

**Save the Children/Burkina Faso
Child Survival 8
Final Evaluation Report**

**Agency for International Development
Cooperative Agreement FAO-0500-A-00-2034-00
September 30, 1992 - March 31, 1996**

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EXECUTIVE SUMMARY

The Burkina Faso Child Survival project (CS8) of Save the Children/US (SC/US) was initiated in October 1992 to March 31, 1996 as a cooperative agreement (#FAO-0500-A-00-2034-00) with USAID as part of Washington's private voluntary organization program. The goal of the project has been to achieve a sustainable reduction of morbidity and mortality of children under age five. The CS-8 in Burkina Faso has adopted a strategy to achieve this goal by promoting protective maternal and child health-related behaviors through village training for health self-management. After reviewing the conditions and needs of the Saponc District, it was decided to focus on the following: control of diarrheal diseases, increase child and maternal immunization coverage, improve maternal and child nutrition, improve prenatal care and promote birth spacing, and control malaria. The strategy is community and family based, focusing on strengthening local institutions and family capacities to practice protective health behaviors.

The project is based in Sapone, Bazega province, 30 kilometers south of Ougadougou, the capital of Burkina Faso. Save the Children in Burkina Faso is known as Foundation for Community Development (FDC, Fondation pour le Developpement Communautaire). FDC has been working in Sapone since 1988, focusing on raising child immunization coverage rates, with funding from USA for Africa. The Child Survival 8 project (CS8) considerably extends the earlier project, with a greater focus on creating village capacities to maintain maternal and child health. The CS8 project is part of FDC's broader community development work, which includes activities to promote well construction, village-based credit and savings, gardening and increased agricultural productivity, and literacy training.

The CS8 project has enrolled all families living in Sapone district, and has created a community-based system for monitoring the attainment of the project goals. The project relies on a team of village health workers who are young women recruited from the district. They have been trained to work as health motivators (animatrices), each with a responsibility for five to eight villages. The health motivators work by mobilizing and training mothers of child bearing age with regard to the health behaviors targeted by the project. They also work to reinforce the local village health committees, including local health workers and midwives, so that they can reinforce the promotional work of the project. In each village they also train local village leaders, volunteers who in turn mobilize and train other women in their section of the village. The project also facilitates referral to and effectiveness of relevant MOH services. Beyond its own staff, the FDC staff also collaborates with two local NGOs (Association Vive le Paysan, AVLP, and Association Burkinabe de l'Action Communautaire, ABAC), training their community outreach workers in the health promotion strategies employed by the FDC outreach workers.

The project was implemented in stages, starting with 18 villages in Ipelce and Sapone subdistricts for the first year, and then at the end of 1993 adding 8 additional villages in Doulogou subdistrict. All families in each of the 26 villages are enrolled in the project. The target population consisted of 25,670 persons, with 5,693 women of childbearing ages (15-49 years) and 4,859 children under the age of five.

An evaluation team lead by Dr. Sally Findley of Columbia University conducted an evaluation of the project on March 25 to April 3. This team reviewed program statistics, interviewed staff and participants, and analysed project health information statistics. Prior to the team's arrival, Save the Children had conducted an evaluation survey in sampled villages and households to ascertain the project impact, relative to the bascline established prior to program implementation. This variety of information sources was used to address the following evaluation criteria: project inputs according to the draft implementation plan; project strengths and weaknesses, from staff and community perspectives, achievement of specific objectives.

This evaluation shows that the project was immensely successful. For most objectives, the outcomes surpassed the objectives, and for no objectives was the project far from success. The attached table summarizes the project achievements for each objective listed above.

SUMMARY OF ACHIEVEMENTS, CS8/SAPONE,1992- 1996

<u>Obicctive</u>	<u>Achievement</u>
80% families w. ORS competence	60-73% of mothers know what to do for diarrhea of their children 99% know of mothers know at least one symptom of diarrhea 92% of mothers had used ORS to treat recent diarrhea episode of own child
60% of mothers know when to add supplemental food to infant diet	88% of mothers know when to start with porridge 96% of mothers knew at least one appropriate weaning food 79% of mothers knew what kind of porridge to use for supplementation
70% of children 6-59 months will receive a vitamin A dose each six months	80% of eligible children received at least one vitamin A dose. 12% of children known to have received two doses.
60% of postpartum women will receive a vitamin A dose two months after delivery	75-140% of eligible women have received vitamin A post-partum.
90% of women of reproductive age will receive two or more anti-tetanus vaccinations 98% of women of reproductive age had	received two anti-tetanus vaccinations. (78% if you don't card the women who lost their health card.)

75% of high risk pregnancies will receive 2+ pre-natal consultations and will have a delivery with a trained midwife

88% of women know the need for 3+ pre-natal consultations
94% of mothers with a recent delivery had at least one pre-natal consultation
68% of women had two + pre-natal consultations

20% of women wishing to delay a birth will use local family planning clinic methods

83% of mothers with a child under age two wish to delay the next birth.
Of these, 48% used modern contraceptive methods to delay the next birth.

50% of men and women 10-49 years old will know at least one method to prevent the spread of STDs or AIDS

65% of women 15-49 years of age and 74% of the men 10-49 years of age have been trained in AIDS prevention.

80% of children 12-23 months will be completely immunized

89% of children 12-23 months are completely immunized

60% of mothers will know methods to prevent malaria and will know what to do in the case of serious malaria.

78% of mothers know what to do to prevent spread of cholera and 80% know what to do for malaria.

Because of the adequacy of the health information system, the evaluation team was able to go beyond these knowledge and behavioral outcomes to one of the outcomes of major interest in this project, namely infant and child mortality. As can be seen in the table below, infant mortality dropped substantially during the project duration. In the first 18 project villages, infant mortality averaged 139 deaths per 1000 for the year preceding March 1994, when the first annual update was conducted. Child mortality (deaths to children 0-4 years of age) was estimated to be 54 per 1000. At the end of the project (Feb. 1996), the infant mortality rate was 70 per thousand, while it was 35 per thousand for child mortality. This is a 50% drop in the IMR (infant mortality rate) and a 35% drop in the CMR (child mortality rate). For the 8 villages added in the second year of the project, the decline in infant mortality over the two year period was from 91 to 68, a decline of 25%. For these villages the CMR declined by 51% to 34 per thousand at the end of the project in February 1996.

Decline in Infant and Child Mortality

Village Group	IMR Baseline	IMR Final	CMR Baseline	CMR Final
18 initial	139	70	54	35
8 additional	91	68	69	34
26 total	135	69	55	35

Across all 26 villages, infant mortality dropped from 135 at the start of their participation in the project to 69 at the end of the project, a 49% reduction. Child mortality dropped from 55 to 35, a decline of 36%. Thus, during the project period infant and child mortality both dropped by about half. These are very impressive results for the project. and are evidence of how well the various components worked.

In addition to the evaluation of the program outcomes, the evaluation team also assessed the quality of the program interventions.

The health information system provides the baseline information for the health project, and the evaluation showed that the system is fully functional and maintains a high level of accuracy. As required, the health information system maintains records of the total population, all births, deaths, marriages, and migrations. It is updated monthly and a complete re-count is taken each year. The health information system staff have mastered the process of data entry and produce annual reports for each village health committee. The villages understand the information and are very involved in collecting information and in reviewing trends.

The training programs also were reviewed by the evaluation team. This evaluation showed that the training of trainer approach used by Save the Children has worked quite well for the persons at the bottom of the training ladder. The village health motivators have been successful in training village women to carry out health education and behavior promotion training sessions. The village women considered the program highly successful and expected to continue their own activities to train other women. The training of the project nursing staff was less successful. Because the project nurses are not as fully trained as they would like, neither are the village health motivators. At the higher levels, better coordination is needed between the project and Ministry training options. The training modules used for the village health motivators could also be revised to contain more pragmatic information.

Pipeline analysis of the project expenditures show that each year the project was spending close to the planned levels. There is a smooth progression from expenditure of 20% of the budget in the first year to expenditure of 76% through the fourth year. It is expected that by the end of the project expenditures will exceed 85% of the budgeted amount.

Interviews were conducted with Save the Children staff, **Sapone** health officials, village health committees, village health workers and leaders, village health motivators, and villagers to assess

the progress the project had made in achieving sustainability. These interviews show that the project has built the foundations for sustained activity through its extensive training and mobilisation activities. These activities have incorporated both staff and villagers, both mothers and village officials. Thus, there is wide interest and involvement in the program, building a large community of supporters. Training has been conducted in a manner which gives them confidence in their ability to continue thyc activities without Save the Children supervision. The following summary points can be made about sustainability:

- 1) Local institutions are able to continue project activities.
- 2) Each village has at least one trained and equiped CHA, TBA, and & WL
- 3) Each village has a functional, community based HIS.
- 4) Availability of opportunities for literacy and income generation activities.
- 5) Materials and logistics for child survival activities are available at the village level.
- 6) Women at the village level adopt the new behaviors in the improvement of their family's lives.
- 7) Health center staff are able to continue to implement child survival interventions.
- 8) MOH can and will continue to provide training support to the district health workers.

What are the lessons learned by this project?

The most important lesson learned here is that community-based strategies to reduce infant and child mortality work. This was no high-tech program with heavy outlays for medical services. Rather, it relied on the existising (and very minimal) health structure with much education, mobilisation, and demonstration of practical things parents can do to protect their children. The education and mobilisation activities originated in the villages. The success in changing attitudes, behaviors, and outcomes is demonstrated in the achievement of the project objectives. More importantly, the whole package worked together to achieve the desired final outcome of a reduction in infant and child mortality. During the three and one-half project duration these mortality rates were cut in half.

The evaluation team highlights the following as the elements of program design and implementation which appear to have most contributed to this result:

Strong Points:

1. Top to bottom training: The strategy adopted by Save the Children for this project was a layered training of trainers strategy. Supervisory staff were trained in the appropriate methodologies, as well as in giving effective **training**. These staff then trained the next layer of the intervention, the village health motivators, who had been recruited from **Sapone** itself, and so on.
2. Mobilisation by education: In the **Sapone** program, the mobilisation strategy used as its fundamental tool education. This is not a quick fix type of strategy, but it does have the major advantage of building two elements essential to continued mobilisation.
3. People-to-people feel: The **Sapone** project had a very strong presence in the villages, a presence that existed both officially and unofficially. The use of residents of the local villages for village health motivators is now well known.
4. Multisectoral back-up: The Child Survival project was complemented by very active and

important interventions in other sectors. In the villages with multisectoral activities, the villagers were quick to recognize the wells they had built as a strong point, as well as others, such as the literacy program and the vegetable gardens, both of which contributed to their ability to adhere to the recommended behaviors.

5. Endogenous sustainability: The project stressed training and education as a means to empower the village residents to protect their own health and especially the health of their young children.

6. Monitoring capacity: One reason why the village based training and mobilisation strategy works so well is that the villagers and project staff can quickly observe the consequences of their acts.

7. Anti-malaria campaign: Perhaps one of the most cost-effective strategy elements was the campaign against malaria.

8. Links to the Bamako initiative: The integration with the national implementation of the Bamako initiative means that the project did not need to create an independent village structure.

9. Collaboration with local NGOs: The collaboration with AVLP and ABAC (some shared staff and project locations) made it possible to make more economic use of resources.

Weak Points:

1. Training and supervision: Although the top-to-bottom strategy works very well for the project outcomes, it is based on a trickle down concept. This works only if there is something trickling down.

2. Collaboration with the Ministry of Health (MOH): There was insufficient monthly and quarterly coordination and joint planning.

3. Supplies: The project often suffered from stock ruptures of one of these essential items, despite the implementation of the Bamako Initiative.

4. Immunizations: A major difficulty with the immunization initiative was the lack of coordination between the vaccination team visits and the FDC program.

5. Collaboration with NGOs: There was insufficient feedback and coordination with the collaborating NGOs.

6. Weighing and growth monitoring:

7. Training and supervision of village registrars: Training should be an activity of the youth club, since they also would be most likely to know about migrations.

8. Utilization of the HIS: Save the Children staff and their partner NGO's complained that they were not adequately informed.

10. Rehydration of children: The porridge promoted by the village leaders and health motivators was felt to be inadequate for severely malnourished children.

11. Feedback to village health committees: The village health committees are eager for information on the village health, but Save the Children prepares only annual reviews of the village vital events and health status.

The evaluation team recommendations have been included in each section of the report: Summary of Achievements, Training and Supervision, Health Information System, Sustainability, Lessons Learned. This section on recommendations is primarily a recapitulation of these recommendations. Please see the individual sections for a more detailed specification of the recommendation.

- 1) Planning and programming: The main recommendation here is for more coordination and integration with FDC partners, the MOH and the NGOs. In addition, in the devolution phase, the village health committees need to be more involved in decisions regarding activities and next steps.
- 2) Training and supervision: More coordination of FDCs training program and that of the MOH. The training chain from top to bottom must be more inclusive at the top, and more dense (repetitive and reaching more village leaders) at the bottom. Supervision should be more two-way, permitting communication up the channel of information about problems and potential innovations.
- 3) Reinforcement of the social mobilisation strategy: This was highly successful, and should be maintained. Reinforcers need to be developed to encourage village health committees and village leaders to continue with this important activity without FDC support and stimulus.
- 4) Maintain and strengthen the village leaders: The women leaders (WL) were highly effective at educating and mobilizing the village women. They should be encouraged to continue this. Retraining and training on new themes should be arranged with training partners, if not through FDC.
- 5) Re-examine the efficiency of certain interventions: Growth monitoring was very time intensive, yet not backed up by appropriate rehydration programs. The team recommends switching to a less labor intensive method for identifying growth faltering and malnutrition. Similar consideration of other interventions (e.g. immunizations) might identify a more cost-effective way to carry out the programmed activities.
- 6) Continue to work multisectorally: The project is strengthened by the involvement of other sectors. This complementarity should be continued and extended. The links between health and other sectors also can be reinforced with the partner NGOs.
- 7) Simplify the HIS: The health information system works well at Saponc, but in this phase of devolution, more attention needs to be placed on a stronger and more reliable system for observing vital events in between the annual updates. Procedures need to be worked out to improve registration of vaccinations. Greater attention should be paid to getting simplified analyses out that can guide village and subdistrict program decisions, as well as to enable villagers to chart their own progress toward their goals.
- 8) Strengthen the links to the Bamako Initiative: The project's commodities are channeled through the village Bamako Initiative structure. This linkage should be maintained, with efforts to ensure continuity of supplies. In addition, this might be an avenue for accessing national level training, whereby the local health workers receive assistance and training from the national level, enabling them to take over functions.
- 9) Emphasize horizontal integration: In the devolution stage, FDC and its partners will undoubtedly market pieces of the project through different donors with separate objectives

(e.g. malaria control, immunization coverage...). While that may facilitate funding, the great success of the program has been in its integration across objectives. The villagers have a good grasp of the ways that different health promotive behaviors can reduce the risk of several diseases. The FDC staff needs to continually work to retain this integration at the village level, even if the program funding and partnership is more narrow.

1. Introduction

A. Project Background

The Burkina Faso Child Survival project (CS8) of Save the Children/US (SC/US) was initiated in October 1992 as a cooperative agreement (#FAO-0500-A-00-2034-00) with USAID as part of Washington's private voluntary organization program. The goal of the project has been to achieve a sustainable reduction of morbidity and mortality of children under age five. The CS-8 in Burkina Faso has adopted a strategy to achieve this goal by promoting protective maternal and child health-related behaviors through village training for health self-management. After reviewing the conditions and needs of the Sapone District, it was decided to focus on the following: control of diarrheal diseases, increase child and maternal immunization coverage, improve maternal and child nutrition, improve prenatal care and promote birth spacing, and control malaria. The strategy is community and family based, focusing on strengthening local institutions and family capacities to practice protective health behaviors.

The project is based in Sapone, Bazega province, 30 kilometers south of Ougadougou, the capital of Burkina Faso. Save the Children in Burkina Faso is known as Foundation for Community Development (FDC, Fondation pour le Developpement Communautaire). FDC has been working in Sapone since 1988, focusing on raising child immunization coverage rates, with funding from USA for Africa. The Child Survival 8 project (CS8) considerably extends the earlier project, with a greater focus on creating village capacities to maintain maternal and child health. The CS8 project is part of FDC's broader community development work, which includes activities to promote well construction, village-based credit and savings, gardening and increased agricultural productivity, and literacy training.

The CS8 project has enrolled all families living in Sapone district, and has created a community-based system for monitoring the attainment of the project goals. The project relies on a team of village health workers who are young women recruited from the district. They have been trained to work as health motivators (animatrices), each with a responsibility for five to eight villages. The health motivators work by mobilizing and training mothers of child bearing age with regard to the health behaviors targeted by the project. They also work to reinforce the local village health committees, including local health workers and midwives, so that they can reinforce the promotional work of the project. In each village they train local village leaders, volunteers who in turn mobilize and train other women in their section of the village.

The project was implemented in stages, starting with 18 villages in Ipelce and Sapone subdistricts for the first year, and then at the end of 1993 adding 8 additional villages in Doulogou subdistrict. All families in each of the 26 villages are enrolled in the project.

B. Area Information

The impact area includes 26 villages in Sapone, Ipelcc, and Douougou subdistricts (8,13, and 5 villages each, respectively) of Bazcga province. The area is 30 kilometers south of Ougadougou, the capital of Burkina Faso. According to the village census conducted in 1993-4, the target population in these villages numbered 25,670, with 5,693 women of childbearing age (15-49 years) and 4,859 children under the age of five.

The majority of the inhabitants are Mossi, speaking Moore. Religiously, there is a mixture of adherents to Islam, Christianity, and traditional African faiths. The people of the area depend on agriculture for their livelihood. During the rainy season (May to September), they raise millet, sorghum, peanuts, beans, and vegetables. Cotton is raised in some parts of the area as a cash crop. During the rainy season, diarrheal diseases become more prevalent, while in the dry season, particularly in the cooler months of December to February, there is a rise in acute respiratory infections.

C. Previous Evaluations

The baseline for this evaluation was established by two operations:

1. Family registration and census, conducted 1993-4 in all villages as the first project activity.
2. Sample survey of 240 women, conducted April 1993.

The family registration and census obtained all basic demographic information on residents in the project area (See Appendix I for the registration forms used in the baseline census.) The registration system procedures, forms, and programs were developed and tested by SC/US at its headquarters in Westport. This census also served to establish the community-based monitoring and surveillance system used throughout the project.

The baseline survey utilized a standardized MCH KAP survey developed as part of the PVO Child Survival Support Project at Johns Hopkins University. It included basic knowledge and practice questions regarding maternal and child health care and nutrition, weaning practices, diarrheal disease control, immunizations, and AIDS and malarial disease prevention.

In May 1994, a midterm evaluation was conducted of the Sapone CS8 project. That evaluation collected additional qualitative materials which are incorporated into this evaluation.

D. Evaluation Methodology

The final evaluation has the following goal:

- Evaluate the SC/Burkina Child Survival VIII project (Sapone) in a way that assesses

the level of achievement of its stated objectives, its response to the recommendation of the midterm evaluation, its effectiveness and sustainability, and make necessary recommendations for future projects.

The Evaluation Team was comprised of the following individuals:

Team Leader

Sally E. Findley, PhD, Associate Clinical Professor of Public Health, Columbia University

Team Members

Arlette Sanou, MD, Director, Planning and Research Unit, MOH
Toussaint Ouedraogo, Nutritionist, Family Health Division, MOH
Oumar Zoundi, Deputy Medical Officer, Bazega Province, MOH
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Jean-Pierre Bembamba, RN, Health Coordinator, FDC, Sapone, Burkina
Gaston Sogbo, RN, Health Information System Manager, FDC, Sapone

In addition, the entire staff of the FDC/Sapone health unit participated in the evaluation,

The evaluation used several methodologies:

1. Interviews with FDC staff, national, provincial, and subdistrict MOH officers, NGO collaborators, and Sapone residents regarding the accomplishments, strengths and weaknesses of the project. The interviews were conducted in the following ways: open-ended discussions, in-depth interviews with standardized questions, and focus group discussions.

It was decided to conduct interviews in two groups of villages: two villages which had received multi-sectoral inputs (health plus other development sectors) and two which had received very little program inputs beyond the health sector project. The four villages selected were Guisma and Souly (complementary programs) and Kalguin and Sabatenga-Yerce (only health programs). Focus group discussions were conducted in each of the four villages with women and men, and also group interviews with the village health committees and village leaders. Health officers were interviewed in nearby subdistrict locations: Ipelce and Sampin. Interviews also were conducted with the deputy health officer for Bazega Province and representatives of the two collaborating NGOs, AVLP and ABAC.

The list of persons interviewed and the questions used for each interview are given in Appendix. All interviews were conducted by the interview team, with assistance from the village health motivators and project health sector staff for the development of questions and conduct of the focus group sessions.

2. Quantitative evaluation with a comparison of survey responses at baseline and at final evaluation. The final evaluation survey used a questionnaire and methodology almost identical to that of the baseline survey.

The baseline and final evaluation surveys used almost identical questions and methodologies. The questionnaire was developed for administration to mothers 15-49 years old who have a child under 24 months of age. It was first designed by the Johns Hopkins University PVO Child Survival Support Project. The questionnaires were adapted by the CS8/Sapone project to mesh better with the actual interventions underway in the project. These revisions also were the opportunity to solicit and use input from the CS8/Sapone and SCF/Burkina Faso staff.

The baseline survey includes 52 questions, covering socio-demographic characteristics of the mother, her breastfeeding and infant nutrition practices, growth monitoring, malaria, diarrhea disease, immunizations, family planning, AIDS prevention, and clean water practices. The final evaluation survey covered virtually the same topics with 59 questions. A copy of the final evaluation questions and results is in the appendix.

Both surveys were conducted by the CS8/Sapone village health motivators and health unit staff. The survey used a simple cluster sampling methodology, similar to that used by UNICEF to evaluate immunization coverage, but at a much smaller scale. Each village in the project was considered a cluster, and eight women were selected per cluster, using a random start method. For the baseline survey, 240 eligible women were interviewed, while for the final survey, 210 women were interviewed.

These surveys are used to calculate the percent of the population with particular characteristics. Where possible and relevant, a comparison was made of the baseline and evaluation findings, to enable an assessment of the amount of change during the project period.

3. Review of project budget documents.

4. Analysis of longitudinal data collected with the health information system.

The project's health information system (HIS) is a longitudinal surveillance system, developed by the Save the Children headquarters in Westport. Before commencing any activities in the village, a complete census was undertaken in each village. Thus, the HIS initial values comprise a baseline for the project (as it was designed to do). These data are updated regularly, but at least yearly. The final evaluation report uses statistics from the end of the last project year (where available), as a means to assess progress toward goals.

The schedule for the evaluation team activities was as follows:

25-27 March	Interviews with FDC staff Review of project documents Preparation of interview guides
28-29 March	Interviews in villages and Sapone (villagers, village health comm., village leaders, district nurses, medical officer, NGOs) Retrieve data from HIS
30 March	Interviews with FDC staff Summarize interview results Analyze focus group responses Compare baseline and final evaluation surveys Compare baseline and final HIS data
1 April	Finalize quantitative analyses Draft summary results and recommendations Prepare preliminary evaluation team report
2 April	Presentation of preliminary evaluation report to FDC, USAID, MOH, NGO, and other invited representatives Continue finalization of analyses and report
3 April	Presentation of preliminary evaluation report to FDC staff and Sapone officials Completion of data retrieval from HIS Final interviews with FDC staff

Dr. Sally Findley prepared the final draft of the evaluation report after returning to the U.S. After review and comment from the field and headquarters staff, the final document will be submitted to SC for submission to USAID.

II. Project Accomplishments

A. Achievement of Objectives

Between the drafting of the **Draft** Implementation Plan (DIP) and the final evaluation, the objectives for the project were specified more narrowly. For each of the main project components, only 2-3 quantitative objectives were retained. On virtually all of these objectives, the **Sapone** project had succeeded or more than succeeded in attaining the target. This section details for each objective:

- a. Project inputs: Adherence to the DIP in terms of staff and resource inputs, participants and numbers trained, as well as the timeliness of the implementation relative to the DIP.
- b. Project strengths and weaknesses: Strengths and weaknesses of implementation, from staff and community perspectives.

c. Achievement of objective: Survey or other evaluation measures indicating degree to which objective goal has been attained.

This section on project accomplishments begins with a discussion of the overall program strategy, as this strategy cuts across the various health objectives.

1. FDC Health Strategy

The general strategy used by FDC to promote improved health behavior relies on training mothers to use materials or practices which are known to better protect infants and young children from the childhood diseases targeted by the project. In addition, the direct education of mothers is complemented by training of village health workers, so that they can be more effective at modelling, stimulating, and supporting the protective health practices. The project also facilitates referral to and effectiveness of relevant MOH services. Beyond its own staff, the FDC staff also collaborates with two local NGOs (Association Vive le Paysan, AVL, and Association Burkinabe de l'Action Communautaire, ABAC), training their community outreach workers in the health promotion strategies employed by the FDC outreach workers.

This community-oriented strategy is key to the FDC strategy. The goal is to increase gradually the number of village residents who are knowledgeable about primary health care, who either provide such care themselves or make referrals to appropriate persons. But FDC assumes that simply knowing how or where to obtain the needed services is not enough: community residents can benefit from economic or social changes which make it easier for them to have the time or financial resources needed to actually carry out the health practice. Thus, their health strategy is complemented by several programmatic inputs which are designed to make life easier, especially for women who are the main caregivers in this region. The complementary services or resources include: construction of wells, development of vegetable gardens, construction of latrines, establishment of village level credit and savings clubs.

Objective 1: Control of Diarrhea

Objective: 80% of the families will have at least one member capable of treating diarrhea with ORT, including knowing where to obtain ORS packets and how and when to use them.

a. Project inputs:

As shown in the Implementation Table, the project inputs for the control of diarrhea involved a series of trainings starting with project staff and then continuing with village health committee members, volunteer health workers, and women. The training is to be complemented with increased distribution of ORS packets and assistance in developing latrines and clean water supplies.

The following table compares the programmed and actual inputs based on monthly staff reports for this objective

Programmed Inputs:

Actual Inputs:

Train 9 health motivators to train villagers and village health workers in hygiene and nutrition practices to prevent and treat diarrhea, including mixing SSS or administering ORT

Midwives and nurses train the 9 village health motivators (animatrices) in diarrhea control practices and train them to train others.

26 village health workers trained as trainers of ORT preparation and administration, and in the use of potable water.

Health motivators trained 165 village health workers in May 1993, followed by a refresher course for 175 village health workers in April 1994, and for 199 in March 1995.

Training of village leaders on prevention of diarrhea and ORT preparation and administration

255 village leaders trained for three days each. Training sessions were held in each village. The 255 village leaders received a total of 510 bowls for measuring water, 2 100 packets of ORT for free distribution to villagers.

Training of 5000 mothers on ORT; families trained in handwashing, use of potable water, and maintenance of latrines.

4204 mothers were trained by village health motivators and village leaders in 499 educational sessions, totalling a participation of 8371.

Construction of latrines with local and non-local material

19 latrines constructed with villagers in year 1; 45 in year 2; 80 during year 3. totalling 144 latrines constructed. 120 demonstration sessions were conducted on the use and maintenance of the latrines, and on clean water practices.

For the diarrhea intervention, the only program input not attained by 100% or more was the number of mothers to be trained. Only 4459 women (89% of the target 5000) were trained. But most women participated in the training more than once, so that the actual number of participants was 7910, 158% of the target.

b. Achievement of diarrhea reduction objective

Quantitative Objectives:

80% of the families will have at least one member capable of treating diarrhea with ORT, including knowing where to obtain ORS packets and how and when to use them.

75% of children under 5 years would receive ORT or SSS in the event of diarrhea.

Outcome Measures: Percentage of survey respondents who express knowledge of ORT treatment, where to obtain solution, when and how to use it, as well as appropriate feeding practices for children with diarrhea. The data obtained from the Final Evaluation Survey, conducted March 10-20, 1996. (See Appendix for details.) Where parallel questions were asked at baseline and final evaluations, the percentage at the end of the project is compared to the baseline, to assess dynamic impact of the project.

Achievements:

(1) Knowledge of importance of giving additional fluids and foods to children with diarrhea (evaluation survey):

From 15% at baseline to 60% at project end say nurse more than usual

From 20% at baseline to 73% at project end say give more fluids than usual

From 6% to 47% say give more soft foods than usual

(2) Knows symptoms of severe diarrhea when should ask for advice on treatment of diarrhea (evaluation survey):

From 71% to 99% know at least one symptom

(3) Use of ORS or SSS when child had diarrhea (evaluation survey):

From 33% at baseline to 92% at project end

2100 ORS packets distributed during project (monthly staff reports)

Summary of Achievements:

The training efforts can be seen in the accomplishment of the two diarrhea control quantitative objectives: Village leaders were trained as planned and mothers of young children were trained. By the end of the project, the participants trained exceeded the target of 5000 women, with almost 8000 participants in the diarrhea educational sessions. This was 158% of the target. By the end of the project, the village health workers had provided training to about 4500 individual women on techniques of caring for diarrheal incidents. This is 89% of the targeted 5000 women to be trained. In 1996 there were an estimated 5826 women of child bearing age, with approximately one family per woman. This means that 76% of the families had at least one member trained in ORS and diarrhea treatment methods, very close to the 80% set as an objective for the project.

The project more than attained the objective of increasing use of ORS to 75% for the children under age 5 years. The percent of mothers with children under age 24 months who reported using ORS or SSS to treat their children's diarrhea rose from 33% to 92% by the end of the project.

The rise in the numbers of women using ORS packets is demonstrated clearly in the attached graph (Figure 1), which shows the ORS users ("utilise") jumping from about 1000 to over 5000 during the project period. This increase use of ORS certainly contributed to the

improvement in child health observed by the villagers, and documented by the fall in infant mortality during the project period (see p. 47), from 135 to 69 births per thousand births.

Croissance d'Utilisation SRO

- Connaissance de traitement avec plus de liquides
» 0,2% a 73%
- Connaissance de traitements d'aliments
» 6,4% a 47%

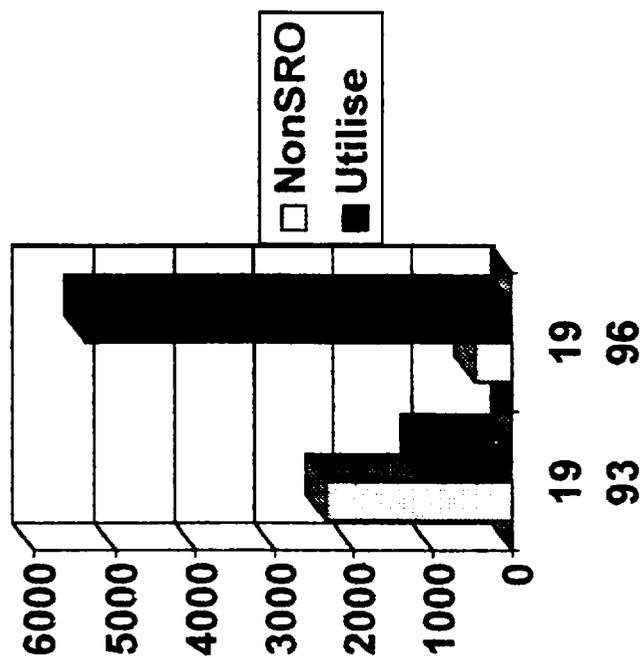


Figure 1

c. Strengths and weaknesses in implementing the program:

A major strength of the program cited by both staff and community residents was its presence in the villages. The village health motivators were selected from the villages, and the residents feel close to them. They are organizing “at home.” Both groups cited the considerable value of having the health workers go to the villagers, conducting the training sessions in the villages and making ORT packets available in the village. This accessibility made it much easier for women to participate and for all to accept the project. Simply not having to go all the way to the health post in the nearby subdistrict town makes it possible for women to participate.

The residents were enthusiastic about the educational sessions conducted by the village health workers and by the village leaders. This is what some of them said about the sessions and the diarrhea training:

“This can give more health to our children. The village leaders are a good thing, because the animatrice alone can not deal with all our needs, but with the village leaders our education can continue, even around the well.”

“One chats and passes the time receiving counsel, and little by little, it starts to come.”

“The health advice clarified much for us about how to raise and nourish children. Before we took care of children almost by chance. The educational sessions on diarrhea have helped us better manage health problems.”

“Women don’t come to the sessions just to see the animatrice. They come because they are interested.”

“Most important have been the sessions on diarrhea.”

“Now I know what to do when my child is sick with diarrhea.” After three

“The sessions on diarrhea have helped us a lot. I had experience myself two times with diarrhea, when using the packets the diarrhea stopped.

“We rapidly treat the little illnesses of our children, and then we avoid the bigger illnesses and the big expenditures for medications.”

“We know that diarrhea is less now. The number of rehydration cases is down, and each diarrhea lasts a shorter period.”

The village volunteers interviewed in the four villages expressed commitment to the program and to their work. One said:

“We will continue to do our educational and mobilisation work. There still are women who find false pretexts for not coming to the educational sessions. We will tell them that this is not good. Everyone has their problems, but we all need to make an effort to participate in meetings.”

“Women are very concerned about diarrhea. They always come to get my advice if their children get diarrhea. They used to have to take their children to Ipelce for rehydration. and now we do it here.”

“I can continue to teach others how to prepare ORS. We will continue even if the animatrice can not come anymore. I know how to make enriched porridge.”

“We will continue with our work. This is the path we are on now, and we must continue to follow it.”

“Since I was chosen, in spite of my very advanced age. I have always given of my time. I enjoy being able to help others.”

“The community encourages us. because we have had no problems mobilizing them. Any time, even during the rainy season, women respond to our calls.”

“Our advice is available here and is much less costly than the hospital.”

Residents also repeatedly cited the benefit of the well drilling and organization for maintaining a clean water supply. We cite here some of their comments, made during the focus group visits in four villages.

“Our principal problem is lack of water. We are tired from going to fetch water. Sometimes we can't even find water. And even for washing, it is difficult to find water.”

“The well has saved women hours of walking and waiting. During the dry season our wives sometimes spent the entire day getting water. Now they can get it here. And so they have time to go to the education sessions.”

“To be in good health, one must eat. Diet is the root of good health.”

The villagers, village health committees, and the village health workers identified only minor weaknesses in the implementation of the diarrhea control activities. They agreed with staff that there have been problems in maintaining the supply of ORS packets in the village health kits. The staff were concerned about the consequences of not having enough in the face of rising demand. The staff also were concerned about the procedures by which they keep track of diarrhea treatment. The computerized data base is updated only once a year, which is not often enough to identify problems. In addition, the village health registers that they do have are cumbersome and flimsy. The village health committees and the village leaders all

commented on the short training they had received, and wanted to have additional training to back up their newly acquired competencies.

The village health workers also worried about the degree to which villagers had actually taken charge of the educational activities. They suggested that the village health leaders be thanked more strongly and more verbally.

Another problem identified by the animatrice concerns the village health leaders. The village leaders are not paid anything. They may have to ask for assistance for a period of 2-3 months. They assume that the village leaders are at great risk for dropping out after a year of hard work and no incentives. As noted above, however, the village health workers do not agree with this position.

2. Nutrition and Vitamin A:

Objective:

- 60% of mothers will know when to start supplemental feeding of infants
- 70% of children between 6 and 59 months will have received one supplemental vitamin A dose in the last six months
- 60% of post-partum women will have received vitamin A in the two months after delivery

a. Project inputs:

As for the diarrheal disease control objective, the strategy for the nutrition component relies training village health motivators, village leaders, and villagers in improved nutritional practices, including consumption of foods rich in vitamin A, weaning foods. The nutritional intervention is backed up by growth monitoring of children. The project also distributes vitamin A capsules to mothers and children. Finally, the villagers are invited to participate in gardening projects which will increase the production of leafy vegetables and other foods rich in vitamin A. Monthly staff reports show the following actual inputs:

Programmed Inputs

The 9 village health motivators will be trained on the distribution of vitamin A, locally available vitamin A-rich foods, and nutrition in general.

Village leaders will be trained in nutrition and weaning practices.

1650 mothers will be trained on weaning foods and practices.

Actual Inputs

9 village health motivators were trained and were able to carry out their functions.

35 training sessions were held for 234 village leaders. 20% of the sessions covered vitamin A foods.

382 educational sessions were held, attended by 8754 mothers. (This includes a double counting of those mothers who attended more than one session.) 309 food demonstration sessions were conducted,

involving 6544 women.

All children 0 to 36 months will be weighed quarterly (every 3 months).

A total of 10,264 weighings were conducted during the project. This is about 5.2 weighings per child 6-36 months, slightly less than 2 per year. Identify and follow malnourished children, by level of malnutrition.

Provide children 6 to 59 months of age with semi-annual doses of vitamin A capsules. Post-partum women will be given semi-annual doses of vitamin A. Increase the cultivation of leafy vegetables and other foods rich in vitamin A.

128 16 doses of vitamin A were administered to children and 1859 to women.

9 village irrigated vegetable gardens started, 4 for women, 5 for men.

c. Achievement of objectives:

Objectives:

- 60% of mothers will know when to start supplemental feeding of infants
- 70% of children between 6 and 59 months will have received one supplemental vitamin A dose in the last six months
- 60% of post-par-tum women will have received vitamin A in the two months after delivery

Measures:

- Percent of survey respondents who know the appropriate age to start supplemental feeding of children, from the Final Evaluation Survey.
- Percent of children 6-59 months who have received vitamin A in the last six months, according to project HIS records.
- Percent of women of child bearing age who have received vitamin A, according to the project HIS records.
- Percent of women post-par-tum who received vitamin A within 2 months of delivery from monthly staff records.

Additional measures:

- Number of children 0-36 month weighed quarterly, according to the project HIS records.
- Percent of children with growth cards, based on Final Evaluation Survey
- Percent of children reported to have been weighed, base on Final Evaluation Survey results
- Percent of mothers who know correct infant feeding practices (to give **colostrum**, when to wean, when to give porridge, what to give), from the Final Evaluation Survey and from the Women and Infant Nutrition Survey, conducted in 1995.

Outcomes:

- (1) Knowledge of appropriate breastfeeding and weaning practices (from the survey):
From 60% of women at baseline to 88% at the project end know that porridge

should be started at age 4-6 months

From 58% of women at baseline to 79% at the project end know what supplemental foods to give simple porridge, without additional fat.

From 7% of women at baseline to 96% at the project end knew what kind of weaning foods to give children.

(2) Percent of children 6-59 months old receiving vitamin A doses (monthly staff records)

Number of children with at least one dose delivered, relative to eligible children

Year 1: 3405 received vitamin A out of 3046 eligible

Year 2: 3633 received vitamin A out of 4540 eligible

Year 3: 2391 received vitamin A out of 4324 eligible

The percent of children with at least one dose of vitamin A is 112% year 1, 80% for year 2, and 55% for year 3. Over the three and half year project period, 9429 vitamin doses were delivered to children. As of year 2, 1169 children had received two doses in the last 12 months.

(3) Percent of women post-par-turn who have received vitamin A (monthly staff records)

Number of women receiving, relative to estimated women post-pat-turn, by year:

Year 1: 866 women, 140% of the eligible post-pat-turn women

Year 2: 605 women, 95% of the eligible post-par-turn women

Year 3: 459 women, 75% of the eligible post-partum women

Additional outcomes:

(4) Additional knowledge of infant feeding practices (Women and Infant Nutrition Survey)

47% of the women surveyed by WINS say they gave colostrum to the infant they currently are nursing

51% of the mothers surveyed by WINS say that breast milk contains water

(5) Percent of children 0-36 months weighed quarterly (HIS records)

Year 1: 1203 children, 66% of the eligible children

Year 2: 861 children, 31% of the eligible children

Year 3: 765 children, 28% of the eligible children

Note that the rainy season months of June-July-August are excluded from the months for which regular weighing was assessed.

(6) Total children participating in growth monitoring with at least one weighing to identify nutritional status (HIS records)

Year 1: 3874 weighings, 2.1 weighings per eligible child 0-36 months

Year 2: 3343 weighings, 1.2 weighings per eligible child 0-36 months

Year 3: 3047 weighings, 1.1 weighings per eligible child 0-36 months

(7) Percent of surveyed women with child 0-23 months participating in growth monitoring (evaluation survey)

From 75% at baseline to 99% at final evaluation had a growth card, according to the baseline and final evaluation surveys.

From 30% at baseline to 76% at final evaluation had had child weighed,

according to the baseline and final evaluation surveys.

(8) Percent of moderately or severely malnourished children monitored regularly, according to the project HIS system

Year 1: 253 followed, out of 233 severely and 920 moderately malnourished (22% of all moderate-severe malnourished children)

Year 2: 339 followed, out of 193 severe and 763 moderately malnourished children (35% of severe and moderately malnourished)

Year 3: 180 followed, out of 63 severe and 423 moderately malnourished children (37% of severe and moderately malnourished)

Summary of Achievements

The project far exceeded the goal of educating at least 60% of the mothers about appropriate breastfeeding and supplementation practices. By the end of the project, almost 90% (88%) of the women knew when to start supplemental feeding (see succeeding graph (Figure 2), “age suppl” and “appropriate”. Three-fourths (79%) also knew what type of foods to give the infant when supplementing breastfeeding or weaning the infant. The additional focus group interviews and survey material from the Women and Infant Nutrition Survey (conducted mid-project) show a high level of understanding of appropriate breastfeeding and weaning practices. Women were enthusiastic about the food demonstrations, and the village leaders had no difficulty in ensuring that the women brought the food needed for the demonstration.

Although not specifically targeted by this project, there remains some education to be done with regard to giving water or tea at a very early age. The final evaluation survey shows that 72% of the women gave water and 22% gave tea to their infant just after the birth. The Women and Infant Nutrition Survey (April 1995) showed that women considered it important to welcome the new “stranger” with water, just as any stranger is welcomed with water. They also give water after breastfeeding, because the infant is thought to have eaten, and therefore to need water.

The vitamin A goals were not completely achieved. The project succeeded in delivering vitamin A to 70% or more of post-partum women, with the vitamins given to 140% of the eligible women in year 1, 95% in year 2, and 75% in year 3. More than 70% (79%) of the children 6-59 months did receive vitamin A. But, the evaluation team was not able to be certain of the number of doses per child. For years 1 and 2, we confirmed that only 169 children out of 4540 eligible children received two doses. For year 3, no children received both doses, apparently due to supply problems.

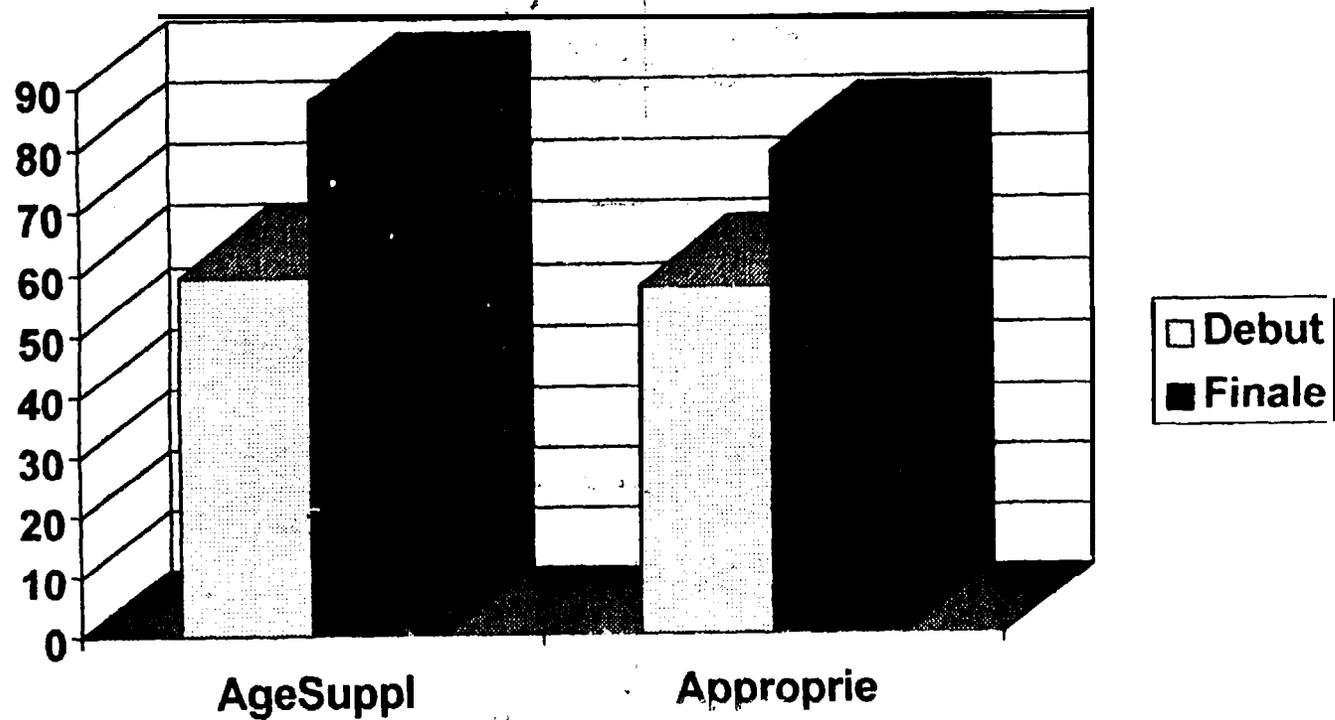
Although not retained as part of the final evaluation criteria, the project did include growth monitoring. As with the delivery of vitamin A, this activity was less successful than originally planned. The original DIP targeted 3500 children to be weighed quarterly. The actual numbers weighed quarterly was one-third or one-fourth of this number, with fewer in the final than initial years of the project. The project was successful at getting at least one weighing done per child, with an average of 3421 children weighed per year. The problem was one of repeating the weighings each quarter. As seen above, only a minority of the

children actually were weighed quarterly.

As seen in the next graph (Figure 3), the project notably reduced the number of children who are malnourished moderately or severely, from a worst 1000 in year I to under 500 in the last project year.

These two programs appear to work less well when the village health motivator is not able to see the mother regularly. The biggest problem encountered here appears to be the difficulty in insuring that mothers bring their children for repeat visits or activities.

Connaissances de Nutrition



Surveillance de Croissance

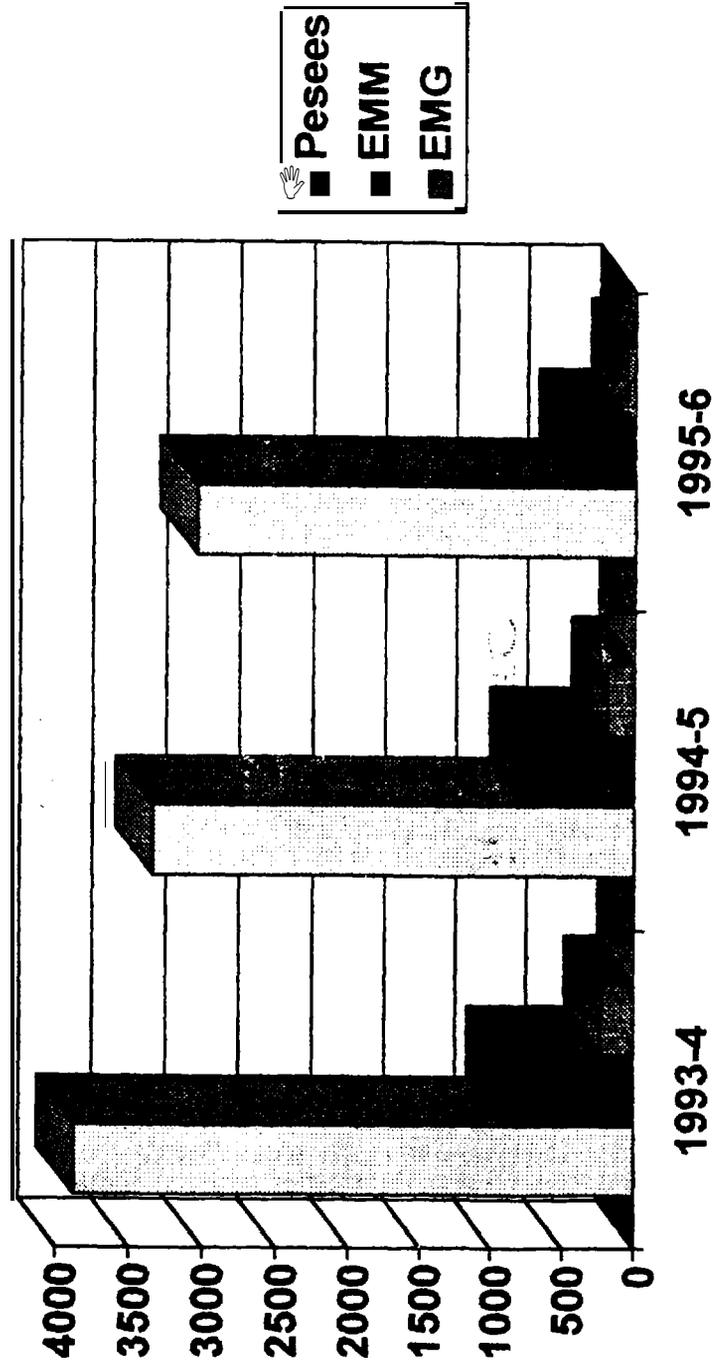


Figure 3

c. Strengths and Weaknesses:

As can be seen from the table above, the project succeeded in making most but not all of the planned inputs. They were able to implement their strategy of recruiting and training village volunteers to share in the work of mobilizing and educating on nutrition issues. They were enormously successful with the training programs on nutrition and weaning practices, providing training to an average of over 3000 women per year.

As with the education for control of diarrhea, village leaders, health committee members and villagers were enthusiastic about what they were learning about nutritional practices. Though they could not see the results as dramatically as when children are brought through diarrhea, they had the following to say about the nutrition education.

“The health committee gets together twice a month. As soon as they learn something, they pass it on to the village leaders, who then transmit this information to the community.”

“The animatrice comes from far away and uses up fuel in order to come to give us advice. So, our feet can walk without fuel. There is no problem of time from our point of view.”

“We (the village leaders) plan to continue our activities in the village, such as educating others about nutrition, malaria, diarrhea, and family planning. We will continue to demonstrate how to make enriched porridge and SSS.”

“We now know how to take care of our children with different porridges, because mother’s milk is not enough.”

“The village health workers have helped us by giving us advice on preparing porridges. The porridge helps our children grow, because they contain building and energizing foods.”

“In following their advice, we have changed our hygiene and our diet. Now we know these things. Those who follow the advice change; those who do not want to follow them, they don’t change.”

“The gardening has helped us improve the health of our family. Part of the production we use to fortify our sauces, and the rest is sold. Then we have money to purchase medicines when we need them.”

Women repeatedly commented on the value of what they had learned for their own diet during pregnancy.

The men who participated in the four focus group discussions also remarked on the change in behavior, and not just in the arena of health. According to the men in one village,

“There has been a change in everyone’s behavior. Now our eyes are opened. People are more involved in village activities. Thanks to the advice on anti-erosive embankments, there has even been an increase in agricultural production.”

“We think that women have received advice, and this advice helps them improve our children’s health. Thanks to the weighing of children and the food demonstrations our children are not so sick. They are better nourished and eat well. This advice has helped us improve our health, so that now certain illnesses do not get worse.”

Two of the planned activities were not implemented fully to the level expected. Vitamin A distribution was less than anticipated. On average, the eligible children received one dose per year, not two. There was a drop in coverage from 1994 onwards, and this correlates with a break in the supply. The village health committees were aware of the supply problem and commented on the lack of availability of vitamin A, as well as other first aid medications. The village health workers also signalled a problem with retaining the vitamin A storage at the proper temperatures.

Another input which was less than anticipated was the weighing of infants. Although this program started fine in 1993-94, they were not able to keep up this pace. Ultimately, children were weighed twice per year, not thrice per year. In this case the drop in weighings was linked to the onerous nature of the job. It attracted more criticism (at all levels) than any other activity. The village health motivators complained that it took inordinate amounts of time, both for themselves and the women. The weighings were the single activity which most contributed to their sense of overwork. While it was possible to integrate the weighings with other educational activities, they still felt that it took almost half of their time. They proposed greater use of arm circumferences for identification of the severely malnourished.

In addition, they felt that the weighings did not give useful data for project staff or parents. As they rightfully point out, they do not have the tools to properly follow and rehydrate the severely malnourished child. It would be better, they counsel, to identify and follow only the severely malnourished. The village health workers felt their assistance in preparing porridge was inadequate.

Further, when they referred the severely dehydrated child to the health center for therapy and antibiotics, they found that parents often did not take their children because they did not have money to pay for medications. They recommended that the village develop procedures for handling the severely malnourished children when the parents say they are too poor. If the policy were implemented children could be saved from dying in their mothers’ arms.

3. High Risk Births and STDs

Objective:

75% of high risk pregnancies will have received 2 or more prenatal consultations, and will have a delivery attended by a trained TBA

90% of women of reproductive ages will have received two doses of anti-tetanus vaccines

20% of women who do not want another child in the next two years will use a modern contraceptive method

50% of the population ages 10-49 will know at least one method to effectively prevent the spread of STDs/AIDS

a. Project inputs:

As with the other components of the Sapone CS8 project, the component focusing on protection for high risk pregnancies actually includes a variety of subobjectives and activities. Regardless of their degree of risk during pregnancy, all women were considered eligible for education about nutrition and health maintenance during pregnancy, proper nutrition while nursing, and prevention of STDs/AIDS. The component is heavily oriented towards education and training, to build a cadre of women (and men) dedicated to the objectives articulated in the objective. Thus, the strategy starts with training (and re-training) of the midwives and nursing staff who serve as trainers and supervisors for the village health workers. The village health workers are, in turn, trained in the basic techniques of birth spacing, identification of high risk pregnancies, and so on. They in turn recruit volunteers to help them mobilize and education the community. With this component, there is a high degree of collaboration with the district ministry of health officers. Referrals for deliveries are made to the district health officers. In addition, youth clubs in each village are invited to manage distribution of condoms. STD prevention is woven into the fabric of each activity, as well as having its own separate training and educational section within the component.

Monthly staff reports show the following actual inputs:

Programmed Inputs

Actual Inputs

26 TBAs trained on the management of high risk pregnancies and childspacing, with a restocking of their kits.

29 TBAs were trained and then retrained once a year, for each of the three years of the project. Kits were restocked in 1993 and 1994 with nivaquine and aspirine (1000 pill boxes)

26 village health motivators trained in childspacing techniques; 650 women of reproductive ages will be trained on infant and maternal health

9 health motivators were trained, and selected village leaders held 187 educational sessions. 2450 households 2343 trained. Allowing for retraining, there were 3590 participants in family planning

training sessions.

All pregnant women will attend prenatal consultations.

Project nurse midwife performed 2,094 consultations, 95% of all pregnancies ending in a birth.

The project nurse does postnatal consultations on all newly delivered women.

The nurse midwife did 377 post-natal consultations among the 2207 women who delivered during the 36 months of the project.

The project accomplished all the planned inputs except the post-partum consultations to all newly delivered women. In addition to these programmed inputs, the reproductive health component included an initiative to educate men and women about STDs and AIDS and to establish a community-based system for distributing condoms. Thus, the educational sessions held on family planning included material on the prevention of the spread of sexually transmitted diseases. In each village, youth clubs were provided with an initial supply of condoms, which they then would renew from the receipts of sales from the first supply.

b. Achievement of objectives

Objectives:

75% of high risk pregnancies will have received 2 or more prenatal consultations, and will have a delivery attended by a trained TBA

90% of women of reproductive ages will have received two doses of anti-tetanus vaccines

20% of women who do not want another child in the next two years will use a modern contraceptive method

50% of the population ages 10-49 will know at least one method to effectively prevent the spread of STDs/AIDS

Outcome Measures:

Percent of women identified as having a high risk pregnancies who received 2 or more pre-natal consultations, according to project HIS records.

Percent of women with high risk pregnancies who had a delivery attended by a trained TBA (or referred to the maternity/hospital), according to project HIS records.

Percent of women of reproductive ages who have received two or more doses of anti-tetanus vaccine, according to project HIS records and to self-reports of vaccinations from the baseline and final evaluation surveys

Percent of women using modern contraceptive methods among those who say they want no more children, according to the baseline and final evaluation surveys

Percent of women of reproductive ages who know at least one method to prevent STD/AIDS transmission, according to the baseline and final evaluation surveys.

Number of women participating in STD/AIDS/FP educational sessions, according to

monthly staff reports

Number of men participating in STD/AIDS/FP educational sessions, according to monthly staff reports

Additional outcome measures:

Percent of women knowing when to first go for pre-natal consultations, according to baseline and final evaluation surveys

Percent of women knowing the necessity for three or more pre-natal consultations, according to baseline and final evaluation surveys

Number of men and women participating in informational discussions about the prevention of STDs and AIDS, according to staff monthly reports.

Training of youth club members regarding prevention of AIDS and sales of condoms.

Outcomes:

(1) Surveillance and consultations for high-risk pregnancies (based on monthly staff records)

During the three project years, there were 2,207 births. Of these pregnancies, 2094 received pre-natal consultations, very close to the objective of complete coverage. (95%) Through her consultations, the nurse midwife identified 139 high risk pregnancies, of which 100% were followed with regular consultations. The nurse midwife records for the followed high-risk pregnancies showed that they all were delivered with assistance, with many going as recommended to the hospital or maternity for delivery. Thus, this is a consultation rate of 100% of all high-risk pregnancies. In principle, then, the project achieved the goal of providing prenatal consultations to at least 75% of the high risk pregnancies. However, we have no data on the number of high risk pregnancies which might have been missed of the 13 pregnancies not followed by the project staff. If the rate of high-risk remains around 5% for this group (as it was for the other pregnancies), then the number missed would not exceed 6-7, hence the goal of a consultation rate of 75% or better would still be maintained.

The proportion of all deliveries attended by trained TBAs or other health workers stayed fairly constant during the project period. In the first year, the baseline survey showed that 8% of the respondents delivered with the assistance of friends or neighbors; at the end of the project this was still at 9% of all respondents' last deliveries.

(2) Surveillance and consultations of all pregnancies

Although the project did not have a goal to ensure pre-natal consultations for all pregnancies, it came close to achieving 100% coverage, with a prenatal consultation rate of 95%. This coverage rate is borne out by the evaluation survey results:

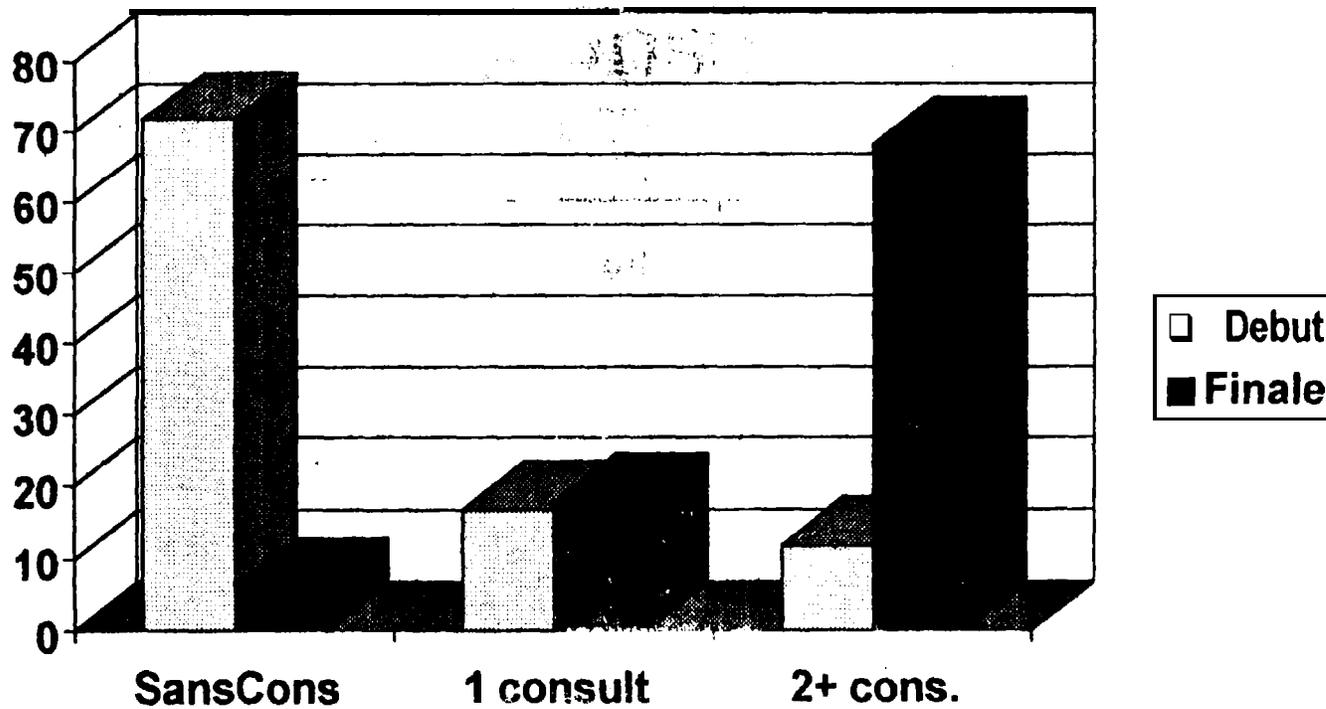
The percent of women knowing the need for three or more pre-natal consultations went from 65% at baseline to 88% at the final evaluation.

The percent of women who know to have the first consultation during the first trimester rose from 42% at baseline to 82% at the final evaluation.

The percent of women having no pre-natal consultations for their last pregnancy dropped from 72% at baseline to 6% at the final evaluation survey.

The percent of women having two or more pre-natal consultations rose from 12% at baseline to 68% at the final evaluation survey. (See attached Figure 4.)

Consultations Prenatales



(3) Anti-tetanus vaccinations (from monthly staff records)

From 70% in year 1 to year 3's 98% of women of reproductive ages had two or more anti-tetanus vaccines.

According to the project monthly reports, the percent with anti-tetanus vaccines exceeds the objective of 90%. The baseline and final evaluation surveys also asked women about their vaccination status, but obtained it only if they had their vaccination card. Unfortunately 10% of the women had lost their card. If only those with cards are observed for vaccination status, the proportions with two or more anti-tetanus vaccines drops to 78% at the final evaluation survey, which is 12% short of the 90% objective.

(4) Use of family planning methods (based on evaluation survey results)

During the project period, the proportion of women who currently have a child under two years of age and who want to delay another birth for at least two years increased. At baseline, the proportion wanting to space their next birth was 69%, and at the final evaluation the proportion had risen to 83%. This increase reflected the participation of women and men in family planning informational sessions conducted by the project staff and village leaders, as mentioned by the community residents in the focus group discussions referred to above.

Of the women sampled in the survey (all have a child under age two years), the proportion who do not want a birth within the next two years rose during the project period. And so did the proportion of such couples using modern family planning methods. At baseline the proportion of those not wanting a birth now who use family planning methods was 33%, and at the final evaluation the percent had risen to 48%, namely from one-third to one-half of all women seeking to delay births. This proportion using modern contraceptive methods exceeds the target percentage of 20%.

(5) Education about prevention of AIDS/STDs (from monthly staff records)

The following are the numbers of persons educated about the prevention of AIDS and STDs:

	Year 1	Year 2	Year 3	Total
Women	618	1187	1943	3748
Men	581	1116	1826	3523
Village leaders	24	3		27
Youth club memb.	0	124	438	562

The total number of women trained ($3748 + 27 = 3775$) is 65% of the total women 1549 years of age in 1996, the last year of the project. The number of men trained constitutes 74% of the total population of men 10-49 years old. Thus, the trainings exceed the goal of 50% of men and women knowing at least one method to protect against STDs and AIDS. However, that is assuming that the training was effective at conveying this information. The focus group discussions indicate that people do know about AIDS and prevention of AIDS with use of condoms (see quotes above). The final evaluation survey did not include a question on AIDS prevention, so it is not possible to verify actual

knowledge on this item.

Summary of achievements

The project provided all the programmed inputs except for the goals with regard to post-partum consultations. For all other inputs, actual training volume exceeded the planned numbers, with more men and women educated about pre-natal care, birthspacing, and prevention of STDs than was originally planned. The workplan called for postnatal consultations for all newly delivered women, but records show that less than one-fourth of all women had post-partum consultations with the project nurse-midwife. Nonetheless, all post-par-turn women were visited by the village health motivator, first to verify the birth for the HIS and then to commence education about infant care and prevention of diar-rhca.

The project came close to achieving the objectives associated with this component. 95% of all pregnant women received pre-natal consultations, and close to 100% of all high-risk pregnancies. The final evaluation survey shows that most women deliver with a trained village midwife or other health worker. Most women know the number of pre-natal consultations needed, and 68% of the women interviewed for the final evaluation survey indicated that they had 2 or more pre-natal consultations. This is slightly shy of the 75% objective for the 2+ consultation rate, but that pertained to high risk women, and as far as we can see the consultations covered 100% of the high-risk pregnancies. The project also was short of attaining its objective with regard to anti-tetanus vaccinations. Although the HIS shows a maternal immunization rate of 98%, the survey shows a rate of only 78%. if we do not count immunizations by women who have lost their immunization cards.

The most striking success for this component concerns the impact of the educational sessions about family planning and STDs/AIDS. The survey showed a marked increase in the percent of couples with young children (under age 2) who prefer to delay their next birth and who are currently using modern contraceptive methods. The percents, respectively, are 83% and 48%. respectively.

c. Strengths and weaknesses

In the discussions held with the villagers, information about family planning was mentioned as one of the main benefits of the project.

“There is the benefit of birth spacing are numerous, such as rest for women, better growth of children, and better for the first child to stay healthy.”

“Since the discussions we have learned. Now we space our births.”

“All the project is important, but for me the most important has been family planning.

Specific questions were asked about the availability of condoms, and in all four selected study

villages the men confirmed that condoms were available.

“Information about AIDS has been important.”

“Condoms are available in the community. They cost 10 francs. This price is reasonable, because the illness is very expensive. Even if it were more than 10 francs, we would buy them.”

“Even if you ask a child where to get condoms, he could take you to the house of the person who sells them.”

“Thanks to condoms, there are very few AIDS cases in the village.”

Both men and women commented on the great contribution the project had made by informing women about the importance of pre-natal care and proper nutrition during pregnancy. It was considered a great savings and facilitator that the nurse midwife and village health motivators provided consultations in the village. With this service, many women found they were able to make prenatal visits. The village health motivators found that women highly valued the privacy afforded by home visits. This privacy also enhanced their ability to provide family planning advice.

“We have learned how to follow pregnancies, and the changes are due to the discussions.”

“The training is good, because women now understand more, and it’s due to the meetings.”

“The village traditional midwife is trained on the factors making for a risky pregnancy. We know when the woman must be evacuated.”

Speaking from the point of view of the village health committee:

“We know who are all the pregnant women. They now agree more readily to taking chloroquine and iron.”

“It is important for all deliveries to be made with the village midwife. We must follow all pregnancies and be concerned about their health, their nutrition, the evolution of their pregnancies, and the spacing of births.”

The interviews with the district nurse confirmed that the project had generated a demand for pre-natal consultations. The two who were interviewed remarked that they were seeing many more women as a result of the mobilization and educational work of the project.

The project staff felt that they missed **very** few pregnancies, mainly **those** of women who migrated out of the area. A few pregnancies are also missed during the rainy season, particularly the month of August when the village health motivators are on vacation. Most women come for visits by the fourth month, which is traditionally considered the time when a

woman may publically acknowledge her pregnancy (especially a first pregnancy).

Among the problems mentioned by the staff or villagers are the following: no educational sessions on family planning and STDs specifically for men; difficulty of covering all the pregnancies with the one project nurse-midwife; insufficient training on current family planning methods for the nurses and midwife.

This was the one technical area where the nurses and village health motivators felt that they were not keeping up with available technologies. In contrast to their colleagues working for the Ministry of Health, they had not had any training on Norplant or some of the newer contraceptive methods. The village health motivators felt they, too, could do more to promote family planning use if they had more training. In addition, they felt that they should be able to make available more family planning methods.

The village health committee and the village health motivators both commented on the problems of maintaining supplies of the basic medications. Pill availability has been variable.

4. Immunization and Malaria Prevention

Objectives

80% of children 12-23 months will have been completely vaccinated.

60% of mothers will know methods to prevent malaria and will know where to take children with malaria for treatment.

a. Project inputs

The last set of objectives concern immunization and prevention of malaria. The strategy for immunization emphasizes mobilisation of the community to participate in the ministry of health vaccination team visits. This mobilisation activity is complemented by logistical support to the vaccination team, to help ensure that it gets out to the villages as planned. For malaria prevention, the strategy involves educational sessions on prevention and treatment of malaria, and sale of chloroquine tablets. Based on monthly staff records, the actual inputs were:

Prowammed Inputs

8 village health motivators trained on immunization schedule and target populations, to provide educational sessions on immunizations to villagers.

Actual Inputs

9 health motivators trained in Nov-Dec. 1992. 2407 women educated about immunizations in 119 discussion sessions held in the villages.

Monthly allotment to Provincial Health Department for transportation costs and cold chain maintenance

Delivered to provincial MOH 1456 liters of gasoline, 1350 liters of kerosene, and 24 propane tanks. Health Department motorcycles were repaired and provided with necessary parts.

Monthly mobilizations for vaccination sessions in villages

Village leaders mobilized the community for visits by the immunization team. 700 village immunization sessions were conducted by the provincial EPI team.

Village health motivators trained in malaria prevention techniques, and they train village leaders to educate about malaria prevention

Village health motivators trained, and 191 village leaders trained on malaria. 329 village discussion sessions held for 6348 women.

b. Achievement of objectives

Objectives

80% of children 12-23 months will have been completely vaccinated.

60% of mothers will know methods to prevent malaria and will know where to take children with malaria for treatment.

Measures:

Percent of children 12-23 months completely vaccinated (BCG, DTP, Polio, Measles, Yellow Fever) according to project HIS records

Percent of children 12-23 months completely vaccinated (as above), according to the final evaluation survey of mothers of children 0-23 months

Percent of mothers knowing at least one activity that can help protect their family from malaria, according to the final evaluation survey

Change in incidence of malaria among children 0-23 months, according to the question on "fever" in the baseline and final evaluation surveys

Outcomes:

I) Percent of children immunized completely (HIS data)

The **ProMIS** records show the following numbers of children 12-23 months completely vaccinated in each year:

	Year 1	Year 2	Year 3	Total
Children immunized	575	885	960	2420
Total children	374	212	259	845
Percent immunized completely	65%	24%	27%	35%

However, the HIS coordinator stated that the immunization records in the project HIS are incomplete, because they have been unable to coordinate with the provincial health department to ensure that project staff are present when the immunization team makes its visit. He considers the data unreliable and suggests using the survey results instead.

Based on the baseline and final evaluation surveys of mothers with children 0-23 months, the following results were found:

Percent of children 12-23 months immunized completely, rose from 69% at baseline to 89% at final evaluation. The drop-out rate from the first to third dose of polio vaccine was only 7%, from 99% having Polio 1 to 92% having Polio 3.

2) Knowledge of malaria prevention (evaluation survey)

The village health motivators and village leaders educated the women in several activities to reduce mosquito breeding, hence transmission of the disease. The methods were basically to clean the courtyard, cut brush around the courtyard, and not allow water to stand in uncovered containers.

Percent of women knowing at least one method to protect the family rose from 13% at baseline to 78% at final evaluation.

Percent of women knowing the treatment for malaria symptoms in their children rose from 73% to 80% (baseline to final evaluation surveys).

3) Incidence of malaria in young children (evaluation survey)

Percent of children 0-23 months with a fever in the last two weeks declined from 55% in the baseline year to 31% at the final evaluation.

Summary of achievements:

Although the percent of children completely vaccinated was fairly high at baseline (69%), the project was able to significantly increase the vaccination rate, ending the project with coverage rate of 89%. The project achieved its goals of ensuring complete immunization of 80% of the children 12-23 months old. However, it did not succeed in registering the immunizations of all children. The project HIS only recorded a complete immunization coverage rate of 35%, just over half the level obtained from the survey. This means that about half of the children's vaccinations were missed by the project HIS. Interviews with the HIS staff indicate that the major reason for incomplete registration was inability of the MOH to alert the project staff well enough in advance of a visit to permit them to be there to register immunizations.

Mobilizations and education about immunizations and malaria prevention were much more successful, with the project successfully mobilizing thousands of women over the three year period. The malaria mobilizations appear to have been quite successful, with a dramatic increase in knowledge about identifying and treating malaria. In addition, the proportion of women knowing what simple steps they can take to prevent malaria rose throughout the project, to 80% of all women.

c. Strengths and weaknesses

The malaria education part of the project reached many more women than was planned, and it appears to have been successful. Women know what to do to eliminate mosquito breeding grounds and, more importantly, they appear to be taking the necessary steps. Against global trends for increasing malaria, the project zone experienced a decline in malaria among young children, based on the baseline and final evaluation surveys. This is definitely a cost-effective intervention, and one which attracted interest from the national program to eradicate malaria when the results were presented in Ougadougou.

In a country where the average coverage level for children 12-23 months is still well below the 80% universal coverage goal of the expanded program for immunization, it is impressive that the project area attained a coverage level of 89%. And this is in spite of interruptions in the supply of yellow fever vaccine. As the local health authorities assured us in individual interviews and at the presentation of the results, the logistical support provided by the project made all the difference in the ability of the team to get out as planned to the villages. But, the deputy health officer for Bazega province also noted the important contribution of the training and mobilization sessions. Before, women learned about immunizations (and other health promotion activities) only when and if they went to the clinic for some other reason. With the CS8 project, the village health motivators have educated the mothers about immunizations in the village, so more women know about the importance of the immunizations, those who go to the clinic and those who do not. Further, the village leaders publicize the visits of the vaccination team prior to their visit, helping to ensure a good turnout. This helps the ministry team be more effective in the use of their time. From the ministry point of view, a weak point is that the project does not operate in all villages of the district, so that these benefits are experienced only in the 26 project villages.

The members of the village health committees also recognized and applauded the mobilisation activities of the village leaders and village health motivators:

“Vaccination is important. There isn’t anymore measles or whooping cough since the vaccination team started coming.”

“ We want each neighborhood to participate in each activity. Even when the neighborhoods are far away. If people refuse to come, we must insist, but especially when they live closeby.”

“All the activities of the FDC are important to us. Now, this is the life of the people.”

“For the fight against malaria, I started with my own compound. There was no problem. The women agreed to do it.”

According to several village leaders:

“I am kept busy with malaria cases, especially the prevention, how to clear the brush away from the houses. When a child has malaria, I go to see the child. If it is

serious, I send them to the village health agent.”

The village health committees noted that there were no problems in the supply of nivaquine. although several village leaders indicated the lack of willingness on the part of women to buy the tablets when needed. Others commented on the advantage for women, especially pregnant women, to be able to buy nivaquine tablets in the village during the rainy season, saving them the long trip to a subdistrict health post.

Another weak point from the ministry view point is the lack of joint planning and coordination of project activities. They would like to be more involved in the actual planning of the training and programmatic aspects of the project. As far as coordination goes, both project staff and the ministry officials indicated difficulties at coordination of activities, some of which were most apparent in the immunization component. The HIS coordinator wanted to be informed of the vaccination team visits, so that he could arrange for the health motivators to be present to update the child immunization records. After a year, they arranged for an exchange of schedules, but unfortunately the exchange was often too late for the project staff, which plans by the first of the month while the vaccination team schedules arrive around the 10th of the month. As a result, the project was not able to update the child immunization records except at the time of the annual update. The delayed update was clearly incomplete, with many immunizations apparently missed by the update team. It would seem that the project would benefit by training at least one village leader or registrar per village to be able to update the records at the time of the vaccination team visit.

Though it was in the context of the EPI discussions that the district and provincial health authorities requested more regular coordination, such coordination could benefit all components of the program, especially as it moves into the next phase of activity devolution. For example, monthly meetings proposed by the Ipelce nurse also could serve as a time to improve coordination with the two local NGOs, ABAC and AVLPL.

Summary of Overall Achievements

The project was immensely successful at attaining its objectives, Indeed for most of the objectives, the outcomes surpassed the objectives. For but a couple did the achievement not quite make the objective. For no objectives was the project far from success. The table below summarizes this experience, comparing the objectives and the achievements.

This summary table shows that for every objective the project met or exceeded the objective. This finding holds even when alternative outcome measures are used. The qualitative measures of success also indicate a fairly high degree of satisfaction with the program. Indeed, the villagers were hard pressed to indicate any weaknesses with the program. Of course, part of that is a general reticence to criticize, and especially not to criticize "gifts". Nonetheless, they conveyed a strong sense of pride, engagement, and commitment that occurs only with true satisfaction.

SUMMARY OF ACHIEVEMENTS, CS8/SAPONE, 1992-I 996

<u>Objective</u>	<u>Achievement</u>
80% families w. ORS competence	60-73% of mothers know what to do for diarrhea of their children 99% know of mothers know at least one symptom of diarrhea 92% of mothers had used ORS to treat recent diarrhea episode of own child
60% of mothers know when to add supplemental food to infant diet	88% of mothers know when to start with porridge 96% of mothers knew at least one appropriate weaning food 79% of mothers knew what kind of porridge to use for supplementation
70% of children 6-59 months will receive a vitamin A dose each six months	80% of eligible children received at least one vitamin A dose. 12% of children known to have received two doses.
60% of postpartum women will receive a vitamin A dose two months after delivery	75-140% of eligible women have received vitamin A post-partum.

90% of women of reproductive age will receive two or more anti-tetanus vaccinations

98% of women of reproductive age had received two anti-tetanus vaccinations. (78% if you don't card the women who lost their health card.)

75% of high risk pregnancies will receive 2+ pre-natal consultations and will have a delivery with a trained midwife

88% of women know the need for 3+ pre-natal consultations
94% of mothers with a recent delivery had at least one pre-natal consultation
68% of women had two + pre-natal consultations

20% of women wishing to delay a birth will use local family planning clinic methods

83% of mothers with a child under age two wish to delay the next birth.
Of these, 48% used modern contraceptive methods to delay the next birth.

50% of men and women 15-49 years old will know at least one method to prevent the spread of STDs or AIDS

65% of women 15-49 years of age and 74% of the men 15-49 years of age have been trained in AIDS prevention.

80% of children 12-23 months will be completely immunized

89% of children 12-23 months are completely immunized

60% of mothers will know methods to prevent malaria and will know what to do in the case of serious malaria.

78% of mothers know what to do to prevent spread of cholera and 80% know what to do for malaria.

The combined impact of these activities has been a measurable improvement in child health and survival. Because of the accuracy and coverage of the health information system, the evaluation team was able to go beyond knowledge and behavioral outcomes to the outcome of major interest in this project, namely infant and child mortality. As can be seen in the table below, infant mortality dropped substantially during the project duration. In the first 18 project villages, infant mortality averaged 139 deaths per 1000 for the year preceding March 1994, when the first annual update was conducted. Child mortality (deaths to children 0-4 years of age) was estimated to be 54 per 1000. At the end of the project (Feb. 1996), the infant mortality rate was 70 per thousand, while it was 35 per thousand for child mortality. This is a 50% drop in the IMR (infant mortality rate) and a 35% drop in the CMR (child mortality rate). For the 8 villages added in the second year of the project, the decline in

infant mortality over the two year period was from 91 to 68. a decline of 25%. For these villages the CMR declined by 5 1% to 34 per thousand at the end of the project in February 1996.

Decline in Infant and Child Mortality

Village Group	IMR Baseline	IMR Final	CMR Baseline	CMR Final
18 initial	139	70	54	35
8 additional	91	68	69	34
26 total	135	69	55	35

Across all 26 villages, infant mortality dropped from 135 at the start of their participation in the project to 69 at the end of the project, a 49% reduction. Child mortality dropped from 55 to 35, a decline of 36%. Thus, during the project period infant and child mortality both dropped by about half. These are very impressive results for the project, and are evidence of how well the various components worked.

III. Health Information System

A. Comparison of HIS planned inputs versus actual achievements:

1. *The project will hire a HIS coordinator and data entry clerk*

The field office hired Gaston Sobogo as an HIS coordinator and Ramata Sankara as data entry clerk.

2. *Conduct a 100% family enrollment in all villages. The census should be completed in 2 months (March 15, 1993), including tabulation, and development of rosters. The HIS will be fully operational by April 1993.*

According to the first and second HIS report, the field office completed a 100% family enrollment in all the villages of the project. The enrollment for the first eighteen villages was completed on 2/23/93 and the next eight villages on 2/28/94. The system became fully operational for the first 18 villages by the end of March 1993, and by the end of March 1994 for the remaining 8 villages.

3. *Each family in the district will have an enrollment card; basic and health information; and each village will have women's and children's rosters kept and used by the promoters,*

Every family (a mother and her children) has a family enrollment card. There are 6,020 family enrollment cards. Viewed cards show updated basic and health information. All

villages have women and children rosters. They are with the village health motivators..

4. *Within a certain time frame, the project will purchase the following: computer, a printer, a large amount of printed materials, and a few related supplies such as pens, kerosene, etc.*

All family enrollment materials have been purchased on time to ensure the proper implementation of the activity. The project computer reached the office on 4/93. Because of an electrical fault, it broke down. It was shipped back to Westport for repair and returned to the office by 2/94. Solar panels were installed in 2/1993.

5. *Budget allocated to the HIS include:*

*\$23,150 will be spent on baseline survey, midterm and final evaluation
 \$8,000 for DIP and annual reports
 \$36,000 for family enrollment, and other components of the HIS
 \$7,500 for a computer and its accessories to be used for program management. This totals \$74,650, approximately 8.4% of the total project budget.*

There are numerous financial document in the FO showing the cost of different HIS activities. A study of the total cost of the HIS was not done.

6. *Provision of technical assistance to the HIS:*

- * Two weeks to help design the baseline survey*
- * One TA visit from Save the Children HQ staff for design and quality control of the family registration.*

In 1/1993, Ahmed Zayan provided TA to the HIS. During 8/93, Gaston Sogbo attended an HIS workshop in Westport. Fode Doumbia provided TA for the baseline survey. Sally Stansfield visited the FO in 1994 where she provided recommendations on how to improve the system

7. *The following is the approximate schedule for the HIS of the project.*

Interventions	Comments
Family enrollment (12/92-2/93) for area I (18 villages)	Completed as planned
Family enrollment (12/93-2/94) for area II (8 villages)	Completed as planned
Rosters will be updated on an on-going basis. they will be updated once every two months through vital events reports (birth, death, and migration).	Update is done monthly
Baseline survey completed (2/93)	Completed as planned by 12/92
DIP completed (4/93)	Completed as planned by 1/93

Monitoring system completed (4/93)	Completed and functional
Internal monitoring reports (Monthly)	Completed as planned
External monitoring reports (Quarterly)	The project produced narrative reports since 1/93
Annual Reports (9/93, 9/94)	Completed as planned
Midterm Evaluation (4/94)	Completed as planned
Final Evaluation (9/95).	Current

8. *The system will be used on a daily basis to conduct project activities, Data are also used for planning and decision making.*

The HIS tools like the rosters are used daily in the delivery of project activities. At the village level, the feedback provides the village leaders with an incentive to monitor the progress of the activities and allow them an opportunity to take actions. The village health motivators use the HIS rosters to ensure that all women and children of the project area received the planned services. Senior project staff use the data to plan project activities. At the end of each report, there is a list of achievement. These data allow the project manager to plan the activities, identify the priority villages, assign project staff to priority tasks. etc. The HIS also enhanced the visibility of the project within government circles and with other partners. The other sectors of SC and other institutions working in the Sapone region seek information on the 26 villages from the project. Finally, the HIS helps the project to generate the required reports and to satisfy the needs of the midterm and final evaluation.

9. *The system will track of a range of village population statistics from basic census records to personal health records. It includes data on immunization, growth monitoring, ORT training, pregnancy, etc.*

The project's HIS tracks a range of indicators. This includes immunization, growth monitoring, ORT training, pregnancy, and family planning practices. The annual HIS report provides a wealth of these data and their analysis.

10. *While the HIS employs manual methods at the village level, reporting at all other levels is incorporated into a computerized system which aggregates and analyzes the detailed village data and prepares reports to suit the needs of the users. The HIS coordinator will be responsible for tabulation and analysis, and generation of reports.*

This activity has been completed as planned. There is a well functioning manual and computerized HIS in Sapone. The HIS coordinator has produced a wealth of reports on project progress and responds to requests for information from SC health and other sectors' coordinators, from the MOH, and other organizations working in Sapone. The HIS coordinator also produced HIS reports containing complete analysis of existing data on March 1994, 1995, and 1996. These reports include tabulation and analysis of the data.

11. *The village health motivators will be under constant supervision by their supervisor, the HIS coordinator, and the project manager. They will not only verify the promoters record,*

but also conduct home visits to check the roster's data on home records.

The collection of data on vital events relies on the input of several people in each village. The village leaders, village health committee, village health worker, and midwife may each hear about a birth, death, migration or marriage. They relay this to the village HIS registrar (volunteer), usually through the village health committee. The village registrar is the person (s) trained to do family registration for the annual updates. The registrar makes note of the event and if he is literate, he fills out the HIS vital event registration form (See attached forms in the appendix.) When the village health motivator next visits the village, she is advised of the event and goes to the family concerned to verify and obtain additional details, as needed. If a new family has moved into the village, the health motivator fills out a new family registration form. This information is then passed on to the Sapone HIS coordinator with regular monthly reports. Before submission to the coordinator, her supervisor may also re-verify any births or deaths. Every 2-3 months the HIS coordinator visits each village and reviews the village vital events and population register with the volunteer registrar and the village health motivator. At this time, he verifies entries and corrects any errors identified at that time.

It. Results of monitoring reports and midterm and final evaluations will be released to all interested parties i.e. communities, MOH, HO, and donors.

In addition to the MOH and SC FO and HO, the FO has a list of several institutions that receive a copy of the HIS report.

13. Data analysis training is provided on a continuous basis to those responsible for tabulating, analyzing, and using the data. The 8 village health motivators and the supervisor will be trained by the HIS coordinator, the FOD, and during TA visits from SC Headquarters health unit.

The project HIS coordinator was trained during a Westport based workshop on practical epidemiology and the use of ProMIS. Additional inputs were provided during TA visits. Mr. Gaston Sogbo, the HIS coordinator has formal training in data collection and analysis. He worked on the national EPI program for 3 years on coverage surveys, operational evaluation, and KAP surveys. Mr. Sogbo trained the data entry clerk and trained the promoters and other project staff during a formal training session in December 1993 for 3 days. A one day refresher training is carried out every year to update staff on most common problems and address new issues.

14. Village health motivators,, VHCs, and VHWs will collect ongoing data in the rosters. Health motivators will compile the data into monthly reports which they will discuss with VHCs. They will then pass the data to the HIS Coordinator in Sapone, who checks data validity and supervises its entry in the computer. Regular computer reports are generated, and cross-checked with promoter reports and rosters for accuracy.

Demographic data was collected at the beginning of the family enrollment. Registration of

birth, death, and migration is ongoing. Each health motivator keeps a manual registry of vital events, and the vital event forms are given to the HIS coordinator for entry into the HIS. Before entering them, the project conducts a door to door visit verify events and and population prior to updating the computerized system. Then, all data are updated on the computer. Immunization data are entered during the annual update. Attempts to update immunization data continuously did not work because of the lack of coordination between the project staff and the MOH vaccination services. The growth monitoring data are updated every 3 months; following the GM/P sessions. ORT training data are updated annually. Pregnancy data are updated monthly, using the project midwives reports, and the family planning data updated is ongoing.

Reliability of data: The annual updates are used to verify the reliability of the existing data in **ProMIS**. As explained, the health motivators go from house to house to verify the data on the family enrollment forms, add or remove necessary data, and fill out birth, death and migration forms.

The evaluation team spot checked the annual update forms for a few large and small villages. The vital events were categorized by date of registration of the event. Any event which actually occurred more than one month prior to the date of the annual update visit was considered to have been an event that had been missed by the regular surveillance system. In the sample of four villages used for the update record spot check, we found no “missed” vital events; all the year’s vital events had been registered close to the date of occurrence. In two of the villages, both births and deaths had been missed. In one village, 10 births and 9 deaths were registered late at the time of the update, and in the other village 8 deaths and 4 births were registered late at the time of the update.

This spotcheck shows that the regular surveillance system appears to be doing an adequate job of catching most events. Although the sample of four villages is not representative, it is a good sign that vital events were missed in only half of the villages checked. The other positive sign is that the correction mechanisms, namely the annual re-registration for the update, are capable of identifying “missed” events, so that at the end of the year, the population registers are complete.

Reliability also was assessed by reviewing the mortality and fertility rates obtained for the villages, based on vital events and population registered in the HIS. This review showed that both the death rates (CDR, CMR, IMR) are well within the range found for Burkina Faso, especially the year one rates which are most comparable to the situation found in zones outside the project area.

The HIS coordinator indicated that corrections made to the vital event registration at the time of the update were not relayed back to the village health motivators or the village registrar. The evaluation team recommends that such feedback be made at the time of the visit. In the case of “missed events”, this could provide an opportunity for the village health motivator and registrar to bring up problems they may experience in obtaining a complete registration of events, which in turn could improve subsequent surveillance accuracy.

No attempt was made to verify the accuracy of migration registrations, but we did examine carefully the process by which migrations are registered. The following are the possible problems of the current system.

- a. Arrivals: If the entire family comes (with a woman), a new family registration is filled out. It is not clear to what household a single malt might be attributed.
- b. Migrant definition: It is not clear how the team defines a migrant as an arrival. Are there duration of residence criteria which apply?
- c. Departures: These are registered by compound. Here, too, there is a problem of definition. A major problem with migration registration is the actual definition of a migration, namely when the individual has actually changed residence and left the village. As this is a zone of heavy emigration to Ougadougou and down to Ivory Coast, such verification procedures are important to ensure validity of the HIS population registry. The HIS coordinator knows that a problem exists in the registration of departures. The village registrar learns of emigrations only when the person is not seen; not when the person is seen to leave. The handling of dependents migrating with the person interviewed is also ambiguous. Normally, children are assigned to their mother's register, but in this case, there is no requirement of residence.
- d. Transfers (within the 26 village zone): This is the move which is most likely to cause problems, as the same person must be subtracted from the origin register and added to the new one. Here, too, we do not know the minimum time for a "visit" to be called a "transfer." This is not a problem with a marriage, where it is cleared that a transfer will be involved, but for other types of transfers, the lack of precision about when a visit/absence is a visit can lead to confusion and inaccuracies in the count of total persons.

Despite these potential errors in registering migrations, the age-sex distribution we obtain with the promiss system have been typical of zones of heavy immigration. The attached graphs show the migration statistics.

1.5. HIS Coordinator's reports to village health motivators provide the latter with timely, actionable feedback for further discussion with VHCs. The MOH staff will participate with SC in the process to monitor and target its activities.

As demonstrated by the project's video, the feedback provided to the health motivators opens discussions with the VHCs and allows the communities to understand their health problems and take appropriate actions. The MOH receives periodic copies of the project reports.

Although the village health motivators review vital events with the village health committee periodically, there is a formal annual feedback cycle. One week before the annual registration update, the health motivator meets with the village to review the vital events of the past year. Reports from the village health motivators and the villagers confirm that this feedback is received with enthusiasm. It may be hotly debated, and the village health committee assured the evaluation team that they use this process to see how well they are

doing at improving their health. The first year, the village health motivators had to tell the villages about this information; after that the villagers asked for it.

“Feedback of information is useful for the village. Since the arrival of FDC in our village, we are all informed about our situation, including births, deaths, departures, arrivals, and other transfers. Thus, we know our people, even though the last census was only in 1985. From this feedback, we can see changes in illnesses since the arrival of FDC. There are fewer of the diseases for which children are vaccinated. Mortality has gone down. Everyone now agrees to have children vaccinated. ”.

16. The MOH will participate in the implementation of the baseline survey.

The MOH participated in the implementation of the baseline survey, the development of the DIP, the midterm evaluation, the final assessment survey and evaluation.

B. Recommendations for Improvement of the HIS System

1. **The ProMIS software:** The version of the ProMIS software currently used by the project is not user-friendly, and the staff are obliged to transfer data from the ProMIS data base to Lotus or Excel to prepare reports and analyses. While the HIS coordinator was trained in downloading the data to EPI-INFO, simply to prepare the aggregations takes a long time, and they often find it easier to re-enter the data, rather than go through the time-consuming process of aggregation, conversion, and re-entry. The old version also did not allow the HIS staff to add the variables they wanted or change the basic process for reporting. The new version of ProMIS resolves many of these problems. It is flexible, easier to download, and more user-friendly. This long awaited new version was delivered to the FDC at the time of the evaluation. The evaluation team recommends that the new version be installed promptly.

2. **Enhanced village-level surveillance capacity:** There is much enthusiasm in the villages for tracking the impact of the project. Yet, the actual surveillance is handled by a few persons. The update forms used by the project serve well for computer data entry, but they appear to be inappropriate for on-going village surveillance.

Thought should be given to developing a vital events calendar or some other simple graphic tool to aid villagers, and especially the village health committee record events. Given the fairly low level of literacy in this zone, attention should be paid to developing the calendar in a non-literate format, e.g. with color coding for weeks or days, assessment of the increased involvement of school children or others in participating in literacy programs.

To enhance the retention of the feedback information. it would be invaluable if the project developed a non-literate or semi-literate form for recording the basic demographics for the population.

3. **Program statistics into the HIS:** As noted above, not all program activities are registered

regularly *in* the HIS. Others are registered, but late and perhaps incompletely. The project relies on monthly reports from field staff, and these reports are not consistent. Nor do they cover all pertinent events. The team recommends working with the village health motivators to develop a process for recording program participation.

4. Supervision of village health motivators and guarantors: As noted above, a minority of the vital events are missed in the current process of vital event registration. When these events are missed, it would improve subsequent completion of registration if the HIS coordinator could discuss the circumstances surrounding the missed event with the motivators, health committee members. In this way, the individuals involved will be better aware to potential problems when they begin to surface again.

5. Coordination with MOH: A request made by the local and provincial health officers was the need to collaborate on planning and monitoring activities. The MOH would like to have monthly meetings to review project activities and accomplishments. The team recommends that the vital events and relevant program statistics be updated regularly and be available for discussion at quarterly meetings. To the extent that the MOH includes program participation statistics, these monthly coordination meetings also can be used to coordinate activities. For example, data on pre-natal consultations can be used to help MOH staff plan for deliveries and post-natal consultations. Likewise, review of the immunization statistics by village can help the vaccination team to program mobile team visits to target villages with great need.

6. Feedback to village health motivators and others: The villagers clearly like to let their village health motivators know about any unexpected events, such as an increase in deaths. Likewise, they should inform the motivators about any events they think could be noteworthy, eg. fewer infant deaths from diarrhea. The same holds for feedback from the health motivators to the villagers.

7. Dissemination of results: The project team has worked well with the villagers. There should be more frequent opportunities for interaction and feedback of results.

8. Training in demographic analysis and applied research: Since its inception, the HIS Coordinator has participated in workshops on the analysis of this data. Yet, he still does not have training in some of the basic demographic methods that he needs to prepare his reports. He could benefit from exposure to some of the materials on applied research and basic demographic measures, prepared by the Population Council in French as part of its Francophone Africa program. In addition, he could use more training in EPI-INFO, file exchange from **ProMIS** to EPI-INFO and spreadsheet basics. The latter two trainings also should be made available to Ms. **Sankara**, the data entry clerk.

9. Equipment: The computer currently used by the HIS is adequate for the system, but there is no second computer for analysis or for other reports. The team recommends that the project consider purchasing another computer. In addition, the printer used by the project is inadequate for the project needs. With the solar power installation, power is no longer a

problem, and they should upgrade to a high speed , laser-type printer, with the proviso that they do a better job at protecting equipment from the frequent dust incursions.

IV. Review of the Project Training and Supervision

The evaluation team reviewed the training and supervision protocols of the project, and found that these were not a strong point of the project. The training and supervision processes are under-documented and suggest inadequate planning and conceptualization to make them effective. Many of the reports are simply a summary of meetings or seminars attended. The supervision reports were not formally structured, although there were good forms used for individual supervisions in the field. In addition, the staff indicate that training events may be planned during festival or rainy season times when attendance is difficult. This section of the report presents the findings of the team regarding the project's training and supervision activities.

A. Training Program Contents

The training programs used at every level of the project were reviewed: training for mothers, for village leaders, for health motivators, and for the nurses and midwives. The training has been organized at all levels by objective, namely with regard to the following themes:

- Control of Diarrheal Diseases
- Vaccination
- Nutrition and vitamin A consumption/distribution
- Health Information System
- Family planning and prevention of sexually transmitted diseases
- Fight against malaria

The training and supervisory structure utilizes the same kind of stepping down process found for other activities. First, project staff train the supervisors and others who will in turn train the village staff. Second, the village health motivators are trained. Third, the village health motivators train the village leaders and the village midwives. Fourth, each level provides monthly supervision (with check lists) which serves as continuing education.

The following summarizes the training modules of the project. The training modules were prepared to orient the target population to commence activities, and then subsequent modules provided continuing education. Each set of training activities differs by the target population, which is how it they are described. Detailed workplans for the training activities are in the appendix.

Training Activities Conducted by CS8/Sapone

Target Population: Mothers, village leaders, and youth clubs

Training team: Village health motivators with backup from the FDC nurses.

Training materials: Written manuals; no final report exists on the trainings.

Training topics: Training was provided in each village on each of the following topics: control of diarrhea; malaria, nutrition and vitamin A, nutrition for pregnant women. Youth club organizers, village leaders, and men and women received training on STD/AIDS prevention.

Target Population: Health motivators

Training team: 3 project nurses and 2 midwives with additional training, prior to conducting this training. Assistance from Health Department of Bazega as needed.

Training materials: Uses existing manuals; no final training report, but there are pre and post-test results.

Topics: Topics covered separately as follows: nutrition and vitamin A, malaria, diarrheal diseases, vaccinations, AIDS/STDs. In addition the village health motivators received training in training techniques (training of trainers), and in the use of felt-board and image box materials. Training also was offered on the HIS, but this particular module was inadequate, since it was not adapted to the level of the health motivators.

Target Population: Village health worker

Training team: Ministry health officers with FDC health unit staff

Training materials: Existing training materials

Training topics: Various, per national themes. Training was selected to enhance the capacity of the village health workers to intervene on the project themes.

Target Population: Village Health Motivators. Continuing Education

Training team: Supervisors (FDC nursing staff)

Training materials: Informational materials plus the supervisory sections of the existing manuals. However, there was no synthesis of the supervision reports.

Target Population: Midwives

Training team: Ministry of Health officers plus health sector coordinator and nurses

Training materials: Not specified, but there are reports of the training

Training topics: Project management, use of image boxes. These trainings included inter-organization exchanges of staff between the NGOs of Sapone (AVLP, ABAC, FDC).

Target Population: Nurses/Health Motivator Supervisors

Training team: Same as for midwives

Training materials: Not specified.

Training topics: Malaria control strategies, oral rehydration therapy. In addition those participating in this training made one exchange trip. In addition, the nurses and midwives based at FDC/Sapone received a basic training and then refresher courses in training of trainers and general training techniques, including using the image box.

Target Population: HIS Coordinator

Training team: SC/US HQ health unit staff

Training materials: Manual plus workshop

Training topics: Use of the software ProMIS and EPI-INFO.

This training was conducted at HQ in the US.

Target Population: Health Sector Project Coordinator

Training team: Not specified

Training materials: Exchanges and tips, seminars

Training topics: Management of small projects

B. Strengths and Weaknesses of the Training Program

The greatest strength of the training programs was that they succeeded in preparing local women as motivators and village leaders to carry out health education and behavior promotion training sessions. The stepping down process clearly worked, with each level of health worker in turn training those next closer to the community. The evidence of the success of the training program lies in the high degree to which the community residents actually learned the messages conveyed by the trainers, as well as the evidence of behavioral changes among the population.

The village leaders had this to say about their training:

“The training we have received is appropriate, and it was good. We are able to do all the things we were trained to do. When we actually do the things for which we were trained, we can see the improvements.”

“But, we could use a longer refresher training, and more often. We forget quickly.”

“We can continue even if the village health motivator doesn’t come. I know how to make enriched porridge. And I can continue to teach others how to make oral rehydration solution.”

Similarly, the other village health workers were satisfied with the training they had received:

“The training of the village health worker is a good thing, but it is not enough. It would be good to have a refresher course. We never stop learning, but we don’t think we should have to ask for training. Yet, it would be good to learn to read and write.”

“The village midwives have been trained. They know the risk factors for pregnancies. They know when to evacuate women at risk for difficult deliveries.”

Thus, what the villagers want is not less but more training: More topics, more refresher courses. This response, together with earlier comments on too much theory, suggests that the training program could be strengthened by shorter, more frequent, and more practical courses. Clearly, this group of villagers is skills-oriented.

The health motivators were not as uniformly positive about their training. While they much appreciated the initial training of three months duration in 1993, they felt that the refresher courses and continuing education since then had not been adequate. For example, they said

that the last training they had received was in September 1995. The problem, according to the health motivators, is that their trainers (the nurses and midwife based at Saponc) are also behind. While the provincial department of health continues to give annual training seminars to its staff, those seconded to FDC have not been able to participate in this training, and they feel they have been left behind. They feel inadequate in the domain of family planning, where much has changed in the past few years. They would like to expand their repertoire beyond condoms and pills, to injectables, Norplant, and IUDs.

One solution would be to re-integrate the FDC nursing staff with the provincial nursing training program. Current procedures would need to be changed. Now, when the department of health conducts a training, the FDC nurses may not even hear about it, let alone be invited. Financing is a problem, and FDC will need to work out a simple solution that will allow their members to participate.

In general, the FDC training programs were based on existing national and international health education and training programs. Though the programs are adequate, they could have been more locally appropriate if local health officers had been invited to make suggestions regarding the curriculum.

The training modules are adequate for addressing the program objectives, but they do contain certain weaknesses:

Inconsistent messages are given concerning water consumption by infants. For the module encouraging breastfeeding, health motivators are trained to urge mothers to stay away from water, while for the control of diarrhea they are trained to encourage more water consumption. The health motivators are not provided with sufficient depth to help mothers understand the differences. For example, the training modules include certain phrases that should not be conveyed uniformly, such as "Water is destructive to the health of the infant."

The training modules are too heavy on the reasons why certain behaviors are recommended, and too light on the actual practices needed to achieve the desired outcomes.

Certain elements are not really necessary for achievement of the objective. For increasing vitamin A consumption, it is actually not necessary for women to know what a vitamin A capsule looks like, yet this is one feature of the training program. It is more important that the women agree to take vitamin A than they know how a capsule looks physically. The practical aspects of behaviors should be predominant in the training modules.

Whether intentional or not, certain details about the health behaviors and problems are vague. For women who are largely illiterate, this can lead to confusion. For example, it is not clear what women are supposed to do with knowledge of the incubation periods for different illnesses. Again, the practical details are more important than the theoretical ones.

C. Supervision

In the project, supervision is viewed as continuing education. Supervision is carried out with formalized evaluation checklists (see the appendix). This allows the supervisor to rapidly assess any inadequacies and take steps quickly to rectify them. Indeed every visit to the villages by the nurse was viewed as a supervisory visit. This is a weakness, as it provides too narrow a perspective for the nurse in his visits to the village. Specifically, it renders the nurse less accessible to the village leaders, health committee members and other community residents precisely when he should be open to their concerns.

The project also suffered by having only one supervision, namely the nurse vis a vis the health motivators. Other supervision could have helped to better manage staff.

Despite the use of supervisory checklists, the supervision had certain weaknesses:

- Inadequate supervision of training sessions on family planning and STD transmission in the field.

- Regular supervision of health motivators (two times per month) was carried out, with use of the supervisory checklist. But there was no synthesis for the monthly report that would help the project assess general staff competence and adherence to the project goals and strategies.

- Inadequate follow-up by the supervisor, who did not sufficiently communicate with the health motivators.

- No process of feedback to the village on the village health motivators.

- Training was paid for continuing education for the village health worker (once per year), covering all the project themes, over a period of 5 days. But this training was not carried out regularly.

- The village leaders received intensive supervision the first two months of their work, but after that supervision was less.

As with the training elements, the supervision is certainly adequate. But it could have been more effective, especially at the village level, if there had been more follow-up.

V. Project Expenditures

A. Pipeline Analysis

This next section of the report reviews the planned and actual expenditures. The percent of annual planned budget actually spent ranges from 42% for the final year (when all expenses have not yet been posted) to a high of 88% for year three. The project has been able to operate within its budget, never exceeding the planned level. Nor has the project grossly

underspent. This suggests the existence of a reasonable budgeting and accounting system. More importantly, the adherence to total budget and to line items is evidence of fiscal responsibility.

PIPELINE ANALYSIS CATEGORIES	ANNUAL BUDGET ANALYSIS		
	YEAR 1 BUDGET	ACTUAL	% SPENT
Evaluation	3,550.00	2,676.73	75.40
Personnel	115,042.00	78,982.38	68.66
Travel	13,600.00	8,350.20	61.40
Communications	11,000.00	4,430.12	40.27
Facilities	1,000.00	2,626.72	262.67
Other direct	22,200.00	23,343.93	105.15
Procurement			
*Supplies	14,500.00	8,912.83	61.47
*Consultants	1,000.00	0.00	0.0
*services	1,500.00	1,747.95	116.53
*Sub-total Procurement	17,000.00	10,660.78	62.71
Total direct	183,392.00	131,670.86	71.80

During the first year, the project spent 72% of the planned amounts. They were underbudget on personnel, travel, communications, and supplies, and overbudget on facilities and services. The underspending reflects the usual delays in recruitment and purchasing. Savings were accrued by hiring persons at slightly lower salaries than had been planned. In addition, printing of the health information system registration forms cost less than expected (reducing the supplies costs). However, rental costs were greater than expected, as were facilities costs. But part of the facility overrun reflects the fact that modifications expected only in year 2 were able to be performed in year 1.

PIPELINE ANALYSIS	ANNUAL BUDGET ANALYSIS			
	YEAR 2			
CATEGORIES	BUDGET	EXPENSES	% SPENT	
Evaluation	15,600.00	12,119.05	77.69	
Personnel	120,744.00	83,751.86	69.36	
Travel	13,800.00	10,775.60	78.08	
Communications	5,000.00	3,046.05	60.92	
Facilities	1,000.00	203.56	20.36	
Other direct	22,700.00	29,165.92	128.48	
Procurement				
*Supplies	5,000.00	11,805.46	236.11	
*Consultants	1,000.00	0.00	0.0	
*services		1,500.00	7,954.15	530.28
*Sub-total Procurement	7,500.00	19,759.61	263.46	
Total direct	186,344.00	158,821.65	85.23	

Expenditures in the second budget year more closely matched the budgeted amount: 85% of the budget was actually expended in the second year. The year 1 and 2 expenditure pattern balance each other out: where year I was over on facilities. year two is under. and vice versa for supplies. Services and other direct expenditures remained higher than expected in both budget years. This item included the interviewers needed in both years for the village census undertaken as part of the household registration. During year 2 there were continued savings by utilizing lower cost forms for the health information system . Savings also continued for personnel.

PIPELINE ANALYSIS	ANNUAL ANALYSIS		
	Y E A R 3		
CATEGORIES	BUDGET	ACTUAL	% SPENT
Evaluation	4,000.00	0.00	0.00
Personnel	126,762.00	111,337.57	87.83
Travel	13,700.00	3,511.80	25.63
Communications	5,000.00	4,066.05	81.32
Facilities	1,000.0	49.20	4.92
Other direc	25,200.00	15,877.12	63.00
Procurement			
*Supplies	4,500.00	6,860.84	152.46
*Consultants	1,000.00	0.00	0.0
*services	1,500.00	19,751.03	1316.74
*Sub-total Procurement	7,000.00	26,611.87	380.17
Total direct	182,662.00	161,453.61	88.39

The third project year came closest to complete expenditure, with 88% of the budget actually spent. This was the year when the franc was devalued, and the project had to raise salaries by 17-30% to offset the devaluation. The devaluation did facilitate economies in the facilities and services costs. Procurement was much higher than expected because all of the midterm evaluation costs were assigned to this year.

PIPELINE ANALYSIS	ANNUAL ANALYSIS		
	YEAR 4		
CATEGORIES	BUDGET	EXPENSES	%SPENT
		31/03/96	
Evaluation	8,354.22	0.00	0.00
Personnel	81,476.19	37,306.59	45.79
Travel	14,362.40	336.21	2.34
Communications	4,857.78	1,087.26	22.38
Facilities	1,120.52	0.00	0.00
Other direct	1,713.03	1,822.60	106.40
Procurement			
*Supplies	0.00	996.47	0.00
*Consultants	3,000.00	0.00	0.0
*services	0.00	1,088.01	0.00
*Sub-total Procurement	0.00	2,084.48	0.00
Total direct	100,451.88	42,637.14	42.45

The accounting for the fourth year is still not complete, as many expenses are not yet reported (e.g. the evaluation). The FO reports expenditures for \$30,878 not yet included in these figures, which would bring the percent spent up to 73%, not including the planned evaluation expenses. Thus, when the project is closed out it will certainly be close to 80-85% of the budget.

CATEGORIES	PIPELINE ANALYSIS			
	CUMULATIVE			
	YEAR 1	YEAR 2	YE 3	YEAR 4
	%SPENT	%SPENT	%SPENT	%SPENT
Evaluation	12%	64%	64%	64%
Personnel	22%	46%	77%	88%
Travel	22%	51%	60%	61%
Communications	27%	46%	70%	77%
Facilities	66%	71%	72%	72%
Other direct	33%	75%	98%	100%
Procurement				
*Supplies	35%	81%	108%	112%
*Consultants	0%	0%	0%	0%
*services	10%	57%	172%	179%
	-2%			
*Sub-total	34%	97%	111%	188%
Procurement				
Total direct	20%	49%	69%	76%

This last table shows the cumulative spend-down of the total budget. It shows a smooth progression from 20% of the total budget in year 1 to 69% by the end of the third year. At the end of the project, it is expected that the total spent will exceed 85%.

B. Budget Adequacy

This is a very labor intensive project. Most of the inputs require supervisory and field workers, so the allocation of 54% of the AID budget to personnel is appropriate. Indeed, by hiring staff at slightly lower salaries than had been planned, the project was able to economize on personnel costs. They experienced no delays in hiring and were able to be operational from the very first year. The other reason why the allocation for personnel is reasonable is that capital expenditures (motorbikes, vehicles) were made using matching funds provided by FDC. The evaluation team questioned the funding of a literacy coordinator from the project, and learned that this was justified, as the project did provide literacy training (via HIS training and other modules) for village health committees and other village participants.

After personnel, the remainder of the budget is balanced between the categories of evaluation, travel and communications, facilities, and procurement. The only category which appears to have been underbudgeted concerns the services cost. These were chiefly comprised of

villagers hired to conduct the household registration. More persons were needed than expected, so the item was overspent.

Save the Children contributed \$226,528 to the total budget of \$886,064. This was allocated for equipment, vehicles, communications, and technical assistance. These components of the budget appear to have been appropriately allocated. The team notes, however, that the health information system could have performed more effectively with two computers instead of the one (which also was out of commission for several months).

Technical assistance was provided by Save the Children/US. The consultant sent to advise on the health information system, Sally Stansfield, made very positive comments and had an effective visit. Dr. Zayan, an in-house consultant sent to assist with programming and implementation plans, was also very capable, helping the project get launched on a good footing.

VI. Lessons Learned

The most important lesson learned here is that community-based strategies to reduce infant and child mortality work. This was no high-tech program with heavy outlays for medical services. Rather, it relied on the existing (and very minimal) health structure with much education, mobilisation, and demonstration of practical things parents can do to protect their children. The education and mobilisation activities originated in the villages. The success in changing attitudes, behaviors, and outcomes is demonstrated in the achievement of the project objectives. More importantly, the whole package worked together to achieve the desired final outcome of a reduction in infant and child mortality. During the three and one-half year project duration these child mortality rates were cut in half.

The evaluation team highlights the following as the elements of program design and implementation which appear to have most contributed to this result:

Strong Points:

1. **Top to bottom training:** The strategy adopted by Save the Children for this project was a layered training of trainers strategy. Supervisory staff were trained in the appropriate methodologies, as well as in giving effective training. These staff then trained the next layer of the intervention, the village health motivators, who had been recruited from **Sapone** itself. The health motivators then proceeded to invite village women to be trained as village leaders, women who would continue to provide advice and demonstrate techniques. The village health motivators and the village leaders then continued to introduce mothers (and fathers) to the behaviors recommended as part of the CS8 package. This layered training strategy increasingly built capacity within the village not only to carry out the protective behaviors but also to continue to train others.
2. **Mobilisation by education:** In some mobilisation campaigns, e.g. for immunizations, the strategy relies on massive media campaigns and door-to-door canvassing to bring people out. This sometimes works for a specific one-day event. However, absent the campaign, there is little lasting mobilisation or, more importantly, regenerative mobilisation. In the **Sapone** program, the mobilisation strategy used education as a strategy. This is not a quick fix type of strategy, but it does have the major advantage of building two elements essential to continued mobilisation: 1) grass-roots commitment to the action about which they are educated and mobilised; 2) building the capacity to self-mobilise. As the village leaders and village health committees indicated during the evaluation team visit, these villagers are committed to continued mobilisation of their neighbors. Why? They know why and they know how.
3. **People-to-people feel:** The **Sapone** project had a very strong presence in the villages, a presence that existed both officially and unofficially. Staff were largely recruited from the villages. They worked in their own district (though not in their own villages). This fostered a sense of shared goals and problems. Both staff and villagers pointed to this commonality as one factor in the project success.

4. Multisectoral back-up: The Child Survival project was complemented by very active and important interventions in other sectors. This means that when the project's health interventions generated a demand for activities or resources beyond the health sector, it was possible to explore meeting them through inviting the villagers to participate in the activities of other FDC activities. This multisectoral complement turned out to be fairly important. The focus group discussions conducted as part of the evaluation were held in two villages with and two without multisectoral activities. In the villages without multisectoral activities the villagers, men and women, underscored repeatedly their **difficulties** in carrying out recommended changes in water consumption because they did not have a reliable drinking water source. The lengthy trek for water also cut into time women had available to participate in educational sessions. In contrast, in the villages with multisectoral activities, the villagers were quick to recognize the wells they had built as a strong point, as well as others, such as the literacy program and the vegetable gardens, both of which contributed to their ability to adhere to the recommended behaviors. While one always wants to believe that women will somehow find time to do whatever is necessary to keep their children healthy, the daily work responsibilities are so vast that they find it hard to give the extra needed. The complementary activities within the village seem to give women enough extra time or money (vegetable garden sales) that they can take on the new behaviors.

5. Endogenous sustainability: The project stressed training and education as a means to empower the village residents to protect their own health and especially the health of their young children. Through various indicators, it is clear that they have succeeded in this empowerment. Most importantly, the education has been carried out in a way that generates motivation to use the education. And they now have seen that application of their newly learned skills has real payoffs, for their health. Thus, the formula for sustainability is there: understanding of the problem, possession of the skills to resolve the problems and respond to needs, motivation to do so, and the confidence that doing so will be successful. This positive feedback cycle is essential to continuation and future success.

The sustainability engendered by training is supplemented by basic developmental interventions which likewise make it possible for the villagers to sustain continued expansion of their capacity to protect their health: wells for water, income generating projects, literacy to learn more, observation of health improvements, etc.

6. Monitoring capacity: One reason why the village based training and mobilisation strategy works so well is that the villagers and project staff can quickly observe the consequences of their acts. The villagers commented during the discussions held during the evaluation about their pride in observing the decline in sickness and death. The observational skills of the village are stimulated by the designation of one or two village registrars. They keep track of vital events, and are the "demographic eyes" of the community, both for itself and for the project staff. Keeping these observers in the village is likely to be important to future success, namely as a means for quick feedback on successful mobilisations and outcomes.

Although the health information system is not the simplest to maintain, it does work. Staff

are able to update basic data monthly. The population base is re-enumerated every year, and vital events missed during the year are added to the records at that time. Villagers and staff receive regular reports on the situation in their community. Given the interest expressed in this feedback, the project would be well-served by increasing the details and frequency of feedback to the community. Additionally, there could be greater retention of basic data in the villages, for example with a simple manual register, that the village could consult between the updates provided by the FDC staff.

7. Anti-malaria campaign: Perhaps one of the most cost-effective strategy elements was the campaign against malaria. With this low-cost educational intervention, the FDC was able to significantly increase efforts by the villagers to eliminate mosquito breeding grounds, with a resultant measurable drop in malarial fever among the children. The rapid adoption of these activities attests to the readiness of the population to adopt simple behavioral innovations, particularly ones aimed at well-known and much disliked diseases such as malaria. The National Campaign to Eliminate Malaria expressed interest in the FDC approach, and this should be pursued. In addition, FDC should consider re-examining suggestions for behavioral changes to see if they can be simplified and made more “adoptable” by the villagers.

8. Links to the Bamako initiative: The integration with the national implementation of the Bamako initiative means that the project did not need to create an independent village structure. The village health committees, village health workers, and midwife were already designated to carry out certain health care functions by the national ministry of health. Though the project had to wait for this structure to be designated, once in place, it means that the project does not need to create a new set of links up from the project to provincial health authorities. The collaboration with the provincial and district health officers simply fits within this larger structure. Further, the flow of any medications or supplies associated with the project can be managed in the context of the Bamako initiative.

Perhaps even more important than the actual structure of collaboration is the establishment of the Bamako Initiative principle: Local residents sell the supplies or services that the villagers would otherwise have to search elsewhere. These are offered at a nominal cost, with any proceeds used to re-stock the supplies. Any profits would be used to generate additional capacity. This fits so well with the FDC project philosophy that it is certain that it was much easier to initiate and sustain the many village-based service functions of the project.

9. Collaboration with local NGOs: The collaboration with AVLPL and ABAC (shared staff and project locations) made it possible to make more economic use of resources. With the contribution of a health motivator from AVLPL, the project was able to have 9 not 8 health motivators. The same is true for villages representing a collaboration between ABAC and FDC. But this collaboration encourages the programs to share their perspectives. AVLPL would not have gotten involved in health activities had it not been for FDC, while the economic development activities of the two NGOs backup the health activities undertaken by FDC.

Weak Points:

1. Training and supervision: Although the top-to-bottom strategy works very well for the project outcomes, it is based on a trickle down concept: The supervisors are trained in new methods, then each successive group trains the next. This works only if there is something trickling down. As we learned from the staff, there have not been regular updates to supervisory staff capacities in several dimensions of the project. The weakness was felt most keenly with regard to family planning methods. A longing for more training also was expressed at every level. In the coming months, the project could consider a way to reorganize retraining to expand capacity at the same time that new village leaders are trained. With greater depth of skills and more trained persons at each level, more staff time could be freed for other activities besides training villagers.

2. Collaboration with the Ministry of Health (MOH): There was insufficient monthly and quarterly coordination and joint planning. MOH recognized the value of the logistical and staff support received from the project, but they were not integrated into the project to the level where they felt they were equal partners. In the devolution phase of the project, it is essential that the FDC staff and the MOH (along with other NGO partners) work together to develop and implement their training and support activities. This will not be easy in the current verticalized structure, and every attempt should be made to loosen the compartmentalization of initiatives by specific disease or health problem. This loosened, more integrated planning approach is needed for both FDC and the MOH.

The collaboration that might be the easiest to achieve would be a collaboration in training. In particular, if the specific training sessions could be open to FDC and other NGOs, that would facilitate timely upgrade of competencies.

3. Supplies: Steps should be taken to ensure that vaccine, medication, and contraceptive supply stocks are not depleted. The project often suffered from stock ruptures of one of these essential items, despite the implementation of the Bamako Initiative.

4. Immunizations: A major difficulty with the immunization initiative was the lack of coordination between the vaccination team visits and the FDC program. Because the village registrar and health motivator were not able to be present at the time of the visit, the FDC surveillance system did not include timely updates of immunization status. These were only updated at the time of the annual review. This delay in updating records leads to incomplete recording of the immunizations. More importantly, this delay made it impossible for the health information system to be used to follow-up on immunizations missed at the time of the team visit. The FDC staff and the MOH must better coordinate the vaccination team visits, and an alternative strategy must be developed to ensure immediate registration of immunization status with the village registrar. The evaluation team recommends that the village registrar be informed about maintaining immunization records, and that he/she be in charge of keeping them up to date, available for review by the village leaders and health

motivators, and passed to **Sapone** for routine entry in the HIS.

5. Coordination with NGOs: There was insufficient feedback and coordination with the collaborating NGOs. Communications and coordination, especially for planning, needs to be regular and mutual, particularly in the next phase of devolution.

6. Motivation and supervision of the village leaders: Currently, the village leaders do not receive any compensation for their work. They need to be more strongly tied in to the village health committee, also a volunteer health structure. Through this linkage, appropriate compensation, including honorific, needs to be established.

7. Weighing and growth monitoring: The process of weighing all the infants regularly was extremely time consuming, and cut into the time health motivators had available for other activities. Both mothers and agents found the monthly weighing very difficult. The evaluation team proposes that FDC consider switching to an alternative growth monitoring process, namely the wrist-circumference method. While not as sensitive to the micro variations in growth, the circumference method has been shown to do well at identifying moderate to severely malnourished children. Once identified, these children would be followed with monthly weighings. This would reduce the time needed for weighing, without great sacrifice to the ability to identify those whose growth is faltering or significantly slowed. The adoption of such a system also would make FDC comparable to the national system, which is moving in this direction.

8. Training and supervision of village registrars: Current practices of training and supervision for the village registrars do not adequately prepare them for event “case finding” and verification of events. Additional procedures should be developed for more complete registration of events, especially migrations not marked by a ceremony, as in the event of a marriage. Perhaps this could be an activity of the youth club, since they also would be most likely to know about migrations. The youth club would report (along with village leaders) to the village registrar, who would then visit the family, verify the event, and record it. The event again would be verified by the health motivator at the next visit. Finally, to make the whole process work better, the village registrars should be invited to participate in additional literacy training.

Another weakness of the HIS is its explicit focus on health events. In order to understand the connection between program activities and vital events, the HIS should include some indicators for individual participation in FDC programs, whether in the health sector or in other sectors, such as literacy. The inclusion of this information also would stimulate use of the HIS system by other sectors of the FDC project, which in turn would lead to greater pressure for complete and reliable data.

9. Utilization of the HIS: Although the HIS coordinator is very competent, the HIS system is not fully utilized, by the health sector or by other sectors within FDC. The annual report of the HIS should be focused on specific sectors or activities. It should be seen as a key input to future program planning, both by FDC and by the MOH or NGO partners. Both partners complained that they were not adequately informed. Further, increased users of the data would subject the

data to scrutiny by more knowledgeable persons, which can only help its accuracy.

The new version of **ProMIS** should enable the HIS unit to be more flexible in responding to data requirements and analytical needs. Nonetheless, it should be expected that much analysis and report writing will continue to be done with **EpiInfo** and through spreadsheets (eg. Lotus, Excel). The team recommends that the HIS coordinator develop a standardized reporting form that can be directly linked to the **ProMIS** data base to generate simple updating reports for each village or district aggregation. This would be very program oriented and if distributed on a regular basis could be very helpful for planning.

10. Rehydration of children: The porridge promoted by the village leaders and health motivators was felt to be inadequate for severely malnourished children. This means that the benefits of growth monitoring are less than they could be. The health motivators should continue to refer severely malnourished children to the clinic for rehydration, but at the same time, alternative rehydration follow-up procedures should be considered. In addition, health education is needed to help parents understand the importance of the referred clinic rehydration. Too often, the health motivators reported that referrals were made but parents refused to go.

11. Feedback to village health committees: The village health committees are eager for information on the village health. FDC prepares only annual reviews of the village vital events and health status. Given the interest in knowing what is going on, FDC should consider more frequent feedback, as well as feedback in a format which is more graphic and readily understood by semi-literate or illiterate persons.

VII. Project Sustainability

A. Community Participation

What resources has the community contributed and will continue to contribute that will encourage continuation of project activities after donor funding ends?

The major contributions of the communities were labor for the implementation of project activities. Project staff believe that the sustainability of project activities will be achieved at 2 levels:

1. Behavioral changes among mothers leading to the practice of measures **that** will help them protect the health of their children and families. The acquired behavior will continue without any additional cost.

And, as was demonstrated above in the discussion of achievements for each objective, it is clear that many villagers have mastered the recommended health protective behaviors and do use them. They, **too**, indicated repeatedly their intention to continue to use the recommended behaviors. As the woman quoted earlier remarked, seeing is believing. Those who have tried ORS (or other

practices) can see the benefit for their children, and they do not hesitate to continue to use the new skills.

“The health advice clarified much for us about how to raise and nourish children. Before we took care of children almost by chance. The educational sessions on diarrhea have helped us better manage health problems.”

“Now I know what to do when my child is sick with diarrhea.”

“We now know how to take care of our children with different porridges, because mother’s milk is not enough.”

“In following their advice, we have changed our hygiene and our diet. Now we know these things. Those who follow the advice change; those who do not want to follow them, they don’t change.”

2. The transfer of knowledge and skills to community members who have been involved in the implementation of project activities. These include, members of the VHCs, the community health agent (CHA), the traditional birth attendant (TBA) and the women village leaders (WL). All these community agents who participated in the implementation of the project have done so without being paid by the project. In some cases the receiver of services or the community remunerated the service provided. Therefore, project staff believe that these community members will continue their efforts without interruption in the absence of project funding.

The health committees interviewed during the evaluation were clear about the ability of the village leaders and villagers to continue with the training and behaviors. They said:

“For all health activities, our leaders will be able to continue without FDC. They will continue the discussions, and the midwife will continue to assist deliveries. We also can oversee the village registrar.”

“We would like to continue our activities, because we believe we have received a certain complement of information that lets us move beyond where we are at. Maybe we won’t continue activities at the same scale as with FDC, but we will continue them. We can continue mobilisation, advice, and the management techniques we have learned.”

The village leaders also expressed confidence in their ability to continue doing the trainings:

“We will continue with our activities. Women can always talk together and maybe train others. The midwife can continue to attend births in the village, saving women the trip to the maternity. The registrar will continue to record vital events. “

“We will continue to unite the village neighborhoods. Women agree to give food for us to use in the demonstrations. This work doesn’t tire us. Time is nothing in relation to health.”

“The village is happy with our work. They thank us and cheer us on. Then, we are very proud. Some even say that thanks to us, people suffer less now. “

“The human body is like a house. If you open it up, dust will come in. But if the door is closed, the house stays closed. If we practice prevention, our children will stay in good health.”

“We must continue. This is the path we have chosen, and we must continue on it. Even if the health motivators don’t come, we will still go on. Because actually, women come out not to be nice to the health motivator but for their own interest.”

“We will continue to do our work. We have notes that help us. We will continue to make the porridge, to teach about food groups and nutrition, and how to take care of our children.”

The village leaders said:

“Yes, we can continue. Training will go on, but we also have patience, tolerance and courage.”

“Many things we can’t get: a plough. cart, schools. But we can learn and gain information from our own energy. Since the literacy program was launched we have learned to read and write in Moore. Thanks to FDC I know how to write. We can record the exact birth dates of our children.”

The collaborating NGOs also expressed their commitment to continuing the activities. The representative of the AVL P said:

“The collaboration has been fruitful for both groups. AVL P can continue to expand its involvement in the communities through the activities of the health motivators. The training has developed a true team able to intervene for health. The complementarity they have established is of mutual benefit and will continue. Because the AVL P staff now has training in health, they can continue to mobilize villagers around health issues.”

One of the health officers interviewed could see the changes in competencies:

“We must continue the activities in the villages, even though there may be fewer resources. We must encourage the people and the village health motivators. The people have already acquired skills, which will persist, even through difficulties.”

The following tables shows key activities of the project by intervention, which of them are likely to continue after the end of the project.

Intervention and Activities	Entities sustaining activities at the community level	Entities sustaining activities at the HCs and NGOs level
Immunization:		
1. IEC	1. CHAs, WLs	1. AVL P and ABAC
2. Organization of EPJ sessions	2. CHAs and	2. None
3. Financial support cold chain and mobile units	WLs.	3. MOH
Control of Diarrheal Diseases		
1. IEC	1. CHAs, WLs	1. MOH
2. Training of mothers	2. CHAs, WLs	2.
3. ORS demonstration	3. CHAs, WLs	3.
4. ORS packets availability	4. CHAs	4. MOH
5. Construction of latrines	5. Families	5.
6. Construction of wells	6. Families	6.
Nutrition/Vitamin A		
1. IEC	1. CHAs, WLs	1. MOH/AVLP/ABAC
2. Training of mothers	2. CHAs, WLs	2. MOH/AVLP/ABAC
3. Distribution of VACs	3.	3. MOH
4. GM/P	4. CHAs (Bande tricolore)	4. MOH
Malaria		
1. IEC	1. CHAs, WLs	1. MOH/AVLP/ABAC
2. Training of mothers	2. CHAs, WLs	2. MOH/AVLP/ABAC
3. Distribution of Chloroquine/Aspirin	3. CHAs	3. MOH
Family Planning/STDs/AIDS		
1. IEC	1. CHAs, WLs	1. MOH/AVLP/ABAC
2. Training of mothers	2. CHAs, WLs	2. MOH/AVLP/ABAC
3. CBD of condoms	3. Youth clubs	
High risk Pregnancies		
1. IEC	1. CHAs, WLs	1. MOH/AVLP/ABAC
2. Training of mothers	2. CHAs, WLs	2. MOH/AVLP/ABAC
3. Prenatal consultation	3. TBAs	3. MOH
4. Referral of complicated cases	4. TBAs	4. MOH

B. Ability and Willingness of Counterpart Institutions to Sustain Activities

What is the current ability of the MOH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

There are three institutions in the project impact area. This includes (1) the MOH medical center and the CSPS, (2) The Association Vive le paysan (AVLP), and (3) the Association Burkinabe A Communautaire (ABAC). Each of the three institutions have a mandate to work in the health sector. The MOH will be mainly responsible for the provision of the health services while the local PVOs will have each one promotor capable of continuing project activities in their respective zones. The promotors have been seconded by the two institutions to the project for the three years LOP.

Interviews conducted with the provincial and local district or subdistrict health officers left no doubt that these agencies were very interested in continuing with the project. Yet, they also recognized that continuing without the logistical support provided by the project would be difficult.

This is what provincial and local health staff said:

The project has been very effective at social mobilisation. This has actually reduced the level of input needed to be made by the department of health. The training provided by the staff has been useful. For the immunisation program, FDC's logistical support has been invaluable, **Sapone** has become an exemplary district. Perhaps most important, the village leaders trained by FDC have become part of the Bamako Initiative management team, helping that initiative work.

The strongest point of the FDC program has been the social mobilisation for the vaccinations and the health education in the villages. Now, the villagers can take charge of certain health problems on their own. We support them through the Bamako Initiative. All the agents can reprovision themselves (aspirin, chloroquin, condoms...) from our stocks. The village intervention has lightened the workload of the district health unit, which is huge. From these zones, I am receiving only the referred cases for malaria or **difficult** deliveries. It will be difficult to continue to have the same impact without FDC input. But, we must do it, even if the resources are limited. We must encourage the people and the health motivators. People already have acquired skills, and these will persist through difficulties. We must **strengthen** our thematic training program for the village health committees and village health workers with regard to mobilisation and health education.

The provincial health officer indicated that the department would continue with their support to the anti-malarial campaign, training for maternal and child health for the village health committees and the village health workers, training and support to the Youth Clubs on

AIDS/STDs, vaccination team visits (thanks to repaired motorcycles, hygiene and sanitation classes through the school, and training in distribution of contraceptives for the village health workers and the Sapone project nurse. Although he was aware of the need to include both nurses and midwives in the new training program for village-based distribution of contraceptives, he didn't have funds to pay for their participation, particularly for the midwife. She would of course be welcome, but he could not guarantee support. At the national level, the staff recognize the importance of including the midwives in their training programs. As a first step, they suggested quarterly feedback and exchange between the MOH and the project staff, specifically from the midwife to the district health officer.

The nongovernmental partner, AVLP, also recognizes the value of the training their staff have received through collaboration with FDC. Both programs have benefited from this collaboration: AVLP now can add health to their portfolio of activities, which otherwise is dominated by agricultural and economic development. And FDC is involved in villages where they otherwise could not have gotten started. The AVLP activities complement and support those of FDC. However, this collaboration does not extend to all the AVLP villages, and they would like to extend the collaboration to other AVLP villages. For continuation, integrated planning is needed.

Comments were not received from ABAC on this topic, due to the recent death of their coordinator just prior to the evaluation.

The following table identifies key interventions of the project and which of the above stated individuals and institutions said they will continue the activities of the project as it is ending.

Intervention and Activities	FGD Women	FGD Men	VH C ASC AV	L V	Chief CSP S	Chief MC	AV LP	Comments
Immunization:								MOH will
1. IEC			XX	XX	XX	XX	XX	support
2. Organization of sessions			XX	XX			XX	fixed
3. Financial support					XX	XX		centers and
4. Satisfaction	XX	XX	XX	XX	XX	XX	XX	some mobile units; costs
Control of Diarrheal Diseases								The demand
1. IEC	XX		XX	XX	XX	XX	XX	for pjct
2. Training of mothers			XX	XX	XX		XX	assistance
3. ORS demonstration			XX	XX			XX	for wells &
4. ORS packets availability	XX		XX	XX	XX	XX	XX	latrines is
5. Construction of latrines								high
6. Construction of wells								families will
7. Satisfaction	XX	XX	XX	XX	XX	XX	XX	construct them
Nutrition/Vitamin A								VAC
1. IEC	XX		XX	XX	XX	XX	XX	distribution
2. Training of mothers			XX	XX	XX	XX	XX	is planned
3. Distribution of VACs					XX	XX		but has not
4. GM/P					XX	XX		started yet
5. Satisfaction	XX	XX	XX	XX	XX	XX	XX	in HCs
Malaria								There is a
1. IEC	XX		XX	XX	XX	XX	XX	national
2. Training of mothers			XX	XX	XX		XX	malaria
3. Distribution of Chloroquine/Aspirin			XX		XX	XX		control program
Family Planning/STDs/AIDS								
1. IEC	XX		XX	XX	XX	XX	XX	
2. Training of mothers			XX	XX	XX		XX	CBD is only
3. CBD of condoms		XX						done by Youth Clubs
High risk Pregnancies								TBAs role
1. IEC	XX		XX	XX	XX	XX	XX	is to
2. Training of mothers			XX	XX	XX		XX	identify &
3. Prenatal consultation			XX		XX	XX		refer high
4. Referral of complicated cases			XX		XX	XX		risk on basis of alist of criteria

C. Sustainability Plan, Objectives, Steps Taken, and Outcomes

What are the steps the project has undertaken to promote sustainability of child survival activities once project funds end? **Please fill in table** (example below with sustainability objectives and outcomes).

Assess the degree of sustainability of project interventions.

Goal	End-&project objectives	Steps taken to date	Outcomes
1) MOH will take on health promotive activities of CS project.	1) MOH will supervise and provide refresher training for 50 CHVs 2) Health Officer will meet monthly with community health committees	1) 2 MOH nurses trained in CHV supervisory methods 2) Health officer attended 3 health committee meetings	1) 10 CHVs being supervised by MOH nurses (20% objective) 2) Health officer attended 3/10 meetings (30%)

Goal	Objectives	Steps taken to date	Outcomes
1) Local institutional are able to continue project activities	Train 26 VHCs, 480 WLs, 2 local PVOs, and 38 Youth clubs to execute project interventions in their villages	1) Organization of communities, identification of VHCs members 2) Training of members of 26 VHCs 3) Establishment of youth clubs in the villages 4) Provision of literacy and econo. dev. programs to VHC members 5) train 2 promotors as project staff in the interventions 6) Involve members of VHCs in project's HIS	1) 21 functional VHCs are currently available 2) 480 Women Leaders are trained and capable of carrying project interventions 3) AVLP & ABAC are planning to use the 2 promotors to expand their CS activities 4) 38 youth clubs will continue to manage the revolving funds for condom sale.
2) Each village will have at least one trained and equiped CHA, TBA, and & WL	26 TBAs, 26 CHAs, and 135 WLS will be trained and equiped to implement project activities.	1) Training and refresher training of TBAs, CHAs, and WLs in the implemmentation of project interventions 2) Provision of bowels, SRO packets, TBA kits, Chloroquine, Aspirin 3) work with VHCs to support an incentive system for TBAs and CHAs	1) 31 TBAs and 26 CHAs are able to continue project activities and are equipped with essential medicines, Chloroquine, Aspirin, and SRO 2) 480 WLs are able to train mothers 3) 28 TBAs assist mothers during deliveries 4) 20 CHAs will be able to carry out first aid activities (Wounds, fever, diarrhea) 5) 28 TBAs, 20 CHAs will implement in collaboration with otehr local institutions the project activities

3) each village will have village based HIS	1) 26 TBAs and CHAs will be able to use a community based HIS to monitor the implementation of the activities 2) 1 community registrar will collect vital events data	1) Training and refresher training of TBAs, CHAs, and village registrars in the establishment of a community based HIS 2) Collect vital events data [Number of death, birth, migration 3) Organize HIS update and feedback sessions with the community members 4) Develop and distribute tools for the community based HIS system	1) 21 registrars, 28 TBAs, and 25 CHAs are able to collect vital events 2) 19 TBAs and 16 CHAs use HIS tool (Cahier d'activitee) to report the following data: (number of assisted deliveries, fevers, wounds treatment, conjunctivitis, referral to CSPS/CM, measles declaration
4) Availability of opportunities for literacy and income generation activities	15 literacy centers and credit committees will be operational in 15 villages	1) 15 literacy centers are open 2) 60 literacy agents are trained as trainers 3) 15 credit committees are trained and active in 15 villages 3) Mobilization of communities on literacy and income generation activities	1) 60 literacy trainers trained 525 community members in literacy 2) Over 360 loans have been given to 200 women and 160 men to support income generation activities. Monies from credit are increasingly coming from the savings achieved
5) Materials and logistics for CS activities are available at the village level	80% of LVs and VHCs are able to acquire their needs for CS interventions in the project area.	1) Training of mothers on local recipes for nutrition interventions 2) The list of essential medicine can be procured from the HC.	1) 26 VHCs work closely with the CSPS and HCs to implement activities and benefit from training and supplies in essential medicines 2) The MOH is supporting and expanding the CBD approach 3) 26 VHCs use local food to implement nutrition demonstration
6) Women at the village level adopt the new behaviors in the improvement of their family's lives	80% of women will use ORS, improve nutritional status, and immunize her children, protect her family from malaria	1) Training of 5000 mothers in CDD, immunization, appropriate nutrition activities, and malaria control.	1) 4,204 mothers trained in project interventions 2) 255 VIs and 165 CHAs were trained in project interventions 3) Build 144 latrines.

7) Health center staff able to carry out cs interventions	Each health center will have at least one person able to implement the activity of the project.	1) Training, support, and retraining of 11 health center staff 2) Project carry out periodic meetings to discuss project interventions and activities	1) 2 medical doctors, 6 nurses, and 3 nurse aids are capable of planning and implementing CS interventions in the project area.
8) Continued collaboration between MOH, Local PVOs and local villages	1) Create links of collaboration between the 3 structures	1) Organize periodic meetings between the 3 groups and project staff 2) Conduct project activities in close collaboration with the three entities	1) The existence of a protocol of collaboration with the MOH 2) The creation of complementarity of activities in the project area
9) Each village is able to pay the cost of CS interventions	1) VHCs are able to pay the cost for vaccination and growth monitoring 2) Beneficiaries are able to pay for ORS, Chloroquine, contraceptive s, prenatal care, etc.	1) Organization and training of VHCs to institute cost recovery systems in their villages 2) Training and equipment of 57 CHAs to carry out project interventions 3) Creation of revolving funds in all villages	1) 17 CHAs have drug revolving fund 2) Availability of 57 CHAs trained and equipped to carry out CS activities 3) availability of a drug revolving fund at the CM and CSPS levels.

In conclusion, the project has built the foundations for sustained activity through its extensive training and mobilisation activities. These activities have incorporated both staff and villagers, both mothers and village officials. The training has been conducted in a manner which gives them confidence in their ability to continue the activities without FDC supervision and further involvement. Further, the training and activities have been established within an institutional framework that facilitates continued coordination and support from each of the groups working in the villages. Indeed, the following summary points can be made about sustainability:

- 1) Local institutions are able to continue project activities.
- 2) Each village has at least one trained and equipped CHA, TBA, and & WL
- 3) Each village has a **functional**, community based HIS.
- 4) Availability of opportunities for literacy and income generation activities.
- 5) Materials and logistics for child survival activities are available at the village level.
- 6) Women at the village level adopt the new behaviors in the improvement of their family's lives.
- 7) Health center staff are able to continue to implement child survival interventions.
- 8) MOH can and will continue to provide training support to the district health workers.

All agreed that it will be more difficult to continue the project at a lower level of financial support, which implies less logistic and staff support. This reduced resource level underscores the importance of coordination and integrated planning at the local level, as suggested by the MOH and NGO partners. Between the project and the provincial MOH, quarterly meetings are needed to ensure coordination and effective use of scarce resources (e.g. training for supervisory staff), and monthly meetings between the district staff, NGOs, and FDC staff.

It is important to note that both FDC and the MOH recognize their own internal funding limitations for upgrading training for the nursing staff in contraceptive delivery and AIDS/STD prevention. Discussions are underway with the World Bank and other donors to obtain additional support for these activities.

Despite the evidence of sustainability from the bottom up, the team has several recommendations for institutional and organisational changes which could strengthen the efforts of the villagers to keep their activities and project going in the coming months and years.

- 1) More coordination with MOH and NGOs: FDC has served as a broker, facilitating a more effective use of MOH health care services and training opportunities by the local populations. At the same time, they have facilitated the involvement of other NGOs in health concerns. To maintain this synergism will require **planning** and coordination of FDC, MOH and NGO partners. The present vertical nature of health sector programs at the MOH does not enhance such integrated coordination, so ways will have to be found to work around the present verticalization.

This coordination is particularly important to ensure efficient and non-duplicative use of resources. Coordination also is needed in the research of additional funds for the project.

Although some donors will continue to fund vertical subunits of the whole package, it is important that FDC maintain its perspective that the entire package is necessary. Only FDC can serve as the broker vis a vis the different donors and the different partners.

2) Talking about devolution: It is important that FDC communicate often with the villagers about plans for continued program activities. The villagers need to be in on decisions about what they will take on, and what they can and can not expect from FDC in the next phase of the project. Mechanisms need to be put into place which will reinforce village health committees and others who take charge of specific activities during the devolution period. There needs to be frequent communication between all partners to make sure that problems are discussed and resolved early on.

One important message that villagers seem to need to hear is that the program will continue, but not in the same form. The villagers will play a more active and independent role, and program staff need to work carefully to help them feel comfortable with this. The team observed great eagerness to continue with many activities, but care is still needed to ensure that this eagerness is not quelled by miscommunication about expected levels of support, ruptures in the flow of supplies, and so on.

3) Coordination with other sectors: FDC is in a favored position. with the multisectoral base of activities. These other sectors are very committed to the health activities. In the coming months the health unit should be exploring ways to further reinforce the health content of the other sectors, particularly the literacy and education sector. Current health messages in the literacy training should be maintained and complemented by others, and arrangements should be made to prioritize village health committee members for adult literacy programs.

4) Integration of training and supervision with MOH and NGO partners: Training is a major component for the project and has played a large role in its present positive results. Without additional external funding for training, the available training resources must be better husbanded to extend their impact among all the partners. FDC should arrange for greater participation at MOH trainings, and vice versa.

Supervision should be more effective: Less emphasis on reporting service delivery, and more emphasis on reporting problems in delivery of services and ideas for stronger programs. The supervision needs to be more of a two-way communication between the staff and the supervisor to facilitate this kind of information exchange.

VIII. Recommendations

The evaluation team recommendations have been included in each section of the report: Summary of Achievements, Training and Supervision, Health Information System, Sustainability, Lessons Learned. This section on recommendations is primarily a recapitulation of these recommendations. Please see the individual sections for a more detailed specification of the recommendation.

- 1) Planning and programming: The main recommendation here is for more coordination and integration with FDC partners, the MOH and the NGOs. In addition, in the devolution phase, the village health committees need to be more involved in decisions regarding activities and next steps.
- 2) Training and supervision: More coordination of FDCs training program and that of the MOH. The training chain from top to bottom must be more inclusive at the top, and more dense (repetitive and reaching more village leaders) at the bottom. Supervision should be more two-way, permitting communication up the channel of information about problems and potential innovations.
- 3) Reinforcement of the social mobilisation strategy: This was highly **successful**, and should be maintained. Reinforcers need to be developed to encourage village health committees and village leaders to continue with this important activity without FDC support and stimulus.
- 4) Maintain and strengthen the village leaders: The women leaders (WL) were highly effective at educating and mobilizing the village women. They should be encouraged to continue this. Retraining and training on new themes should be arranged with training partners, if not through FDC.
- 5) Re-examine the efficiency of certain interventions: Growth monitoring was very time intensive, yet not backed up by appropriate rehydration programs. The team recommends switching to a less labor intensive method for identifying growth faltering and malnutrition. Similar consideration of other interventions (e.g. immunizations) might identify a more cost-effective way to carry out the programmed activities.
- 6) Continue to work multisectorally: The project is strengthened by the involvement of other sectors. This complementarity should be continued and extended. The links between health and other sectors also can be reinforced with the partner NGOs.
- 7) Simplify the HIS: The health information system works well at Sapone, but in this phase of devolution, more attention needs to be placed on a stronger and more reliable system for observing vital events in between the annual updates. Procedures need to be worked out to improve registration of vaccinations. Greater attention should be paid to getting simplified analyses out that can guide village and subdistrict program decisions, as well as to enable villagers to chart their own progress toward their goals.
- 8) Strengthen the links to the Bamako Initiative: The project's commodities are channeled through the village Bamako Initiative structure. This linkage should be maintained, with efforts to ensure continuity of supplies. In addition, this might be an avenue for accessing national level training, whereby the local health workers receive assistance and training from the national level, enabling them to take over functions.
- 9) Emphasize horizontal integration: In the devolution stage, FDC and its partners will undoubtedly market pieces of the project through different donors with separate objectives (e.g.

malaria control, immunization coverage...). While that may facilitate funding, the great success of the program has been in its integration across objectives. The villagers have a good grasp of the ways that different health promotive behaviors can reduce the risk of several diseases. The FDC staff needs to continually work to retain this integration at the village level, even if the program funding and partnership is vertical.

APPENDIX 1

Members of the Evaluation Team