GANZOURGOU CHILD SURVIVAL PROJECT

PHASE II

FINAL EVALUATION REPORT

AFRICARE
BURKINA FASO
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FINAL EVALUATION OF GANZOURGOU CHILD SURVIVAL PROJECT AFRICARE/BURKINA FASO

GANZOURGOU CHILD SURVIVAL, PROJECT FINAL EVALUATION EXECUTIVE SUMMARY

The Ganzourgou Child Survival Project (GCSP) of Africare/Burkina Faso was initiated in 1990 as a Cooperative Agreement (#OTR-0500-A-00-0104-00) with USAID under the FVA/PVC Child Survival Support Program. The goal of the project is to decrease morbidity and mortality rates among children below 5 years of age and women of reproductive age (WRA). Phase II of the GCSP began in October 1993, and ends September 30, 1996.

The main interventions of the GCSP are:

* strengthening and augmenting existing health structures through training and support, and by increasing community health mobilization capacity; and
* health promotion through community and household education on maternal and child health themes: immunization, nutrition and growth promotion, diarrhea1 disease and malaria control, maternal health and family planning, and AIDS/STD prevention.

A final evaluation of Phase II of the GCSP was conducted from July 3 to July 19, 1996. The evaluation was coordinated by an external consultant, Waverly Rennie, MPH, assisted by Marguerite Joseph, MPH, Child Survival Program Manager, Africare/Washington. A participatory methodology involved Africare project staff as well as partners in the Department of Zorgho (a total of 21 team members) in all the phases of the process. The goal of the evaluation was to document the project activities and to study the impact of the project components, effectiveness of the intervention strategies, and issues of sustainability.
The Ganzourgou Child Survival Project was based in Zorgho, the provincial capital. Each project staff health promoter was based in a project village and covered one to two other villages. During Phase II, the project expanded its activities into 10 new villages, almost doubling coverage from 13 to 23 villages. The project health promoters increased in number from 5 to 9, and several of the previous promoters were replaced. The promoters received several training in maternal child health, IEC, and training of trainers, and then trained villagers selected by their communities to serve as volunteer neighborhood counselors (NCS). The NCS received training and refresher courses in local language literacy, child survival interventions, and IEC, resulting in the creation of a cadre of 350 consistently active NCS in the 23 villages. Training in these subjects was also provided to staff of the five area health centers, 23 traditional birth attendants and 23 volunteer curative health workers associated with the Ministry of Health. Activities included health education talks, growth promotion and nutrition demonstrations, home visits by promoters and neighborhood counselors, and support to Ministry of Health (MOH) services. Recommendations formulated by project staff themselves during the mid-term evaluation led to a reorientation of project approaches and methods. This increased community participation, strengthened institutional linkages, and reinforced the capacity of community volunteers to continue health education activities when the Africare health promoters are no longer in the villages.

-An education guide for village-level health workers was developed during Phase II of the Ganzourgou Child Survival Project. This guide uses simple brief text in Moore and large

pictures to illustrate health messages. A total of 350 of these guides have been distributed to NCS in project villages, to Africare project staff, and to project collaborators.

The following table shows some of the improvements in health knowledge and practices as measured by the baseline and final KPC surveys.

Progress Toward Knowledge and Practice Goals (Mothers Surveyed in KPC Survey)	*Baseline March 1994*	*Final June 1996*
report use of ORT for diarrhea	27%	83%
cite use of enema (pepper, leaves) for diarrhea	63%	7%
cite poor hygiene as cause of diarrhea	29%	65%
gave colostrum to index child	14%	82%
breast-feed within 8 hours of birth	25%	69%.
children <4 months old exclusively breast-feed	7%	22%
give eggs to children	negligible	50%
give mango/papaya to children	25%	75%
know correct age for measles immunization	11%	42%
know mosquitos carry malaria	5%	57%
know that eliminating stagnant water can prevent mosquitos/malaria	3%	51%
ever heard of modem contraceptive method	49%	94%
reported use of modem contraceptives	7%	18%
know that AIDS can be transmitted through sex	70%	94%
know that AIDS can be prevented by: single partner condom use	44% 11%	76% 49%

As seen above, certain interventions were highly successful. There was a marked degree of improvement in diarrhea prevention and treatment, and nutrition practices. Growth monitoring in the villages was enthusiastically supported by the women and by the NCS. However, this intervention was initially very labor-intensive, and only later was focused enough on a smaller target population (< 2 years and malnourished children) to make it more feasible. Referral centers for cases of malnutrition were not very appropriate or effective.

Several approaches to malaria prevention were taught, including environmental ones, but although the TBAs were provided with chloroquine for routine prophylaxis in pregnant women, during the evaluation it was observed that almost none were prescribing the chloroquine correctly. The TBAs were specially trained in prenatal care and safer delivery practices, and received a substantial TBA kit. The project was not able to achieve its objective to set up obstetric emergency evacuation plans. The immunization intervention was less successful than the others, efforts in this area not having resulted in a major improvement in immunization coverage or dropout rates. This seems in part due to the difficulty of the MOH in providing the services.

The HIS seems to have been the weakest aspect of the project. The information collected on the numerous forms was neither well-disseminated nor well-used for supervision and management. Evolving project objectives were not monitored well by the HIS. Several valuable exercises were held to re-evaluation project direction and strategies, including the mid-term evaluation and a team retreat in January 1996. More big-picture thinking would have helped increase sustainability and effectiveness of project efforts.

The training component, in addition to teaching CS, IEC and TOT, strengthened the health promoters' quantitative and qualitative research skills. Much effort went to creating a strong cadre of project promoters, however, before developing the neighborhood counselors.

Changes of personnel in the field, country, and Washington offices led to some delays in implementation, but in general the management of the project was successful and effective.

Conclusion

The final KPC survey shows a remarkable increase in mothers' knowledge, which is the result of the intensive education efforts of project staff and neighborhood promoters. Health practices have also improved greatly. After the mid-term evaluation, strengthening of counselors' roles and skills, and institutional linkages for sustainability were emphasized.

Intensive efforts in the next few months will be necessary to ensure that the neighborhood counselors are sufficiently skilled, well-integrated into existing structures, and equipped to continue their work, and that community and institutional leaders are actively supportive of these village-level health activities. A six-month extension of minimal project funding would permit these sustainability activities to be carried out and ensure that the impressive achievements of this successful project are not lost.

LIST OF ACRONYMS

ABBEF	*Burkina Family Planning Association*
AIDS	*Acquired Immune-Deficiency Syndrome*
ASV	*Village Health Volunteer*
ATB	*Burkina Theater Workshop*
CBD	*Community Based Distribution of Contraceptives*
CDD	*Control of Diarrhea1 Disease*
CJAS	*Africare Youth Club for Health*
CREN	*Nutritional Rehabilitation Center*
CRS	*Catholic Relief Services*
c s	*Child Survival*
CSPS	*Government Health Center*
DIP	*Detailed Implementation Plan*
DPEBA	*Ministry of Basic Education and Literacy*
DPS	*Provincial Health Directorate*
DPT	*Diphtheria/Pertussis/Tetanus Vaccine*
EPI	*Expanded Program on Immunization*
GCSP	*Ganzourgou Child Survival Project*
HIS	*Health Information System*
HIV	*Human Immune-deficiency Virus*
IEC	*Information, Education, Communication*
IGA	*Income Generating Activities*
KPC	*Knowledge, Attitudes and Practices*
MCH	*Maternal Child Health*
MOH	*Ministry of Health*
MSA	*Ministry of Social Affairs*
NC	*Volunteer Neighborhood Counselor*
NGO	*Non Governmental Organization*
PHC	*Primary Health Care*
STD	*Sexually Transmitted Disease*
TBA	*Traditional Birth Attendant*
TOT	*Training of Trainers*
TT	*Tetanus Toxoid*
USAID	*United States Agency for International Development*
WRA	*Women of Reproductive Age*

I. INTRODUCTION

A. Background

The Ganzourgou Child Survival Project (GCSP) of Africare/Burkina Faso was initiated in 1990 as a Cooperative Agreement (#OTR-0500-A-00-0104-00) with USAID under the FVA/PVC Child Survival Support Program. The goal of the project is to decrease morbidity and mortality rates among children below 5 years of age and women of reproductive age (WRA). The second phase of the GCSP began in 1993, as the first phase was ending. The Revised Detailed Implementation Plan for Phase II was submitted in September 1994. The project end date for GCSP II is September 30, 1996.

The main interventions of the GCSP are:

* strengthening and augmenting existing health structures through training and support, and by increasing community health mobilization capacity; and
* health promotion through community, group and household education on maternal and child health programs such as immunization, nutrition and growth promotion, diarrhea1 disease control and oral rehydration, malaria control, maternal health and family planning, and AIDS/STD prevention.

B. Area Information

The project area, in the Meguet District of Ganzourgou Province, covers 23 of the 33 villages in Meguet, an increase from 13 villages covered in the first phase of the GCSP. The area is 110 kilometers east of Ouagadougou, the capital of Burkina Faso. The population of the villages covered by the project totals approximately 30,000, with a target population of roughly 6,000 children under the age of five, and 6,000 women of reproductive age (both estimated at 20% of total population).

The majority of the inhabitants is Mossi and speaks Moore. There are followers of Christianity, Islam, and traditional religions. About 90% of the inhabitants are agriculturalists, raising millet, peanuts, beans and corn during the rainy season (June to October) and raising livestock (cattle and goats) throughout the year.

Common health problems include malaria, diarrhea, acute respiratory infections, measles, and HIV/AIDS. Other major health problems include nutritional deficiencies (high levels of protein-energy malnutrition and iodine deficiency), tuberculosis, and periodic meningitis outbreaks.

C. Previous Evaluations

The final evaluation of Phase I took place in March 1994 (after Phase II began). The baseline survey for the second phase also was carried out in March 1994, using a standardized Child Survival Knowledge, Practice and Coverage (KPC) survey developed by the PVO Child Survival Support

Project (CSSP) at Johns Hopkins University. The survey uses the World Health Organization 30-cluster sample survey methodology, and includes basic questions regarding maternal and child health care and nutrition, breast-feeding and weaning practices, diarrhea1 disease control, immunization, and AIDS and malaria prevention.

A Mid-Term Evaluation of GCSP II- using an innovative participatory approach- was carried out in March 1995. This gathered both quantitative KPC and qualitative data, and formulated a large number of lessons learned and recommendations for project activities. These have been incorporated into the project and were used as part of the basis for this final evaluation, as was the participatory methodology.

In June 1996, the project team carried out a Final KPC Survey. The results are found in the Final Survey Report, and were analyzed by the team to identify key questions for the final evaluation.

D. Evaluation Methodology

The goal of the final evaluation, which took place July 3 to 19, 1996, was to document the project activities and to study the impact of the project components, the effectiveness of the selected intervention strategies and issues of sustainability. The Final Evaluation was carried out by the evaluation team, led by an independent health consultant, and made up of representatives from Africare/Washington, Africare/Ouagadougou, and Africare/Zorgho, as well as staff from the Ministries of Health, Social Action, and Literacy, Save the Children/Saponé, and UNICEF. (See Appendix A for a complete list of team members.)

The evaluation team used a modified version of the participatory approach that had been used successfully during the midterm. The team worked together to develop the questions for the evaluation within the USAID guidelines, according to the program and schedule attached in Appendix D.

Africare health promoters gathered quantitative and qualitative data from their reports and observations in their own villages, while the external members of the team reviewed project reports and other documentation. Individual interviews and group discussions were held with the project staff concerning: training and continuing education, accomplishments and appropriateness of project activities, project management and administration, lessons learned, and sustainability.

In addition, the evaluation team designed and carried out a qualitative field survey in eight of the 23 project villages. The project villages were divided into "stronger" and "weaker" villages. "Stronger" or "weaker" was defined according to the activity levels of the health committee and the village health team, and the degree of facility with which project agents were able to implement activities in the village. An equal number from each category was chosen for the survey, in order to understand the factors contributing to the project's successes and failures at the village level.

Methods used to evaluate the impact of the project training, education and awareness-raising activities on health knowledge, skills and behavior included:

*standardized interview questions,
*open ended discussions,
*focus group discussions, and
*observation checklists.

Interviews and observations were also carried out in the 5 health centers (CSPS) in the project area, as well as in the provincial capital, Zorgho, and in Guagadougou with the Provincial Health Director, the Ministry of Social Action, the Ministry of Literacy, SOS *SIDA* (a local non-governmental organization), and Save the Children/USA. The discussions and observations particularly focused on the level of skills and initiative among the volunteer neighborhood counselors, and the potential for continuation of health activities initiated under the child survival project. (See Appendix I for copies of the data collection instruments.)

II. PROJECT ACCOMPLISHMENTS

A. Overall Achievements

1. Project Expansion

Among the noteworthy accomplishments of Phase II of the Ganzourgou Child Survival Project was the expansion into 10 new villages, almost doubling coverage from 13 to 23 villages. The total number of volunteer neighborhood counselors (NCS) involved in project activities increased from approximately 250 to 450 before it dropped down to 350 consistently active NCS.

Health promoters gradually turned responsibility over to NCS, whose home visits increased, as seen in the following table.

Time Period	Home Visits by Health Promoters	Home Visits by Counselors
Nov-Dee 1994	98	34
1995	697	706
First half 1996	26	876
TOTAL	821	1,616

2. Responsiveness to Participatory Mid-Term Evaluation

The Project did an outstanding job of responding to the 131 lessons learned and recommendations from the Mid-Term Evaluation in March 1995. These recommendations, which were formulated by project staff members themselves, led to a marked reorientation of approaches and methods which increased the participation of the community, strengthened linkages with existing institutions, and reinforced the capacity of community volunteers to continue health education activities when the Africare health promoters are no longer in the villages. During the final evaluation, these recommendations were reviewed with the team and project coordinator to assess progress and results. Highlights of these recommendations and the results are found in Appendix H.

3. Strengthening of Local Actors' Capacities

A major undertaking during this second phase of the project was the intensified training of existing community-level traditional midwives (TBAs), volunteer village health agents (ASVs) linked to the Ministry of Health, and the Project-created corps of volunteer neighborhood counselors (NCS). More in-depth literacy training in the local language, Moore, was done with the NCS to allow for their more effective participation in training and project activities. This training was carried out by the Provincial Direction of Basic Education and Literacy (DPEBA) during a 45 day session.

A training of trainers (TOT) was held for the project health promoters and supervisory staff to enable them to organize and conduct a training in health education and prevention for the NCS. The TOT was conducted by *Mwangaza*, a local organization specializing in community development and training. Subsequent to the TOT, the project staff planned and implemented a five-day training session for the NCS covering child survival themes including growth promotion and communication, counseling, and community mobilization techniques. This training was done in the Meguet, Kabouda and Tanghin areas of the project for the 275 NCS who were able to participate. Also

participating in this training were 23 volunteer village health agents (ASV) from the project villages. 24 TBAs also received training in child survival and maternal care.

An education guide for village-level health workers was developed during Phase II of the Ganzourgou Child Survival Project. This guide uses simple brief text in Moore and large pictures to illustrate health messages on nutrition, exclusive breast-feeding, control of diarrhea1 diseases, maternal care, family planning, immunization, malaria and AIDS. A total of 350 of these guides have been distributed to NCS in project villages, to Africare backstopping and project staff, and to project collaborators.

4. Improved Health Knowledge and Practices

The following table shows improvements in health knowledge and practices as measured by the baseline and final KPC surveys. More detailed descriptions by intervention are found in the following section.

Progress Toward Knowledge and Practice Goals (Mothers Surveyed in KPC Survey)	*Baseline March 1994*	*Final June 1996*
child < 2 had diarrhea in last 15 days	54%	36%
report usage of ORS for diarrhea	10%	76%
report use of ORT for diarrhea	27%	83%
cite use of enema (pepper, leaves) for diarrhea	63%	7%
give antidiarrheal/antibiotics for diarrhea	16%	5%
cite "wind" as a cause of diarrhea	19%	2%
cite poor hygiene as cause of diarrhea	23%	65%
gave colostrum to index child	14%	82%
breast-feed within 8 hours of birth	25%	**69%**
introduce foods between 4-6 months	55%	87%
give eggs to children	negligible	50%
give mango/papaya to children	*25%*	*75%*
give foods rich in protein	49%	84%
give foods rich in calories	**40%**	78%

Progress Toward Knowledge and Practice Goals (Mothers Surveyed in KPC Survey]	*Baseline March 1994*	*Final June 1996*
know mosquitos carry malaria	5%	57%
know that eliminating stagnant water can prevent mosquitos/malaria	3%	51%
ever heard of modern contraceptive method	49%	94%
learned about modern contraception through health promoter or health worker	HP 60%; HW 31%	**HP 90%; HW 21%**
know that AIDS can be transmitted through sex	70%	94%
know that **AIDS** can be prevented by: single partner condom use	44% 11%	76% 49%

B. Analysis of Project Accomplishments vis-à-vis Objectives Outlined in the Detailed Implementation Plan.

CONTROL OF DIARRHEAL DISEASES (CDD):

Inputs/Activities: Nine health promoters and nine health center staff were trained in prevention of diarrhea through exclusive breast-feeding and hygienic practices, and the prevention of dehydration with oral rehydration therapy. The health promoters and health center nurses trained in turn 275 neighborhood counselors (out of a total of 500 planned) and 23 village health agents. The training took place during the rainy season, when many of the NCS were not available.

Counselors in all villages were provided with material for oral rehydration salts (ORS) demonstration, as well as posters and the counselors' manual, which includes pictures for IEC sessions. Initially, free stocks of ORS were provided to all NCS. When MOH policy on ORS **changed** from the free distribution of ORS packets to their sale at 125 CFA/packet, it was decided to select only one counselor per neighborhood to sell ORS, initially at a reduced price. Eventually, 99 ORS packet sale points were established (100 planned). At the time that ORS packets became payable, the counselors added to their diarrhea education talks recommendations and demonstrations of oral rehydration therapy (ORT), including traditional remedies such as guava leaf or other herbal teas, and rice water, *zoumkoum* (millet flour water) etc. which are more accessible to families.

Messages on prevention of diarrhea, prevention of dehydration with ORS and home-available fluids, and danger signs during an episode were given during 239 education sessions at the village level, reaching 5,565 participants. Hygiene messages on potable water and personal, food and environmental hygiene were given during 73 education sessions reaching 1,375 participants. Six

hundred sessions on diarrhea and hygiene were planned, but it was felt that mothers had learned enough about diarrhea, and were more interested in other topics, especially family planning and AIDS.

Follow up home visits including nutrition counseling were made by health promoters and NCS to children with diarrhea.

Outcomes: The objectives for this intervention were:

* 60% of the children under two in target villages who have had diarrhea in a previous two-week period will have been treated with oral rehydration solution (ORS).

  Results: Reported usage of ORS for diarrhea episodes showed a dramatic increase from 10% at 1994 baseline to 76% in 1996, along with an increase in reported use of ORT from 27% to 83%.

* 80% of mothers increase the frequency of administration of home available fluids, breast milk and food during diarrhea1 episodes in children under two, according to the child's weaning status.

  Results: 95% of mothers reported continued breast-feeding during diarrhea, up from 63% at the baseline. 88% of mothers who breast-feed said they give more than or same as usual during diarrhea.

* 60% of mothers with children under two know when and where to refer a child no longer responding to ORT.

  Results: 58% said they would seek treatment for prolonged diarrhea; 48% cited specific signs of dehydration, and 60% said they would seek treatment when the child becomes weak.

Strengths: A strong education campaign was initiated at the start of the project, and a very high level of awareness about prevention and treatment has been reached among mothers. According to the KPC survey, the prevalence of diarrhea in the last two weeks went from 54% in January 1994 to 36 % in June 1996. Poor hygiene was cited as a cause of diarrhea by only 23 % of mothers in 1994, and by 65 % in 1996. Knowledge of importance of hand washing increased greatly. Use of enemas made of hot pepper or leaves for the treatment of diarrhea dropped from 63 % to 7 % , and antidiarrheal use from 16% to 5%. In 1994, 19% of women cited "the wind" as a cause of diarrhea as compared to 2% in 1996. There was a sizeable increase in the number of women who begin immediate breast-feeding, gave colostrum instead of expressing and discarding it, and in the number of women who exclusively breast-feed till 4-6 months.

Emphasis was placed on ORS demonstration, especially during follow up at the household level. Interviews with health center staff confirmed that mothers bringing children with diarrhea to the health center from project villages were almost uniformly knowledgeable about ORS preparation. Another strength was that when ORS packets were to be sold in accordance with the Bamako Initiative, the project strategy changed to focus on promotion of home-available fluids such as guava leaf tea, because the new cost of ORS was perceived as an obstacle to its use. During the final survey women reported knowledge and use of such home treatments.

Weaknesses: In this second phase of the project, although field personnel engaged in education about the importance of potable water, the project was not able to follow through with matching

support for well-digging activities. This created a degree of frustration, as did recommendations to use soap for hand washing which often is financially impossible.

Another weakness is the fact that although education on ORS began early on in the project, ORS packets were not always available at the village level. Government health centers, which are not easily accessible to many of the villages, would often run out, and ORS packets were only distributed by neighborhood counselors when the health centers could provide them. ORS packet sales points were finally established in the villages in early 1995; however, sales are very weak compared to the level of previous free distribution.

A perceived negative effect of the emphasis on home rehydration is that mothers reportedly continue giving ORS or ORT rather than seeking treatment at health centers even when they are referred.

Positive or Negative Side Effects: It was felt by the health promoters that the emphasis on hand-washing to prevent diarrhea resulted in greater overall cleanliness and fewer cases of skin diseases.

IMMUNIZATION:

Inputs/Activities: Throughout Phase I and the first year of Phase II of the GCSP, the project used health education to promote the use of the provincial health department's immunization services. The strategy was then expanded to include provision of logistical support to the Ministry of Health. Africare provided funds on a quarterly basis ($50/month/health center) for gas and some motorcycle repairs for the monthly immunization sessions by five health center outreach teams, and fuel for vaccine refrigerators in the health centers.

Nine project health promoters, 275 neighborhood counselors and 23 village health agents received training in information-education-communication (IEC) on vaccine-preventable diseases, correct dosages and schedules. The health promoters and NCS assisted the health center outreach teams by mobilizing the communities for vaccination sessions, and by following up on defaulters (in a non-systematic fashion). The health promoters and NCS also did 118 education sessions on immunization against the 7 vaccine-preventable diseases (yellow fever is included in Burkina Faso's EPI) reaching almost 6,000 people in the project villages. Immunization messages also were communicated during sessions on prenatal care and diarrhea control.

Outcomes: Objectives for the immunization status of children under 12 months are:

* 85% have received DPTl
  Results: 79% received DPT 1
* 75% have received the measles vaccine
  Results: 57% received measles vaccine
* 75 % have received Polio3.
  Results: Not in final survey report

The vaccination objectives for women of reproductive age (WRA) are:

* 80% of WRA who have delivered in the last 12 months have received at least two doses of TT during their pregnancy;

  Results: 71% of women had received at least two doses of TT

* 80% of mothers know that a child should be fully vaccinated before the age of one, and that 5 contacts are necessary.

  Results: This specific question was not included on the final KPC survey. 42% of mothers knew the correct age for measles immunization, up from 11% in January 1994.

The efforts in this area have not resulted in a major increase in immunization coverage. Neither the coverage nor the dropout rate improved significantly. The final KPC results show a 4% increase in access. Measles coverage increased by 5 % from 52% to 57 % ; the DPT dropout rate, previously at 35 % , improved slightly to 28%. Knowledge improved more than coverage: the percentage of mothers who know that their child should be vaccinated for measles at the age of 9 months increased from 11% in January 1994 to 42% in June 1996. The percentage of women who knew that tetanus toxoid protects both the mother and infant increased from 44% to 79% in 1996.

Strengths: Monthly scheduled vaccination sessions and awareness building was started at the village level which increased demand for vaccination and helped make services more accessible. Given that the national EPI coverage rate has dropped to about 35 %, even maintaining their coverage rate is an accomplishment.

Weaknesses: The assistance given by the project to the health centers for fuel to run the vaccine refrigerators and health center motorcycles, and for motorcycle repair clearly is not sustainable. Prior to the arrival of the project, the Provincial Health Department and the health centers experienced problems obtaining funds which were supposed to come from the MOH for these activities. Now that the Bamako Initiative has been established, the health centers will probably continue to experience these problems unless the health center management committees choose to prioritize immunization and support these expenses.

Another weakness with this intervention is that community level health workers were underutilized in vaccination activities. They assisted the health center by announcing planned visits to each village, but follow-up of absentees was only done on the actual day of a session. There was little follow-up of absentees or dropouts undertaken on a regular basis. The health centers do not have a well-developed system for drop-out follow-up, and this could have been promoted by the project and done more effectively using the NCS. In discussions with the Provincial Health Director, he stated his opinion that the drop-out rate was largely due to the long distances people must travel to health centers or immunization outreach activities, and to displeasure with side effects. He acknowledged that the dropout follow up system was not working, and needed to be changed.

Side Effects: Positive collateral aspects of support for immunization activities included the mobilization of mothers and children for growth monitoring and IEC activities, and the strengthening of health center contact with outlying communities. The outreach also demonstrated to health center staff the value of the NCS, which increases the likelihood of continued collaboration after Africare support ends.

It was stated by health center and Africare staff that this collaboration increased follow up of defaulters, but the results of the KPC study do not confii this. A negative aspect of this intervention may be that the five health centers' budgets have been supplemented for 2 years now by Africare for immunization outreach activities, and it is not clear that they have been adjusted back up by the MOH to include sufficient funds for continuation of activities after Africare leaves.

GROWTH MONITORING AND NUTRITION:

Inputs/Activities:

TRAINING AND STUDIES: The health promoters were trained and participated in refresher courses in growth promotion, exclusive breast-feeding, infant/mother nutrition, and in IEC, including counseling. The health center nurses, health auxiliaries and the lay midwives who work in the health centers were also trained in these subjects. Together with the village volunteers they identified growth monitoring training needs, and trained 275 Neighborhood counselors and 23 Village Health Agents in exclusive breast-feeding, growth monitoring and promotion, food groups and enriched porridge demonstrations, and communication techniques.

An exchange visit was organized with the Save the Children/USA's Child Survival Project at Saponé, to increase knowledge of nutrition interventions in the two project areas. An additional training of health promoters in Primary Health Care reinforced their knowledge of nutrition.

Africare carried out a study with technical assistance from APAIB/WINS which increased Africare health promoters' knowledge of research techniques and of nutritional beliefs and practices relating to women and children. Qualitative and quantitative research was carried out on factors influencing malnutrition including food availability, dietary taboos for children, pregnant and lactating women, and breast-feeding and weaning practices.

NUTRITION DEMONSTRATIONS: Both health promoters and counselors carried out nutrition education sessions including demonstrations of enriched porridge using ingredients provided by the mothers themselves, in some cases supplemented by cornmeal, milk powder and oil provided as a test project with one health center by Cathwell/CRS. The demonstrations were carried out either by nurses in the health center, or by health promoters, counselors and TBAs in the villages, either in groups or during home visits. Visual aids included the counselor's manual, with illustrations, and cooking equipment, either the demonstration equipment at the health centers, or mothers' own utensils.

About 300 nutrition demonstrations were done at the community level. Household demonstrations by the health promoters began at the beginning of the Project for 6 villages, and in the remaining villages began in January 1995. The promoters each carried out about 10 household nutrition demonstrations a month, until they stopped doing these demonstrations in January 1996, as they phased responsibility over to the NCS.

The majority of the NCS began their demonstrations in January 1995, with some beginning a few months later. They did a total of about 140 household nutrition demonstrations a month, and they continue to carry out this activity.

GROWTH MONITORING: The health promoters held weighing sessions in the villages, assisted by the counselors, during which they explained the benefits of regular baby weighing and other project interventions. The health promoters interpreted the weights, giving appropriate nutritional advice to the mothers. An illustrated manual was developed for neighborhood counselors' use in village level education. At least 202 education sessions were held in 23 villages for a total of 6,259 participants. 73 % of children under 2 in project villages were weighed at least three times during 1995.

The MOH growth charts were no longer available after early 1995. Health center staff and health promoters cut regular notebooks in half horizontally to provide inexpensive health records. The five health centers and the health promoters kept registers of children weighed, and copied weights onto growth charts for those children who had them.

Home visits for follow-up were made to C 1 year old and malnourished children in years 1 and 2 of GCSP II. Home visits were focused on malnourished children in year 3. The Project had planned to obtain Salter scales from UNICEF or the MOH for the NCS to use for growth monitoring in the villages. However, at the beginning of the evaluation, it was felt that the growth monitoring activities were not sustainable, since the health promoters thought that most of the counselors would not be capable of reading the scales, and that almost none would be able to interpret the growth chart or weight tables. It was, however, thought that many mothers understood the basic road to health concept.

Outcomes:

The objectives of the project's nutrition intervention are:

* 15 % of mothers of children under four months report that the child breast-feeds exclusively
  Results: 22% of mothers of children under 4 months report exclusive breast-feeding, up from 7% at baseline.
* 50% of mothers with children 4-6 months report giving their child supplementary feedings;
  Results: 87% of children began receiving supplementary feedings, up from 55%.
* 75 % of mothers report that they increase the quantity of food they consume during pregnancy and lactation
  Results: The Africare/APAIB/WINS study in June 1995 showed 47% of mothers reporting increased quantity of food during pregnancy, and 82% reporting increasing quantity of food during lactation.
* 80% of the mothers report improved nutritional quality of their diets when pregnant and lactating.
  Results: The Africare/APAIB/WINS focus groups showed general agreement that women should eat "good", varied foods, but also mentioned millet beer as a blood fortifier.

The project has seen a marked degree of improvement in nutrition practices. Introduction of breast milk to the newborn within 8 hours of birth was reported by 25% of mothers in January 1994, and by 69% in June 1996. The percentage of mothers giving colostrum to the newborn infant also increased dramatically from 14% to 82%. Exclusive breast-feeding also increased from 7% to 22% of mothers with infants **<4** months of age. Consumption of eggs, mangos/papayas, foods rich in protein and rich in calories went from negligible to **50%**, 25 to 75 % , 49 to **84%**, and 40 to 78 % respectively.

The objective of consumption of increased quantity of food by 75% of lactating women was met, but pregnant women did not report this level of increased consumption. The focus groups during the qualitative Africare/APAIB/WINS study in June 1995 showed that women did not increase food intake during pregnancy for fear of a big baby and attendant difficulties in delivery.

The evaluation team set out to assess whether or not the counselors were in fact able to carry out growth promotion activities effectively. It was believed that at least one counselor in each village would be able to write the date, name and weight of each child, and a few of these would be able to correctly place the weight on the road to health chart. However, since these charts are no longer available, emphasis was placed on whether the counselors could accurately identify and counsel malnourished children.

A simplified weight sheet written in local language and number format was developed by the evaluation team. The sheet gave a danger threshold (70% or less of the standard) for weight at each month up to 30 months.

In each of the 8 villages visited during the evaluation, there were at least two or three counselors who were able to read the scale accurately, interpret the weight according to the sheet, and give the mothers appropriate nutritional advice. The figures collected for the non-representative sample of approximately 140 children weighed during the evaluation showed that approximately 10% of the children weighed were severely malnourished (c 70%).

It was suggested during a consultation with a nutritionist that the danger threshold should be raised to 80 % , which will pick up more cases of malnutrition which need to be followed by the counselors before they get to the severe stage. However, the field staff felt that they should stick with the MOH use of 70% as the threshold of malnutrition.

A review of project growth monitoring figures in 13 villages for which data was available for December 1994 and 1995 shows the following results:

Time Period	Number children 0-11 months	Percent weighed	Total Below 80%	Between 70-80%	Below 70%:
December 1994	545	68%	26.8%	15.3%	11.5%
December 1995	572	5 1 %	18.5%.	12%	6.5%

This table shows that the rate of malnutrition among children weighed in these villages has dropped, but it is difficult to draw conclusions about changing nutritional status from these figures. The lower percentage of children weighed in 1995 makes comparison difficult, and the lower percentage of severe malnutrition could be because those children who were weighed previously and found severely malnourished were not brought back by their mothers. For the 23 project villages, 73% percent of children under two were weighed at least three times in 1995.

Negotiations have begun with UNICEF to provide Salter scales in all 23 villages for growth monitoring by neighborhood counselors.

Strengths: Follow-up of malnourished children was considered a part of the growth promotion activities right from the beginning. Nutrition demonstrations with locally available foods were done at the time of home visits, as well as larger demonstrations with community groups or at the health center. Locally available and culturally acceptable foods such as shea butter, soumbala (fermented beans), peanut butter/sauce, fish, or greens were promoted as additions to the millet-based cereal.

Weaknesses: The design of this intervention was initially very labor-intensive. For several years project health promoters were expected to weigh all children < 5 years old. They were also expected to follow-up all c 1 year old as well as malnourished children. This was very difficult for the health promoters to achieve, and was not necessarily the best use of their time. It was only in June of 1995 that growth monitoring prioritized < 2 year old and the follow-up of malnourished cases only.

Another weakness was that the system for referral of malnutrition cases was not very effective. Malnourished children, when identified, were supposed to be referred to the health center, which had limited ability to deal with them. The health center would refer cases to the CREN (Centre de Recuperation Nutritionnel) in Zorgho. The CREN did not seem appropriate to these needs, as the CREN was designed to deal with children and their mothers on an inpatient basis, as opposed to working with the family at the community level. It was found almost impossible for mothers to leave their homes for a period of time as long as three months.

Positive and Negative Side Effects: Growth promotion was a draw for mothers to health education activities. It also provided a side benefit which was held in great esteem by the mothers- the health promoters helped mothers establish fairly accurately the age of their children.

Another side effect was an increased interest in carrying out kitchen gardening activities. This had been foreseen under the first phase of the GCSP, when match funds were used to drill several borehole wells in project villages. However, not every village has a borehole, and the water from these boreholes can not fill the needs for drinking and household water as well as for gardening. The population is now interested in more wells and dams to provide water for additional gardening activities.

An unexpected benefit of growth promotion was that it sparked additional interest in literacy and numeracy training. Numerous counselors stated during growth promotion activities that they wished they had paid more attention during the literacy training, vowing to catch up with the others who had mastered reading and writing.

MALARIA CONTROL:

Inputs/Activities: Training was provided to nine project health promoters in July 1994. The health promoters trained the 275 counselors, 23 AVS and 24 TBAs in prevention (including prophylaxis for pregnant women) and treatment. The AVS has already been trained in treatment, and are supposed to be supplied in chloroquine by the health centers.

108 Education sessions on prevention and treatment of malaria, especially early treatment and ways to reduce fever, were carried out by the health promoters, using an MOH flip chart. 24 traditional birth attendants were provided with supplies of chloroquine and iron to be given to pregnant mothers on a weekly basis.

Outcomes: The objectives for this intervention are:

* 50% of WRA know at least two measures that can be taken to prevent malaria
  Results: Fifty-one percent of mothers in 1996 knew that eliminating stagnant water would help prevent malaria compared to 3% in 1994, and 30% cited mosquito nets.

* 65 % of mothers report taking their children to health professionals at the onset of a malaria episode
  Results: Seventy-six percent of women state that they should take a febrile child to the health center, as opposed to 42% in 1994. In 1996, 49% said to give Nivaquine, as opposed to 22% in 1994.

This intervention was successful in increasing knowledge, as seen above. Only 5% of mothers in January 1994 knew that mosquitos carry malaria, and in 1996 57% did.

Strengths: Education on malaria prevention targeting pregnant women and children was supported by the provision of prophylaxis for pregnant women at the village level. Several approaches to prevention were taught, including environmental ones that women could do at no financial cost.

Weaknesses: The TBAs were provided with chloroquine for routine prophylaxis in pregnant women, but during the evaluation it was observed that almost none were prescribing the chloroquine correctly. AVS were supposed to have supplies of chloroquine, but they were frequently out of stock. Although bed nets were recommended preventive devices, the social marketing of these items had not yet been expanded to the project area.

Positive and Negative Side Effects: A side benefit of malaria prevention activities was improved environmental hygiene, which contributed to diarrhea prevention. The women decreased the number of mosquito breeding sites through filling ditches and cutting vegetation around the compounds. An obstacle to clearing vegetation is that the women need to raise corn right around the compounds, where the soil is richer due to disposal of refuse near the houses.

MATERNAL CARE/FAMILY PLANNING:

Inputs/Activities: Nine project health promoters, 275 neighborhood counselors, 23 village health agents (AVS) and 23 TBAs were trained in the importance of prenatal care, tetanus toxoid and

nutrition for pregnant and lactating mothers as well as in the advantages of family planning and contraceptive methods. The health promoters, counselors, health center personnel, AVS, and CJAS members were trained in family planning IEC and safe motherhood techniques. The agents received samples of the different methods available in the health center (pills, spermicides, condoms) to use during IEC sessions, and a wooden penis for condom demonstrations.

The TBAs were specially trained in prenatal care and safer delivery practices, and received a substantial TBA kit including aprons, razor blades, alcohol, compresses, gloves, etc. In addition, samples of condoms were included, for discussions of family planning during prenatal or postpartum visits. The health promoters, counselors and TBAs were trained to refer women to health center for clinical methods.

138 maternal care and family planning education sessions at the village level were carried out for a total of 3,128 participants. The education sessions for the two subjects are conducted separately, but there is some overlap of the themes. Promoters discuss the advantages of prenatal consultations, the schedule of visits, and other things mothers can do to promote a healthy pregnancy and safe delivery. The villagers are extremely interested in family planning and often specifically ask promoters to discuss it with them. The promoters talk about the advantages of family planning, explain and demonstrate various methods. They also provide information on the price of the contraceptives and where they can be bought.

The planned qualitative research protocol on constraints to use of contraceptives was not done, due to the unavailability of planned technical assistance from Population Council. Instead, informal discussions with mothers were conducted at the village level to better understand constraints to family planning use.

The planned establishment of mechanisms for obstetric emergency evacuations was not achieved, in part due to lack of referral infrastructure.

Outcomes: Maternal care/family planning objectives are:

- 65% of women have attended prenatal consultation at least once during the first 6 months of her pregnancy

  Results: **Women who had prenatal consultations marked on health cards increased by 9% from 41 to 50%.**

- 80% of women of reproductive age (WRA) are able to cite at least one modem method of contraception and know where to obtain it

  Results: **Knowledge of modern contraceptives went from 49 to 94% of mothers according to the final survey. During focus group discussions, women indicated good knowledge of where to obtain methods, both from village condom sellers and health center staff.**

- 75% of WRA know where to seek assistance for prenatal complications

  Results: **During focus group discussions, women indicated good knowledge of where to obtain prenatal care.**

- 10% of women in the project area will report using modem contraceptives

  Results: **Reported use of modern contraceptives increased from 7% to 18%.**

Maternal care/family planning results were relatively positive. The rate of women receiving at least one prenatal visit at a health center increased somewhat according to the final survey, but remains low due partially to the long distances women must travel in order to reach the health center. In one health center, it was found that prenatal care is not available every day, thus women are required to make several trips within the same week if they wish to obtain prenatal, immunization and curative care. This is being addressed by the DPS. The number of women who received basic prenatal care and delivery assistance from trained TBAs increased greatly, and the health center personnel all mentioned numerous cases where the trained TBA or counselor accompanied women to the health center for their first prenatal visit or for referral of pregnancy-related problems.

Strengths: The education strategies used in the project appear to have been appropriate and effective, raising women's knowledge and interest in maternal care and family planning. Attempts were made to educate men and older women, whose influence on reproductive behavior is extremely powerful. The project also increased availability of family planning methods through village condom sellers. The project has been working to obtain DPS consent for TBAs to distribute pills in the villages, reporting to the health center nurses.

Weaknesses: Because much of the training in family planning occurred late in the project, little family planning activity and supervision took place. During a training in March 1996, TBAs received initial training in community-based distribution of pills, but this does not seem to have been followed up.

Family planning services at the health centers require spousal consent. This poses a problem because husbands are not often available in the daytime to go to the health center with their wives, nor, officially, can a woman seek family planning independently if she should feel the need to do so.

It was difficult to assess the validity of the reported figure of 11% of the women surveyed who reported pill use. Special emphasis was placed during the survey to ensure that women really understood the question, and responded with their actual practice, not their intention, but it was somewhat difficult to ascertain where the women would be getting the pills. The five health centers only had about lo-15 registered pill users at the time of the evaluation, which would represent about 1% of all WRA. Some pharmacies in the larger towns carry pills, but they are very expensive. However, pills are reportedly readily available in the markets, although their quality is questionable.

The project was not able to achieve its objective to set up an obstetric emergency evacuation plan. This objective was perhaps overly ambitious as the Province of Ganzourgou does not have a referral system in place, nor are the health centers or the provincial hospital in Zorgho equipped to handle many obstetric emergencies.

Another weakness raised is the fact that prenatal care is not easily accessible to all women as some villages are far from any of the five health centers in the intervention areas. TBAs were trained in the basics of prenatal consultations but are not actually carrying them out as expected.

Positive and Negative Side Effects: The traditional birth attendants reported receiving higher fees for their services, and more recognition in their communities. The workloads of pregnant women reportedly are being lightened by a newly aware community.

AIDS:

Actual Inputs/Activities: **Nine** health promoters, 275 neighborhood counselors and 23 village health agents (ASV) were trained in **HIV/STD** modes of transmission and prevention. The health promoters, trained in July 1995 by SOS SIDA in AIDS IEC, trained the counselors and the **TBAs** and **ASVs**. Members of the CJAS were trained in AIDS IEC by the health promoters, and in forum theater about AIDS by the Burkina Theater Workshop (ATB). The CJAS developed several interactive theater presentations about AIDS and family planning, which they presented **at least** 8 times to large audiences. They also carried out several film/discussion sessions with groups of youth.

Activities by the health promoters and counselors included health education talks, stories and a few "health markets", during which the team went to a market day and carried out mass education. Teaching aids included videos, wooden penis for condom demonstration, and the counselors' handbook with pictures. Condom stocks were made available in the villages by 99 condom sellers (100 planned), who were chosen by the villages with project assistance.

85 Education sessions were carried out by health promoters and counselors, with 2,636 participants. AIDS is a popular subject among the villagers, and is often suggested for health education sessions. The promoters and counselors do condom demonstrations during the sessions, using a wooden penis.

Outcomes: The objectives for this intervention are:

- 85% of the project's neighborhood counselors will be able to inform and refer families with respect to AIDS

  Results: **This was not assessed quantitatively. NCS and CJAS do group sessions under supervision of health promoters as well as independently, and those sessions that the evaluation team observed were quite good.**

- 75 % of the population will have participated in an AIDS education session by the end of the project

  Results: **Only 2,636 people were documented to have attended education sessions, but the AIDS knowledge objective has been effectively attained for women. In 1996, 98% of women had heard of AIDS, and 82% cited the health promoters and counselors as their source of information. The knowledge levels for men seems high, based on the focus group discussions held.** The numbers recorded for education sessions do not include the people who attended CJAS theater-forum sessions on HIV/AIDS. The evaluation team counted about 400 people at one theater presentation alone.

- 60% of the population will be able to cite two modes of transmission.

  Results: **In 1996, 94% cited sex, and 47% cited contaminated objects as compared to 1994, when 70% and 10% cited these modes. Knowledge of fidelity and condom use as means of prevention went from 44% to 76% and 11% to 49% respectively.**

Strengths: Knowledge of AIDS is fairly high in the area, both through the project's and other groups' health education activities and through the presence of many seropositive and AIDS cases in the villages, often returnees from **Côte d'Ivoire**.

Condom demonstration materials such as wooden penises and condoms were used by the project health promoters and village vendors for education sessions. The promoters and counselors seemed to be fairly comfortable discussing STDs/AIDS and demonstrating condoms, which led to open discussions and active participation.

Weaknesses: Education messages were not targeted to men until the final year of the project. In addition, although education activities aimed at women had started in Phase I of the project, condoms were not easily accessible to the population, The health centers do not seem to have a regular supply, although some of the commumty pharmacies do. In October of 1994, the project was finally able to set up condom vendors at the community level using the new PSI local distributor. However, the choice of condom seller was not always well-adapted to certain target populations. Certain of the condom sellers selected were older men, which is appropriate for some users, but which was recognized by the older men themselves as an obstacle to youths' purchase of condoms. Sales by village condom vendors are weak, and the vendors are demotivated. The population seems to prefer obtaining condoms from people they do not know.

Positive and Negative Side Effects: The education sessions on AIDS and family planning caused men and women to talk about issues relating to reproductive health, often for the first time.

The importance of AIDS, and the strong interest in it, led village elders to listen and give credence to women and young people, who brought this information.

HEALTH INF'ORMATION SYSTEM:

The GCSP health information system (HIS) instruments included:

1. registers for children
2. registers for women
3. *sheet for declaration of death
4. *sheet for declaration of birth
5. *monthly activity calendar for health promoters
6. individual growth monitoring forms
7. vaccination cards for women and children
8. *forms for recording growth promotion sessions
9. *educational sessions forms
10. *forms for number of home visits to children
11. *forms for number of prenatal consultations
12. *sheets for children's vaccination sessions
13. *sheets for women's vaccination sessions
14. *sheet for water point monitoring
15. *sheet for synthesis of educational sessions

N.B. The growth monitoring forms and the vaccination cards are kept by the women in the villages.

The forms filled out monthly by the health promoters (marked with an *) constitute (with a narrative section added after midterm recommendations) the health promoters' monthly reports. This was submitted to the field supervisor, the Assistant Coordinator. He synthesized the figures in these

reports, and the Program Assistant was in charge of synthesizing the narrative part of the monthly report.

Strengths: The system allowed measurement of activities carried out in each project component, and of project process indicators such as number of active NCS (although the definition and periodicity of this datum was less than ideal), number of home visits by NCS and health promoters. Certain infrastructures necessary for child survival activities were followed, e.g. the functioning of drilled and dug wells. The HIS also allowed quantitative feedback to health promoters about their work, and collected information which could be useful for the Provincial Health Department (e.g. number of children/women vaccinated/weighed in the 23 project villages).

Weaknesses: The HIS seemed to be the most poorly performing aspect of the project and was acknowledged as weak by project staff. The HIS was very elaborate, yet it was not designed to collect much of the information needed to measure progress towards objectives. The numerous forms, which were not the standard DPS forms, required great quantities of time to fill out, and the information collected was often neither complete nor reliable. In addition, the information was not regularly communicated to either the DPS or to the project staff and impact areas. In addition, the health promoters' monthly activity calendar seems to have been under exploited for planning, management and supervision purposes, as were the data collected on other activities. The lack of qualitative information hindered evaluation of the usefulness of some activities; for example it is known how many home visits were made, but it is not known what effect these home visits had.

The project objectives were changed several times, but the indicators were not changed and neither did, necessarily, the data that was collected. The final KPC survey did not collect all the information necessary for measuring progress towards those project indicators which had remained stable since the baseline.

The HIS seems to have been the neglected aspect of the project, which may not have greatly affected project impact (except perhaps in vaccine dropout rate) but certainly makes it difficult to measure effectiveness.

DIP reviewers had suggested that a reliable and objective means of measuring mother's knowledge be used by the project to monitor progress. Bi-annual assessments in the form of mini-surveys were to be conducted for this purpose, and to measure neighborhood counselor knowledge and the level of the community's support of and participation in project activities. These were not done.

The final KPC survey shows the remarkable increase in mothers' knowledge, which was generally known about by project staff. However, the monitoring of counselors' skills and community support and especially of linkages for sustainability were not done and the lack of effort in this area is seen in the somewhat tardy attempts to make sure the counselors are solidly competent, well-integrated into existing structures, and equipped to continue their work. The project must now decide how it will leave data collection at the village **and** health center levels.

TRAINING AND SUPERVISION:

Strengths: Numerous trainings were held during Phase II of the GCSP, for an almost entirely new set of health promoters, for health center personnel, for TBAs and AVS, and for counselors. (A complete list of project training activities is found in Appendix F).

The initial emphasis was on creating a cadre of health promoters with good communication, technical and training skills, and strengthening health center staff capacities. This seems to have been done fairly successfully. The project let the counselors self-select by their willingness to participate in activities and come for trainings. It was found that in some villages, 95% of the counselors participated, and in others, 50%. Some villages were harder hit by the epidemic than others, but some villages also showed greater levels of dynamism and motivation in general than others.

Particularly after the Mid-Term Evaluation, the training methods used by the health promoters to train the counselors were very participatory. The participants were divided into work groups, presented in plenary, and then reviewed and received feedback on their presentations. They also used role plays, (home visits, education sessions) demonstrations (enriched porridge, condom use, etc.) and songs. The training was held several times for clusters of counselors from several villages grouped together, which was an efficient use of trainer time but also provided a good exchange of ideas and fostered an esprit de corps among the counselors.

The feedback from project personnel was entirely positive. All the staff felt that they had learned an enormous amount of information on health, i.e nutrition, exclusive breast-feeding, control of diarrhea1 diseases, malaria, maternal care/family planning and AIDS. Five of the 9 personnel interviewed had a background in health but all felt that their knowledge and skills were greatly reinforced by the Africare trainings. Most of the staff did not have a great deal of experience with community mobilization and health education through the use of alternative strategies such as story-telling and songs, which were mentioned by all as new and useful skills. Also mentioned was the fact that participating in qualitative and quantitative research during the project was an interesting and useful experience.

Weaknesses: The promoters were often tied up for long periods while being trained, and then carrying out trainings. The importance of creating a cadre of permanent community members with knowledge and skills to carry out health education and promotion was a later emphasis, and was done somewhat too late in the project cycle for optimum impact.

Some of the reasons for this included the longer than expected time to carry out the training of the health promoters, and the difficulties coordinating schedules with the groups contracted to carry out training in literacy and primary health care (PHC). Training had to be scheduled when the community volunteers were available **to** take time away from cultivation and devote time to training activities.

For example, the neighborhood counselor Primary Health Care training in April 1996 was complicated by the epidemic of meningitis which hit some of the project villages. The desire to avoid grouping people together during this time was counterbalanced by the imminent rainy season which would prevent training for the next 4-5 months.

Supervision of the promoters in Zorgho and the field was frequent, but the promoters spent less time supervising neighborhood counselors than carrying out activities with them. There was a certain reluctance to hand over responsibility, skills and ownership from the project promoters to the village counselors and the community leaders. Village health agents were not always integrated into the supervision of neighborhood counselors, nor were health center staff. Supervision remained fairly administrative rather than performance-based until a checklist was developed late in the project.

C. UNEXPECTED POSITIVE AND NEGATIVE OUTCOMES OF THE PROJECT

These are discussed for each intervention; overall ones are discussed here.

Positive: An added activity which was not included in the child survival objectives was prevention of Guinea worm. The health promoters and the counselors carried out health education in collaboration with the health center staff. Several thousand filters were sold or distributed in the affected zones, achieving fairly high coverage and use rates. The population was very motivated to use these filters, and was extremely impressed with the subsequent reduction in cases, often quite marked between project villages and non-project villages.

Staff from the health centers, provincial health offices and ministries were very impressed by the capacities of the population to learn, and carry out health promotion activities. The changes in knowledge and behaviors made Ministry staff more motivated to work in a mutually respectful way with villagers.

Women's roles were validated as public education sessions explained the importance of mothers' actions in promoting health. In addition, women NCS became seen as having "expertise," especially those who had learned to read. Men reported helping their wives more with child-rearing tasks.

The literacy training, besides creating a great sense of general empowerment for men and especially women, also allowed villagers to access information in local language newspapers published by agricultural extension and other development agencies. One person who received literacy training was subsequently hired by the literacy ministry as a local literacy trainer. Others were better able to obtain and keep track of small loans for income generating activities.

During the neighborhood counselor literacy training program, some people who were too busy to participate replaced themselves with other members of their families or neighbors, many of whom were younger, and could learn rapidly and teach the NC. In addition to increasing the number of people reached by literacy training, this also means that these younger people have been introduced to the importance of health issues.

Negative: The project was handicapped by several changes in personnel during the first phase of the project, which had created a somewhat turbulent playing field for the second phase. Changes in Washington and Ouagadougou back stoppers also caused delays, although this seems to have worked out well in the end.

The emphasis on creating competent health promoters may have overemphasized their role as service providers, and may have somewhat disempowered the NCS. Health promoters tended to underestimate the NCS' capacities.

The precedent of sponsoring feasts, and the distribution of the Cathwell supplies at one health center, created an expectation by chiefs, especially, of receiving some reward for their participation in community events.

D. Final Survey Results and Project Expenditures

The Final Evaluation Survey results and a pipeline analysis are attached in Appendices J and K.

III. Project Sustainability

A. Community Participation

The project started out aiming for community use of and participation in services provided through Africare health promoters and health center staff outreach activities. After the mid-term evaluation, emphasis was placed on increasing community participation and community ability to continue health activities after project end by creating a sufficient number of trained volunteers in each village. In addition to the technical training, the literacy training helps counselors carry out various tasks, and facilitates renewal and reinforcement of health knowledge.

The community contributed in many ways to the implementation of project activities. They selected the counselors and TBAs to be trained and contributed to the construction of the houses for the health promoters. During training of counselors and ASVs, community contributions were made of refreshments and lodging for trainers and counselors as well as locales for the training. The community participated in mobilization, and provided locales and seats, tables, etc. for meetings, health education talks, weighing and immunization sessions. Villagers contributed to providing material motivation through small in-kind or cash payments for services by TBAs, and in a few cases by helping to cultivate the NCS' fields.

The community contributed food for many gatherings and trainings that occurred in the village; the women brought food, (e.g. millet, soumbala, shea butter, leaves) utensils, and fuel for the cooking demonstrations, and helped cook and taste the different porridges. The women and sometimes men were active in choosing topics for health education talks. The community selected individuals to sell condoms in the villages.

Village Chiefs became more involved in project activities during Phase II of the child survival activities. Feedback from the mid-term evaluation encouraged Chiefs to pay more attention to project objectives and keep informed about activities. Some chiefs called meetings to follow up on issues and for decision-making. The chiefs often made visits of encouragement for training or health education activities. Occasionally a Chief has demonstrated personal support such as purchasing gloves for a TBA.

B. Ability of NGOs to Sustain Activities

There are almost no local or international NGOs active currently in the area who could continue support to Africare-initiated activities. Save the Children/USA and Plan International have closed down their operations in the area for lack of funding. Africare obtained Catholic Relief Services (Cathwell) supplies for the health center of Koulweogo, which then provided foodstuffs to health

promoters for demonstrations in the villages. If the Cathwell supplies continue, they may be used by the health center or counselors for demonstrations or for nutritional recuperation, although it is believed that these supplies can be more contentious than useful.

Promaco contributed the first stock of condoms free of charge to the village-level sellers. They will continue to oversee condom sales in the villages, or at least ensure a good supply to neighboring markets.

Sahel Action had been contacted by Africare about collaboration. Sahel Action's main emphasis is on credit, so initially their activities were not a complementary as they may be now in the future plans of the villages. Mothers' knowledge of and demand for modem health care has been greatly increased, and now income-generating activities may be a next step to increase women's access to health care and improved nutrition.

Another NGO associated with Canadian development assistance, *la Caisse Populaire* of Burkina which focuses on small credit, has just opened an office in Zorgho, and may be a resource for groups of counselors or villagers who seek small loans for income-generating activities linked to health, or serving as motivation for the counselors.

The US Peace Corps office has just received 30 new health education volunteers. At least one Volunteer who has been doing health education in the Central African Republic will be assigned to Ganzourgou Province, and initial discussions with the Provincial Health Department (DPS) indicate interest in using the volunteer to help follow up on continuing community health activities initiated under the CSP. This would provide some technical assistance and facilitate creation or strengthening of linkages between the counselors and other resource people.

APAIB/WINS worked with Africare on the qualitative and quantitative nutrition survey, but does not have ongoing funding to continue working with the DPS. SOS/SIDA carried out the training of health promoters in AIDS, and plan to remain in contact with the CJAS, but do not have funds to support CJAS' work, nor to include them in training activities for which *SOS/SIDA may have* funding.

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

MINISTRY OF HEALTH

Provincial Health Department (DPS): There was a good history of collaboration between the DPS and the GCSP project. ORS was supplied initially free to the project promoters and counselors by the provincial health director, who also contributed their technicians to training in CDD. The provincial health offices ensured an initial training in growth promotion, and provided growth charts until these were out of stock. The DPS will continue to provide vaccines and vaccination services, but they do not have the budget to continue the outreach activities as they were financed with Africare support. It is hoped that the Management Committees will make available sufficient funds to ensure supply of fuel for the vaccine refrigerators, which had previously received support from Africare. Another alternative suggested was cost-recovery for vaccinations either at the health center or during outreach vaccination activities.

Overview of Health Center Services: The evaluation team visited the five project area health centers to hear their assessment of the project's activities at their level, and in the communities, and the potential for continuation of these activities. These visits also served as a basis for understanding the existing health structure in the area, which was and will be the source of health care and supervision to those villages which have been involved in project health activities. (A case by case description is found in Appendix E.)

The health centers usually have three staff members, who provide curative and preventive MCH/family planning care. They all carry out EPI activities, both fixed and outreach. Some health education is done in the clinics, mostly on an ad-hoc basis with individual clients.

Only three of the five health centers had stocks of ORS packets. All five had ORS demonstration materials, although all but one center's materials were dirty, as were the cooking demonstration materials which were available in three health centers. Review of registers for diarrhea cases seen in the months of May and June of 1995, as compared to May and June of 1996 did not enable the team to draw conclusions in relation to increase or decrease in number of cases, treatment and/or care seeking, due to incomplete data.

All five of the health centers had between 10 to 12 family planning clients. This seems to indicate that many individuals come into the town of Zorgho for these services, if the KPC survey was an accurate reflection of contraceptive use. The pill was the only available contraceptive, except for one center which had injectables. All health centers had some cotton and gauze available but not much else.

Health Center Management Committees: With the establishment of the Bamako Initiative Pharmacies, assisted by Pharmacists without Borders, the recently established Health Center Management Committees are supposed to assure the provision of essential drugs at the health center level. These committees have been established in the province of Ganzourgou for several months and seems to be working fairly well. These Management Committees, however, do not seem to believe that they should go beyond pharmacy management to community health management and promotion, and that the health center/B1 should cover more than just the community immediately next to the health center.

The Management Committees have been approached by the project about their capacity to provide some support to the community-based health activities, e.g. restocking of TBA kits. They seem interested to various degrees, some seeming to fear encroachment on their funds.

MINISTRY OF SOCIAL ACTION (MSA)

The Ministry of Social Action (MSA), which used to be part of the MOH, might take over support of certain activities ensured previously by the Africare CS project, including supervision and refresher training of the counselors. MSA has also taken on oversight of some CJAS activities.

The MSA is developing a new cadre of health promoters who visit the villages to do health education talks, demonstrations and sale of non-prescribed products. The MSA health promoters will visit the villages each quarter, and have access to fuel and motorcycles. They plan education about nutrition in the high risk villages, which will be identified with the health centers. MSA also will conduct training about malaria in October 1996, in Meguet, in which they plan to include the local counselors trained by Africare .

The MSA health promoters have begun doing education in family planning and HIV/AIDS. They have also done education on immunization and small credit in four villages. They will also do training for their promoters this year on family planning and female genital mutilation.

The evaluation team, including the representatives of the MOH and the MSA, suggested that MSA's activities be increasingly coordinated with what the MOH and the counselors, TBAs, village health agents, and condom sellers are doing. Given the limited resources available for transport, this seems especially important to coordinate, e.g. bringing MOH outreach EPI workers along to deliver services during MSA's village visits for EPI IEC activities.

MSA is also responsible for management of the CRENS, and their collaboration in referral and recuperation of malnourished children should support the growth promotion efforts of the counselors. The Provincial Coordinator of MSA, Mr. Dabiré, said that the CREN in Zorgho, which is currently closed due to lack of staff, will be opening again soon with new staff. He had been unable to obtain figures from the DPS on average caseload. He stated that most of the children who do come to the CREN are orphans, and that there has not been a mother and child together there since November 1995, at least. There are no referrals from health centers other than of orphaned children, because mothers are unwilling or unable to come to Zorgho for the three months' standard stay. Beginning in October, the center will have a social worker and a nurse, as well as fuel and transport. He seemed interested in possibly training or using the counselors as community relays. They will do a feasibility study in Meguet before the establishment of a CREN, for which funding has been earmarked.

MINISTRY OF BASIC EDUCATION AND LITERACY (DPEBA)

The DPEBA carried out the Moore literacy and numeracy training for the health promoters and counselors, provided documentation, and assisted Africare to develop the counselors' manual in Moore. They may be able to provide some refresher training for NCS, and will continue to provide copies of the Moor&language newspaper that they produce, which has also been an outlet for articles about health written by counselors or the DPS.

D. Sustainability Plan, Objectives, Steps Taken, Outcomes

Many of the outcome objectives of the project are ones that relate to the continued ability of the health system and communities to offer health education and services at the village level. As described above, the project has strengthened government health services, worked to create a cadre of competent community volunteers, and has begun negotiations with several groups to provide for the continued implementation, supervision and training for village level activities initiated by the Project.

In addition to the many project activities aiming at reinforcing community capacities, the mid-term evaluation made numerous specific recommendations for sustainability. During the final evaluation, the team analyzed these recommendations to see which had been carried out, and worked to develop a list of activities necessary to their accomplishment. The project staff then set up their work plans for the rest of the project period in function of these objectives. These activities focused on reinforcing the capacities of the neighborhood counselors, and creating or solidifying linkages with local institutions who could take over or oversee ongoing activities. See Appendix G for this list, and Appendix H for the Mid-Term Evaluation recommendations and accomplishments to date.

All project staff interviewed felt that certain aspects of the project were sustainable and had left their mark. All felt that the knowledge acquired by mothers and neighborhood counselors was valuable and would be shared with other community members. (Fathers in focus group discussions brought up the fact that their wives often came home with information from educational talks that they shared with the family). Many staff members felt that education activities would probably continue to a certain degree.

About half of the staff were of the opinion that growth promotion activities would continue due to the fact that they are popular activities, and those who are able to carry out growth promotion would be able to help those who either cannot read the balance scales or write. The rest of the staff felt that it was not realistic to expect growth monitoring/promotion at the village level by NCS to be sustainable. Many individuals mentioned that health promotion activities would be sustainable if there is some support from Ministry of Health personnel. Project staff agreed that reinforcing these links will be a priority activity for the rest of the project period, and should have received more emphasis before.

During the evaluation, the counselors interviewed stated that they will continue to do health education, and refer patients to the **ASV** or the health center for treatment or family planning services that they can not provide. **ASV** and **TBAs** stated that they plan to continue treatment and prevention, respectively, of malaria and anemia, but the results of the evaluation show a need for refresher training in correct dosage and administration of both treatment and prophylaxis.

The health centers will continue to carry out their family planning and prenatal care services, serving as a reference center for clients and information source for counselors and **TBAs**. The health center staff differ in their level of commitment to supervising village volunteer activities. (See Appendix E.)

The following are sustainability goals and objectives elaborated by the team, and their assessment of progress.

GOAL	END OF . . PROJECT OBJECTIVES:.	STEPS TAKEN TO DATE	OUTCOMES
-There will be **health** resource **people available in the villages**	-A core of trained counselors and **TBAs** will have been created in each village	-Selection and training of 215 counselors and 23 **TBAs** in PHC -343 counselors were trained in literacy	49% passed the final literacy exam (this is about the average for these courses) and 350 received refresher literacy training. -215 counselors and 23 **TBAs** were trained in PHC; most passed post-test
-These trained counselors and TBAs will continue their activities after **project end**	-Motivation and **support coming from or facilitated** by the project are taken over by the community	**-Supervision and refresher training of** actives -Provision **of** supplies **-Encouragement of fees and support** from community	**-About 2/3 of the counselors are active. Each village has > 8 active volunteers** **-Promoters and NCS meet monthly** **-Meetings held with chief in 16 villages** **-About ½ villages provide some support to NCS; all TBAs receive fees** **-Discussions begun for NC and TBA resupply**
-Existing institutions will support **activities of counselors and TBAs**	-Creation of working linkages **between NCS, health** center staff and management committees, and other ministries	-Discussions and collaborative activities with institutions **-Creation of end-of-**project plan	-NCS from 6 villages already organized their own meetings with health staff **-Promoters organized 8** health center/NC meetings -End-of-project plan agreed on

Iv. Lessons Learned/Recommendations

A. Project Design

1. Integrated projects, including water and income-generating activities, are more effective in improving health because they are better able to generate interest, and enable women to take action to address the causes of ill health and malnutrition. In this project, some felt needs were not met and this made true community involvement less feasible.
2. Short-term projects are too short for long-term results to be measurable, so they tend to focus on short-term measurable results. ***Future projects should be funded on a minimum four year cycle.***
3. The literacy effort was extremely worthwhile, and was one of the most frequently mentioned interventions by community members.
4. It was difficult for the project health promoters to shift from seeing themselves as service providers to facilitators and supervisors of the ***NCS'*** work. ***Future projects should place the locus of initiative and responsibility with the community members, and make the role of project promoters one of helping the community to educate itself***
5. Men did not feel an integral part of health promotion activities because the integration of men started only in the last year of the project. Men's agreement to the use of family planning and AIDS prevention methods is essential, but they also play a very important role in health-related behaviors such as hygiene and nutrition of children, and in health-seeking decision making. The evaluation showed men's interest in being more informed and involved in health matters. ***Men should be included in the design and implementation phases as full actors, and interventions should be specifically targeted at the roles men play.***

B. Project Implementation-Technical

1. Exchanges with other projects or sectors were some of the most valuable activities. The project found that they had to be very pro-active to ensure that they could identify available resources or actors, and ensure collaboration with other ministries, NGOs, or sectors. If not, there were many missed opportunities.
2. The neighborhood counselors' levels of motivation and capacity vary greatly, as do levels of community dynamism and organization. Dropping villages or counselors who did not perform well freed project energies to focus on those communities or counselors who are the most productive. Special effort had to be made to work with those groups who were the most disadvantaged or least developed.
3. The health promoters increased the participatory nature of their educational sessions, but mastery of the open-ended story approach was difficult.
4. It was sometimes difficult for mothers to apply knowledge obtained, due to lack of services or commodities. ***Efforts should be made to avoid creating demands that are impossible to fill, given available government health services or economic realities.***

C. Project Implementation-Administrative

1. Participatory staff meetings and respect by the senior staff of project personnel's contributions led to a working atmosphere with good personnel morale. However the high turnover in staff, particularly senior staff, particularly in Phase I created a certain lack of clear administrative and managerial behavioral expectations, rules, regulations and discipline. It led to the setting of negative precedents which were difficult to control later. ***Expectations regarding work performance, financial arrangements and resource management should have been more clearly established and clarified.***

2. The project HIS was not used optimally, and lost focus as the indicators were updated and the HIS was not adapted. ***A wall chart of indicators and a large project map showing population, resources and infrastructures would have been useful visual aids for prioritization, planning, management, and supervision.***

D. Project Sustainability

1. Helping health center personnel see "what's in it for them" in working with the neighborhood counselors increased their willingness to spend time training and supervising, and increased the validation of ***NCS. Associate public health workers who will eventually be responsible for the supervision of project-initiated activities in the process of choosing and installing local health volunteers in the villages in their catchment area.***
2. The non-monetary benefits received by neighborhood counselors such as literacy and technical training, t-shirts, manuals, and supervisory visits were very important in creating motivation, an ***esprit de corps***, and validating the neighborhood counselors. ***Involve communities in needs identification, data gathering, problem-solving, evaluation and feed-back. This involvement is essential especially to validate and support the work of neighborhood volunteers.***
3. More time should have been invested in the training and follow-up of the neighborhood counselors. These individuals completed the last part of their formal training only a few months before the end of the project and will not have had sufficient supervision and follow-up **to** ensure lasting mastery of their health promotion skills. ***During the remaining months of the project, project staff should focus on reinforcing NC skills.***
4. Institutional collaborations, especially multi-sectoral ones, enabled better use of resources. ***Special effort must now be made to strengthen linkages with MOH and other institutions, in order to transfer oversight of project-initiated activities. Health center staff should ensure continuous supervision of*** NCS ***and TBAs to update their knowledge, This is especially true for TBAs, since most are illiterate and have difficulty remembering new information, especially***

medication dosages (chloroquine and iron). A dosage sheet for non-literate workers (TBAs, ASVs) should be developed.

APPENDICES

APPENDIX A:

MEMBERS OF THE EVALUATION TEAM

TEAM LEADER
Waverly Rennie, MPH, independent consultant

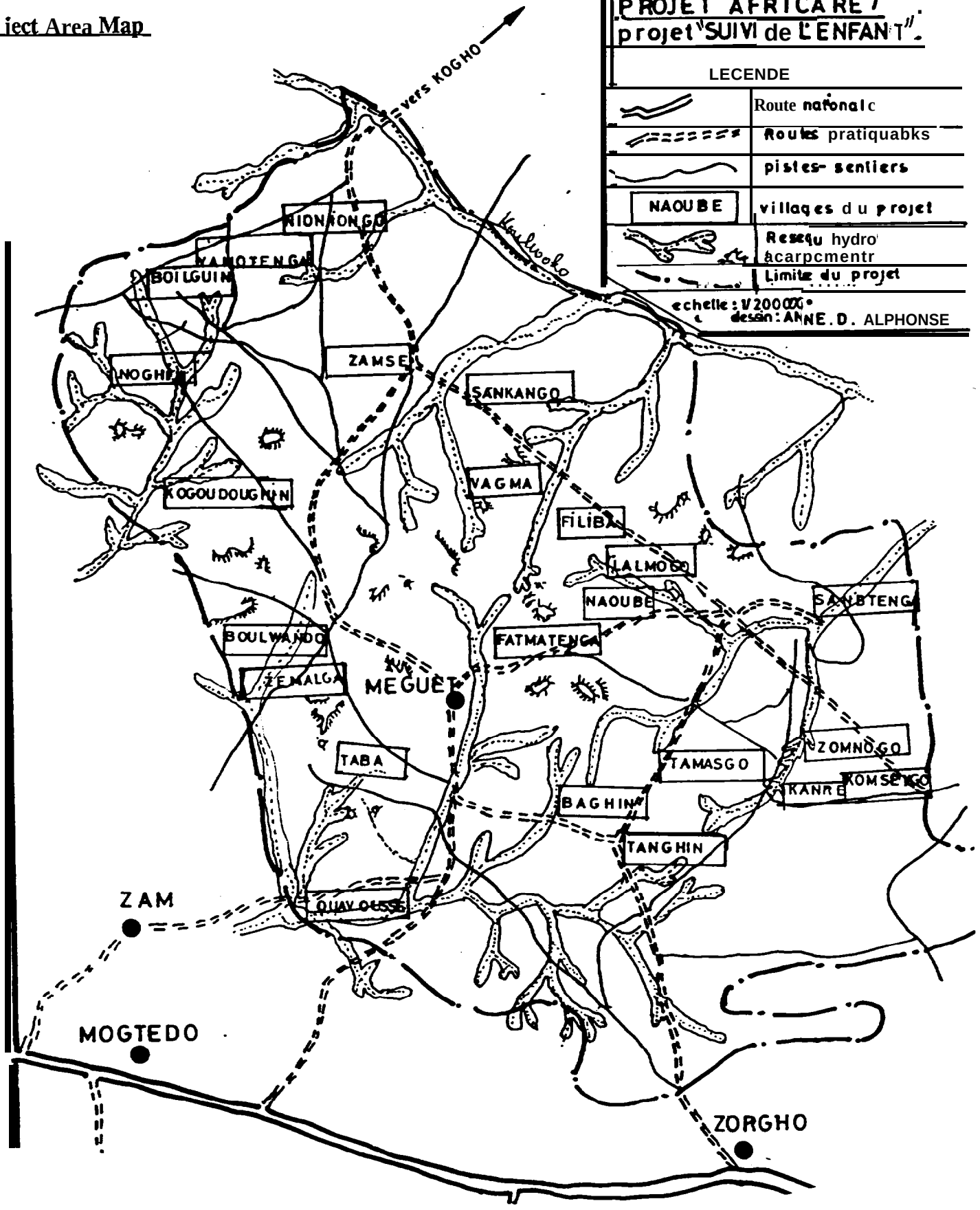
AFRICARE
Marguerite Joseph, MPH, Washington
Ali Danaye Goumba, Ouagadougou

COLLABORATING AGENCIES
Jean Charlemagne Yoda, DEP, Ministry of Health, Ouagadougou
Pulcherie Zombré, DPS Zorgho
Gaston Sebgo, HIS Coordinator, Save the Children/USA Saponé
Aimée Dabiré, Ministry of Social Action, Zorgho
Omer Sobgo, DPEBa, Zorgho
Dr. Marie Berthe Ouédraogo, UNICEF Health Program Administrator, Ouagadougou

AFRICARE/ZORGHO
Wendy Greene, MPH, Project Coordinator
Hamidou Diallo, Assistant Coordinator
Aminata Rabo, Program Assistant
Justine Dimdaogo, Health promoter since 1994
Abzeta Kabore, Health promoter since 1994
Amélie Kabore, Health promoter since 1991
Fatimata Kabore, Health promoter since 1994
Haoua Kouama, Health promoter since 1994
Joanna Kouama, Health promoter since 1991
Adama Rouamba, Health promoter since 1994
Pascal Tiendrebeogo, Health promoter since 1994
Gustav Zombré, Health promoter since 1994

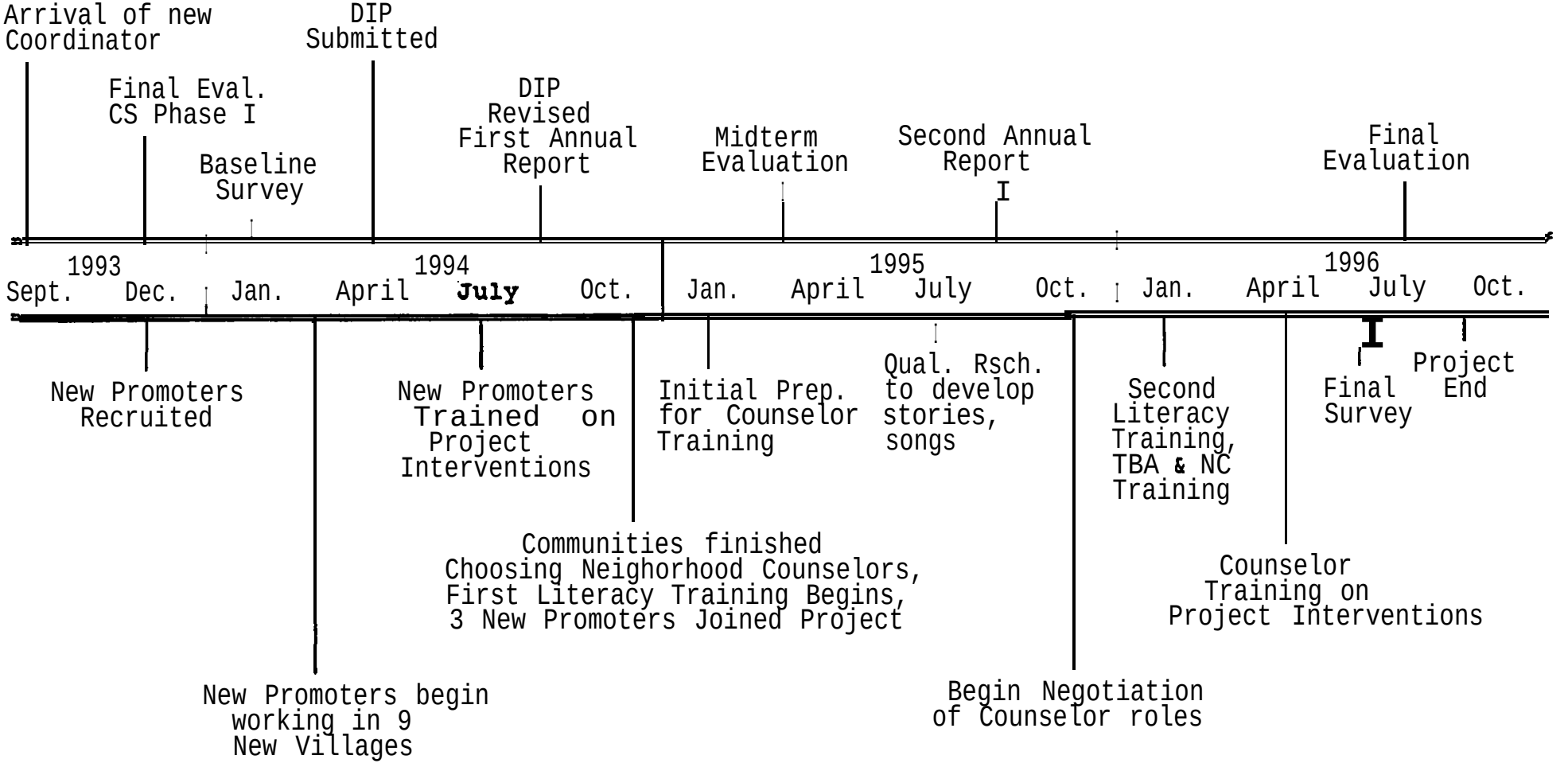
APPENDIX B:

Project Area Map



APPENDIX C:

GANZOURGOUCHILDSURVIVALPROJ-ECT CHRONOGRAMOFMAJORACTIVITIES SEPTEMBER1993 -SEPTEMBER1996



APPENDIX D:

Schedule for Final Evaluation

Phase I:	**PRELIMINARY PLANNING MEETINGS**	Step 1 :	Define the goal and objectives of the evaluation
		Step 2 :	Identify the evaluation team members
EVALUATION TEAM AND COORDINATING GROUP July 2-3		Step 3 :	Logistics and administrative arrangements
		Step 4 :	Develop the project "map"
Phase II:	**EVALUATION PLANNING WORKSHOP**	Step 5 :	Set up and guide the evaluation team
		Step 6 :	Define the questionnaire
		step 7 :	Identify sources/techniques for data collection
EVALUATION TEAM July 3-5			
Phase III:	**DEVELOPMENT OF** DATA **COLLECTION TOOLS**	Step 8 :	Develop the interview guidelines, observation guides and individual questionnaires
EVALUATION TEAM AND COORDINATING GROUP July 6-S			
Phase IV:	**COLLECTION AND ANALYSIS OF DATA**	Step 9 :	Orient field teams
		Step 10:	Conduct interviews and observations
EVALUATION TEAM AND COORDINATING GROUP July 9-12		Step 11:	Analyze data collected
		Step 12:	Summarize fieldwork findings
Phase V:	**WORKSHOP TO FORMULATE LESSONS LEARNED**	Step 13:	Review findings and formulate lessons learned
		Step 14:	Assess, as a team, the participatory evaluation process
EVALUATION TEAM July 15-16			

Phase VI: PREPARATION AND DISSEMINATION OF REPORTS EVALUATION TEAM AND COORDINATING GROUP July 17-19	Step 15: Summarize lessons learned Step 16: Prepare the evaluation report Step 17: Develop plan of dissemination and discuss evaluation fmdings

DATA COLLECTION: LOCATIONS, INFORMANTS INTERVIEWED/OBSERVED

VILLAGES
1-Baghin 5-Lalmogo
2-Tanghin 6-Fatimatenga
3-Kanré 7-Zamcé
4-Zomnogo 8-Nonghin

HEALTH CENTERS (CSPS)
I-Koulwéogo V-Zamcé
II-Kabouda
III-Méguet
IV-Salogo

CATEGORY	l/I	2/II	3/ III	4/ IV	5/ V	6	7	8	SUM
Village chief	1	0	0	1	1	1	0	1	5
CSPS staff at CSPS I-V	3	1	1	1	1	X	X	X	7
CSPS Mgmnt Committee	1	1	3	2	12	X	X	X	19
Focus Group (FG) mothers	10	9	7	9	9	6	7	6	63
FG fathers	6	6	8	9	10	12	6	9	66
FG counselors	6	10	8	7	6	7	13	7	64
Interview NC dropouts	2	1	0	0	1	0	0	0	4

Observe NC Growth Promot	9	11	10	6	7	7	13	8	71
Observations NC Educ talk	4	3	3	4	2	3	2	4	25
Exit interview mothers	2	4	2	2	3	2	4	2	21
Interview/ observation TBA	1	1	1	1	1	1	1	1	8
Interview AVS	1	1	1	1	1	0	1	1	7
Interview Condom seller	1	1	1	1	0	1	0	1	6

APPENDIX E:

Status Report on Health Centers and Villages

Koulweogo - Health Center staff know the project trained neighborhood counselors and Health promoters and have had informal contact with them. They mentioned that people needing health services in the communities have been referred to them by project staff. The nurse in charge, Ramatou Toguyeni does not have an active relationship in terms of outreach and technical assistance to community level volunteers, and did not see the need for regularly scheduled meetings. The health center staff here, as well as in the other health center, is a part of the Health Center Management Committee whose main role is to implement the Bamako initiative. Their Management Committee activities have mainly been limited to running the health center pharmacy.

Kabouda - The nurse in charge, Phillip Traore, was very interested in the CS project work, knows all the neighborhood counselors and Health promoters and has regular contact with them. He has been around since the beginning of the project and assisted with some of the training as well. Mr. Traore expects to maintain regular contact with community level volunteers and intends to continue giving technical assistance and support.

Meguet - The nurse in charge, Gorou Faustin has only been at this health center for one year and has not had much contact with the community level project-associated people. He agreed that the neighborhood counselors could be of use to their communities in terms of health education. It is uncertain as to whether he will be of support or give technical assistance to them when Africare leaves, unless more effort is made to create linkages.

Salogo - The nurse in charge was not there, and the assistant is apparently not well informed about Africare project activities and does not know the project staff nor the neighborhood counselors well. He was able to inform us about health center activities, including vaccination sessions in the villages.

Zamse - The dynamic nurse in charge, Cisse has been around for four years and has participated in community level activities right from the start. He has held regular meetings with the neighborhood counselors and Health promoters both at the health center and out in the villages. He feels that the center and these individuals can work well together and continue to support each other even after Africare leaves.

ABILITY TO CARRY OUT GROWTH PROMOTION BY VILLAGE

VILLAGE	Read	Analyze	Write	Counsel
Baghin	9/9*	not tried	3/9	8/9
Tanghin	10/11	not tried	1/11	10/11
Kanre	10/10	not tried	5/10	10/10
zomnogo	5/6	not tried	2/6	5J6
Lalmogo	3/7	3/7	2/7	4/7
Fatimatenga	5/7	3/7	2/7	5/7
Zamcé	5/13	4/13	4/13	5/13
Nonghin	4/8	6/8	2/8	5/8

*Number of neighborhood counselors tested who succeeded over number of NCS tested during Final Evaluation Survey

Read = Able to read the weight on the scale
Analyze= Able to analyze if the child's weight for his age is above the danger threshold
Write = Able to write the weight on growth chart or on health notebook
Counsel = Able to counsel mother appropriately according to child's weight for age

APPENDIX F:

Training Activities

Ganzourgou Child Survival Project II TRAINING ACTIVITIES

YEAR ONE

1) 30 Cluster Survey Techniques, January 1994: The Coordinator and Field Supervisor attended a one-day training on the WHO 30 cluster **survey**. The training was conducted by survey consultant Evelyn Gorsline.

2) AIDS, **March 1994: The** Program Assistant conducted a training for 14 members of Africare Youth Group for Health on AIDS; definition, transmission, prevention, and misconceptions.

3) Family Registration, March 1994: The 4 newly recruited Health Promoters were trained on how to conduct the family registration in their villages. Training techniques included lecture/discussion, role play, and field practice. The project's Field Supervisor was the primary trainer.

4) Qualitative **Research Methods, March 1994:** The Program Assistant attended this one week training which was conducted by Project collaborators, ***l'Association pour la Promotion de l'Alimentation Infantile au Burkina*** (APAIB). The training covered focus group methodology.

5) The Ganzourgou Child Survival Project, July - August 1994: The project conducted this training on administration issues and technical interventions for the 4 new Health Promoters. Promoters from the first phase participated as both trainers and trainees in some of the sessions.

6) Training on Breast-feeding, EPI, ORS and Guinea Worm, April 1994: The Health Promoters and the Field Supervisor attended this one week training organized by UNICEF. Africare was invited because of the collaboration with UNICEF on the Bamako Initiative.

7) Proposal Writing Workshop July 1994: This session was organized and conducted by **the** Africare Country Representative. The Coordinator, Field Supervisor and Program Assistant attended.

8) Control of Diarrheai Diseases Update, July 1994: This training was held in July and organized by the MOH. Unfortunately, there was not room for all of the project Health

Promoters to attend and it coincided with the training on project interventions. The Program Assistant attended and later conveyed the information to the Health Promoters.

9) Fundamentals of WordPerfect, September 1994: Africare was invited to participate in this training, held by APAIB. Only the Program Assistant attended as the secretary was on vacation.

YEAR TWO

1. Training on Document Management, October 1994: this session was organized by APAIB and the Women and Infant Nutrition Support (WINS) project and was designed to prepare support staff to maintain documents in a more organized manner. The project secretary attended.

2. Literacy Training for Viiage Neighborhood Counselors, **Oct -** Dec. 1994: the Neighborhood Counselors were invited to attend a literacy training. The training was designed as the first step in preparing them to take on child survival activities, such as growth monitoring and keeping records of the children's immunization status. Of the 343 counselors who finished the session, 168, 46 of whom are women, passed the final exams. While the project would have liked better results they were assured by the provincial primary education authorities, who organized the training, that these results are about average.

3. English as a Second Language, Oct. - Dec. 1994: the Field Supervisor attended English classes in Ouagadougou twice a week to enable him to better make use of the many project related documents that are in English.

4. Quantitative Research Update, November 1994: in preparation for a KAP nutrition survey Africare and APAIBJWINS conducted this session to prepare the interviewers. The project health promoters and interviewers recruited from outside of the project participated. The training was organized and conducted collaboratively by Africare and APAIBJWINS.

5. Project Intervention Training, December 1994: in November the project recruited three new health promoters. This accelerated two week training, conducted by the Field Supervisor, prepared them to begin project activities in the villages assigned to them.

6. Training of Trainers, February 1995: designed to prepare the health promoters to train the newly literate neighborhood counselors, the specific objective of this session was to review and decide upon the curriculum and methodology the promoters would use during the neighborhood counselor training on the project interventions. The session, perhaps more than being a training of trainers, ended up being a well needed review and update/refresher course on the basic project health messages. The session was extremely participatory: it was conducted by the promoters themselves, under supervision of the field supervisor and coordinator.

7. Midterm Evaluation, March 1995: the evaluation trained project staff on participatory evaluation methods, aspects of which have since been used by the project in an ongoing basis and a variety of circumstances, ex. village activities and relations with community member, and other project activities that require team coordination and assessment.

8. Qualitative Research Methods Training, May 1995: again in collaboration with APAIB/WINS the 9 project health promoters and 2 supervisors learned how to conduct, and write reports on focus groups and individual in-depth interviews. The training was held as part of the two operations research projects conducted on the nutritional attitudes and practices of women and children in the project area.

9. AIDS and Female Genital Mutilation Training, July 1995: two trainers, one from the MOH and the other from a local AIDSJIEC volunteer group, were invited to Zorgho to discuss these topics, requested by the Health Promoters. The training was also attended by nurses in the project zone and a representative of the Provincial Social Work Department. The participants included 8 animators, 4 nurses and one agent of Action Sociale.

10. Nutrition IEC Training, Sept. 1995: the project's new program assistant attended a two week training on the content and methodology of IEC nutrition. Organized by APAIB/WINS, the training was held in Ouagadougou. This training was one of the recommendations of the nutrition operations research conducted earlier in the year.

11. Forum Theater Techniques, Sept. 1995: the Atelier Théatrale Burkinabè conducted this training of 15 members of the Africare Young People's Club to enrich the club's repertoire of public education methods. Forum theater uses an interactive methodology to get the audience to act out real life situations where tough choices have to be made. The training was one week long.

12. IEC Nutrition, October 1995: Two nutritionists, one from APAIBJWINS and the other from the Ministry of Health, were primarily responsible for this training. The project Program Assistant also collaborated with them as she had recently attended a similar training in Ouagadougou. The Project Health Promoters and 9 auxiliary midwives from the provincial health department participated. The training also covered the nutritional needs of pregnant and lactating women and weaning practices.

YEARTHREE

1. Literacy Refresher, Jan. - March 1996: Approximately 350 neighborhood counselors attended this 45 day training organized and carried out by the Provincial Primary Education Department. Each of the project's 23 villages had at least one training center and while the project supported the cost of the trainers and supervisors, plus the books used by the counselors, other villagers were encouraged to attend if they provided their own materials.

2. Interpersonal Communication with Adults/Adult Education Techniques, February 1996: This three day session was part of the collaboration between the project and Mwangaza, a local community development NGO. This training for the Animators helped prepare them to conduct the Neighborhood Counselor training.

3. Maternal Health, February 1996: The project asked an MOH midwife to conduct this training to prepare nurses from the 5 health centers, the project Health Promoters and a representative from the Provincial Social Work Department to train and work more closely with the village TBAs. Among the topics covered were pre and post-natal consultations, high risk pregnancies and the signs that call for obstetric evacuation, neo-natal care, basic anatomy, and exclusive breast-feeding.

4. CDD Refresher, February 1996: The project sponsored this training conducted by and for provincial health department personnel. The training covered case management and lasted three days.

5. The Bamako Initiative, February 1996: To better understand the role of health center Management Committees and Burkina Faso's relatively recent self-management health strategy, the project asked one of the members of the provincial BI coordinating team to come in and explain the initiative to the Project promoters. The session lasted just a few hours but was extremely useful to the promoters who felt afterward that they could better discuss the initiative with village communities.

6. Basics of Family Planning, March 1996: The Africare Youth Club for Health received a three day training from a member of the Provincial Social Work Department. They then began to work on a play on family planning to present to audiences in Zorgho and the project villages.

7. TBA and Village Health Agent Refreshers, March 1996: Following the maternal health training of February two nurses conducted a 14 day training/refresher session for 24 TBAs in the project area. Simultaneously 24 village health workers received a refresher on malaria case management, the treatment of cuts and bruises, how to deal with fevers and other basic primary health care topics.

8. Moore Literacy Training: The project's 9 Health Promoters attended a 6 day training session on how to read and write in Moore. The training was essential to their being able to formally train the village Neighborhood Counselors. The Provincial Primary Education Department conducted the training.

9. Neighborhood Counselor Primary Health Training, March - April 1996: Preparation for this training involved developing a training curriculum and methodologies in collaboration with Mwangaza and getting approval on the content from the Provincial Health Director. The project's Health Promoters conducted 7 one week training sessions for a total of 215 neighborhood

counselors. The training covered basic information on the project's interventions plus competency-based training on how to conduct home visits and growth monitoring and education sessions. The entire training was conducted in Moore and the neighborhood counselors were given guides in that language with pictures to which they can refer in the future.

APPENDIX G:

'Activities towards Sustainability Objectives

*RESTE A **FAIRE** PAR LES ANIMATEURS **DANS** LES VILLAGES*

Feedback de l 'enquete et de 1 'evaluation, et negotiations des étapes futures avec:

- ***chefs***
- ***conseillers***
- ***AV***
- ***ASV***
- ***vendeurs de condoms***
- ***CSPS***
- ***Comité de Gestion***

Supervision formative initiale des conseillers en

- ***Techniques de Causerie Educative, VAD***
- ***Immunization***
- ***Pesée***
- ***Conseils nutritionnels/AME***
- ***Demonstration de bouillie***
- ***Demonstration de SRO/TRO***
- ***Paludisme***
- ***LMD***
- ***PF/Santé Maternelle***
- ***SIDA***
- ***SIS et reference***

Supervision formative initiale des AV en

- ***Techniques de Conseils***
- ***Immunization***
- ***Soins pré, peri et post natals***
- ***Administration correcte de chloroquine et fer***
- ***Conseils nutritionnels/AME***
- ***Hygiene***
- ***PF/Santé Maternelle***
- ***SIDA***
- ***Observation de leur trousse***
- ***SIS et reference***

Organisation d 'une causerie Vielles pour Vielles avec presence de 1 'AN

Creation des premiers liens/supervisions entre CSPS et Conseillers, AV
Creation des premiers liens/supervisions entre Action Sociale et Conseillers, AV
Creation des premiers liens/supervisions entre DEPBA et Conseillers, AV
Creation des premiers liens/sup entre Sahel Action ou autres et Conseillers, AV
Disposition des balances, fiches de poids et culottes par conseiller adepte
Disposition des tamis filtres chez conseillers

RESTE A FAIRE PAR LES ANIMATEURS AU ***NIVEAU*** *DES CSPS*
Suivre/encadrer les Comités de Gestion
Faire des cartes pour les conseillers
Obtenir les tamis filtres

RESTE A FAZRE PAR LES ANIMATEURS AU SIEGE ***D'AFRICARE***
Reunions mensuelles Aout, Sept.
Organiser une journee par semaine a partir d'aout pour la recherche du travail
Remettre les registreslfiches (doivent être organist en avance)
Deux jours pour resoudre les affaires administratif en fin septembre

RESTE A FAIRE PAR DIRECTION DU ***PROJET***
Informer Prefet
Informer DPS
Obtenir balances et culottes
Organiser recyclage en alphabetisation pour conseillers
Organiser ou clarifier modalités pour seances de vaccination
Participer dans les rencontres avec CSPS, CdG quand disponible
Suivre le deroulement des plans de travail, aider à trouver des solutions
Voir possibilité d'échanges avec d 'autres projets

APPENDIX H:

Selected Recommendations/Lessons Learned from Mid-Term Evaluation

Current Status - July 1996
Lessons Learned and Recommendations from the Mid-Term Evaluation

Training: Lessons Learned/Recommendations	**current status**
It is important to provide more technical training to neighborhood counselors, village curative health volunteers and traditional birth attendants so they may effectively accomplish their roles in the project.	Training on Child Survival and IEC themes done by Mwangaza and health promoters, with MOH participation.
Literacy refresher courses should be arranged for village health volunteers.	Done by Ministry of Basic Education and Literacy. Volunteers >45 years old had more difficulty with literacy skills.
Future technical training for project promoters should include expressed priorities such as demonstration of enriched porridges, teaching techniques, etc.	Technical training was provided by APAIB/WINS, teaching techniques by Mwangaza. More face to face practice needed.
Refresher training of the CJAS members should be done on themes already covered.	Done on AIDS, theater, and family planning.
MOH personnel should be further associated with project training activities, either as participants or co-facilitators	Training done several times with MOH staff as participants or trainers.
An analysis of the project promoters' training needs based on their roles and tasks should be made. Active and participative training methods for adults should henceforth be used in all future training activities.	Re-evaluation of tasks led to a training in use of theater, stories, and discussion groups for training and health education.
For future training, a detailed training plan should be prepared in advance, and a report prepared at the end.	Plans and reports prepared for AIDS, breast-feeding, maternal health and Bamako Initiative training.

Health Information System and Supervision: Lessons Learned/Recommendations	Current Status
Exchanges with other similar projects should be organized.	A 3-day visit to Save the Children/USA's project at Saponé permitted learning about their HIS, sustainability strategies, CBD of pills by TBAs, and nutrition demonstrations.
The project should find a way to assess the populations' opinion of project activities.	A system was not developed. Informal exchanges and links with communities permit adaptation of activities to community needs.
The HIS should be adapted to changing indicators and needs, e.g. now only growth falterers need to be followed up at home; data forms should be adapted.	Partially achieved. However, certain data was not collected in indicator's format, e.g. data on children weighed is divided up into < 12 months and 12-59 months but the indicator is " % of children <two weighed 3 + times in last year"
Give monthly HIS synthesis to DPS.	This began late in the project.
To increase HIS effectiveness, qualitative data collection instruments should be developed to complement the quantitative data.	Qualitative data collection began, but has not been sufficiently exploited for planning and feedback.
To reinforce personnel motivation, project director should institute a performance evaluation system	Done once a year ago, and again at the end of the project.
Although the promoters know and follow the NCs, include village health workers and other community members in their supervision.	This has not happened, as the communities continue to perceive the promoters as the major actors, and because the NCs are still perceived as project, not community-related, volunteers

Studies: Lessons Learned/Recommendations	Current Status
Promoters and NCs should hold discussions with older women on child feeding practices and diarrhea management to understand advice given to mothers.	Discussions held with mothers and older women. Information used to do stories and Skits.
Do study on pregnant and lactating mothers' knowledge and attitudes to improve maternal health interventions.	Findings from study and training helped refine interventions

Community Health Activities: Lessons Learned/Recommendations	Current Status
In the future, the goal of the educational talks should be to include the participants in discussion and reflection on the theme in relation to their knowledge, practices and resources.	Training in use of open-ended stories aimed to elicit more active discussion and reflection, but closed-ended stories tend to prevail. Songs, dances and skits were developed and successfully used by the promoters and NCs.
Given the importance of water to health, it is imperative for Africare to find financing to increase availability of clean water in the project zone.	Several funding proposals were submitted, but without receiving funds.
For confidentiality, weighing of children should take place so that the mothers can be informed of their child's progress separately from the group. This will put mothers more at ease to discuss problems.	This was tried, but the mothers reportedly prefer to remain with the other mothers during weighing. It was then suggested that increased discretion and respect in communication would encourage falterers' participation.
Find a simpler growth monitoring approach than the growth curve.	A simpler growth curve was still very difficult for the NCs to use.
To increase the impact of growth monitoring, the promoters and NCs counseling skills should be improved to assist mothers in applying nutritional advice given.	The promoters received nutrition communication training. They and the counselors reportedly place more emphasis on identifying growth falterers and giving appropriate advice.
In the health centers, the nurses should reinforce the nutritional advice given by the promoters and NCs.	The nurses received training in nutrition IEC but have limited ability to manage serious cases.

To reinforce the follow up of high-risk children identified during growth monitoring, a well-organized follow up system is necessary; this could include a follow up sheet for each child and a list of children at risk of malnutrition for each neighborhood/ village.	A follow up sheet for malnourished children was developed, as well as a list of growth falterers in each village. Some home visits were done, but it is not clear what the impact was on improving nutritional status of these children.

Sustainability: Lessons Learned/Recommendations	**Current Status**
The management committees of the Bamako Initiative should ensure fuel to ensure sustainability of immunization outreach.	The management committees seem unwilling to spend "their" money on outreach
To ensure sustainability of CJAS activities, the project must involve other services (Social Action, DPS) in the management of the club and encourage income generating activities by Club members.	Social Action has begun working with the CJAS. Several paying parties have been organized by the CJAS, but not yet admission charges for their plays.
To ensure sustainability of community meetings for health, the chiefs and notables must be responsibilized to initiate, organize and direct community meetings on child survival themes.	An effort was made but the chiefs and notables either do not or can not conduct health meetings.
Collaboration between the project and the DPS can be improved by : - holding bimonthly meetings between the DPS and the project direction - Official transmission of monthly project reports to the DPS	Meetings were held occasionally according to the availability of the parties. The monthly reports were not regularly sent.
To improve collaboration between the nurses and promoters, quarterly meetings should be held between the two partners; organize visits to health centers by NCs, and inform the nurses on project activities	Meetings have been held between the promoters and the nurses, and many of the NCs have met with the nurse of their health center.
Project director should ensure pursuit of collaboration with current partners (DPEBAM, UNICEF, APAID-WINS, PROMACO) and develop new initiatives with other partners (Social Action, Sahel Action, etc.)	Some existing collaboration has been strengthened, and new links have been initiated with Social Action (with CJAS) but not with Sahel Action.

The collaboration between the nurses and the NCs is well established especially in immunization; in the future, this should be reinforced through better sharing of information on activities.	Good relations and collaboration with the Management Committees