochure) Approximately 100 completed applications for the CDD workshop were received. Criteria for the selection of NGOs included the following:

- the existence of established community-based infrastructures and networks;
- interest in health activities;
- access to large target population;
- interest in initiating/expanding CDD activities; and,
- proven effectiveness in community-level activities.

Countries where PRITECH had on-going programs (Kenya, Uganda, Cameroon, and Gambia) received first priority and selection was made in collaboration with PRITECH country representatives. Twelve NGOs were selected from the following countries: Cameroon, Ethiopia, Gambia, Ghana, Kenya, Malawi, Sierra Leone, Tanzania, and Uganda. The participants were selected to create a heterogeneous and complementary group, so as to ensure a wide range of experiences and backgrounds. Three types of NGOs were selected: 1) church related health organizations; 2) community-based organizations/associations; and 3) family planning/Community-based Distribution associations (See Appendix 2, List of Participants).

Five African professionals representing various countries and disciplines were selected to assist in the workshop and serve as regional consultants during the project implementation phase. Individuals with both technical and community development experience were chosen (See Appendix 3, Profiles of Regional Consultants). These consultants participated in a Training of Trainers (TOT) workshop and planning meeting in the week prior to the initiation of the workshop. The TOT aimed to strengthen their consulting skills in order to provide a full range of technical assistance services to NGOs. The trained consultants participated in the two-week NGO workshop as members of the training team.

In March, 1992, PRITECH and CEDPA held the regional workshop entitled "Extending ORT Services Through Community-based NGOs" in Nairobi, Kenya, for 23 participants from the twelve NGOs from nine Anglophone African countries. The workshop curriculum was developed by CEDPA and PRITECH with technical oversight provided by PRITECH technical unit staff.

A representative from the PRITECH technical unit and the Senior Program Manager for PRITECH's Central Eastern and Southern African Region (CESA) participated in the workshop along with a CEDPA trainer and consultant, and the five regional consultants.

The workshop covered the integration and implementation of CDD activities in NGO community-based programs, and was divided into four major components or content areas: technical updates on diarrhoeal diseases; community participation and IEC planning; designing training activities; and intervention planning and implementation. A curriculum was developed for each session, including behavioral objectives, outlines, and process for presentation. During the workshop, participating NGOs developed proposals for community-based projects aimed at: (1) changing behavior of mothers/caretakers through outreach programs; and (2) providing support to existing facilities in order to improve CDD delivery.

The major outputs of the workshop included detailed intervention plans prepared by each NGO team. The plans reflected an improved knowledge of CDD technical information and project design skills. All proposed activities were integrated into the existing infrastructure of the community-based NGOs and built on established relationships both at the community and government level. The workshop stressed the importance of working within the policy and frameworks of the National CDD programs in each country. The following components of home case management of diarrhoea were emphasized: 1) the importance of using home available fluids, including breastmilk, for prevention of dehydration; 2) the need for encouraging feeding during diarrhoea; 3) recognition of early signs of dehydration that indicate the need for referral to a trained health care provider; and 4) importance of stressing catch up feeding after diarrhoea has stopped. (For more specific details, see workshop report, "An Initiative to Extend the Control of Diarrheal Disease Services Through Community-Based Non-Governmental Organizations".)

B. Phase (3): Follow-up and provision of small start-up grants and technical assistance to selected NGOs to ensure CDD activities are broadened and strengthened within the organization and extended to a larger population.

During the week immediately following the Nairobi workshop, CEDPA, PRITECH, and the five Regional consultants met with the following objectives:

- decide which NGOs would receive "seed" money under the CEDPA/PRITECH mechanism;
- review NGO proposals developed during the workshop;
- decide on technical assistance needs for each NGO;
- discuss the consultant process and logistical issues; and,
- prepare an action plan for the four month follow-up period (April - July, 1992).

The project had budgeted for seed funding for five NGOs. Four proposals were initially selected to receive seed funding: Aga Khan Health Service, Kenya; Uganda Red Cross; Ghana Red Cross; and the Christian Health Association of Malawi (CHAM). The remaining proposals were

not considered strong enough to be able to develop viable projects with the seed money and small amount of technical assistance available within the framework of this project. Unfortunately, it was not possible to provide assistance to the Ghana Red Cross; the USAID mission in Accra would not provide travel concurrence for the technical assistance visits, because of plans to develop a health project, and concern about the number of contractors working in-country. At the request of the PRITECH representative in Cameroon, it was later decided to provide funding to the Federation of Churches and Evangelical Missions in Cameroon (FEMEC) for implementation of a workshop.

During the month following the workshop, written comments were provided by CEDPA/PRITECH to each of the twelve NGOs on the plans developed during the workshop. The three NGOs selected to receive seed money were to be provided with technical assistance in revising their plans before proceeding with funding of their interventions. Each NGO was responsible for developing a scope of work for the technical assistance required which would then be reviewed and approved by CEDPA and forwarded to the identified consultant.

Two of the three NGOs, the Uganda Red Cross and Kenya/Aga Khan, received technical assistance with their proposals prior to funding. As mentioned earlier, the Ghana Red Cross project had to be dropped because of the refusal of USAID to authorize the provision of technical assistance. Visits scheduled for the Christian Health Association of Malawi (CHAM) were cancelled several times due to a variety of complications, including delays in receiving the scope of work, identification and availability of consultants, delays in obtaining proper clearance and travel concurrence from the Government of Malawi and USAID, processing of travel advances, and approval of daily rates. Assistance was provided to CHAM in revising its proposal by CEDPA from Washington, and CHAM proceeded with finalizing its proposal and beginning implementation. The CEDPA Training Director and Project Coordinator were both in Malawi on other assignments during the period from February-April, 1992, and both met with CHAM during this period to provide assistance and advice as needed.

The regional consultants provided technical assistance during the project implementation process, in the areas of training and needs assessment (See Appendix 4, Summary of Technical Assistance). To ensure that the technical assistance provided was of high quality and met the needs of the NGO, a consultant evaluation form was designed. The form was completed by the NGOs and forwarded to CEDPA after the technical assistance visits. (See Appendix 5, Consultant Evaluations). Technical assistance visits were conducted by two of the five consultants who participated in the TOT.

C. SEED GRANTS

After finalization of the NGO proposals, subcontracts between CEDPA and the NGOs were drawn up and initial disbursements of funds made. Although the total amount of each seed grant was small (around $5,000), the terms and conditions of CEDPA's subcontract with PRITECH required that specific disbursement and reporting procedures be followed in the grants to the NGOs.

Seed monies were provided to the three projects as mentioned above, the Uganda Red Cross, Kenya/Aga Khan Health Services, and the Christian Health Association of Malawi, and funds were provided to FEMEC/Cameroon for implementation of a workshop on maternal education for treatment and prevention of diarrhoeal disease.

Following are brief summaries of the three projects funded and the status of their activities at the time of preparation of this report, and the Cameroon workshop. More detailed information on each project including workshop and needs assessment report is available from either CEDPA or PRITECH.

1. Uganda Red Cross: Control of Diarrhoeal Diseases Project

The Control of Diarrhoeal Diseases component is being implemented within an existing Primary Health Care project in 5 villages in Kiryanga Parish, Masindi District, in mid-western Uganda, in collaboration with the CDD program and through the District Medical Officer's (DMO) office. The parish has 6 community health workers, 35 village health committee members, and 38 Traditional Birth Attendants (TBAs), and a total population of 2,074 people. The project goals and objectives are as follows:

Goal: To reduce morbidity and mortality due to diarrhoea among children under 5 years, in 5 villages of Kiryanga Parish within 18 months, by introducing use of Home Available Fluids (HAF) in management of diarrhoea at home.

Objectives:

1. Conduct an update workshop on HAF for 30 members of the District Health Team and other Extensions Workers in the District within the first month of the project period.

2. Identify and train at least 10 District Technical Trainers from the District Health Team and Extension workers, who will be trainers at the parish level (Kiryanga) within the first month of the project period.

3. Carry out Community Needs Assessment within the first four months of the project period, to identify at least five available and acceptable HAFs which can be used in the management of diarrhoea at home.

4. Orientate at least 150 community leaders from the five villages of Kiryanga Parish on the use of HAF in the management of diarrhoea at home within the second month of the project period.

5. Identify and equip at least 50 Community's Own Resource Persons (CORPS) with knowledge and skills which will enable them to counsel and educate mothers and caretakers of children to prepare and administer HAF to children affected by diarrhoea.

6. Sensitize and mobilize at least 50 % of the households in the five villages of Kiryanga Parish to adopt the use of HAF in the management of diarrhoea at home.

7. Propagate the use of HAF through three main media, namely: recipe book, posters, and folk media within the project period.

8. Sensitize at least 25% of the caretakers in the five villages of Kiryanga Parish to recognize the danger signs of diarrhoea for early referral. This sensitization will be done by at least 50% of the trained CORPS.

Project implementation began in June, 1992. As of the follow up meeting in Nairobi in mid-August, 1993, the following activities had been completed:

a. Rapid appraisal

A rapid appraisal was conducted to help polish and finalize the proposal. Methodologies used included group discussions with community leaders and visits to Community Health Workers (CHWs), women, TBAs, and government officials. Key findings included the following:

- diarrhoea was ranked number 3 as a problem in the community;
- the government had tried to popularize the use of ORS, but distribution had been inadequate; ORS was being sold, but was too costly for most to afford;
- SSS was found to be popular, but people had difficulty remembering the formula;
- in general, people were aware of the causes of diarrhoea, including poor environment and sanitation and bad water; however, some misconceptions existed regarding the causes and treatment of diarrhoea; some of these misconceptions were harmful; for example, food is often withheld from children with diarrhoea;
- the concept of using HAF for prevention of dehydration was new to both the community and to health workers.

This appraisal reinforced the need to sensitize health workers about the use of HAF; it also led to the decision to leave out ORS and focus on use of HAFs, because of problems with ORS related to costs, availability/supply, and government policy.

b. Sensitization and Update of District Health Team and Extension Workers; and
c. Training of District Core Team

The orientation for the District health team and extension workers involved thirty participants, including the District Health Inspector and his deputy, District Health Educator, District Health Visitor, extension workers, two Red Cross field staff, and the District health committee. The purpose of the training was to create awareness among members of the District Health Team of the concept of HAF and obtain their support for project implementation, update participants' knowledge on the CDD programme in Uganda, discuss experiences of CDD programmes in Masindi, and identify some HAFs.

The following HAFs were identified by the group:

porridges:	posho, maize, millet, rice, soya, cassava
soups:	beans, soya, rice, groundnuts, meat
juices:	banana, pineapple, passion fruit, orange, lemon
beverages:	tea, coffee and honey, milk, water

From the group of thirty, thirteen were selected by the participants themselves to act as technical trainers. These thirteen, the District Core Technical team, received three additional days of intensive training. This training covered issues pertaining to diarrhoea in greater depth, discussed the community needs assessment, identified methods of adult learning and community mobilization, allowed participants to share personal experiences on CDD activities, and prepared participants for the training of the Community's Own Resource Persons (CORPS).

(See "Report on Orientation and Training Workshop for the District Health Team and Extension Workers, Masindi District, 23rd-27th August, 1992", for further details)

d. Needs Assessment

The Core Technical team planned and conducted the needs assessment in November, 1992. The needs assessment consisted of a household survey of 205 households, and focus group discussions with mothers of under-fives, CORPS, CHWs, TBAs, and community leaders and elders to examine community beliefs about causes of diarrhoea, how diarrhoea is managed at home in Kiryanga parish, and the community's food and fluid habits in relation to diarrhoea. The results of the needs assessment were analyzed and discussed in June, 1993. The long delay between completion of the assessment and discussion of the results was due to delays and postponements by the Ministry of Health. While the Red Cross could have held the briefing without the presence of the Ministry personnel, they felt it absolutely essential that the entire team be present and persisted until this was possible.

One of the major outputs of the needs assessment was the decision to utilize "Community's Own Resource People" (CORPS), comprising of VHWs, TBAs, teachers, and women's club members, as opposed to using only TBAs. It was recognized that the number of TBAs would be inadequate in providing the services to all the priority households in Kiryanga. Discussions with community elders, VHC members, and the District Health Team led to the recommendation that the training focus instead on a strong group of CORPS.

e. Sensitization of community leaders and identification of 10 CORPS from each of the 5 villages

In June, final arrangements were made with Masindi for orientation of community leaders based on the findings of the needs assessment report. Trainers were assigned to different villages, and the trainings were conducted concurrently over a two-day period. The purpose of the training was to create awareness about home management of diarrhoea using HAFs, seek support for

implementation, identify some HAFs, and identify CORPS to be trained. Criteria were established for selection of the CORPS, and included the following:

- able to read and write
- must be exemplary
- ready to do voluntary work
- should be decent in behavior
- bright and creative
- a resident of the area
- should respect himself and others
- should be honest, tolerant, interested
- able to conduct and address meetings
- flexible
- have a good home
- active person
- a person who knows and loves his/her job

f. Training of CORPS

Participants consisted of Resistance Council members, teachers, youth leaders, women leaders, CHWs, and VHC members. The training covered definition and causes of diarrhoea, use of HAFs, home visiting, and referral. The CORPS will educate mothers and caretakers of children under five years old. Each CORPS is expected to be responsible for at least ten homes.

Key Issues

The project has paid a lot of attention to community involvement and collaboration with the Ministry of Health and other appropriate partners. The rapid appraisal and needs assessment were important in ensuring community participation and input into the process, as well as for increasing the understanding of project implementors of their target group. For example, the discovery that the concept of use of HAFs for prevention of dehydration was new not only to community members but also to the District Health team led to the sensitization of the health team on the benefits of use of HAFs. The analysis of the needs assessment results was postponed several times due to the Red Cross's determination to include the Ministry of Health representatives in the process. Although this has in some cases slowed down implementation, establishment of such a foundation is likely to prove beneficial in the long run. The project received 3 technical assistance visits. The purpose and outputs of these visits is detailed in Appendix 4.

The District Medical Officer hopes that the Red Cross project will be a model for the government CDD programme, as this will be the first project to attempt use of HAFs.

2. Aga Khan Health Service, Kenya - Project to Improve Diarrhoea Home Case Management in Mtaa Location

The Mombasa Primary Health Care Projects (MPHC) is a comprehensive, community-based PHC project covering three locations in Kinango division, Kwale District, in Coast Province. The CDD project is being implemented in Mtaa location. The project goals and objectives are as follows:

Goals: To achieve an improvement in the health status of children 6-36 months through effective home case management of diarrhoea in Mtaa Location.

Objectives:

1. Increase the proportion of mothers and caretakers who can effectively manage diarrhoea at home by 40% over the baseline level;

2. Increase the number of health workers in Mtaa with skills to counsel mothers and caretakers of children with diarrhoea and malnutrition to as to improve home case management, decrease the number of referrals and thereby mortality due to diarrhoea.

As of August, 1993, the following activities had been completed:

a. Create awareness

Meetings were conducted with the MOH, Ministry of Education (MOE), Aga Khan project team, project implementation committee, village level leaders, men, women, and school teachers to raise awareness about the project.

2. Baseline Information

A survey was conducted among 565 mothers to obtain information on current knowledge, attitudes, and practice in relation to diarrhoea, its cause and treatment. One key piece of information that emerged from the survey was the gap between knowledge and behavior. Although respondents gave the correct answer regarding the connection between hygiene and diarrhoea, their knowledge of the cause is not reflected in behavior to prevent diarrhoea. Other critical issues that emerged were the excessive use of drugs, and the general lack of care during and after the illness. A small, non-scientific study revealed the serious impact of an episode of diarrhoea on the health status of the child in terms of weight loss and growth. It was found that a five-day episode of diarrhoea resulted in an average weight loss of 1.5 kgs, which took approximately five months to recover.

c. Health Worker Training

Fifteen participants including 1 nurse, 1 public health trainer, 7 teachers, and 6 AKHS project staff received training in counselling, CDD, and home case management of diarrhoea. The counselling training was designed to improve communication between the health workers and their clients; project staff feel they have seen a change in attitude among health workers and teachers in the way they relate to people as a result of the counselling training. In March, 1992, this group received a refresher training in the use of HAFs, and training in MIS.

d. Training for Community Based Health Workers (CBHWs) and Mothers

This training was conducted in February, 1993. The purpose was to develop knowledge and skills in community-based CDD home case management, and to be able to put these skills into practice. Of the 393 mothers involved in this training, only 217 actually completed the full five-day course without missing any sessions. The mothers recognized their difficulty in attending the entire course, and came up with the concept of the CDD task force, to ensure that each community had at least one individual who had been fully trained (see below).

e. CDD Task Force

This task force was formed at the suggestion of mothers in recognition of their difficulty in attending all five days of the training workshop, and their desire to have at least one trained individual in their community. The task force consists of 17 people who serve as volunteers at the village level; each of the 13 villages has at least one representative on the task force. The 17 chosen to serve on the task force were young mothers who could read and write. They received an additional four days of training in counselling, record keeping, and ORS, and serve as a referral point in their community for home case management of diarrhoea. Other community volunteers can come to this person with any questions or concerns they might have about their work or specific cases.

Key Issues

The approach used in this project was empowering to women in the community. The methodology of small groups and focus discussions played an important role in the empowering process. In the small groups, the women felt free to talk and to figure things out for themselves, and to become aware of the fact that they were figuring things out for themselves. According to one project staff, "I could see their eyes light up when the idea of HAF was introduced; they realized they had these things in their home all the time, and that they could manage this problem with their own resources." In addition, the project implementors were flexible enough to allow input from the community, and to adapt the project accordingly. The CDD Task Force is an excellent example of a community solution to a community problem.

3. Christian Health Association of Malawi - Diarrhoea Prevention Programme

The Christian Health Association of Malawi (CHAM) provides 30% of the curative, preventive, and basic health care services in the country through 146 CHAM units. The CDD project will be implemented in a pilot phase for one year in one health unit in each of the three regions in Malawi. Project activities will be implemented by the health centre Primary Health Care (PHC) team composed of health centre staff and other extension workers from community services, agriculture, fisheries, and the MOH. The projects will involve training of village educators (volunteers), local leaders, and influential elderly mothers in exclusive breastfeeding, use of HAF, referral, and continued feeding during a diarrhoea episode.

Goal: To improve the nutritional standards and health status of children under the age of five in villages near Koche Health Centre (South), Mlanda Health Centre (Central), and Nkhorongo Health Centre (North).

Objectives:

By the end of 1993,

1. thirty percent of the mothers in Matuwi, neighboring villages, and other pilot areas will be breastfeeding their children exclusively up to the age of 4 months;

2. the level of immunization coverage for children aged 10 months will increase from 65% to 85%;

3. the construction of pit latrines will increase from 67% to 80% (total houses 1,659, houses with latrines = 1115); and

4. the number of caretakers administering Home Available Fluids (HAF) to children 0-5 years with diarrhoea, and continuing feeding of children 0-5 years with diarrhoea will increase.

CHAM initially planned to implement the project in only one health centre; however, with encouragement from CEDPA, they decided to implement pilot projects in one health centre in each of the three regions in Malawi. The activities outlined here have taken place in Koche Health Centre in the South.

a. Needs Assessment

The Health Centre PHC team met with the community to identify and prioritise problems. The following were identified by the community as priority problems:

- protection of shallow wells
- food distribution (during period of drought)
- elephants destroying gardens
- distribution of seeds
- treatment of dysentery
- chlorination of water
- functional literacy classes
- education on control of diarrhoea
- pit latrines

The PHC team addressed some of these problems before attempting to implement the CDD project: 10 wells were protected, and proper government authorities were contacted about the elephant, seed, and chlorination problems.

b. Training

The following training courses have been conducted:

- training of trainers for health workers and other extension workers;
- training of village motivators in supervising and advising mothers in the promotion of breastfeeding and use of local available fluids, and prevention of diarrhoea
- sensitization of influential community leaders (including TBAs) to obtain support for the project.

c. Curriculum Development

Village Motivators had previously been trained; however, no written curriculum existed for the course, and the course had included very little on exclusive breastfeeding. This project provided an opportunity for re-training, and for the development of a formalized curriculum. With the assistance of the Project Officers and Entrepreneurs Training, a Malawian NGO that offers training services, CHAM developed a curriculum for training village motivators in prevention and home-case management of diarrhoeal disease. The curriculum was reviewed by CEDPA and PRITECH and will be field-tested shortly.

Key Issues

The approach used in this project established a foundation on which future projects and activities can be built. The project strengthened an existing PHC structure, namely the health centre PHC team, especially in skills for approaching and mobilizing a community. The problem prioritization, in which the communities' priorities were addressed first led to the establishment of trust between the community and the health centre team, and facilitated implementation of the project. The curriculum developed can be used in CHAM facilities throughout the country, and the process used can be replicated to develop curricula on other topics.

4. Federation of Churches and Evangelical Missions in Cameroon (FEMEC)

The goal of the project is to improve the treatment and prevention practices for diarrheal diseases of at least 9,000 women in the Central Province throughout the Women's Association of the Presbyterian Church of Cameroon.

Objectives:

1. Mothers will be able to identify diarrhea and cite the key points of home case management.

2. By the end of 1994, 50% of mothers in the zone will be able to treat their children afflicted with diarrhea at home by use of appropriate liquids, continuation of breastfeeding, and frequent feeding with appropriate foods during illness.

3. Mothers will be able to recognize diarrhea and cite 5 danger signs indicating the need for immediate medical treatment at the health center.

4. Mothers will be able to cite at least 4 methods of prevention of diarrhea, for example, frequent washing of hands, measles vaccination, breastfeeding exclusively until the age of 6 months, good methods of weaning, and the proper use of latrines.

Implementation is to be carried out in three phases to accomplish the above objectives.

Phase 1

1. Increase awareness of national leaders and conduct a three day training for 5 members of the national bureau and 19 advisers of the Presbyterian Church.

2. Nineteen advisors of the church will train 6 groups of 15 leaders, during 6 training sessions lasting 2 days each. (90 people will be trained)

3. These 90 people will then each train one group of at least 35 members, during short monthly training sessions (3,150 will be trained)

4. These 3,150 people will train at least 2 mothers from the community (6,300 mothers will be trained)

Phase 2

Phase 1 process repeated: Training again of 6 groups of 15 leaders with six (6) 2-day long training sessions

Phase 3

Training of 7 groups of 15 leaders with six (7) 2-day long training sessions

CEDPA/PRITECH provided funding for the first phase of this project, a workshop entitled: "Seminar Workshop on Maternal Education for the Fight Against Diarrheal Diseases".

The workshop was held December 16-17 1992, at the Centre for Women's Training, Faculty of Protestant Theology, Djoungolo, Yaounde, Cameroon. Participants included:

- 5 members of the National Bureau of Presbyterian Churches of Cameroon
- 30 regional leaders of the Women's Council of the Association of Christian Women of the Presbyterian Church of Cameroon (EPC). EPC is one the 10 churches belonging to FEMEC. (Federation of Evangelical Churches and Missions of Cameroon)

The content of workshop included the following:

1. Physiology of the disease
2. Identification of three types of diarrhea and their symptoms
3. Diagnosis of the severity of the diarrhea and identification of appropriate methods of treatment, including at home methods and when to refer.
4. Instruction on the preparation of treatment solutions (SSS, ORS) and foods such as boiled rice and corn, yoghurt and bananas
5. Prevention measures
6. Essential information for parents about diarrhea

D. FOLLOW-UP MEETING

A follow-up meeting for consultants had originally been planned for November, 1992 to evaluate actions to date and plan for follow-up and NGO monitoring for the period January-August, 1993; however, the process of arranging the technical assistance visits, developing subcontracts, and processing disbursements took longer than initially anticipated. Because of the delays, it was decided instead to hold a follow-up meeting at the completion of the project activities and to include representatives from the NGOs that had received the seed money. The objectives of the follow-up meeting were as follows:

1. To share experiences and lessons learned in implementation of community-based CDD projects;

2. To discuss strategies for sustainability of community-based CDD projects;

3. To evaluate the CEDPA/PRITECH process utilized to extend CDD services to communities through NGOs, including the initial workshop, use of regional consultants to provide technical assistance, and issues related to project implementation; and,

4. To consolidate project curricula in order to develop a generic curriculum outline including session topics, key messages, and suggested approaches for training community-level workers in home-based management of diarrhoeal diseases.

The meeting provided an excellent opportunity for the NGO representatives to share ideas and lessons learned in the project implementation process and also to provide feedback on the overall process. The regional consultants acted as both facilitators and participants during the meeting, helping to process and synthesize the lessons learned as well as providing their own insights into the process.

In general, meeting participants felt that the overall process had been successful. The initial workshop had provided valuable technical information about CDD and served as a catalyst for the development of the CDD projects. The seed grants enabled the selected NGOs to begin

project implementation and established a sense of accountability to CEDPA that was motivational. The technical assistance provided by the regional consultants had been timely (except in the case of CHAM) and valuable.

A major output of the follow-up meeting was the development of a list of lessons learned in implementation of community-based projects (see below). The second major output was the development of "Guidelines for Training of Trainers of Community Health Workers". (See Appendix 6) While these guidelines were developed specifically for CDD programs, they include generic sections which can be utilized in other trainings across a variety of sectors, for example, Adult Learning Methods, Community-based Processes, Conducting Community-based Participatory Needs Assessment, Supportive Supervision, and Evaluation.

The results of this meeting are outlined in detail in a separate report entitled "Meeting on NGO Initiatives for Community-Based Control of Diarrhoeal Diseases Programmes: Lessons Learned and Future Directions".

III. SUMMARY OF LESSONS LEARNED AND RECOMMENDATIONS

Overall, the NGO initiative achieved its broad objectives. Representatives from 12 NGOs received technical training in CDD and strengthened skills in the project design process. The skills of a group of African consultants in providing technical assistance were enhanced, as was their technical knowledge of CDD and the use of HAFs for home case management of diarrhoea. With only a small amount of seed money, three NGOs successfully began implementation of community-based projects demonstrating the use of HAFs and working in collaboration with Ministry and other local officials. The three NGOs that received seed funds agreed that the CEDPA/PRITECH workshop had given them the vision and motivation to design and carry out the projects, that their commitment to CEDPA helped them to move ahead and persist with the projects, and that the workshop had given them the confidence to proceed with the new technology, Home Available Fluids. All felt that the CEDPA money was complementary to the money they already had, and enabled them to model an HAF project.

While it was not possible to conduct an impact evaluation within the framework of this project, it can cautiously be concluded that the initiative did result in increased knowledge and awareness of the use of HAFs and the importance of continued feeding in home case management of diarrhoea among both health workers and community members. Approximately 60 health workers and over 300 community workers received training on home case management of diarrhoea using home available fluids and more than 200 community leaders received awareness and sensitization training on the dangers, management, and prevention of diarrhoea.

As with any project, some components did not proceed as smoothly or effectively as possible and should be revised or modified in future efforts. Following are the major lessons learned in implementation of this initiative. The lessons are divided into two sections: those related to working with NGOs and those related to implementation of community-based projects.

A. LESSONS LEARNED: WORKING WITH NGOS

Workshop

1. **Participant selection process.** Applications were sent through CEDPA alumni and PRITECH country representatives. Several hundred were sent out, and nearly 100 were returned. While this indicated a large demand for this type of workshop, it falsely raised expectations as only twelve NGOs could be selected. Participants from nine countries were selected, four from countries with PRITECH programs. Given the financial and time constraints of this initiative, it might have been more appropriate to limit the number of countries involved and increase the number of NGOs from each country. This would allow for greater ease in follow-up as well as a multiplier effect in a given country.
   Recommendation: Future workshops of this type should limit participant selection to fewer countries. Selection should be based on knowledge of the country setting and which NGOs have the greatest potential to achieve the workshop goals.

2. **Workshop Preparation.** The following factors influenced the overall outcome of the training: 1) It is difficult to prepare a workshop in Washington with limited training needs assessment information; 2) African trainers were brought into the process for only one week prior to starting the workshop; also, the African trainers changed at the last minute due to factors beyond the control of CEDPA; 3) The time frame between participant selection and start-up of the workshop was too short to allow for inputs by participants and trainers into the curriculum content; 4) CDD technical knowledge of trainers was not standardized prior to starting to plan for training.
   Recommendation: Adequate time needs to be allocated for planning of training with a well selected training team responding to a training needs assessment of potential participants.

3. **Prevention Strategies in Diarrheal Disease Control.** Prevention of diarrhea was of keen interest to participants as most of their community-based work is targeted towards prevention. The workshop curriculum did not provide a detailed breakdown of prevention strategies or critique which ones might be more effective, easier to implement, more cost effective, etc. No research data was available to support emphasizing particular aspects of prevention.
   Recommendation: A future workshop of this nature should provide more time for exploring prevention strategies. Available research should be compiled to provide the data necessary to direct appropriate intervention planning and message selection.

Workshop Follow-up: Technical Assistance and Seed Grants

4. **Ensuring Adequate Time for Administrative Procedures and Project Implementation.** The administrative procedures required for managing the seed grants took more time than anticipated. In order to carry out a technical assistance visit, the NGO had to develop a

scope of work which was then reviewed by CEDPA. If modifications were required the scope would be returned to the NGO for revision. Once the scope was finalized, the consultant needed to be identified, and mutually agreeable dates decided upon; travel and rate concurrences needed to be obtained, and travel advances processed. While all of this is fairly standard procedure for fielding consultants, it was difficult to carry out given the short time frame for the three projects (after revision and finalization of the proposals and development of the subcontracts, all of the NGOs had less than one year to utilize the seed money and the technical assistance). The constrained time frame also did not allow for any of the usual delays that occur during project implementation, especially when donors and ministries are involved.

Recommendation: Given the realities of implementation of community-based projects in developing countries and donor requirements, the time period for project implementation should be a minimum of two years.

5. **Strategies for Sustainability.** The concept of seed grants was not well accepted by the NGOs. Although it had been made clear from the start of these projects that only a small amount of seed money would be provided, it became obvious during the follow-up meeting that the NGOs had believed at some level that if their projects succeeded, they would somehow be able to obtain additional funds. The organization providing funding is perceived as a "donor", and NGOs depend upon donors for their survival. The perception existed that the project was being "terminated in the middle", despite their very successful implementation efforts to date. The expectation of the organizers had been that the project would continue within the existing structure of the NGO; however, NGO representatives felt that the projects would have more impact and more potential to influence policy if external technical assistance was available throughout the entire implementation process.

   Recommendation: The concept of seed money for community-based projects needs to be carefully considered. The issue of what will happen after the seed money runs out needs to be directly and specifically addressed during the project planning phase. As mentioned above, the time period for implementation needs to be adequate to allow the project to progress to a stage where it can be sustained.

6. **Follow-up with Workshop Participants**. Except for the comments provided to the NGOs on their written proposals, follow-up with the participants from the initial workshop in Nairobi was limited to those NGOs receiving seed grants. Maintaining contact with **all** of the NGOs would have provided a unique opportunity to evaluate the impact of the training workshop, as well as to further cultivate the establishment of a network of NGOs.

   Recommendation: A system for follow-up with all the workshop participants should be built into the project design, possibly through a follow-up survey, telephone interviews, etc.

Other lessons learned in relation to the process included the following:

- **needs assessments/baseline surveys** were instrumental in project design, planning, and implementation; while the regional consultants provided technical assistance in implementing the needs assessments in this initiative, future workshops could cover the process and methodology for conducting needs assessments in-depth, to develop this capability within the NGO itself;

- ongoing **external technical assistance** must be provided in order to enhance the credibility of the project, motivate NGO staff, and increase project visibility and thus the potential for influencing policy; the technical assistance provided with the CEDPA funding was essential to the project implementation process; when it wasn't provided, as happened in Malawi because of logistical difficulties, project implementation slowed significantly.

- **technical updates** of the NGO staff and others such as MOH workers occurred in the project implementation process -- thus, a **multiplier effect** from the original workshop was experienced;

- the process allowed for **comprehension and assimilation of technical information** at a variety of levels; NGOs at various stages in their ability to implement community-based CDD projects were able to benefit from the workshop experience;

- resource mobilization can result from **networking and partnership**; a tremendous amount was accomplished with only a small amount of "seed" money and from the sharing of experiences during the workshop and follow-up;

B. LESSONS LEARNED: IMPLEMENTATION OF COMMUNITY-BASED PROJECTS

Several common themes emerged as key elements in the successful implementation of community-based CDD projects. These themes reflect the lessons learned during this activity. Most of the lessons are applicable not only to CDD programmes and thus can be treated as guidelines for an approach to successfully implementing community-based programs:

1. **Collaboration/Networking** - The NGOs worked with a multitude of groups at a variety of levels to implement their CDD projects, including child caretakers, community members, teachers, public health officers, agriculturalists, Ministry of Education staff, and Ministry of Health personnel including District-level staff, health centre staff, national programme managers, outreach workers, and divisional level workers. In all the projects, careful attention was paid to protocol, sensitization in order to generate support, and involvement of the appropriate people at appropriate stages. This type of collaboration, while time consuming, provided the foundation on which to build a successful programme.

2. **Community Involvement/Participation** - Adequate time must be allowed to ensure full involvement of the community in the project. All of the seed projects fully involved the communities from the initiation of the project throughout the implementation process. The communities participated in the projects in a variety of ways, including problem prioritization, needs assessment, baseline surveys, selection of community workers, and sharing of cultural beliefs and practices. A variety of methodologies were used to facilitate participation including focus and small group discussions, individual interviews, and surveys. This type of involvement results in true ownership of both problems and their solutions and is empowering to the communities as they discover their own capacities. Flexibility and patience are required by the implementing organization in order to truly allow the communities to exercise some control over project implementation.

3. **Development of Counselling Skills** - Training of health workers in counselling skills resulted in improved attitudes in their relationships with community members, thus increasing the effectiveness of their interactions. Effective communication is central to the success or failure of this type of community-based programme.

4. **Avoid Overburdening of Community Health Workers** - All of the projects looked beyond the CHW to fully utilize a wide variety of resource people within the community - teachers, school children, TBAs, young mothers, men, intersectoral outreach workers; this effort to avoid overburdening the CHWs will increase the potential for sustainability and may reduce the drop-out rate.

5. **Use of appropriate technology: Home Available Fluids** - The use of HAF as an approach is empowering and sustainable because it does not create reliance on external resources or technology -- people realize that they have the resources they need to address the problem in their own homes. It is a sound alternative to ORS and SSS, and not subject to either logistical breakdowns or lack of appropriate supplies. At the same time, the concept of use of HAFs is new to both health workers and communities; while ORS and even SSS were perceived as medicines, by definition HAFs are not medicines. Project implementors should be prepared to face some initial skepticism and doubt about the effectiveness of the use of HAFs.

6. **Decentralization in implementation** - Decentralization in order to place responsibility and authority in the hands of those working closely with the communities is essential in enabling the projects to understand and respond to identified needs and problems in timely and effective ways. All of the projects allowed decision-making authority and responsibility to lie at the appropriate level - health centre public health team, divisional level health facilities, a core training team, etc.

7. **Integration into existing structures** - All of the CDD projects were integrated into existing infrastructures, broader Primary Health Care (PHC) programmes, or ongoing projects. This "piggybacking" resulted in a mutually beneficial relationship, as it

facilitated CDD project implementation and also resulted in the strengthening of the existing programmes, especially in terms of technical knowledge and the establishment/strengthening of collaborative relationships within and outside the community.

8. **Ministry of Health collaboration** - A good working relationship with the Ministry of Health is a challenge, but is also essential to the success of the project. Ministries are beginning, in some cases, to recognize that NGOs can fill the gap between government facilities and the communities. NGOs have the flexibility and experience in working with communities to try out innovative approaches, and look beyond constraining, static, and/or impractical policies.

9. **Utilization of experiential learning** - The projects demonstrated the need to allow the experiential learning process to work, rather than simply giving the "answers" to the community. For example, project implementors disagreed with the community's established criteria for selection of village workers which included literacy; however, the criteria was allowed to stand, and the community to make adjustments as they determined necessary. Such an approach requires time, patience, and flexibility, but is an essential element of community ownership of the project.

10. **Technically sound solutions that are responsive to practical needs** - The projects have demonstrated a shift in paradigm from "hard science" towards practicality and utilization of what actually works on the ground and can be sustained over the long term. For example, ORS, though effective, is subject to logistical and economic constraints and thus is more difficult to sustain. Sustainable alternatives such as HAF are needed at the community level.

IV. RECOMMENDATIONS FOR FOLLOW-UP PROGRAMMING

The establishment and facilitation of a network of NGOs that can learn and work together to share experiences and lessons learned is a methodology that should be replicated. While the PRITECH project has terminated, mechanisms can be explored for continuing this initiative under the BASICS project. Two programmatic approaches should be developed: A) Continued support for the network of NGOs already established; and B) Replication of the process with an umbrella NGO organization such as the International Red Cross Society.

A. Continued Support for NGOs

1. Funding for the seed projects should be continued so that the projects can complete their activities. Continued external technical assistance should be provided for training, materials development, and evaluation, utilizing the regional consultant network already established. The projects should be promoted as demonstration projects for implementation of community-based home case management of diarrhoeal disease using HAFs, either to influence government policy, and/or to serve as models for replication within the country.

2. The guidelines for the curriculum for training of trainers of community health workers developed at the Follow-up meeting should be expanded and developed into a comprehensive curriculum that includes objectives, session plans, and teaching activities.

3. A refresher training for the NGOs that participated in the initial meeting should be held; a needs assessment should be conducted prior to the workshop to assess the training needs of the NGOs so that the workshop can better meet their needs and develop their institutional capacity to implement community-based programs.

B. Replication of the Methodology

An international umbrella organization such as the International Red Cross Society has PHC programs and a strong infrastructure of community-based volunteer in its country programs. Integrating improved home management and control of diarrhoeal diseases into the Red Cross programs would have widespread beneficial effects.

Following is a suggested plan for implementation of a four-year program to work with NGOs in improving their capacity to implement community-based CDD and other projects, considering the lessons learned in this NGO Initiative:

Year One

- Selection of Red Cross country programs for participation in the initiative. The countries should be limited to a defined region to allow for follow-up and provision of technical assistance.

- Identification of regional consultants to participate as trainers and to provide technical assistance. The consultants should be within the same region as the NGO participants.

- Training needs assessment of selected NGOs by Regional consultants and U.S.-based PVO.

- Design of workshop and curriculum development.

- Implementation of NGO workshop.

Year Two

- Implementation of NGO projects with technical assistance provided by regional consultants.

- Technical Meeting for NGOs and regional consultants to share general experiences in project implementation and to focus in-depth on a specific technical theme; technical

theme to be determined based upon NGO needs, for example, IEC strategies, Community Mobilization, CHW Motivation, etc.

Year Three

- Implementation of NGO projects with technical assistance provided by regional consultants.

- Meeting of NGOs and regional consultants to discuss sustainability strategies for NGO projects.

- Documentation/publication of project outputs, for example workshop reports, training curricula, IEC materials, etc.

Year Four

- Implementation of NGO projects, including strategies for sustainability.

- Evaluation of NGO projects.

- Meeting of NGOs and regional consultants to share lessons learned and develop strategies for replication, sharing with other in-country NGOs, policy advocacy, etc.

Appendix 1: Workshop Brochure

Workshop Strategy

The two-week workshop will be attended by representatives of approximately ten non-governmental organizations (NGOs) with the potential to provide training in the treatment and prevention of diarrheal diseases in the home. These NGOs will develop community-based CDD programs targeting families not yet reached by existing health care systems.

Phase I - Design

Each NGO attending the project design workshop will design a community-specific outreach project that will function outside of the existing health care system to increase knowledge of diarrhea prevention methods and use of oral rehydration therapy (ORT). The projects will either add a CDD component to ongoing outreach programs or expand existing CDD activities.

Phase II - Implementation

Up to five of the participating NGOs will be selected to receive small grants and technical guidance from a resource specialist for the implementation of their projects. The other NGOs will leave the workshop prepared to implement CDD activities within the context of their existing programs. All participating NGOs will have access to CEDPA and PRITECH resource personnel in the implementation of their CDD projects.

CEDPA

The Centre for Development and Population Activities (CEDPA) is an international non-profit organization dedicated to improving the skills of professionals who manage family planning, health and development programs in developing countries. Since its founding in 1975, CEDPA has provided management training to over 3,200 individuals from 100 countries in Africa, Asia, the Caribbean, Latin America and the Middle East. As follow-up, CEDPA works with its alumni to strengthen local institutions and increase their capacity to carry out effective health, family planning and development programs.

PRITECH

Technologies for Primary Health Care (PRITECH), sponsored by the U.S. Agency for International Development, is a consortium of experienced, internationally known organizations led by Management Sciences for Health. PRITECH assists developing countries in implementing national diarrheal disease control (CDD) programs and related activities, often as part of integrated programs of maternal and child health. PRITECH's mission is to promote effective diarrhea treatment and sound preventive measures wherever children suffer from diarrhea.

If your organization is interested in participating please contact:
Ralph Stone, CEDPA
1717 Massachusetts Ave., #202
Washington, DC 20036

Telephone: (202) 667-1142
Fax: (202) 332-4496
Telex: 440384
Cable: CEFPA

Help families control infant diarrhea – NGOs can make a difference.

Extending CDD Services Through Community-Based NGOs.

A two-week project design workshop on the control of diarrheal diseases (CDD) through community-based programs. Sponsored by CEDPA and PRITECH.

Dates: **March 23 – April 3, 1992**
Location: **Nairobi, Kenya**

Meals, accommodation, tuition and educational materials will be provided by CEDPA & PRITECH.

Rationale

The demand for more effective diarrhea prevention and treatment programs is too great for the existing health system alone. CDD activities will have limited impact as long as the clinical health worker, with only marginal access to the target population, remains the primary contact for diarrhea prevention and treatment. Opportunities for offering more extensive CDD services through community-based organizations have not yet been fully explored. This workshop is the basis of a strategy to develop alternative outreach channels to promote effective diarrheal prevention and treatment practices through community-based NGOs.

Selection of Participating NGOs

The NGOs represented in the project design workshop must meet the following criteria.

- Work in Anglophone Africa
- Demonstrated interest in health care delivery
- Ongoing community-based programs
- Access to a large target audience
- Interest in initiating or expanding CDD activities
- Proven effectiveness in community-level programs.

CEDPA anticipates inviting representatives from 10 - 12 NGOs from both rural and urban areas.

Participating NGOs are requested to send at least two representatives – one senior-level manager and one mid- or junior-level project manager.

Workshop Structure

Module 1: Controlling Diarrheal Disease
Home case management
Prevention of diarrhea
Nutrition and breast feeding
Role of health facilities

Module 2: Community Activities
Assessing community practices
Selecting messages
Undertaking specific activities

Module 3: Project Planning
Problem description
Project goal and objectives
Project description and work plan
Monitoring and evaluating activities
Project resources and budget

Expected Outputs:

- Development of an organizational strategy for adding or expanding CDD activities;
- Documentation of shared NGO experiences in carrying out community-based CDD programs to complement government services;
- Increased knowledge and skills in technical aspects of CDD;
- Increased knowledge and skills in the process of project planning and proposal writing; and
- Funding of up to five organizations with small grants for adding or expanding community-based CDD activities.

Appendix 2: List of Workshop Participants

EXTENDING CDD SERVICES THROUGH COMMUNITY-BASED NGOS
CEDPA/PRITECH WORKSHOP

PARTICIPANT LIST

UGANDA RED CROSS

1. Mrs. Hope Akongo
   Primary Health Care Coordinator

2. Justus Tibezinda
   Programme Officer

ACTION FOR DEVELOPMENT/UGANDA

3. Ms. Beth Bamwine
   Networking Officer

4. Ms. Gasumba Winifred
   Committee Member

SIERRA LEONE HOME ECONOMICS ASSOCIATION

5. Josephine Aaron-Cole
   Project Director

6. Louisa Thomas
   Counsellor/Supervisor

GAMBIA FOOD AND NUTRITION ASSOCIATION

7. Kinday N'Della Samba
   Nutritionist

8. Mr. Joseph Rex Top Jassey
   Nutritionist Coordinator

CAMEROON/FEMEC

9. Mme. Lydie Zoung-Kanyi
   Dept. des Femmes

10. Mme. Helene Medjo-Akono
    A.C.F.

TANZANIA HOME ECONOMICS ASSOCIATION

11. Generosa Hilary Ngonyani
    Assistant Head
    Family Life Division

12. Ms. Angeline Kopwe
    Head Family Life Division

FAMILY GUIDANCE ASSOCIATION OF ETHIOPIA

13. Mr. Araya Demissie
    Director of Programmes

14. Mr. Fekadu Chala
    Regional Coordinator

CHRISTIAN HEALTH ASSOCIATION OF MALAWI

15. Percy Kantunda
    Primary Health Care Coordinator

16 Alexandre Nyambi
    Primary Health Care Coordinator

GHANA RED CROSS

17. Ms. Theresa Babero
    Health Coordinator

18. Mr. Faisal Azu-Billa Anabah
    Regional Secretary

CHRISTIAN HEALTH ASSOCIATION OF KENYA

19. Ms. Esther Nbiyu
    Development Project Coordinator

20. N. P. Wangai
    Project Officer

KENYA CATHOLIC SECRETARIAT

21. Anne M. Mukuria
    Primary Health Care/Community-
    Based Health Care Coordinator

AGA KHAN HEALTH SERVICES, KENYA

22. Janet Kipoto
    Community Nurse

Appendix 3:
Profiles of Regional Consultants, Trainers, and Workshop Resource Persons

Profiles of Regional Consultants, Trainers, and Workshop Resource Persons

Regional Consultants/Trainers

JOHN D. ALWAR - John is a pediatrician and a member of the faculty and the Department of Pediatrics at the Nairobi Medical School. He has been involved in diarrheal disease programs for over ten years and has conducted both clinical and community-based research in diarrheal diseases. He has been a consultant with a variety of international agencies including WHO, UNICEF, DANIDA, AMREF and PRITECH. John's expertise in CDD covers many areas including clinical training, monitoring and evaluation and research.

GRACE EBUN DELANO - Grace is the Program Coordinator and Deputy Director of the Fertility Research Unit of the Department of Obstetrics and Gynecology at the University College Hospital in Ibadan, Nigeria. She has over 30 years experience in training in MCH/FP, community-based distribution, women in development and adolescent sexuality. She has worked as a consultant for Pathfinder, UNFPA, Columbia University, JHPIEGO, World Bank and WHO. She is the co-author of over eight books on MCH/FP, the latest of which focuses on adolescents questions about sexuality. Grace's expertise is specific to CDD in the areas of integration of CDD into CBD/FP programs.

JAMES S. LWANGA - James is a psychotherapist by profession at the Counselling and Guidance Center at Makerere University in Kampala, Uganda. He is currently a Senior Counsellor/Lecturer in Psychotherapy and Behavioral Sciences in Medicine at Makerere. James has been involved in diarrheal disease research, conducting studies on cultural beliefs associated with diarrhea and traditional healers management of diarrheal diseases. Presently he is the Chairman of the Central Facilitating Team and Technical Coordinator for the Uganda Traditional Healers Initiative. He has been a consultant for UNDP, PRITECH, Africa Development Assistance and other Uganda-based NGOs. James' expertise in CDD is in the area of community needs assessment and counselling training.

ESTHER SEMPEBWA NAGAWA - Esther is currently the Project Manager of the Mombasa Primary Health Care Project of the Aga Khan Health Services, Kenya, She is a sociologist/demographer by training and has been working in community-based health care programs for the past 10 years. Special interest and skills are in community-based training and education as well as monitoring and evaluation of project activities at the grassroots level. She has been a consultant for WHO, UNICEF, AMREF and CORAT Africa. Esther's expertise in CDD include monitoring and evaluation and training at the community level.

PENINA OCHOLA - Penina is currently the Head of the Community-Based Health Care Department of the African Medical Research Foundation (AMREF), which for over 15 years has been a pioneer in all aspects of CBHC throughout Eastern and Southern Africa. She is an excellent trainer and curriculum designer. She has a keen sense of working with the community

and places community participation as her guiding light. She has conducted many consultancies especially geared towards health care planning at the government level. She is a strong proponent of collaboration between governments and NGOs.

Trainers

KATHERINE A. BURNS - Kate has worked in the international health development field for over 17 years. She is a nurse by training with a Masters in Public Health. The majority of her work has been with non-governmental organizations at the grassroots level. She has worked long-term in Tunisia, Brazil, Somalia, Philippines and Kenya. Short-term assignments have taken her to most countries in Africa as well as Asia. Her specialty areas include training, program design, implementation, evaluation and health information systems in all aspects of Primary Health Care. She was the Country Representative for PRITECH in Kenya.

RALPH STONE - Ralph is the Director of The Centre for Development and Population Activities' (CEDPA) Training Division. He has an M.A. in International Development from Columbia University and is currently pursuing an Ed.D. program in Human Resources Development at George Washington University. Over the past 10 years he has worked as a trainer in several countries in Africa and South Asia. As a training consultant prior to joining CEDPA, his assignments included work with the Centers for Disease Control, PRITECH, UNICEF, Peace Corps, Delphi Research Associates and other USAID contractors.

Resource Persons

LARRY CASAZZA - Larry is a pediatrician in the Technical Unit of the PRITECH Project based in the headquarters office. He works extensively with national CDD programs in effective case management training of health care provides and with lactation management programs at the national level. He comes to the PRITECH Project through The Johns Hopkins School of Hygiene and Public Health. Larry works closely with the WHO CDD program and worked previously with the World Bank.

AGMA PRINS - Agma is the Regional Senior Program Manager for Central, Eastern and Southern Africa (CESA) for the PRITECH Project. Her formal training includes African Studies and a Masters Degree in Public Health. She has over 10 years experience in Africa in the design and implementation of both community and national level development programs including primary health care, water and sanitation, diarrheal diseases and income generation. Her technical skills include training, educational materials development, program design and evaluation.

Appendix 4: Summary of Technical Assistance

Summary of Technical Assistance

1. UGANDA RED CROSS

Project Title: Control of Diarrhoeal Diseases Project

Contact Address: Uganda Red Cross Society
P.O. Box 494
Kampala, Uganda
Tel: 258701/2

Project Summary: The CDD component is being implemented within the existing PHC project in Kiryanga Parish, Masindi District in mid-western Uganda, in collaboration with the CDD program and through the DMO's office. The intervention on CDD services will address the management of diarrhoea using HAF including breastfeeding. Eleven TBAs, 6 CHWs, 35 VHC members, and 15 Red Cross officials are expected to be trained to improve their knowledge and counselling skills to enable them to disseminate IEC on home case management of diarrhoea effectively. The above target groups already exist and were chosen because they are the Community's Own Resource Persons (CORPS) as well as influential to mothers and caretakers.

Summary of Implementation:

Activities

1. Orientate 30 members of the DHT on the use of HAF.
2. Identify and train 10 District technical trainers from the District Health team (number 1) and extension workers who will be trainers at the Parish level (TOT).
3. Orientate 150 community leaders on the use of HAF.
4. Community needs assessment (CNA) exercise to identify 5 HAFs - 10 technical trainers will be involved in the CNA.
5. Baseline survey.
6. Train 50 CORPS (10 each from 5 villages) to enable them to educate caretakers of children on use of HAF.
7. Home visits
8. Community meetings.
9. Compile a recipe book, develop posters, establish drama/music groups.

The management of diarrhoea using HAF was a new concept to both health workers and the communities.

Technical Assistance:

1. **Purpose**: 1. Revision of project plan and budget;
   2. Training in needs assessment

Dates: April 28-30, 1992

Consultant: James Lwanga.

Primary Outputs: Decision to leave out ORS and focus on HAF because of problems related to costs, availability/supply, government policy. Intervention will focus on TBAs who will carry out counselling of mothers/caretakers, IEC activities especially BF and HAF and how they are related to diarrhoea.

TBAs chosen because they are more respected group than VHWs and other extension workers in the community, have a "stronger" relationship with the mothers than other groups, are very influential where mothers and children are concerned; and may not need formal incentives like other groups.

2. **Purpose:** 1. Visit target areas for the project.
   2. Design needs assessment tool.
   3. Assist URC to revise the draft proposal.

Dates: June 22-26, 1992

Consultants: James Lwanga and Penina Ochola

Primary Outputs: Confirmed good collaboration and well-established working relationship with District Health Team;

Plan revised so that project only piloted in one instead of four Parishes;

TBAs are few and would be inadequate in providing the services to all the priority households in Kiryanga. Discussions with Community Elders, VHC members, and DHT recommended that the training focus on a strong group of CORPS comprising of VHWs, TBAs, Teachers, Women Club members, etc.

Intensive awareness raising exercise on HAF would be carried out in Kiryanga Parish prior to the training.

Need to conduct workshops for orientation and training for caretakers and health workers, because HAF concept is new to both health workers and community

members. Recommended that first workshop be conducted for the District Health Team.

House-to-house survey tool; focus group discussion tool.

3. **Purpose:** Training of research assistants; Supervision of data collection; Data processing and analysis; Report writing.

Dates: November 29 - December 16, 1992

Consultant: James Lwanga

Primary Outputs:

- Report of Community Needs Assessment of Kiryanga Parish, Masindi District:
- community beliefs about causes of diarrhoea;
- how diarrhoea is managed at home;
- community's habits in relation to food and fluids as far as diarrhoea is concerned;
- incidence of diarrhoea
- environmental factors related to causes of diarrhoea.

2. AGA KHAN HEALTH SERVICE, KENYA

Project Title: Proposal to Improve Diarrhoea Home Case Management in Mtaa Location

Contact Address: Aga Khan Health Service, Kenya
Mombasa Primary Health Care Project
P.O. Box 83013
Tel:312953/4/5

Project Summary: The Mombasa Primary Health Care Project (MPHC) is a comprehensive, community-based PHC project covering 3 locations in Kinango division, Kwale District in Coast Province. The CDD project is being implemented in Mtaa location. There is one dispensary in Mtaa serving part of the location. The objectives are as follows:

1. To increase the proportion of mothers and caretakers who are able to effectively manage diarrhoea at home by 40% over the baseline level.

Activities:

a. Create awareness about the project.
b. Establish size of target population.
c. Establish baseline levels of knowledge and practice.

d. Identify CBHWs for training
e. Assessment of training needs for the CBHWs.
f. Designing of the training curriculum.
g. Training of CBHWs.
h. Evaluate progress.

2. To increase the number of health workers in Mtaa with skills to counsel mothers and caretakers of children with diarrhoea and malnutrition so as to improve home case management, reduce number of referrals and thereby mortality due to diarrhoea.

Activities

a. Conduct training needs assessment for 15 health workers regarding diarrhoea, malnutrition, and counselling. These health workers will form the core team for training and supervising the CBHWs.
b. Train health workers.
c. Set up monitoring system.

One week of training has already been carried out for the health workers. Content of training included: counselling; diarrhoea - clinical and home case management; cultural beliefs and practices regarding diarrhoea and counselling.

CBHWs will be the main health educators. They will be supported by Health Workers. CBHWs include teachers, pupils, community leaders, and ordinary community members.

Nutrition education will be one of the key activities of the study.

Improved home/case management will include:
- increased fluid intake
- increased food/feeding
- breastfeeding
- catch-up growth
- improved hygiene
- recognition of signs for referral

Technical Assistance

1. **Purpose:** Conduct field visit to target villages for study;
   Revise Proposal;
   Discuss counselling/CDD Home Case Management workshop content and plan the workshop;
   Conduct training workshop; Report on the TA

Dates: September 22 - October 4, 1993

Consultant: James Lwanga

Primary Output(s): Conducted a training workshop for 25 participants. Workshop objectives:

1. To equip participants with knowledge and skills which will enable participants to effectively counsel mothers and child caretakers and thereby improve diarrhoea home case management.

2. To update participants with knowledge on diarrhoea home case management.

Participants:

community health nurses	9
public health technicians	6
primary school teachers	7
public health officer	1
information systems assistant	1
secretary	1

3. CHRISTIAN HEALTH ASSOCIATION OF MALAWI

Project Title: Diarrhoea Prevention Programme

Contact Address: Christian Health Association of Malawi
P.O. Box 30378
Lilongwe 3, Malawi

Project Summary: The Christian Health Association of Malawi (CHAM) provides 30% of the curative, preventive, and basic health care services int he country through 146 CHAM units. Only 61% have started community-based management of diarrhoea, income generating activities, health education, and other PHC-related activities. The diarrhoea prevention programme has been started as a full programme around Koche Health Centre in Mangochi District. Koche Health Centre covers 6 villages which are supervised by Koche PHC team composed of health

centre staff and other extensions workers from community services, agriculture, fisheries, and Ministry of Health.

The project will be in a pilot phase for one year in one health unit in each of the 3 regions in Malawi: Mlanda in Ntcheu in the Central region, Koche in Mangochi in the South, and Nkhorongo in Mzimba in the Northern region. Village educators (volunteers) local leaders, and influential elderly mothers will be trained in:

- exclusive breastfeeding
- use of HAF
- referral
- continued feeding

The health centre PHC team in Koch has already been trained as trainers with existing PHC funds from OXFAM/UK.

Activities

1. Briefing the CHAM PHC Committee
2. Discuss CDD policy and activities with MOH
3. Discuss with Regional and Health Centre staff
4. Identify with HC staff where programme should be done.
5. Conduct needs assessment.
6. Educate the community on the programme
7. Prioritise problems with community by health centre staff and discuss proposed programme with village leaders.
8. Plan meeting involving the community leaders, volunteer health centre team, Regional PHC Coordinator, Community Development Assistant, Agriculture Assistant, Health Surveillance Assistant.
9. Collection of materials for training courses.
10. Conduct trainings.
11. Monitoring of activities by PHC committee.
12. Terminal evaluation.

Technical Assistance:

Purpose: Assist in planning for curriculum development workshop

Dates: April, 1993 (one day)

Consultant: Stacey Lissit

Primary Outputs: Agenda for curriculum development workshop, list of session topics for Village Motivators curriculum, Session plan format.

Appendix 5: Consultant Evaluations

ANNEX J
CONSULTANT ASSESSMENT FORM

Consultants Name: James Lwanga Today's Date:
Requesting Organization: Uganda Red Cross
Dates of Assignment 22-26 June, 1992

1) Summary of Scope of Work:

Visit target areas and design needs assessment tool.

2) Did Consultant Achieve SOW to the satisfaction of requesting NGO? Yes

3) Please comment on the following:
Technical ability of the consultant Very good.

Ability to work with NGO staff and other agencies excellent

Ability to work with community (if applicable) very good

Quality of Outputs Good

Language Capability (if applicable) more than adequate

4 Overall Rating of Consultant:
Very poor / poor / average / good / very good ✓

5 Would you recommend using this consultant in the future? Very much

6) Other comments: Mr Lwanga has proved a good consultant. Ready and patient enough to train the people he works with

Title of person completing the form Head of PHC Programme

NOTE: Please complete this form at the end of the consultancy and give to consultant on send directly to the CEDPA - Washington. It is only through direct feedback from you that we know if a particular consultant is meeting the needs of your organization.
Thank You - Use reverse for further comments:

BEST AVAILABLE COPY

ANNEX J
CONSULTANT ASSESSMENT FORM

Consultants Name: Perina Ochola Today's Date:
Requesting Organization: Uganda Red Cross
Dates of Assignment 22-26 June 1992

1. Summary of Scope of Work:

Visit target area and design needs assessment tool.

2) Did Consultant Achieve SOW to the satisfaction of requesting NGO? Yes.

3) Please comment on the following:
Technical ability of the consultant Very good

Ability to work with NGO staff and other agencies very good

Ability to work with community (if applicable) excellent

Quality of Outputs good

Language Capability (if applicable) more than efficient

4. Overall Rating of Consultant:
very poor / poor / average / good / very good ✓

5) Would you recommend using this consultant in the future? ...

6) Other comments: Mr Ochola has a wide experience in Community approaches and methodologies.

Title of Person Completing the form Head of PHC Programme

NOTE: Please complete this form at the end of the consultancy and give to consultant on send directly to the CEDPA - Washington. It is only through direct feedback from you that we know if a particular consultant is meeting the needs of your organization.
Thank You - Use reverse for further comments:

BEST AVAILABLE COPY

ANNEX J
CONSULTANT ASSESSMENT FORM

Consultants Name: JAMES S. LWANGA Today's Date: 24/11/92
Requesting Organization: AGA KHAN HEALTH SERVICES (KENYA)
Dates of Assignment 22nd September to 3rd October 1992

1) Summary of Scope of Work:
- To revise study proposal
- To train health workers in Counselling and diarrhoea home case management.
- Write report of his visit etc.

2) Did Consultant Achieve SOW to the satisfaction of requesting NGO? YES HE DID.

3) Please comment on the following:
Technical ability of the consultant
JAMES KNOWS HIS FIELD VERY WELL.
Ability to work with NGO staff and other agencies
EXCELLENT.
Ability to work with community (if applicable)
JAMES WOULD WORK AT ANY LEVEL.
Quality of Outputs
VERY GOOD WORK OUTPUT.
Language Capability (if applicable) very fluent English speaker.

4) Overall Rating of Consultant:
very poor / poor / average / good / very good ✓

5) Would you recommend using this consultant in the future?
Definately YES.

6) Other comments:
JAMES WORK ROUND THE CLOCK, HE IS VERY GOOD AT CO-ORDINATING.

Title of Person Completing the form PUBLIC HEALTH OFFICER.

NOTE: Please complete this form at the end of the consultancy and give to consultant on send directly to the CEDPA - Washington. It is only through direct feedback from you that we know if a particular consultant is meeting the needs of your organization.
Thank You - Use reverse for further comments:

BEST AVAILABLE COPY

Appendix 6: Guidelines for Training of Trainers of Community Health Workers

GUIDELINES FOR TRAINING OF TRAINERS OF COMMUNITY WORKERS

1. Adult Learning Methods

   a. Team building
      Workshop agenda
      Knowing one another
      Workshop norms
      Sharing responsibilities

   b. Introduction of adult learning
      Characteristics of adult learning
      Roles and qualities of a good facilitator/trainer
      How adults learn
      Creating a good atmosphere for adult learners
      Methods of helping adult learners learn
      Introduction to Psycho-social methods for adult learning

2. Community-based Processes

   - The concept of community
   - Community analysis: resources, problems, needs, structure/functional, cultural beliefs
   - How to sensitize/mobilize communities (awareness raising)
   - Identification of Community's Own Resource People (CORPS) and community-based criteria for selection

3. Conducting Community-based Participatory Needs Assessment

   - What to assess in CDD intervention
   - Methods of conducting needs assessment
   - Methods of collecting information: rapid appraisal, individual interviews, focus groups, household surveys, observations
   - Analysis of information for CDD and prioritizing problems
   - How to involve community people in needs assessment for CDD
   - Why assess, when to assess, where to assess for CDD intervention
   - How to use information collected for CDD programme planning and training
   - How to analyze information collected
   - Planning for feedback, providing feedback, discussion on feedback.

4. Diarrhoea

a. Recognition of diarrhoea, causes and dangers of diarrhoea

i. Definition of Diarrhoea -
passing of loose and watery stools at least 3 times in a day;
individual losing water

ii. Causes of Diarrhoea -
poor personal hygiene
lack of sanitation
use of contaminated water
poor food handling hygiene
other diseases such as malaria, measles, AIDS, intestinal worms;
malnutrition

iii. Dangers of Diarrhoea -
dehydration
growth failure
other complications
death

b. Management of diarrhoea

i. Assessment of dehydration - ask, look, feel; signs and symptoms of dehydration

ii. Prevention/management of dehydration using ORS, Home Available Fluids[1]. Rehydration should be started as soon as diarrhoea starts -- do not wait for dehydration to set in.

iii. Continued feeding during diarrhoea and extra feeding during convalescence ("catch-up" feeding) Food should be given frequently, breastfeeding should continue.

iv. Hygiene - food, environmental, personal, to avoid spreading the diarrhoea within the household and community.

v. Referral - reasons referral is sometimes necessary, when to refer, where to refer, follow-up.

---

[1] Health workers must establish which fluids are readily available and acceptable in the community;

c. Prevention of Diarrhoea

- exclusive breastfeeding up to 4 months;
- breastfeeding instead of bottle feeding;
- washing hands with soap: after going to toilet, before eating, before food preparation, before feeding child
- using clean water
- immunization
- proper use of latrines
- proper disposal of baby stools
- food hygiene and storage
- keeping compound clean
- proper disposal of refuse
- prompt treatment of illnesses such as malaria, worms

d. Cultural Beliefs and Practices

- definition of diarrhoea
- causes of diarrhoea
- management of diarrhoea
- prevention and control

5. Communication Skills

- What is communication?
- Reasons for communication
- Qualities of a good communicator
- Aspects of communication, e.g. verbal, non-verbal, listening, empathy
- Communication skills

6. Counselling

- What is counselling?
- Rational for counselling
- Qualities of good counselling
- Types of counselling -- Counselling in the context of a CDD programme
- Techniques of counselling
- Problems in counselling: problems and solutions
- Counselling a mother with a child with diarrhoea
- Human and material resources required for a good counselling session
- Skills in counselling

7. Collaboration/Networking

- What do we mean by collaboration?
- Identification of whom to collaborate with
- Benefits/constraints in collaboration
- Ways of collaborating
- Factors which can enhance better collaboration

8. Development and Use of IEC Materials

- Purpose and importance - link to session on adult learning
- Types of materials: poems, pamphlets, posters, songs, objects
- How to develop simple IEC materials
- How to develop messages
- When and how to use IEC materials

9. Planning and Conducting Community-Based Learning

- Organizing training at the community level
- Developing session plans
- Logistics: venue, informing participants, identifying resource people, meals, supplies
- Application of adult learning methodologies and communication skills
- Evaluation of training programme

10. Supportive Supervision

- Definition of supervision
- Importance of supervision
- Role of the supervisor
- Purpose of supervision
- Supervision styles, e.g. - autocratic, democratic,
- Qualities of a good supervisor
- Supervisory skills

11. Monitoring and Evaluation/Record-Keeping

Monitoring

- What is monitoring? Why and when to monitor a CDD programme
- What to monitor: indicators for CDD
- Developing tools for monitoring CDD interventions
- Who should monitor?

Evaluation

- What is evaluation?
- Why we need to evaluate a CDD intervention
- Methods of evaluating a CDD intervention
- Differences between monitoring and evaluation
- When/how often should evaluations be done
- How to use information obtained from evaluation
- Sharing the Feedback

Record Keeping

- What needs to be recorded
- Developing community-based tools for recording information
- Tools for summarizing information at the household, community, and health centre levels
- Interpretation and use of information being recorded; feedback and information sharing
- Action planning
- Report writing