

**ADVENTIST DEVELOPMENT AND RELIEF AGENCY
(ADRA – GUINEA)**

**MATERNAL HEALTH AND CHILD SURVIVAL PROJECT OF
SIGUIRI
SMIS
Second Annual Progress Report
Oct 2001 – Sept 2002**

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List of Acronyms

ADRA	Adventist Development and Relief Agency
BCC	Behavior change and Communication
BHR/PVC	Bureau of Humanitarian Response and Private Voluntary Organization
CA	Community Agent
CLSS	Community Life Saving Skills
CS	Child Survival
DIP	Detailed Implementation Plan
DHS	Demographic and Health Survey
EOC	Emergency Obstetric Care
FG	Focus Group
HC	Health Center
HFA	Health Facility Assessment
HIS	Health Information System
HKI	Helen Keller International
HP	Health Post
HQ	Head Quarter
HVT	Health Volunteer
IEC	Information Education and Communication
IPC	Inter Personal Communication
MH	Maternal Health
MOH	Ministry of Health
LSS	Life Saving Skills
PHC	Primary Health Care
PRISM	Pour Renforcer Les Interventions de Santé de la Reproduction et des MST /SIDA
PDM	Positive deviant Mother
SHIS	Social Health Insurance Scheme
TA	Technical Assistant
TBA	Traditional Birth Attendant
TS	Technical Support
USAID	United States Agency for International Development
VDC	Village Development Committee
WRA	Women of Reproductive Age

Summary

In FY 2002, ADRA/Guinea completed the second year of its 4-year child survival initiative, *Child Survival XV*, in the Prefecture of Siguiri in Upper Guinea, with a considerable progress towards the achievement of project outcomes. The project is designed with the overall goal of improving the health of mothers and children. It intervenes in nutrition, vaccination, malaria prevention and safe motherhood. With NGO Networks funding, family Planning was added as a fifth intervention during the year.

During the reporting period, an internal review of the detailed implementation plan (DIP) was carried out. As a result of this review, all the 72 target villages instead of the 48 that were originally planned for the year, were selected. It was envisioned that a longer presence in the target communities, than was previously planned, would contribute greatly to enhanced behavior change. Coping with the demands of the above change in implementation strategy was a challenge but the commitment of ADRA and the kind support of its partners put the implementation process on course.

Overall, approximately 90% of the target activities planned for the year were accomplished. The major accomplishments include the completion of all the initial training for 12 animators, 15 MOH staff, 72 health volunteers, 72 traditional birth attendants and 216 village committee members in communication, management and the five interventions areas; completion of feasibility studies and household surveys in 36 pilot villages for the installation of social health insurance schemes; the setting up of 12 social health insurance schemes in 12 villages; the completion of hearth cycles in 12 villages and the conduct of census of children 0 to 3 years and pregnant women.

The factors that militated against the non-achievement of all the targets of the year include, rains that denied project staff access to project sites in July, August and September. The MOH required that a revised national TBA curriculum be used in the training of TBAs throughout the country. Unfortunately, the revisions as well as the approval processes were bedeviled with delays that caused disruptions in the implementation schedule of the TBA training. With tenacity of purpose and the support of partners such as Save the Children, ADRA managed to over the odds and did carry out this important training.

In furtherance to the planned interventions, the project made good strides in its effort to increase synergy with the agency's food security project being implemented in the twelve sub-prefectures of Siguiri. As part of this integration, the project will explore the possibility of transmitting maternal and child health messages on a radio program that the food security project initiated in FY01 on a rural radio based in Kankan, the provincial capital of Upper Guinea. This radio covers the entire prefecture of Siguiri in modulated frequency (FM), with a repeater antenna site in Siguiri, and carries out programs in Malinke, the local language.

Introduction

The Child survival and health indicators in Guinea are considered among the lowest in the Developing world. According to the 1999 DHS, infant and maternal mortality are estimated at 98/1000 and 528/100,000 births respectively. The complete vaccination coverage for Children, 12–24 months, is estimated at 26 percent. At the request of the people in the prefecture and the support of the Ministry of Health (MOH), ADRA/Guinea Submitted a child survival and safe motherhood project proposal to the BHR/PVC of USAID/Washington and was approved. The grant was \$1 million and the life of The project is 4 years (Oct. 1, 2000 – Sept. 30, 2004).

The project is being implemented in the *Prefecture* of Siguiiri in the upper Guinea region. The prefecture has 12 *sub-prefectures* and 129 districts (equivalent to villages). According to the most recent demographic information (MOH, 2000), the population of the prefecture is about 311,000 persons.

The project intervenes in *six sub-prefectures*, namely Doko, Franwalia, Kintinia, Siguiiri Center, Niagassola and Norassoba. And it covers 72 villages. The major intervention areas are nutrition, vaccination, malaria prevention and safe motherhood. The project targets 38,610 WRA and 33,332 children between 0-60 months.

The goals of the project are as follows:

- . Engender improved knowledge of good health behaviors
- . Increase acceptance of good health practices
- . Improve the overall health of the targeted communities

Strategies:

- . Strengthening BCC activities with the view to promoting the adoption of good health behaviors and practices
- . Strengthening the capacity of MOH staff in order to improve the quality of services at the health centers/health posts level
- . Empowering targeted community for health

The expected project impacts are as follows:

- . A sustainable reduction in chronic malnutrition
- . A reduced incidence of vaccine preventable diseases
- . A reduction in maternal mortality
- . A reduction in malaria related mortality among children <5

The project fits with USAID/Guinea's strategic objective of "Increased utilization of FP/MCH and STI/AIDS prevention services and products" and contributes directly to its four intermediate results of: 1) increased access; 2) improved quality; 3) increased demand and 4) improved coordination of FP/MCH and STI/AIDS prevention services and products.

During the reporting year, the focus of the project was on completing its recruitment process, integrating the last 48 villages, introducing all of the projects interventions into the 48 villages and completing all initial training at the project, MOH and community levels.

ACCOMPLISHMENT

In spite of the challenges faced, ADRA was able to accomplish approximately 90% of its planned activities.

1.1 Administrative

The office set-up was completed with all the necessary logistics and systems in place for full operation. The last 6 additional field animators were recruited during the year. This completes the staff complement planned for the project. A new assistant director was also hired following the termination of the appointment of the former due to incompetence.

1.2 Programmatic

Planning

1.2.3 Establishing Community Structure

During the period, the last 48 villages were selected thus completing the 72-targeted communities. To ensure the long-term sustainability of the CS interventions, the project has identified village development committees (VDCs) as one of its key strategies. All the VDCs were also installed. Different steps were taken in order to engage the community in the design and implementation of CS activities.

1) Identification of villages/Photo identification

As a first step, ADRA/Guinea carried out photo identification exercises involving the target communities in the selection of the 48 districts (please refer to Annex A). Among other things, the exercise enabled ADRA to: make the initial contact with local authorities and the community and to share with them the objectives of the project; identify the key members of the community(religious leaders, elders, traditional healers, etc.); identify the different local associations present; assess the existence of community social insurance schemes being operated in the sub-prefecture; identify the key activities and routines of the communities, such as market days, mining days, agricultural days, etc.

2) Setting up of village development committees

After the village identification exercise, 48 village development committees (VDC) were established. Additionally, 96 community health volunteers were selected. Among these volunteers, 48 are TBAs. The exercise was carried out in collaboration with local authorities and the community members.

3) Conducting a general census of target group

With the village identified, the project proceeded with the conduct a censuses of children 0-3 for nutrition, 0-11 for vaccination and of pregnant women for safe motherhood and vaccination activities. The censuses were conducted in the village centers where project intervenes and not the sectors¹ It is estimated that approximately 45% of the population live in the sectors. To cover the sectors in addition to the village centers, ADRA will need additional human and material resources.

Each VDC is consisted of five members: one president, a vice president, a treasurer, a TBA and a nutrition/vaccination volunteer. ADRA worked with the local MOH, Save the Children and Africare to develop/adapt criteria for the selection of the villages, members of VDC and community volunteers (Annex B). Priority was given to health volunteers and TBAs who were already working in the field (i.e. CBDs from the PRISM project and MOH's TBAs). Approximately 60% of the VDC members are women.

1.2.2 Development of HIS tools

During this period, project finalized setting up its HIS. Data collection tools now exist for all

¹ The sectors are the outlying areas of the villages. They often have scattered settlements making accessibility quite difficult.

interventions and are being tested in the field. The animators and the VDCs fill these forms and registers that are compiled monthly by supervisors (please refer to Annex C).

1.2.3 Supervision plan

During this reporting period, the project finalized its supervision plan to follow up activities implemented in the field. The plan includes the zones covered and the designated supervisor. The zones were determined by dividing the six sub-prefectures into three. Each zone consists of two sub-prefectures and 24 villages. Each has two animators and one supervisor. The supervisors are the technical staff on the project. The system that is put in place allows for monthly qualitative and quantitative supervision and bi-annual performance evaluation. Norms for supervision were also finalized this period. The norms developed include the number of supervision to be conducted per month, the necessary tools to be used for supervision, and a guide to interpret supervision results.

1.3 Training

ADRA considers knowledge and skill acquisition fundamental to effecting behavior change in the community. Training is also a veritable means of enhancing capacities that are fundamental ensuring the sustainability of project outcomes. Approximately 95 % of the training planned for the year were completed. The various training activities were conducted with and for a number of project stakeholders; project staff, MOH staff, VDCs, TBAs, etc. The table below and the appendices referenced provide details on the key training activities conducted during the year.

1.3.1 Communication/community mobilization/community organization

The objective of the training was to equip health volunteers with the necessary communication and community mobilization skills they need to organize or conduct health and other community development activities. In all, 318 persons, made up of project staff and community members benefited from the training in this area. Training modules developed by the MOH and other PVOs such as Save the Children, Africare, PRISM and EUPD.

1.3.2 Nutrition

The training in this area of intervention was to provide the trainees with the necessary technical knowledge needed in conducting nutrition activities such as monthly weighing, interpretation of growth chart and the nutritional status of the child, counseling of mothers on appropriate nutritional practices, and conduct of BCC activities in their respective villages. The topics covered included the following; types and causes of malnutrition; the nutrition of a young child; the nutrition of a pregnant woman; the importance of breastfeeding (immediate and exclusive breastfeeding), food diversification and the different types of food as well as appropriate weaning practices. (Refer to Annex D). Key BCC messages for nutrition and target groups were also discussed and identified during the training sessions. Training modules prepared by the nutrition department of the MOH were used. A combined team of ADRA and MOH personnel conducted the training. A total of 6 ADRA animators and 96 health volunteers (HVTs-48 for nutrition/vaccination and 48 TBA) conducted the training.

Additionally all the animators also received training in the Hearth nutrition method. The CS technical staff conducted the training. The training manuals of Africare were adapted (refer to Annex E).

1.3.3 Vaccination

The purpose of this training was to 6 ADRA staff and ninety-six health volunteers (48 for nutrition/vaccination and 48 TBA) was to equip field volunteers with the technical knowledge they need to conduct effective behavior change activities on vaccination to improve the poor vaccination coverage at the community level. The training covered the importance of vaccination, the different vaccine preventable diseases, the vaccination calendar for children < 2 and pregnant women and the side effects of vaccination. During the training sessions, key BCC messages and the different target groups for BCC activities were also identified. Training modules prepared by the national vaccination program as well as other reference documents developed by UNICEF/WHO/UNESCO.

1.3.4 Malaria Prevention

A key approach ADRA is using in reducing the incidence of malaria is to increase the community's knowledge on the causes and prevention of malaria. And in this effort project animators have an important role to play. In March 2002, 12 animators were trained in the causes and prevention of malaria (refer to Annex F). During the training sessions, priority messages in malaria prevention were also identified. Project and MOH staff conducted the training and training modules from the MOH national malaria prevention program as well as other support documents prepared by UNICEF/WHO/UNESCO were used. The training lasted for 3 days. Post-tests were given from the assessment were encouraging.

In an effort to improve the capacity of MOH staff and to improve the quality of health care provided in the project zone, the project trained 27 MOH health center and health post staff in the case management of malaria in March 2002 (refer to Annex G). MOH staff conducted the training and training modules from the MOH national malaria prevention program as well as other support documents prepared by UNICEF/WHO/UNESCO were used.

In collaboration with INTRAH SIG, a local NGO of traditional practitioners that work in the area of malaria prevention, the project provided orientation to 48 HVTs in the causes and prevention of malaria. The orientation lasted for three days. Training modules were developed in collaboration with INTRAH SIG as none existed. Reference documents from the MOH as well as UNICEF/WHO/UNESCO were used to develop the module (refer to Annex H).

1.3.5 Safe Motherhood

As shown in the table below, all the 12 animators received training in safe motherhood and CLSS. This was to introduce them to the concept of community partnership for safe motherhood and also equip them with the technical knowledge they need to conduct behavior change activities in promoting safe motherhood in their districts. The training covered among other things the definition of safe motherhood, the different sections of safe motherhood and the role of the animators in implementing safe motherhood activities. During the training, important safe motherhood messages were identified and translated into the local language. Project developed the training module (as none existed) in collaboration with the MOH *prefectoral* directorate (refer to Annex I &J).

Training of Trainers

Project trained 8 trainers comprising of the chief maternity medical doctor, 1 mid wife, 1 DPS staff responsible of primary health care, 1 DPS staff responsible for community based distribution, 2 DPS health center staffs, and 2 project staff in CLSS. The training took place from August 2-4, 2002. Save the Children facilitated it. The objectives were to present the concept of community partnership for safe motherhood, present the newly revised TBA training curriculum and to enable the trainers to become familiar with the new module. Practical training sessions were also held with the trainers.

Training for supervisors

Fifteen (15) MOH supervisors, health center staff responsible for prenatal care and vaccination, received training in CLSS. The training took place from August 5- 7, 2002 in Siguiri. The objectives of the training was to present the concept of community partnership for safe motherhood, review the new supervision tools developed by the national MOH safe motherhood program, and discuss the roles and responsibilities of supervisors in supervising the trained TBA. The newly trained trainers conducted the training.

The 72 TBAs representing the 72 villages also received a 10-day training in CLSS. This training was funded by the Networks project. The training provided the TBAs with the technical and practical knowledge in the care of pregnant and lactating women and their newborn. During the training, the trainees had the opportunity of taking practical sessions held at the maternity department of the hospital in Siguiri. The national TBA curriculum was used to train the TBAs. The training covered 6 modules including care during pregnancy; care during labor; care during delivery; care after delivery; TBA-collaboration with the health centers; TBA-collaboration with the community (refer to Annex K).

1.3.6 Family Planning

Under the Networks funding, all the 12 animators benefited from training in family planning in March 2002. The training, which lasted for 4 days, covered the following areas: anatomy and physiology of the reproductive organs of male and female; notion of conception and contraception; the menstrual cycle, the different methods of contraceptive and their side effects; infection prevention and counseling skills in FP. Key messages in FP were also identified during this training session (refer to Annex H). The objective of the training was to provide field animators with the knowledge and skills they need to provide accurate messages in FP to the community and increase demand for such services. Project animators will be referring community members to the health centers and HVTs for their family planning product needs. The training was conducted in collaboration with the MOH regional trainers in family planning.

Forty-four health volunteers also benefited from a similar training from June 28 to July 3,2002. Upon the completion of their training, HVTs were provided with free initial stock of family planning products to allow them to sell to the community. The products were provided by PRISM, a project of USAID/Guinea. HVTs were encouraged to replenish their stock at the health centers.

Table 1

Training organized during October 01 – September 02

N°	Training Topics	Period	Duration	NAC		#of participant	Professional affiliation
				Pre test	Post test		
1	<u>Project Level</u> Communication 3As: Appraisal, Analysis and Action Interpersonal communication Community organization and community mobilization and supervision/monitoring techniques	Dec 01-05, 2001	5 days	35%-	78%	6	Project Animators
2	Field training	Dec 01, Jan 02	45 days	-	-	6	Project Animators
3	Formative Research: Roles of facilitator, observer and secretary; facilitating Focus group, interviewing/observing	January 02, 2002	2 days			6	Project Animators
4	Nutrition/Vaccination (refer to annex c for training topics covered) acceptable level of knowledge (ALK)=60%	January 2002	5 days	35%	75%	6	Project Animators
5	Hearth refresher training(refer to annex)		3			12	Project Animators
6	Malaria Prevention (refer to annex) acceptable level of knowledge ALK) was 70%	April, 02	4 days	8%	91.7%	12	Project Animators
7	Family Planning (ALK = 70%refer to annex)	April, 02	4 days	41%	83%	12	Project Animators
	Safe Motherhood (Refer to annex) (ALK = 70%)	July, 02	5 days	53%	100%	12	Project Animators
1	<u>Community Level</u>						

2	Communication/ Nutrition/Vaccination	February 02	3 days	22%	63%	96	48 HVTs +48 TBAs
3	Communication/community mobilization/organization/ roles and responsibilities ALK=50%	July/Aug. 02	4 days	10%	65%	216	VDC presidents/vice presidents/treasure r
4	Malaria Prévention (refer to annex d for training topics)	February	3 days	22%	82%	69	72 HVTs
5	Family Planning (refer to annex- ALK= 60%)	July 02	5 days	18%	68%	44	Health volunteers
6	Safe motherhood/CLSS (refer to annex)	Aug –Sep 02	10 days	--	-	72	72 TBAs
1	MOH Level						
2	Malaria Prevention/case management	March	3 days	14%	74%	27	MOH health center/post staff
3	Family Planning (refer to annex- ALK=65%)	March	4 days	22%	78%	27	MOH Health and post staff
4	Safe motherhood/CLSS	Aug. 02	3 days			6	MOH trainers
		Aug. 02	3 days			15	MOH health center staff

Note: Pre-and post-test were not always possible to conduct for HVTs and TBAs, as most are illiterate. The results under pre-test and post-test reflect the % that did obtain the acceptable level of knowledge (ALK) score.

1.4 Field Activities

1.4.1 BCC

As stated elsewhere in this report, the change in strategy did cause some delays in implementing behavior change activities. As a result, BCC activities were suspended from October 2001 to January 2002 as project staff were occupied with the selection of the 48 new villages. BCC activities resumed in February in the 72 districts. Twelve (12) field animators and 72 community health volunteers implement BCC activities. Key messages in all the interventions were transmitted this period as project integrated all its interventions. A total of 1,019 BCC sessions were conducted during this period by project animators and a total of 1,023 BCC sessions were held by HVTs (Please refer to Annex k). Existing MOH visual aids for nutrition and vaccination were used during the sessions.

1.4.2 Nutrition

Approximately 46% of children 0-3 (3,406/7,348) participated in monthly growth monitoring activities during this period in the 72 villages. Prior to the project, no such activities were taking place. This result has been encouraging as it demonstrates not only the acquisition of knowledge by mothers but also change in practice as mothers are bringing their children for monthly weighing sessions and are monitoring their growth.

Table 2 Annual Growth Monitoring status of children in 72 villages

SOUS-PREFEC.	Appox. #Child. Regist.	Appox. #Child Weigh.	Gap	% Gap	Colour				%			
					Gr.	Yellow	Red	Total	Gr.	Yel.	Red	Total
COMMUNE URB.	1396	516	881	63.08	413	84	19	516	80.09	16.22	3.69	100
NORASSOBA	1116	491	625	56.03	419	118	17	554	75.63	21.27	3.09	100
DOKO	1214	895	320	26.33	597	267	31	895	66.76	29.79	3.45	100
NIAGASSOLA	900	536	364	40.42	362	152	23	536	67.44	28.28	4.29	100
FRANWALIA	1047	547	501	47.82	400	91	23	515	77.74	17.72	4.54	100
KINTINIAN	1675	423	1252	74.76	342	75	9	427	80.22	17.61	2.17	100
TOTAL	7348	3406	3942	53.65	2533	786	123	3442	73.60	22.84	3.56	100

As can be seen from the table above, the percentage of children suffering from malnutrition remains high. The reduction of malnutrition has therefore been accorded high priority by ADRA/Guinea CS project.

Hearth is one important community-based nutrition strategy that ADRA is employing to correct moderate malnutrition among children 9 months to 3 years old. The two most important aspects of hearth is that it uses locally available food to correct malnutrition and it also empowers the community (mothers in particular) by building their capacity through training to solve the nutrition problems afflicting their families. During this period, ADRA closed the first cycle of hearth initiated during the last reporting period (September 2001) in the 6-pilot districts.

A total of 72 children (12 children/village) with moderate malnutrition participated in the first cycle of hearth. These children were identified during GM activities. The indices weight/age and weight/height were used to appreciate the nutrition status of children. As can be seen from the result, at the end of 12 days, the average weight gain per children and per village was between 200 to 400 grams; the recommended weight gain based on world health organization (WHO) standard. The 12-day result is an indicator used to appreciate the efforts of the project in transferring knowledge to the participating mothers and in following up correctly the activities of hearth. At the end of the sixth month the average weight gained per child did equally continue to increase. ADRA is very encouraged by the results for a number of reasons: 1) the curb continued to ascend after the 12 days ie “ the sustainability phase”; and 2) the results are mostly attributed to the efforts of PDM and HVTs; hence behavior change in nutritional practice seem to have been taking place among the participating mothers.

TABLE 4: RESULTS of the 12-day and 6-month of hearth.

SUB-PREFECTURES	SITES	Average weight of children in day 1	Average weight gain in 12 days	Average weight gain/children in 12 days	Average weight gain in 6 months	Average weight gain/children in 6 month
COMMUNE UR.	Falama	96800	101500	392 g/child	106800	2470 g/child
NORASSOBA	Fandia	94000	96700	363 g/child	103500	1600 g/child
DOKO	Fidako	104700	107900	258 g/child	123400	1558 g/child
NIAGASSOLA	Kolita	91200	95800	418 g/child	71300	1429 g/child
FRANWALIA	Kamaya	98400	104100	475 g/child	88100	1411 g/child
KINTINIAN	Balato	93000	94900	290 g/child	97300	1300 g/child

Only children 9 – 36 months were considered for the hearth; 12 children/village participated; all 12 children/village ie 71 children participated until day 12; at 6 month 61 children participated.

Note:

The implementation of hearth sessions was also not without challenges. Some difficulties encountered were: 1) unavailability of local ingredients like eggs; 2) drop out of children due to the displacement of mothers; 3) illness of children preventing them from eating well; 4) weak follow-up by positive deviant mothers after the 12th day (ie during the sustainability phase). 5) weak follow up of PDM and participants mothers by HVT and animators. ADRA will apply the lessons learnt in the second cycle, which begins in FY03.

1.4.3 Safe Motherhood

1.4.3.1 Installation of trained TBA into the community.

Thirty-six (36) trained traditional birth attendants were integrated into their respective villages after their training this period. The main objective of this activity is to recognize and validate the trained TBA and her new skills by the community. This is an essential activity of success of safe motherhood as TBAs have a crucial role to play in preventing maternal and neonatal mortality as most deliveries are done at home. Hence, their acceptance by the community is indispensable. Key elements were shared with the community during this event which gathered key community leaders, health center staff, project staff and the community at large. Among these were the new role and responsibility of the TBA, her new skills, the materials received and their use, the fees associated with her services (1000 Guinea Franc or .50 cents based on the MOH standard) and the community's responsibility toward the TBA. The remaining 36 TBAs are in the process of being installed in their respective villages.

1.4.1.2 21 Social health insurance for EOC (MURIGA)

The installation of social health insurance schemes to pay for emergency obstetric care is an important component of the safe motherhood intervention. As such, project completed 12 feasibility studies and 12 household surveys in 12 villages during the year and set up 12 MURIGA 1/village (Refer to annex L). The studies allowed project to gather information on the number of household/village, the number of women of reproductive age that are ready to participate in MURIGA and the amount that community members propose for saving. The studies equally permitted ADRA to involve the community from the design phase by seeking their ideas on MURIGA, the difficulties they encounter in managing emergency obstetric care and their willingness to participate. The survey questionnaires targeted heads of households, religious and local authorities and health center/posts staff. Project animators conducted the survey.

In conducting the feasibility studies in the villages, the following criteria were considered.

- Population size
- Availability of health center/posts
- Availability of market days
- Accessibility in all season
- General knowledge/notion of the community on MURIGA.

Three of the above criteria population size, accessibility and the general notion of the community regarding MURIGA were accorded priority. In all, four hundred and fifty five households (455) and 1,659 WRA were registered in the 12 villages and are currently participating in the health insurance. The community also decided on an amount of 200 Guinean francs (ie the equivalent of 10 cents or a dime in US) for the monthly savings as well as the person in the community who should keep the funds, the Imam (the religious leader). In some of the villages, ADRA found out that there already existed MURIGA set up by the MOH. ADRA will strengthen these insurance schemes rather than installing a parallel MURIGA. The village development committees already set up by the project manage the 12 MURIGAs). The 12 MURIGAs have all the necessary management tools and are currently functional.

During this period, project also completed feasibility studies and household surveys in 24 districts. As the next step, project will be setting up 24 more MURIGAs at the beginning of year three.

1.5 SUSTAINABILITY

One of the means by which ADRA plans to achieve sustainability is by empowering community members as well as partners particularly the MOH. In this regard, the following activities were undertaken.

ADRA continues to participate in “Food Security Advisory Committee” established the last reporting year. This committee is made up of representatives of the ADRA Food Security Project, ADRA CS, MOH, the Prefecture Office, representative of youth associations, women’s association and other stakeholders. The purpose of this committee is to allow information sharing, to coordinate activities and to create a sense of ownership of the ADRA initiatives among the people in the prefecture.

An MOU between village development committees, MOH and ADRA was formulated. The objective of the MOU is to serve as a tool to officially transfer ownership of village level activities to the community and the MOH and to strengthen partnership for long-term sustainability. The MOU is currently being discussed with VC members and village authorities. Some have already been signed.

The integration of community activity into that of the MOH: Two strategies were identified during the reporting period: 1) ADRA animators will provide health centers chiefs with copies of their monthly reports; and 2) HVT and field animator (where possible) will assist in the monthly meeting organized by the health centers at which monthly activities of each village are presented. The project considers the second approach in particular, as responding to its goal of ensuring the continuity of field activities by CVD/HVTs and their integration into the MOH/HC activities for monitoring.

Joint supervision/monitoring by animators and VDC members of field activities conducted by HVTs. It is anticipated that by the end of the project, VDC presidents will have the capacity to: 1) monitor and supervise HVTs and TBAs activities and 2) provide monthly feedback to the community of GM, vaccination and other health activities carried out by HVTs and TBAs.

The political, community and religious leaders in the 72 villages are involved in the planning and implementation of CS field activities on a monthly basis.

At least 28 MOH staff are involved in monthly activity planning, implementation and monitoring with the field project staff of ADRA and VDC members.

Twenty-four (24) health volunteers conduct behavior change activities in project interventions in 24 villages.

A joint quarterly supervision by the MOH *prefectoral* director and the ADRA project has been instituted to enhance synergy.

Joint supervision at the community level with CS field staff and health center staff to transfer competence to improve the integration of project activities and eventually transfer ownership.

Empowerment of VDC members through training and decision-making is another means by which sustainability is being addressed.

The capacities of MOH health center/post staff are being enhanced through training in the 5 intervention areas of the project.

ADRA is also using the Hearth approach in nutrition as a way of empowering women particularly the positive deviant mothers, as community facilitators. By building their capacities through training on the appropriate nutrition practices, mothers are given the opportunity to educate other mothers on appropriate and life saving nutritional practices and gain the respect and confidence in their respective community.

1.6 FACTORS CONTRIBUTING TO SUCCESS

The following factors contributed significantly to the strides so far made:

1.6.1 Support of National and Local government officials

ADRA/Guinea continues to enjoy tremendous support at national and local government levels. Government officials have shown keen interest by actively participating in monthly and quarterly planning meetings and monitoring sessions.

1.6.2 Interest and support of the community

Without the support and interest of the community, ADRA would not have been able to achieve its target in the implementation of its activities in the field. ADRA continues to get the support of the community through its participatory problem and solution identification exercise known as the 3A (appraisal, analysis and action). Through this approach, the communities were able to see the tremendous health problems in their community, their role as problem solvers as well as the role ADRA in facilitating the change. The fact that ADRA accorded primary place to the community, getting their support and engagement was possible.

1.6.3 Competence and dedication of project staff

The competence and dedication of project staff have also been another important contributing factor to these accomplishments. The fact that most of them are sons and daughters of Siguiri has equally helped greatly, especially in field activities, as staff members are known, respected and heard in the villages covered by the project. Also the fact that language is not a barrier has contributed to the creation of good rapport between staff and the community members.

1.6.4 Good Partnership/Collaboration

Another major contributing factor to success is the excellent collaboration and partnership ADRA has with the MOH and local and International NGOs.

2. FACTORS IMPEDING PROGRESS

2.1. Geographic/Economic

The prefecture of Siguiri is one of the most rural and unattractive areas in Guinea. The harsh weather conditions especially during the dry season discourage many a good worker.

Siguiri is 700 km away from Conakry and requires over 12 hours travel (one way) and very high costs. Due to the poor road condition, access to project sites is difficult and takes longer hours than normal. This affects the quality of supervision and logistics coordination with the ADRA office in Conakry. The situation is more challenging during the rainy season.

There is limited existence of basic infrastructures such as electricity and telephone, rendering the working environment very difficult.

The limited economic activities in Siguiiri have also been found to be discouraging for people to take jobs in Siguiiri. This makes recruitment processes very challenging for ADRA.

2.2 Infrastructure/Communication

Communication remains a challenge to ADRA. Telephone and e-mail is very expensive since the only means is by satellite phones. The public electricity supply in Siguiiri is unreliable (just about 100 days in a year due to the high cost of fueling). As a result, ADRA is compelled to use of generators for long hours resulting in high operating costs.

Furthermore, there is a dearth of qualified technicians and appropriate repair pieces for project equipments such as generators, computers and photocopy machines. Most of these have to be hauled to Conakry for repairs, thus causing delays and loss of man-hours.

2.3 Technical Implementation

2.3.1 BCC Technical materials

There exist limited visual BCC materials especially for safe motherhood, vaccination and malaria. This renders community BCC activities challenging particularly since 90% of the community is illiterate. What exist currently are BCC materials developed by the MOH/UNICEF and NGOS for nutrition.

2.3.2 Training materials/modules for community health volunteers

There are very limited training modules developed by the MOH and other organizations for training at the community level (eg the training of community health volunteers). This continues to render some community level –training very challenging.

2.3.2 MOH staffing

The limited number of health agents in certain health centers/posts continues to be a problem to the project. As a result, outreach vaccination/PNC activities have not taken place in some villages as planned. This has also rendered the integration of field activities into those of the MOH difficult. This is particularly a concern to the project as it impacts not only on long-term sustainability but also on the community's confidence in the health care system.

2.3.3 Logistics/Vaccination

One of the major problems affecting the efforts at increasing the vaccination coverage in the target area is the limited availability of motorcycles to MOH field staff as well as the poor conditions of these motorcycles. These have limited outreach vaccination and pre-natal care (PNC) programs in the project area. Currently, four out of the six sub-prefectures (Kintinian, Frawalia, Niagassola, Siguiiri center) do not have motorcycles. And in the other two sub-prefectures, the conditions of the motorcycles are very poor. Therefore, vaccination activities in the area are highly dependent on ADRA's support. The reality is that unless ADRA's motorcycles are available, vaccination activities are neither planned nor implemented.

The situation is aggravated further by the lack of funding by some health centers for maintenance and fuel despite the availability of motorcycles to conduct outreach activities. The fact is that some health centers are running in deficit and they do not generate enough funds to cover their needs.

2.3.4 Weak community participation

Community participation/mobilization in the mining zones such as Kintinian and Frawalia for GM, vaccination and hearth sessions continues to bother ADRA. Some of the reasons are:

- a. inadequate mobilization efforts by local leaders;

- b. the preoccupation of community member with traditional mining activities.
- c. lack of interest in non-mining activities

Traditional gold mining constitutes an important income generating activity in Siguiiri. The reality is that almost 5 out of the 6 sub-prefectures are mining zones. Therefore in 6 out of the 7 days community members are absent during the day and only available at night. In one sub-prefecture(ie in Niagassola) the community completely moves to the near-by sub-prefecture of Kintinia do to mining. Hence, mobilizing the community and planning GM and vaccination activities remains a problem.

2.3.5 Weak utilization of health centers/posts

The low utilization of health care services continues to be a problem. Some of the reasons are lack of financial resources to pay for health care services, overcharging, ignorance, the isolation of certain districts, and poor reception of patients. Although, this is not a unique problem to ADRA, it could have a negative effect on project outcomes if not curtailed. The problem is multifaceted and needs intervention at all level (ie at the community level, MOH level, etc).

2.3.6 Poor capacity of health center/post staff

Pre and post-tests conducted during training sessions revealed that the health center/post staff have very low levels of knowledge on basic health topics. Some of the reasons are: 1) inadequate funds allocated to staff training and refresher training by the MOH; 2) limited follow-up/supervision and 3) poor remuneration. This is a concern to the project, as it will have a direct effect on the quality of care provided to the community.

3. ACTIONS TAKENS/PROPOSED ACTIONS

3.1 Communication

The use of solar panels will reduce the operating costs of generators. ADRA's food security project is anticipating to get funding to install solar panels in FY03. The project is discussing the conditions that will permit it from benefiting from this facility.

3.2 Technical

3.2.1 BCC Technical Materials

ADRA plans to adapt materials for safe motherhood and vaccination that are being developed by PRISM. The testing of these new materials is on-going and it is believed that the exercise could be completed early FY03. ADRA also intends to use materials developed by other partners such as PSI and PRISM for family planning in BCC and training activities.

3.2.2 MOH Staffing

ADRA has drawn the attention of the DPS to this problem, which incidentally is a common problem faced at the national level and it does not appear there is any immediate to it. ADRA will help to address it, at least in part, through training of MOH staff.

3.2.3 Logistics/Vaccination

ADRA continues to work plan/coordinate as much as possible, outreach vaccination activities with the MOH health agents to address the shortage of logistics (ie motorcycles) in the field. This strategy has alleviated some of the challenges faced in the field in conducting outreach services. The project was also able to obtain 11 cold chains from the World Bank to ensure the quality of vaccines being administered to women and children in its target area.

3.2.4 Community participation/mobilization in GM/vaccination activities

ADRA has started dialogues with the village mining authorities and local government officials in order to address this issue. In collaboration with the above authorities, it has been decided to issue tickets to mothers who participate in GM activities before they will be allowed to enter the mining zone for mining. The plan is being tested in some villages to know how it works. ADRA will closely monitor this approach to see the changes it brings about. In FY03, ADRA will conduct focus groups discussions in the communities to identify the real issues and to come up with other solutions.

3.2.5 Weak utilization of health care services

ADRA will continue to inform and sensitize community members on the importance of using the health centers/post for their health care needs by making the optimum use of available resources, especially at the community level, ie VDCs, local authorities, village elders, field and MOH staff. By collaborating and involving the health center staff in all its activities, the project hopes to improve the relationship that exists between health workers and community members.

3.2.6 Poor knowledge of technical areas in PHC by health center/post staff

More refresher training and follow-up of health center/post staff will be done within the limits of ADRA's funding opportunities.

3.2.7 Mining activity

Project has started to collaborate with the owners of mines and their managers in order to mobilize community members for health activities. BCC activities also have been targeting these groups. Furthermore, due considerations are given to mining days in planning community health activities. In almost 90% of the sub-prefectures, the community is engaged in mining activity either full-time or part-time in 4 to 5 months out of the year. Where possible, activities will take place in the night in order to increase community participation.

4. TECHNICAL SUPPORT NEEDED

4.1 BCC

ADRA will welcome the opportunity to gain some technical support in reviewing its BCC strategies and activities.

4.2 Sustainability

ADRA will require TS in reviewing its sustainability strategies and activities implemented in the field.

4.3 Capacity building

Technical Support will be needed in reviewing ADRA's capacity building strategies and activities.

4.4 HIS

ADRA will appreciate assistance by way of TS in the analysis, interpretation, and calculation of indicators.

5. CHANGES FROM THE DIP and PROGRAM DESCRIPTION

The only change in the DIP relates to the selection of the 72 target communities. As already mentioned in this report, this activity was originally planned to take place over the first three years. ADRA has found it very prudent to undertake the activity in the first two years in order to ensure a longer period of project activity in all the communities.

6. INFO./ISSUES RAISED AT THE MIDTERM EVALUATION

Not applicable.

7. MANAGEMENT SYSTEMS

7.1 Financial Management System:

ADRA manages the financial aspects of the project at multiple levels.

Drawdowns

ADRA Guinea is a sub-recipient of ADRA HQ, therefore drawdowns are requested by the ADRA HQ finance department against an ADRA letter of credit. These drawdowns are initiated in response to a request by the field. The decision to approve a drawdown is made based on the financial reports provided by the finance department of ADRA Guinea.

Accounting

At the field level, the working budget is the base of the chart of accounts in the computer program that is used to track expenditures. This program maintains balances in USD and can produce reports in both local and USD currencies based on an established exchange rate that is adjusted monthly based on Guinea Central Bank Publishing.

The accounting program provides project administration with income statements that can compare current total expenditures with total budget amounts. As an alternative, it can also compare either total expenditures, or monthly expenditures to budget to date, or monthly budget. This allows the managers to review on monthly basis expenditure pipelines so as to follow the expenditure plan made in the DIP.

Petty cash

The daily administration of ADRA Guinea's finances frequently requires the payment of small amounts for minor expenditures. The most efficient manner of caring for this type of payment is through the establishment of a petty cash system. Therefore, a petty cash system is in use. Presently, there is one petty cash in Conakry for GNF 500'000 (about USD 253.04) and another one in Siguiri for GNF 2'500'000 (about USD 1'265.18). The petty cash replenishment is done with a check from the bank, based upon the documented expenditures made to that point.

Bank accounts

The project maintains three bank accounts to be able to operate the project smoothly. There is one local currency account that is used for day-to-day transactions. There are two in USD currency, one in Washington used to receive funds and to pay for US-based expenses and another one in Conakry used to make transfers and change to local currency.

Checks are drawn up by the accountant, and approved by the project manager or program director and the finance director. Signatories to the checks are the finance director and project manager or program director, the country director and the chairman of the ADRA Guinea Board of Directors.

Financial reports

Monthly financial statements are sent to the ADRA HQ office. The expenditures are traced by the Financial Analyst who refers potential problems to the Senior Finance Administrator. This helps to avoid inappropriate use of funds and aids in tracking project activities.

Financial Audit

ADRA Guinea is a participant in the overall institutional audit of ADRA International, mandated by Office of Management and Budget (OMB) Circular A-133. The accounting firm of Price Waterhouse Coopers (PWC) conducts this audit annually. The scope of this audit includes all Federal projects for which ADRA International is a funding recipient. Examinations of implementing field offices are scheduled based on availability of qualified providers of audit services and other logistic considerations. Any material findings associated with the implementation of projects in Guinea are reflected in the overall audit report provided by PWC to ADRA International. In that report the implementing field office associated with each finding is specifically identified. ADRA International works with those field offices and donor agencies to resolve all findings. Audit findings from previous projects have been addressed and resolved, and at present there are no outstanding issues from those findings.

Elements to be developed

ADRA Guinea has, in the past few months, been working on a financial management manual. It is anticipated the final document will receive board approval by April 2003.

7.2 Human Resources

7.2.1 Line of command: (Please refer to Annex M)

7.2.2 Reporting: Project has 4 different reporting mechanisms in place to follow-up field activities.

1. Annual and Quarterly reports prepared by the Project Director, reviewed by the Program Director and Country Director, ADRA/Guinea. The report is then sent to the ADRA/HQ for further review and submission to the donor.

2. Monthly technical reports prepared by the technical officers responsible for the different technical areas of the project.

3. Monthly field reports prepared by the field animators. These reflect the different field activities such as BCC, GM, and vaccination implemented in the targeted villages.

4. Monthly supervision reports prepared by the technical officers. These reflect the results of their supervision visits of field animators, health volunteers and village committees.

7.2.3 Supervision

The project has developed a supervision plan that it follows. The plan includes the zones covered and the designated supervisors. The zones were determined by dividing the six sub-prefectures into three. Each zone consists of two sub-prefectures and 24 villages. Each managed one supervisor and two animators. The supervisors are the technical staff on the project. The system that is put in place allows for monthly qualitative and quantitative supervision and bi-annual performance evaluation. Norms for supervision were also finalized during the reporting period. The norms developed include the number of supervisions to be conducted per month and the tools to be used for supervision.

7.2.4 Staff turnover:

The project did not encounter any major staff turnover. The only staff that left the team was the assistant project director. He was replaced as a result of incompetence. He has since been replaced. The project has the full complement of staff and does not anticipate any major changes.

7.3 Communication System

Different mechanisms exist to foster communication and team building. Among these are the following:

- a) Access to email and radio system to communicate with the country office in Conakry and ADRA/HQ;
- b) Monthly visits of project director to main office in Conakry.
- c) Monthly administration meetings in main office in Conakry represented by senior administration and project staff;
- d) Weekly general staff meetings in the field and main office;
- e) Annual program committee meeting represented by senior administration and project staffs.
- f) Quarterly Program committee (PROCOM) meetings that alternate between Siguiiri and Conakry.

With its partners, ADRA/CS participates in partners meetings organized by the USAID mission and other coordination meetings organized in the field. These opportunities allow for regular sharing of information and joint decision making at all levels hence strengthening communication and team building.

7.4 Relationships with local partners

ADRA CS continues to have excellent collaboration and partnership with the local partners such as the MOH, local NGOs and the community. Different tools are used to encourage and maintain such partnership. Among them are monthly coordination meetings, bi-annual information sharing meetings, bi-annual coordination meetings, sharing of monthly reports, joint monitoring and training, joint planning and implementation of field activities and joint funding of training activities. Some examples of key activities accomplished are as follows.

7.4.1 ADRA/INTRA SIG

During this period, ADRA signed an MOU with INTRA SIG, a local NGO of traditional medical practitioners who work in malaria prevention in Siguiiri. The objective of the MOU is to create synergy and harmony in malaria activities undertaken by ADRA and INTRA SIG in the field and to avoid the duplication of efforts. Under this MOU, ADRA, INTRAH SIG and the MOH jointly developed malaria-training modules for VDC and developed BCC messages for malaria prevention. Furthermore, INTRA SIG also covered the cost associated with the training of ADRA's 24 health volunteers in 4 sub-prefectures.

7.4.2 ADRA/DPS-MOH

Training is one area where ADRA/CS collaborates with the MOH. During the period, ADRA elaborated training modules in malaria prevention, family planning and safe motherhood for field animators. Training activities were also conducted jointly. Joint monitoring and supervision visits also continue to feature allowing ADRA to be able to not only strengthen the capacity of MOH staff but also ensure that long-term sustainability is possible by inculcating in the people the sense of ownership of the project.

7.4.3 ADRA/MOH

Project continues to participate in bi-annual coordination meetings organized by the local health office. This period project participated in the bi-annual *prefectoral* coordination meetings, This coordination meetings regrouped all the DPS in the region, HC/HP heads, projects, and other local partners present in the region. The objective of the meeting was to share information on: 1) the different health activities

accomplished by the health centers/posts/hospital of Siguiri; 2) the epidemiological status of childhood diseases and to identify the potential epidemics; 3) the accomplishment and challenges of different projects and partners involved in health activities; 4) the financial situation of the health centers/posts/hospitals. The meeting revealed the different challenges the health care system faces in the Upper Guinea region such as; shortage of certain vaccines such as polio and measles; maintenance problem related to motorcycles; absence of outreach vaccination programs; movement of the population to different zones such as gold mines; over-charging in the sale of drugs and supplies; poor patronage of health centers/posts/hospital services by the community; the poor financial state of most health centers and the weak community participation.

The challenges facing the health care system in Siguiri are many and very much similar to the challenges faced nationally. The project will continue to contribute to the improvement of the system as well as the conditions of the people.

7.4.5 ADRA/MOH/PRISM

ADRA participated in a workshop organized by PRISM and the MOH from December 13 to 18, 2001. The objective of the workshop was to review and update the already existing TBA curriculum. Among the organizations that participated in the workshop were PRISM, Save the Children, MOH, Peace Corps and local NGOs involved in safe motherhood initiatives. This was an important workshop to ADRA as the training of TBAs is an important activity under its safe motherhood intervention. ADRA also assisted in a second workshop organized by the MOH from July 8 to 12, 2002 to finalize the national TBA curriculum. ADRA used the curriculum in the training of the 72 TBAs in its target zone.

7.5 PVO Coordination/Collaboration

ADRA/Guinea's involvement in PVO coordination/collaboration takes many forms. These include periodic meetings, visits, sharing of action plans, joint monitoring visits, and joint activity planning. The strong relationship has allowed ADRA/Guinea to benefit from the lessons learnt by other organizations, especially those implementing CS projects. Some results of this good partnership are as follows:

7.5.1 ADRA/World Bank

In concordance with the MOU signed between ADRA and the World Bank, ADRA received 11 cold chains in August 2002 for the health centers and selected health posts of its target zone. This helped greatly to ensure the quality of vaccines being administered to women and children.

7.5.2 ADRA/Guinea and ADRA/International

From June 10–20, ADRA /Guinea was visited by a director of health at the International headquarters in Washington. The objective of the visit was to provide technical support to the project. During the visit, the project implementation plan and HIS tools were discussed and reviewed. Field visits were also conducted to see GM and nutrition (hearth) activities. The project benefited greatly from the many valuable recommendations that came out of this important visit.

7.5.3 ADRA/CS and ADRA Food Security Project

During this period, the two projects discussed and identified joint activities they could be implemented in order to create synergy in the field and enhance project outcomes for the two projects. Action plans have been developed for activities that will take place in FY03.

7.5.4 ADRA/CS/ADRA/Polio-Nutrition project (PASMIC)

From May 6-10, technical exchange visits were made to ADRA/PASMIC. Some of the lessons learned are as follows: to include children with severe cases of malnutrition in the hearth sessions but as observers; to accompany mothers of severely malnourished children to the health centers and follow up their status; to organize two sessions of hearth (with 8 to 12 participants in each) simultaneously in a village that has large

numbers of moderate malnutrition cases; to use of the individual growth charts during the hearth sessions in order to better educate mothers. The ideas were applied in the second cycle of hearth that the project started in August 2002.

7.5.5 ADRA/SAVE

From June 11 - 18, 2002, ADRA/CS received technical visit from Save the Children. The objective of the visit was to conduct an evaluation of family planning services and products in project sites and to do training need assessment of MOH staff. This has allowed ADRA to plan better its family planning intervention and in particular its training activities..

Prior to this, ADRA received technical support from Save the Children in reviewing and finalizing its HIS in February. Specifically, the review looked among others at how functional the HIS was, how useful and appropriate the tools developed were in collecting data, and what strategies there were to integrate the community activities into those of the MOH. In addition to the HIS, the project also benefited from the visit by developing a strategy to integrate its community level activities with those of the MOH to ensure sustainability.

In July 2002, the project benefited from a technical assistance from Save the Children in planning and implementing its community partnership for safe motherhood/CLSS training activities. As a result, the following activities were accomplished; 12 ADRA field and technical staff were oriented in community partnership for safe motherhood; 6 MOH staff and 2 project staff trained as trainers in community partnership for safe motherhood and TBAs were trained.

7.5.6 ADRA/HKI

The project continued to collaborate with HKI in the distribution of Vit A capsules to post-partum women and children. During this year's MOH's national vitamin A distribution day that took place from May 20 - June 3, project animators mobilized community members in the 72 villages and assisted the MOH in the distribution of vitamin A capsules to children 6 - 11 months. The project equally provided logistics support to the health centers that needed it to ensure the success of the exercise.

7.5.7 ADRA/PRISM/MOH (Regional IEC Committee)

As a member of the regional IEC committee spearheaded by PRISM, ADRA/CS participated in two quarterly regional IEC meetings held during the year. Some outcomes of the meetings were as follows: (1) an evaluation of BCC activities in the 15 prefectures in Upper Guinea were undertaken; (2) *prefectoral* level quarterly action plans, which will integrate the different BCC activities of the different partners were developed; (3) the organization of theatres, the projection of films and football match were identified as good BCC strategies to mobilize the community; (4) common strategies and messages in vaccination and safe motherhood developed for the region; (5) BCC materials for vaccination and safe motherhood prepared (in draft).

7.5.8 ADRA/PRISM

During the period, a visit to ADRA was made by PRISM, a USAID grantee implementing RH activities in the region. One of the main objectives of the visit was to strengthen synergy between the two projects. The two partners identified the different areas of collaboration notably; BCC, family planning, safe motherhood and vaccination as well as the specific actions required from each intervention. As a result of this collaboration, ADRA received free family planning products and IEC materials to distribute to 44 trained HVTs as their initial stock. ADRA will also have access to IEC materials developed by PRISM for vaccination and safe motherhood once completed. This will ensure that the different partners in the region are diffusing common and harmonious BCC messages.

Annex A

The Seventy-Two Districts/Villages Covered by ADRA/CS

Sub-PREFECTURES	Targeted Districts	Distance of Districts/Villages in relation to :		Population	
		Sub-Prefectures	Prefectures		
SIGUIRI CENTRE (COMMUNE URBAINE) 05 Km from Siguiri town	Falama	15 km	15 km	957	
	Bambala	12km	25 km	678	
	Niandankoura	15 km	18 km	1838	
	Diléngbè	25 km	15 km	1473	
	Tiguibiry	07km	7 km	4118	
	Dankakoro	07km	7 km	1473	
	Kinièbakoro	15 km	10 km	3783	
	Sébékoro	20 km	15 km	957	
	Diatéla	18 km	19 km	571	
	Sougoula	15 km	17 km	1507	
	Saourou	30 km	30 km	894	
	Sambaya kofilani	15 km	18 km	383	
	DOKO 50 Km from Siguiri town	Kourémalé	33 km	83 km	1815
		Kodiarani	19 km	69 km	2609
Kolita		38 km	47 km	3370	
Dalamban		50 km	100 km	3145	
Souloukouni		28 km	37 km	905	
Tomboko		07 km	56 km	1220	
Soumbarakoba		18 km	38 km	2402	
Alahiné		18 km	40 km	894	
Bouréfnè		28 km	22 km	852	
Oudoula		49 km	75 km	2630	
Tomboni		51 km	55 km	1680	
Kinièbakoura		25 km	54 km	712	

SUB-PREFECTURES	DISTRICTS	KM of Districts in relations to :		POP	
		SUB-PREFECTURE	PREFECTURE		
KINTINIAN 35 Km from Siguiiri town	Balato	9 km	25 km	3388	
	Boukaria	7 km	25 km	1124	
	Doubaya	17 km	65 km	1065	
	Didi	35 km	39 km	1527	
	Fatoya	05 km	25 km	1258	
	Kamatiguiya	20 km	38 km	880	
	Diadaya	65 km	45 km	753	
	Mankitin	80 km	74 km	775	
	Fifa	20 km	78 km	1810	
	Tintissabani	30 km	18km	668	
	Samani	27 km	65 km	1840	
	Alahiné	07 km	50 km	2575	
	NIAGASSOLA 140km from Siguiiri town	Balandougou	35 km	105 km	1544
		Fidako	17 km	152 km	1366
Sininko		47 km	97 km	883	
Dialawassa		57km	78 km	1385	
Dora		65 km	200 km	571	
Tondo		52 km	83 km	522	
Fètèkou		49 km	184 km	546	
Kinièkourou		44km	111 km	480	
Farabalén		49km	110 km	437	
Kèdala		70km	80 km	871	
Bananinkoro		17 km	149 km	292	
Kouyakouy		70 km	205 km	1200	
NORASSOBA 95Km from Siguiiri town		Fandia	03 km	90 km	1352
		Kossokoba	40 km	145 km	2495
	Dalaninkan	60 km	155 km	2861	
	Tassiliman	71 km	166 km	1497	
	Fragbèba	10 km	82 km	375	
	Léléda	68 km	75 km	2230	
	Landi	05 km	97 km	2230	
	Norakoro	12 km	73 km	1277	
	Gbènkoro	07 km	99 km	3071	
	Lémouroutombo	54 km	140 km	281	
	Todakoudoukan	60 km	155 km	459	
	Kossokougè	58 km	148 km	330	
		Kamaya	40 km	62 km	1304
		Sambaya	11 km	75 km	1770
Diambaya		14 km	62 km	1098	
Kofilani		25 km	56 km	760	

FRANWALIA 45 Km from Siguiro town	Bougouroun	10 km	50 km	2798
	Koudédi	24 km	69 km	430
	Koma	37 km	83 km	1579
	Fèfè	26 km	62 km	872
	Sobata	47 km	85 km	937
	Kossogna	48 km	67 km	280
	Kotoma	43 km	60 km	434
	Bèndougou	59 km	80 km	1172

*** The above population figures include the population of the sectors (outlying communities of the villages). At this point, project target only the center of the villages. Therefore, approximately 45% of the total population is not covered.**

Criteria of Selection of target villages

Villages

- . With a health center and or a health post
- . With an outreach vaccination program
- . With already existing community -based distributors
- . Accessible

Village Development Committees Members

- . Dynamic
- . Influential
- . Available
- . Volunteer
- . Heard
- . Preferably a literate

Composition of VDC

- . One president
- . One vice president
- . Treasurer (responsible for community organization and community information system)
- . One health volunteer
- . One TBA

Volunteers

- . Volunteers
- . Available
- . Honest
- . Resident of the community
- . Who can read and write in local language*

HIS tools at different levels

Village development committee level

- . a register to carry out census of children 0-11 months and to follow up on vaccination activities for children 0-11 months
- . a register to do census of pregnant women and to follow up on PNC activities
- . a register to carry out census of children 0-3 years and for growth monitoring activities of children 0-3 years
- . a reference form for children 0 to 3 years
- . a register for BCC activities
- . a register for TBAs to register deliveries made , their status , Vit A administered and other care provided
- . a register to track vitamin A and other medication needs

Animator-level

- . a recapitulation form for growth monitoring (GM) activities for children 0-3 years
- . a recapitulation form for vaccination activities of children 0-11months and pregnant women
- . a recapitulation form for BCC activities (covering all interventions) and for referrals
- . a form for BCC activities (covering all interventions)
- . a recapitulation form for safe motherhood (pregnancy results)

These forms are filled by the animators and compiled monthly by supervisors.

Project level

- . A qualitative and quantitative supervision form to supervise activities performed by field animators, VDC and health volunteers

**Training Topics for Field Volunteers (HVTs) and Animators in
Communication/Nutrition/vaccination**

I. Orientation

- Goal and objective of ADRA/CS project
- Roles and responsibilities of HVTs
- Quality of a good HVT

II. Communication

- Learning to listen and observe
- Priority messages
- Visual Aids
- Home visits
- Group animation

III. Vaccination

- Definition
- Importance
- Vaccination calendar
- Target groups for vaccination
- Side effects
- Priority messages

IV. Nutrition

- Community responsibilities
- Community participation
- Community activity development
- How to weigh a child
- How to record the weigh on the child's weight card
- How to trace the curve
- How to interpret and fill the community growth chart
- How to inform the community on the results
- The different food groups
- The different food available locally
- The nutrition of a child
- The nutrition of pregnant women
- Food hygiene
- How to animate a nutrition session

V. Key Messages

- Key messages for vaccination and nutrition

Training Topics for Hearth**I. General Notion**

- a. Objective of Hearth

II. Principles of Hearth

- a. Utilization of locally available produce
- b. Training of trainers
- c. Behavior change
- d. Progressive coverage of the community
- e. Utilization of results
- f. Offering children with the age of 3 years 700 to 800 Kcal + 26 to 30 protein/day

III. Conditions for the success of Hearth

- a. Creating a suitable environment in the community
- b. Integrating Hearth in the HIS system
- c. Ensuring that children are immunized
- d. Putting in place a referral system for sick children
- e. Ensuring a system of information sharing and follow-up in the community

VI. The Different Phases of Hearth

- a. Preparation Phase
 - Identification of malnourished children
 - House visit
 - Second Identification
 - 24 hour study
 - Analysis of the 24 hour study
 - Education messages on exclusive BF/food
 - Diversification/hygiene/vaccination/GM
 - Identification of the positive deviant mother (PDM)
 - Market research
 - Systematic de-worming
 - Opening of Hearth
- b. Implementation Phase
 - Selection of the first day for Hearth
 - Selection of recipes
 - Participation of mothers
 - Final Identification
 - Culinary learning sessions
 - Meal preparation
 - Nutritional education of participants by the PDM

- Sharing of meals by children in the Hearth
- Identification of 2nd day recipes
- Encouraging/motivating mothers

c. Follow up of Hearth

- Weight and height measure of children on 1st day
- Weighing only after 12 days
- Weight and height of children one month and two months later
- Home visit of PDM by HVT

d. Result and Closure of Hearth

Sharing of result obtained in the 12th day (average weight gain by child)

**Training topics for project animators and HVTs
in malaria prevention**

1-Definition

2-Mode of transmission

3-Factors that favor the spread of malaria

- Uncovered water
- Dirt
- Stagnant water
- Old tires
- Herbs/flowers

4-Danger signs

- Fever
- Recognition of simple fever
- Recognition of severe case of fever
- Aches in generals
- Aches in joints
- Fatigues

5-Prevention

- Individual prevention means
- Community prevention means

6. What to do in case of fever

7. Socio- economic consequences of malaria

8. Priority messages

Training of health center and health post staff in malaria
Training topics covered

- I. General notion on malaria
- II. Biological cycle of parasites causing malaria
- III. The magnitude of malaria in Guinea
- IV. National malaria control program ; objectives and strategies
- V. Challenges faced in Guinea in malaria prevention
- VI. Definition and physio-pathology of simple cases of malaria
- VII. Clinical manifestation s of malaria
- VIII. Diagnostic and treatment of simple cases of malaria
- IX. Diagnostic and treatment of severe cases of malaria

Training of health center, health post staff and project animators
in family planning. Topics covered

- I. Orientation of participants in project interventions
- II. Anatomy and physiology of the reproductive organs of male and female
- III. Notion of conception and contraceptive
- IV. The menstrual cycle
- V. Counseling in FP
- VI. Physical examination of FP clients
- VII. General notion in FP
- VIII. Different methods of FP
 - Natural method (exclusive breastfeeding)
 - Barrier methods (condom/spermicides)
 - Combined oral contraceptives
 - Progesterone oral contraceptive
 - Injectables
 - Surgical contraceptives
- IX. Infection prevention
- X. Management and monitoring tools for FP activities in the HC and at the community level

Training of project animators in safe motherhood

Module I Definition and the different components of safe motherhood

- Prenatal care
- Clean and safe delivery
- Post -natal care
- Post abortion care
- Essential obstetrical care
- Family planning

Module II Roles of project animators in promoting safe motherhood

- Transmit messages to the community (BCC)
- Encourage referrals
- Coordinate safe motherhood activities implemented by HVTs and TBAs
- Coordinate safe motherhood activities in collaboration with health centers
- Assist in the training of HVTs in safe motherhood
- Supervise and monitor the use of management tools by HVTs and TBAs

Module III Prenatal care

- Transmitting appropriate messages
- Prevention and case management of infections
- Promoting anti-tetanus vaccination
- Prevention of malaria and anemia
- Detection and management of the risk factors related to pregnancy such as
 - . women with > 5 children
 - . close pregnancies (last pregnancy is <2 years old)
 - . short height (<1meter 50 centimeter)
 - . pregnancies with still birth or babies that died right after delivery
 - . cesarean delivery of last pregnancy
 - . physical handicap

Detection of danger signs

- Hemorrhage
- Non-movement of fetus
- Fever
- Persistent Vomiting
- Vaginal discharge of bad odor
- Edema
- Paleness (anemia)

Module IV Assisted delivery

Module V Key messages for safe motherhood

Training module for TBAs on safe motherhood and life saving skills

Module I During pregnancy

- Promotion of PNC
- Preparation of the family for the delivery
- Importance of prophylaxis during pregnancy
- Detection of pregnancies and deliveries with risks

Module II During labor

- Reception /care of pregnancy women in labor
- How to manage pregnancy with excision wounds
- How to manage a prolonged labor
- How to manage a hemorrhage during labor
- How to manage convulsion during labor
- How to manage fever during labor
- How to manage danger signs during labor
- How to care for pregnant women during labor
- Dangerous practices during labor

Module III During delivery

Hand washing

Materials and equipments of TBAs

Handling the head of newborns during delivery

How to receive and care for new born babies

Care of the umbilical area

How to manage the entanglement of umbilical cords

... Clearing the respiratory system of babies

Reanimation of blue newborns

Reanimation of newborns who do not cry

Care of the eyes

Importance of keeping newborns warm

- What to do in case of retention of the placenta or body members/parts
- Delivering and examining the placenta and body members of newborns
- Decontamination of materials
- Dangerous practices during delivery and reanimation of newborns

Module IV After delivery; postpartum period

Care of instruments and the elimination of waste/discharges

Counseling of women after delivery

Administering Vitamin A after delivery

Management of postpartum hemorrhage

The different elements of early post -natal visit

Referrals made during late post-natal period

Module V Collaboration with health centers

Module VI Collaboration with the community
Promotion of social health insurance schemes for EOC
Collaboration with other community health agents

Table 2. Results of BCC activities conducted by VDCs and project animators in the 72 villages in the reporting period

Summary of BCC activities of HVTs

SUB-PREFECTURES	Estimated pop.	Malaria				Safe Moth./Mutuelles				Nutrition				Vaccination				Planning Familial			
		# of sess.	Participants			# of sess.	Participants			# of sess.	Participants			# of sess.	Participants			# de IEC	Participants		
			W	M	Total		W	M	Total		W	M	Total		W	M	Total		F	H	Total
COMMUNE URBAINE	11589	51	202	160	362	48	255	213	467.8	63	347	168	514.2	59	333	161	494.7	47	140	82	221.2
NORASSOBA	9665	48	114	114	229	34	100	50	150	67	158	85	242.8	73	140	74	214.5	63	110	59	168.8
DOKO	10615	54	240	240	479	41	215	97	312.2	74	353	92	445.3	31	164	60	223.7	47	86	50	136
NIAGASSOLA	6312	36	76	55	131	25	61.5	51	112	62	201	76	276.7	49	146	59	204.7	36	64	42	105.3
FRANWALIA	10990	70	199	206	406	48	121	76	196.8	79	337	144	481.7	70	249	127	375.8	59	157	96	252.5
KINTINIAN	9087	31	90	48	138	30	117	87	203.8	43	286	64	349.3	31	142	38	179.7	27	54	32	86.17
TOTAL	58258	290	921	823	1744	226	869	574	1443	388	1681	629	2310	313	1174	519	1693	279	610	360	970

Summary of BCC activities of Animators

SOUS-PREFECTURES	Estimated pop. of districts centrals	Malaria				M.S.R/Mutuelles				Nutrition				Vaccination				Planning Familial			
		# of sess.	Participants			# of sess.	Participants			# de IEC	Participants			# de IEC	Participants			# de IEC	Participants		
			W	M	Total		W	M	Total		W	M	Total		F	H	Total		F	H	Total
COMMUNE URBAINE	11589	52	202	84	286	61	382	160	542	81	331	114	445	74	316	145	461	51	220	103	323
NORASSOBA	9665	48	96	61	157	73	251	121	372	72	314	140	454	60	264	103	367	61	142	72	214
DOKO	10615	39	274	87	361	41	271	84	355	79	495	143	638	40	255	76	331	30	155	42	197
NIAGASSOLA	6312	38	59	46	106	40	110	45	155	59	176	56	232	50	165	77	241	32	49	32	81
FRANWALIA	10990	21	42	57	99	45	182	127	308	66	242	108	350	61	231	95	326	33	109	53	163
KINTINIAN	9087	39	117	75	192	40	208	107	316	45	291	75	366	38	161	63	223	42	78	35	113

Table 4 Status of the 12 MURIGA set up

Sub-prefectures	Village	Population	WRA per Village (20% of pop.)	# of Household	#of WRA that participate	% of WRA that participate
Siguri Center	Djilèngbè	1,073	214	37	98	45%
	Falama	1,662	332	27	102	31%
Doko	Kolita	3,268	653	21	153	23%
	Dalamba	3,050	610	24	151	25%
Norassoba	Dalaninkan	1,930	386	38	111	29%
	Fandia	1,040	208	82	142	68%
Niagassola	Balangougou	1,445	289	29	149	51%
	Dialawassa	2,281	456	15	57	12%
Franwalia	Kamaya	1,045	209	43	109	51%
	Djambaya	836	167	42	76	45%
Kintinian	Doubaya	1,022	204	56	145	71%
	Didi	2,802	560	43	179	31%
Total		21,454	4290	457	1,472	34%

C

Guineaaaae

ORGANIGRAMME OF CS PROJECT OF SIGURI

