

CHILD REACH (USNO)

Plan Burkina Faso CHILD SURVIVAL PROJECT XIV

**USAID Child Survival Grant
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Burkina Faso, Koupela Health District

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THIRD ANNUAL REPORT

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ABBREVIATIONS

ABBEF: Association Burkinabe pour le Bien-Etre Familial
ALZ: Association Lagem Zoodo
APC: Assistant Project Coordinator
ARI: Acute Respiratory Infection
CBO: Community-based organization
CHA: Community Health Animators
CHWs: Community Health Workers
CMC: Community Mobilization Coordinator
CS: Child Survival
CSP: Child Survival Project
DCM: Diarrhea Case Management
DIP: Detailed Implementation Plan
DMT: District Management Team
DMO: District Medical Officer
DRS: Direction Régionale de la Santé
DSF: Direction de la Santé de la Famille
HCMC: Health Center Management Committee
HCN: Health Center Nurses
HIS: Health Information System
FCI: Family Care International
IEC: Information Education and Communication
ICP: Infirmier Chef de Poste
KPC: Knowledge Practice and Coverage
LQAS: Lot Quality Assurance Sampling
MCM: Malaria Case Management
MEC: Monitoring and Evaluation Coordinator
MNH: Maternal and Neonatal Health
MOH: Ministry Of Health
NHA: National Health Adviser
OCA: Organizational Capacity Assessment
OR: Operational Research
ORS: Oral Rehydration Salt
PC: Child Survival Project Coordinator
PCM: Pneumonia Case Management
PSI: Population Services International
TBA: Traditional Birth Attendant
TOR: Terms Of Reference
TT: Tetanus Toxoid
UNICEF: United Nations Children's Fund
UNFPA: United Nations Population Fund
USAID: United States Agency for International Development
USNO: United States National Office
VHC: Village Health Committee
WCBA: Women of Childbearing Age

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Attachments

MTE Recommendations Action Plan

PROGRAM ANNUAL REPORT (YEAR 3)

I. EXECUTIVE SUMMARY

Plan Burkina Faso completed the third year of its Child Survival Project (CSP) in the health district of Koupela. The goal of the project is to improve health status of children under five and women of childbearing age. Project interventions include immunization, malaria case management, diarrhea case management, exclusive breastfeeding, acute respiratory infection, and organizational capacity building.

The district population is estimated at 313,597 inhabitants in 2002. The target population includes 58,893 children under five and 71,500 women of reproductive age.

The third year was characterized by major achievements listed below:

- The Mid-Term evaluation (MTE) has been completed and results disseminated to partners and all stakeholders including the District Medical Team, Health Center Nurses (HCN), Project staff, local administrative authorities, and the communities.
- Reinforcement of behavior change activities through educational talks, drama, radio broadcast, home visits and folk media was done by Health Centre Management Committees (HCMCs) and Community Health Workers (CHWs) with support from Community Health Animators (CHAs) and health agents. ~~There was very high~~ community was highly involvement in all these activities.
- Partnerships have been reinforced with all the partners working in Koupela district. The advisory committee is now functioning well and is recognized as a good model of partnership.
- Training of project staff, HCNs and CHWs continued to take place in order to equip them with new skills for their participation.
- The actors implementing the project were supervised.
- The monitoring system was improved by the introduction of Lot Quality Assurance Sampling (LQAS) after the MTE. All staff received training and the methodology is now widely used in the whole region, where health agents were trained on the request of the health regional office in Tenkodogo. Periodic results from LQAS impacted the CHAs' activities.
- In spite of its recent involvement in the process, the local Association Lagem Zoodo (ALZ), which is in charge of the implementation of the mobilization component, has acquired skills necessary to carry out its activities and is doing well.

The project is well integrated into the health district and is making progress without any major constraints. Key interventions such as malaria, immunization, acute respiratory infection, diarrhea, and community capacity building are part of the district annual plan and the five-year strategic plan of the Koupela health district. CSP staff and the District Management Team (DMT) design and carry out project supervision and monitoring together. DMT members participated in all the meetings initiated by the project and vice versa.

Plan Burkina Faso is now scaling up strategies developed and implemented in the CSP to its other program areas. The focus is now on the key Child Survival (CS) interventions in the six other districts where Plan operates. The CSP experience has shown that Plan should “do a few a

few things, but do them right.”- The Plan Burkina Faso Country Strategic Plan (2002-2011) and five-year Country Program Outline (2002 – 2006) are based on this motto.

The success of the partnership with the Maternal and Neonatal Health (MNH) project has attracted many visitors both from within and outside the country: the Global Health Council, US Congress members, and the Plan Mali CSP team. The CSP has the full support of the former US ambassador in Burkina Faso, who visited the project several times.

Ownership of project by community members is also developing with participation of all community members including women and men.

II. ACCOMPLISHMENTS AND CONSTRAINTS

A. Program progress

Table 1: Objectives Matrix for Immunization

Objectives	Objective on Target	Y3 achievement or comment
1-1 Increase proportion from 47% to 60% of children, 12-23 months of age, fully immunized prior to their first birthday.	Yes	<p>Tendencies indicate that the set goal will be reached by the end of the project. Vaccine shortages didn't affect the figures in a significant way.</p> <p>Progress made since MTE by vaccine for children under 12 months (target population of EPI) up to September 2002:</p> <p>BCG: 75% to 87% DTCP1: 67% to 82% DTCP3: 48% to 77% Measles: 56% to 66% Yellow fever: 50% to 65%</p>
1-2 Increase proportions from 40.2% to 60% of children from 12-23 months that received Vitamin A supplementation with immunization after 6 months of age.	Yes	<p>Two Vitamin A campaigns carried out: 103% of children aged from 6 months to 5 years were covered during the first session and 89% during the second session.</p> <p>A new strategy has been developed for micronutrient supplementation; a National Day has been adopted by the Ministry Of Health (MOH).</p>
1-3 Increase proportion from 69.8% to 80% of mothers with children, 0-23 months of age, vaccinated with Tetanus Toxoid 2 (TT2) during their last pregnancy.	Yes	<p>Progress made since MTE for pregnant women (target population of EPI) up to September 2002 is for VAT2+ 48% to 56%.</p> <p>A recent study carried out by MNH in the project area (September 2001) has shown that 93.3% of women with children under 12 months received at least TT2.</p>
1-4 Increase proportions from 14.5% to 25% of mothers with children 12-23 months of age that received Vit. A supplementation 6 weeks after last delivery.	Yes	<p>HCN does post-delivery Vitamin A supplementation for mothers. 1,956 women in the postpartum (13%) received Vitamin A supplementation during the National Micronutrient Days.</p>



Table 2: Objectives Matrix for Diarrhea Case Management (DCM) and Breastfeeding

Objectives	Objective on Target	Y3 achievement or comment
2-1 Increase from 83% to 95% the proportion of children aged 0-23 months having received same amount or more breast milk/fluids during the last diarrhea episode.	Yes	The assessment was done in 80 villages spread over 16 health centers. An assessment (LQAS) done in June and July 2002 has shown that 74% of mothers with children aged 0-5 years know that children must receive the same amount or more breast milk/fluids during diarrhea episode.
2-2 Increase from 27.9% to 60% the proportion of mothers with children aged 0-23 months who know how to prepare and administer Oral Rehydration Salt (ORS).	Yes	LQAS done in June and July 2002 shows that 56% of mothers with children aged 0-5 years know how to prepare and administer ORS. This was highlighted by a study done in 80 villages.
2-3 Increase from 32% to 70% proportions of mothers with children aged 0-23 months that recognize dehydration as a sign for referral of diarrhea cases.	Yes	92% of mothers with children under 5 (according to the last LQAS)
2-4 Increase proportion from 49% to 70% of mothers with children aged 0-23 months who report washing their hands before preparing their child's food and feeding.	Yes	701 Educational sessions done 192 radio broadcasts 104 villages sensitized using drama and folk media 780 CHWs trained 25 health centers equipped with megaphones to facilitate sensitization campaign Next LQAS will address this topic.
2-5 Increase from 4% to 25% the proportion of mothers who exclusively breastfeed their child from 0-6 months.	Yes	A study made by MNH (July to September 2001) showed that 16.9% of mothers practiced exclusive breastfeeding.
2-6 80% of health facility staff, CHWs, and Traditional Birth Attendant (TBAs) trained and equipped to manage diarrhea.	Yes	Training session for newcomers in the district will be carried out in the coming months. More than 80% of health facility staff, CHWs and TBAs were trained in diarrhea case management.

Table 3: Objectives Matrix for Pneumonia Case Management

Objectives	Objective on Target	Y3 achievement or comment
3-1 Increase from 32.3% to 60% the proportion of mothers who seek appropriate treatment at a health facility for childhood pneumonia.	Yes	434 educational sessions carried out 144 radio messages were broadcast 104 villages sensitized using drama and folk media
3-2 Increase from 20.5% to 50% the proportion of mothers who recognize chest in drawing as a danger sign to seek treatment for childhood pneumonia.	Yes	434 educational sessions held 144 radio messages broadcast 104 villages sensitized using drama and folk media
3-3 80% of health facility staff, CHWs, and TBAs trained in Pneumonia Case Management (PCM).	Yes	Training session for newcomers in the district will be carried out in the coming months. More than 80% of health facility staff, CHWs and TBA were trained on PCM.

Table 4: Objectives Matrix for Malaria Case Management

Objectives	Objective on Target	Y3 achievement or comment
<p>4-1 Increase from 21.6% to 50% the proportion of children with fever receiving appropriate Chloroquine treatment.</p>	Yes	<p>LQAS done in 110 villages from June to July 2002.</p> <ul style="list-style-type: none"> - 83% of mothers of children under 5 years know that they must give chloroquine first if their child has fever. - 33% of mothers know the appropriate Chloroquine treatment. <p>Two local radio stations are already broadcasting messages on this issue. Chloroquine and paracetamol are available in all villages.</p>
<p>4-2 Increase from 60.6% to 80% the proportion of mothers who report taking Chloroquine prophylaxis during their last pregnancy.</p>	Yes	<p>LQAS (June to July, 2002) highlighted that the majority of mothers (93%) reported that they have taken Chloroquine prophylaxis during their last pregnancy. Findings of another study carried out in September 2001 by Burkina Faso National Center of Research and Training on Malaria can be paralleled with LQAS results. This study has shown that 90% of women delivering in four health centers have received Chloroquine prophylaxis during their pregnancy.</p>
<p>4-3 Increase from 1.5% to 20% the proportion of children under five sleeping under impregnated bednets.</p>	Yes	<p>21% of children under 5 years are sleeping under impregnated bed nets according to the results of June to July, 2002, LQAS</p> <p>9238 impregnated bednets have been distributed throughout the project area since 2000</p>
<p>4-4 80% of health facility staff, CHWs, and TBAs equipped and trained in Malaria Case Management (MCM).</p>	Yes	<p>All CHWs and TBAs received training and each village was equipped with Information Education and Communication (IEC) material.</p>

Table 5: Objectives of Capacity Building

Objectives	Objective on Target	Y3 achievement or comment
<p>1. Plan's Capacity Building</p> <p>1.1 100% of project staff trained in CS technical skills</p> <p>1.2 Two operational research (OR) projects designed and implemented in CS project</p>	Yes	<p>All the staff received training, but no operational research was done</p> <p>An OR on bednet use has been planned for October 2002. It will be carried out by a student from the National School of Public Health</p>
<p>2. Partner Capacity Building</p> <p>2.1 6 partner employees (2 from each partner organization) trained in CS technical skills</p> <p>2.2 Internal Organizational Capacity Assessment (OCA) conducted in 3 out of 3 partners</p> <p>2.3 Financial records completed and balanced in 3 out of 3 partners</p> <p>2.4 Computerized Health Information System (HIS) functioning in 2 out of 3 partners</p>	Yes	<p>All project partners trained in CS technical skills.</p> <p>Internal tools have been used to assess partner's capacity including ALZ, Health District.</p> <p>Contracts have been established with partners working with CSP who completed and balanced financial records. The health district and ALZ have been endowed with computers for data management. HIS of the district has been performed. The Monitoring and Evaluation Coordinator (MEC) is working closely with District HIS manager.</p> <p>Training on OCA is planned for the second quarter of next year.</p>

<p>3. Health facility</p> <p>3.1 80% of health center staff trained and equipped in DCM, PCM, MCM</p> <p>3.2 21 of 21 HCMC have supplemental drugs purchased from cost-sharing funds at least twice during past year</p> <p>3.3.40% increase over baseline in users satisfied with services received</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>More than 80% HCN have been trained in DCM, PCM, MCM and EPI management.</p> <p>The project started with 21 health centers but now 4 more health centers have been built and equipped. All the 25 HCMC purchased supplemental drugs from cost-sharing funds each month since 2000. The rate of health center attendance is increasing according to the HCMC members. It is corroborated by the MTE where focus group participants confirmed satisfaction with services delivered by the health agents.</p>
<p>4. Community-based organizations</p> <p>4.1 414 of 414 CHWs trained in key interventions</p> <p>4.2 100 of 207 Village Health Committees (VHCs) are functioning</p> <p>4.3 100 of 207 VHCs' financial records show deposits and withdrawals.</p>	<p>Yes</p>	<ul style="list-style-type: none"> - 780 CHWs have been trained in key interventions as the number of villages increased from 207 to 275 and HCMC members were trained regarding MTE recommendations. This aside, some villages have more than 2 CHWs, which increases the number of trainees. - With support from project staff, village committee members, nurses and CHAs have drafted internal rules and regulations, which will be adopted during a general assembly in each village. - 89 Village Health Committees have been set up; these committees are functioning (support CHWs, purchase drugs, etc.)

B. Constraints faced

1. Meningitis and Cholera epidemics

During the third year of the project, the district faced two major epidemics: cholera and meningitis. The cholera epidemic lasted from August to October 2001 and 13 cases were identified with 3 deaths. The Tenkodogo Health Region was the most affected in the country with 536 cases and 9 deaths. From January to May 2002, the meningitis outbreak caused 361 cases and 61 deaths in the Koupela health district.

A provincial crisis committee (local authorities and partners) was set up at district level. The project staff provided technical assistance to the DMT. CHAs and nurses worked closely together, spread key messages, did monitoring and data collection in the villages, and organized CHWs. Plan has endowed the health centers with drugs and consumables. At national level, Plan participated in the National Committee of Epidemic Management activities.

These epidemics slowed down some project activities, namely outreach activities, behavior change activities (home visits), and health agent training.

2. Project and health district staff turn over

Three members from Koupela DMT transferred out of the district. A newcomer from another health region replaced the District Medical Officer (DMO). It took some time for the new staff to understand and master the project process, goals and objectives. The Project Coordinator (PC) organized an explanatory session for them during which an overview of the project was presented. All new staff received a summary of the project status.

The project lost 6 health agents who were posted to other areas or attended a health school. Newcomers participated in an orientation workshop. Reports of health agent training sessions are available in each health center; they are being used as reference documents by new staff. A training session on immunization is planned for September and will be funded by United Nations Children's Fund (UNICEF). It will cover the whole district.

CSP staff: 3 CHA and the project secretary left and were replaced in short time. By the end of June, 7 CHAs formerly managed by Plan were transferred to ALZ.

C. Technical assistance requirement

Technical support is required for organizational capacity assessment. The monitoring system focused on quality data management needs to be improved by specific training for all staff in the project.

A training on Knowledge Practice and Coverage (KPC) for key staff of the project is needed to improve their skills and prepare the final KPC survey. January to February 2003 would be the most suitable period for this training.

D. Description of substantial changes during project implementation

No significant changes have been made to the project that would require modification to the cooperative agreement.

E. Implementation of MTE Recommendations

Results of the MTE have been disseminated at regional, provincial and community levels. A dissemination workshop was organized jointly with MNH for local administration authorities including the High Commissioner, prefects, Health Center Management Committees, local office managers, and other partners. CHAs and health agents shared the findings at community level.

Recommendations	Activities for the implementation
1. Make the partner coordination more dynamic	Discussions with all partners came up with the nomination of a focal point for the advising committee, represented by CSP MEC. This position has been functional for one year. Terms Of Reference (TOR) have been drafted for him. He is working closely with the project bilingual secretary. Since the MTE, two quarterly meetings have been held with most districts' partners. During these quarterly meetings, the DMT presents progress achieved in the district, as do other project coordinators.
2. Reinforce the district and local partners' capacity	The development plan (that was to be designed in the second quarter of 2002) has not been completed on account of the departure of the DMO and other members of the DMT. But all district partners participated in designing the five-year district development plan. ALZ received management support from Plan staff based on the institutional assessment carried out at the beginning of the partnership.
3. Improve stock management	100 drug boxes were endowed to 100 VHC for safety storage. Drug management tools have also been designed and discussed with the CHWs who will use them to provide support to HCNs/CHAs.
4. Develop a sustainability mechanism for CS interventions	All the activities of CS have been integrated in the health center activities. Community-based organization (CBOs) that can work on CS interventions have been identified and the CHAs will train their members. After the MTE two quarterly meetings were held with CHAs, HCNs, the DMT, ALZ and CSP staff. A specific meeting on sustainability with all stakeholders and main community leaders was planned for September 2002; this meeting has been postponed to November 2002.
5. Develop human resources	The former Assistant Project Coordinator (APC) has been promoted to PC. Plan has been using performance analysis for staff evaluation since June 2002. Such periodic evaluations have proved a good way of identifying training needs. The PC was trained on IMCI. Plan restructured its human resource department at national

	<p>level in order to underline a clear human development policy and provide sufficient/relevant support to field staff. UNICEF, MNH, Plan and the DMT with the participation of HCN reviewed the job description of health agents in September 2002.</p> <p>Internal promotion was made and the former Assistant of Project coordinator has been promoted as Project Coordinator.</p> <p>In partnership with UNICEF, MNH and the DMT, Health Center staff job descriptions have been reviewed in September 2002. This helps clarify their role. DMT's job descriptions will go through the same process.</p>
6. Reinforce use of follow up tools adding LQAS	<p>All CHAs and HCNs were trained on LQAS, and the first application was done in June and July 2002 through specific tools addressing CS interventions. The LQAS methodology has been disseminated in three other districts in Tenkodogo health region upon the request of regional health authorities. The project staff conducted the training for 40 participants. There is an on-going process to design tools for CHWs.</p>
7. Emphasize danger signs of malaria and chemoprophylaxis for pregnant women during IEC sessions	<p>During the refreshing session for CHWs, trainers focused on this topic. Trainees included this topic in educational sessions.</p> <p>Key messages on malaria have been reviewed for the IEC campaign. Translation of these messages into the local language facilitated their use by the CHWs and CHAs at the village level.</p>
8. Continue bednet promotion	<p>527 CBOs in the project area have been identified by ALZ; they will be involved in bed net promotion. This theme was developed during the Africa Malaria Day and the launching ceremony of Roll Back Malaria, which took place in Koupela in July 2002.</p> <p>A local radio station continued to broadcast messages on the topic. 104 villages received specific educational talks by theatre and folk troupes on malaria and impregnated bed nets.</p> <p>Each village received one visit per month from the CHAs during which bed net use and other issues were addressed.</p>
9. Revitalize impregnation centers	<p>Needs assessment has been done and a protocol will be signed with the district management team.</p>
10. Revise content of immunization messages for Women of Childbearing Age (WCBA)	<p>Key messages have been reviewed during a workshop with CHAs and the Community Mobilization Coordinator (CMC).</p>

11. Improve follow up system for immunization coverage for WCBA	Registration of WCBA was not done but a census of pregnant women as a pilot project has been done in 13 health center areas.
12. Promote support groups for exclusive breastfeeding	The meningitis outbreak impacted the implementation plan. This activity will be carried out in December 2002.
13. Promote messages about link between breastfeeding, immunization and Acute Respiratory Infection (ARI) prevention	CHAs have integrated this link and trained the CHWs during refresher training.
14. Implement follow up system on use of ORS packets	Population Services International (PSI) has a follow-up system for ORS. Collaboration with PSI will be promoted in this area to ensure good use of ORS.
15. Reinforce knowledge of mothers in nutrition, in identifying danger signs of ARI	The HCNs addressed messages during educational talks and home visits.
16. Reinforce messages on ARI prevention	Immunization and breastfeeding were added to ARI prevention messages in order to show their influences in protecting children from ARI. The CHWs and CHAs included this topic in their IEC campaign. 434 educational talks were done.
17. Bring theater and folk media to a maximum of villages	The number of villages that benefited from educational talks increased to 104. A local troupe based in Koupela was identified and carried out awareness raising in 14 villages. This experience will help this troupe reinforce its capacity in mass group sensitization.
18. Design and use of visual and audio supports	CHAs and HCNs revised the visual supports. These materials will be developed during this fiscal year. Plan Koupela office owns a video camera, which is used to capitalize project activities.
19. Organize radio talks in local radio stations	The talks have begun with the topic of malaria and we are discussing with the local radio stations to take this forward.
20. Reinforce CHWs skills on CS interventions	780 CHWs received competency training on CS interventions in 25 training sessions.

21. Reinforce monthly supervision of CHWs	All CHWs received monthly supervision from CHAs and HCNs based on supervision tools designed by the project in collaboration with the DMT.
22. Reinforce management system among CHWs	CHAs and HCNs discussed the management tools of CHWs in two meetings.
23. Institutionalize monthly meetings among CHWs, HCMC members, CHA and health agents	Regular meetings held by CHAs on a monthly basis are an opportunity for continuous training and follow-up.
24. Reinforce IEC materials of CHWs	All 25 health centers have been equipped with megaphones to facilitate educational talks conducted by the CHWs.
25. Reinforce skills of HCMC members on CS interventions and management	All HCMC members have been trained during a refresher session held in May and June 2002. The members of HCMCs support the CHWs during their educational talks.
26. Reinforce health centers management	The HCMCs were supervised once every quarter with one control. HCMC members held monthly meetings with the Infirmier Chef de Poste (ICP) and the CHA, which gave them the opportunity to reinforce their management skills
27. Implement HCMC network	The HCMC network has been set up with support from UNICEF, MNH, and DMT. Their activities focus on surgical and obstetrical emergencies for the time being.
28. Reinforce the collaboration between HCMC and VHC	CHAs supported HCMCs to hold monthly meetings with HCMC and VHC members.
29. Implement VHC in all the villages	CHAs and HCNs trained CHWs. Results of the MTE have been shared with community leaders during the training. The CHAs provide support to the community for setting up and organizing VHCs.

Review of DIP phase-out plan

1. Communities organizational development and empowerment

- All the members of HCMC were trained on the project interventions. They committed to support CS activities.
- The CHWs received training on the project interventions. Training and supervision by the CHAs and the HCNs improved the quality of services they offer to the community.
- The project helped 89 villages to set up VHCs or reinforce old/existing ones. VHCs support the CHWs to mobilize community members for sensitization campaigns; these committees also purchase drugs for the CHWs and supervise their activities.
- The HCMC network, which was set up this year in partnership with MNH, UNICEF, DMT, will continue to share the cost of surgical and obstetrical emergency between the patient, the health management committee and the MOH. This strategy will be extended to impregnated bed net management in the project area.

2. MOH and NGOs institutional strengthening

- MOH: the health centers and the DMT received institutional support (equipment and training). The HCN are regularly supervised by DMT members in collaboration with local partners. The project works to bring the DMT to adopt the strategies of CSP within the district strategic plan and include all the activities in their plan of action. The DMT is involved in all CSP activities and has the capacity to manage CS activities. The DMT uses CSP approaches in other health activities.
- ALZ: the project has improved the capacity of this local association to manage CSP interventions. This association received institutional development and is able to work with the DMT to reinforce social mobilization.
- Tin Tua: The role of Tin-Tua has become less important since the partnership with Association Lagem Zodo has begun. ALZ has sound expertise in literacy programs. Tin-Tua participated in all the process of the mid term evaluation in November 2001 and is still taking an active part to Koupela district's partners quarterly meetings.

3. Individual behavior change

All villages have at least two CHWs trained on the project interventions and they hold educational talks regularly. The knowledge they have acquired will be used to continue sensitizing community members and support the HCN to organize immunization campaigns.

VHC and HCMC members will continue to support CHWs activities. More emphasis will be put on home visits by CHWs.

During the LQAS, 76% mothers of children under five knew that mosquito is the vector of Malaria, which is significant progress: during the baseline study mosquitoes

were not mentioned as a cause of Malaria. As a result of this awareness, 32% of mothers are using impregnated bed nets.

Mothers respond positively to immunization as evidenced by the increasing coverage of vaccines in the project area, which has been consistently ranking 1st in Tenkodogo Health Region since 2001.

Malaria Chemoprophylaxis for pregnant women is well accepted as 93% took chloroquine during their last pregnancy.

According to a study conducted by MNH in September 2001, 16.9% of mothers of children under twelve months mentioned that they have practiced exclusive breastfeeding.

4. Financial sustainability

- The impregnated bed nets are managed by the DMT. The recovery cost will be used to purchase new impregnated bed nets. The reinforcement of the capacity of HCMC members will facilitate the management of the bed net component and health center activities.
- At village level, drug cost recovery has been used to buy drugs. VHCs include their purchases in the HCMC purchase.
- All HCMC purchase drugs on a monthly basis and support health center activities.

F. Impacted factors on project management

1. Financial management

The project did not face any financial management issues. Financial assistance from the United States National Office (USNO) has been received once a year. Financial monthly reports are sent regularly to the USNO.

2. Human resources

This third year was characterized by some changes in the management of the project. The former APC has been promoted as PC and a new APC was hired in March 2002.

The local association (ALZ) has been managing the social mobilization component since the breaking of the contract with Mwangaza.

Country Management Team members (Country Director, Program Support Manager, and National Health Adviser) have regularly supervised field staff and given them all the support needed.

The Human Resource Director supports the project with advice for staff management.

The Program Unit Manager follows up on the achievement of the project and provides support for the implementation

3. Communication

The project has efficient communication systems (e-mail and good logistics). This facilitates the connection with the Country Office and partners.

4. Local partner relationships

A MOU has been signed with ALZ for the social mobilization component and a partnership was developed with the DMT for the technical aspects of the project. A partnership has also been developed with the MNH project. Plan houses the MNH project for free and supports CHA salaries. MNH pays the salary of the CMC. The CMC and CHAs work for both projects.

MNH and CSP have set up an advisory committee including all partners of Koupela health district. This committee meets on a quarterly basis. District key partners are UNICEF, United Nations Population Fund (UNFPA), Association Burkinabe pour le Bien-Etre Familial (ABBEF), ALZ, Direction Régionale de la Santé (DRS), Family Care International (FCI), SFPS, and Direction de la Santé de la Famille (DSF).

5. PVO coordination/collaboration

The project staff benefits from PVO collaboration in the form of training sessions on sustainability and Integrated Management of Child Illness.

Connections with CAs such as CSTS, the CORE Group, Measure and BASICS have been established, and experiences from other CSPs are shared.

6. Other relevant management systems

During the fiscal year 2002, Plan Burkina Faso introduced a new tool for Project Outline management and monitoring. It allows staff to more easily follow-up the annual budget.

Software called PPM N'dugu (Program and Project Modules) was developed to enhance the project management system. The staff received training on this new system and the software will be used during this fiscal year.

7. Organizational capacity assessment

- Two financial audits have been carried out: the USAID audit was done in January 2002, and the Plan annual audit in March 2002. No major issues were found.
- MTE in November 2001: the project staff and the partners participated to all the activities of the MTE. The project is implementing the recommendations.

G. Success and major issues

1. Problem: Meningitis epidemic

Koupela health district was affected by the meningitis epidemic (361 cases with 61 deaths). Meningitis W135 was identified for the first time as the main strain. Vaccines were not available in the country to cover vulnerable persons.

In 2001, more than 80% of people aged from 2 to 30 years in Koupela district have been immunized against *Nesseiria Meningitides* serogroup A and C.

A crisis committee, chaired by the High Commissioner, carried out activities to control the epidemic. This committee included all the 9 prefects of Kourittenga departments and the district partners. An action plan was designed by the DMT with the support of key partners (Plan, UNICEF and MNH). The plan of action rested on the following components:

- Communities received information through IEC campaign messages on local radio stations. HCNs, CHAs, HCMCs, and the prefects played an important role in community mobilization.
- Care for all cases: All the health centers received national directives for treatment.
- All health centers received drugs for free treatment.
- DMT members and partners ensured the supervision of HCNs.
- The laboratory made the cerebrospinal fluid analysis.
- Data was compiled every Monday and presented to the members of the crisis committee in Koupela.

Plan contributed drugs for the treatment and vaccine for HCNs and their staff. Lessons learned from this outbreak will be used in the coming year to prevent further outbreaks.

2. Success: Impregnated bednet promotion

The CSP introduced long-lasting impregnated bednets in the district as a malaria control strategy in August 2001. Preparatory meetings with CHWs, HCMCs, HCNs and the DMT were held to clarify the management of the bed nets.

CHWs, CHAs, HCNs, HCMCs, folk media and theater groups contribute to implementing IEC campaigns on the topic.

Radio messages were prepared and broadcasted in Moore (local language) by two local radio stations.

To get involve the community in this strategy, the district and the project staff held many community meetings to explain project objectives and interventions. Village chiefs, community leaders, CHWs and HCMC members participated in these meetings.

The initial KPC showed that only 1.5 % of children under five slept under impregnated bed nets. For the time being, impregnated bednets are available in 25 sale points (drugstores). By end of June 2002, 4058 bed nets had been sold in the project area. The relevance of the partnership behind the malaria control activities implemented in the Koupela health district contributed a lot to the choice of Koupela for the national launching of Roll Back Malaria in Burkina Faso. The Prime Minister chaired the launching ceremony on July 12th.

3. New methodology: Introduction of LQAS

During the MTE, LQAS has been used to measure immunization coverage. The staff of the project got training during the MTE for the use of this method.

The project staff conducted training sessions for 27 HCNs and 20 CHAs. All the participants and the DMT found this method very useful and relevant. The first application was done in June/July 2002 with two topics (Malaria and diarrhea).

LQAS is seen by all partners as a good and rapid method of monitoring.

The Regional Health Officer responded very positively to LQAS, and he received support from the project staff to train 40 HCNs in his 4 health districts (Tenkodogo, Zabre, Ouargaye and Koupela). A tool for data collection was drafted during the session by the participants and will be applied to prenatal care and safe delivery.

LQAS is used quarterly to measure progress towards project objectives and goals.

ANNEX 1
MTE RECOMMENDATIONS ACTION PLAN

MTE RECOMMENDATIONS ACTION PLAN

Recommendations	Activities	Responsible	Period	Observations
PARTNERSHIP				
Make the partner coordination more dynamic	Organize quarterly meetings of partners	MCD	Once every 3 months	
	Make the focal point functional	MCD	January 2002	
	Organize workshop on project progress	MCD	Every 6 months	
	Design a MOU with PSI for ORS promotion	PC	Q1 2002	MCD
Reinforce the district and local partners' capacity	Design an institutional development plan	PC	Q2 2002 and continuous	
STOCK MANAGEMENT				
Improve stock management	Give boxes to the CHWs to put drugs	PC	March 2002	
	Train CHWs in stock management	ALZ	Continuous (Q1-Q2)	In collaboration with district for technical aspects
SUSTAINABILITY				
	Design a sustainability plan	PC	Q2 2002	
	Organize monthly, quarterly and annual meetings to discuss sustainability	MCD	Q3 and Q4	
	Integrate CS activities in CSPS microplans	HCN	Q1 2002	CFs, HMC

Develop a sustainability mechanism for CS interventions	Organize a platform for meeting among community actors	CFs	T1 2002	HCN, HMC
	Train members of organized groups on CS interventions	APC	Continuous	CFs
	Design an OR on sustainability	MCD	Q3 2002	All partners
	Continue follow up of CS interventions at CSPS level	MCD	Continuous	DMT Members
	Maintain CS strategies at district level until their target diseases are no more a public health problem	MCD	Continuous	DMT Members
	To attract funds for CS interventions reinforcement realize a social marketing when disseminating results at national and international level	PSM	Q1 2002	PC, NHA
	Use the website www.childsurvival.com to disseminate CS information	PSM	Q1 2002	PC, NHA
	Increase meetings between DMT, CF, and HCN for better field workers involvement, specifically HCN	MCD	Quarterly	PC

HUMAN RESOURCES

Develop human resources	Make internal promotion every time it is possible	Human resources director	Continuous	PSM
	Identify other structures for staff transition when the project ends	PUM	September 2003	
	Help CFs organize themselves into an association at the end of the project	PUM	September 2003	
	Train personnel in CS interventions according to the needs	PSM	Continuous	With CMT
	Review and complete job description of health agents at CSPA level to facilitate their involvement in CS.	MCD	Continuous	
	Assess training needs and design a training plan to reinforce health agent skills	APC	Q1 2002	MCD and PC
	Choose younger CHWs	CF	Continuous	HCN

PROJECT FOLLOW UP

Reinforce use of follow up tools adding LQAS	Ensure availability of ideogrammes at village level	PC	Q1 2002	With DMT
	Review and adapt CS follow up indicators	MEC	Q1 2002	
	Train all Plan staff and CS staff in the use of LQAS	APC	Q1 2002	PC and MCD
	Train HCN in the use of LQAS	APC	Q1 2002	PC and MCD
	Use LQAS for follow up	MEC	Quarterly	CFs, HCN

Recommendations	Activities	Responsible	Period	Observations
Intensify BCC activities				
MALARIA				
Emphasize danger signs of malaria and chemoprophylaxis for pregnant women during IEC sessions	Integrate danger signs for malaria and chemoprophylaxis for pregnant women	CF	January 2002	
	Redesign key messages on malaria	CMC	January 2002	
Continue bednet promotion	Introduce theater in IEC sessions	CF	Continuous from January 2002	
	Organize media campaigns	CHM	March 2002	Quarterly
Revitalize impregnation centers	Support impregnation centers in Koupele and Pouytenga	IEC person	February 2002	
Work with community structures for promotion and sale of bednets	Identify community groups for promotion and sale of bednets	ALZ	February 2002	
IMMUNIZATION				
Revise content of immunization messages for WCBA.	Integrate the 5 doses notion	CF	January 2002, continuous	With support of HCN
	Revise radio messages	CMC	January 2002	
Improve follow up system for immunization coverage for WCBA	Organize registration of WCBA	PC	March 2002	With support of MCD
		CF	April 2002, continuous	

BREASTFEEDING				
Promote support groups for exclusive breastfeeding	Organize mothers groups for exclusive breastfeeding promotion	TBA	March 2002, continuous	
Promote messages over link between breastfeeding immunization and ARI prevention	Integrate appropriate messages in IEC sessions	CF	January 2002, continuous	
DIARRHEA				
Implement follow up system on use of ORS packets	Identify other sale point of ORS	CF	February 2002	
	Assess the sale situation	CF	February 2002	Quarterly
Reinforce knowledge of mothers in nutrition	Train CF	APC	February 2002	
	Integrate the nutrition subject in IEC	CF	February 2002	
ACUTE RESPIRATORY INFECTION				
Reinforce messages on ARI prevention	Integrate these messages in IEC sessions	CF	January 2002	
Reinforce the knowledge of the mothers in identifying danger signs of ARI	Integrate appropriate messages in IEC sessions	CF	January 2002	
MEDIA				
Bring theater and folk media to a maximum of villages	Identify villages which should receive theater and folk media	CF	Q4 2002	
	Identify new troupes	PC	Q4 2002	
	Train troupes on CS interventions	APC	Q4 2002	
	Organize theater and folk media presentations	PC	Q4 2002	
	Promote local troop to reduce costs	PC	Q4 2002	

Design and use visual and audio supports	Revise visual supports	CMC	April 2002	
	Design audio visual support on project interventions	APC	April 2002	
	Distribute the audio visual supports	CF	May 2002	
Organize radio talks in local radio stations	Contact local radio stations	CMC	January 2002	
	Plan radio talks	CMC	February 2002	
	Make local radio talks	CMC	March 2002	Quarterly
COMMUNITY HEALTH AGENT				
Reinforce CHWs skills on CS interventions	Identify CHWs to train	CF	April 2002	
	Organize training sessions in communication techniques, literacy classes	APC	April 2002	
Reinforce monthly supervision of CHWs	Supervise CHWs monthly	CF	January 2002	Monthly supervision with HCN support
Reinforce management system among CHWs	Look for management tools, adapt them and make them available to CHWs	MEC	January 2002	
	Train CHWs in the use of management tools	MEC	March 2002	
Institutionalize monthly meetings among CHWs, HMC members, CFs and Health agents	Organize monthly meetings	CFs	January 2002	
Reinforce IEC materials of CHWs	Provide megaphones to the CHWs	PC	April 2002	

HEALTH COMMITTEE MANAGEMENT				
Reinforce skills of HCM members on CS interventions and management	Identify HCM members to be trained	CF	April 2002	
	Organize training sessions	APC	April 2002	
Reinforce health centers management	Supervise monthly HCM members	CF	January 2002	
Implement HCM network	Assist technically the organization of the network	MCD	February 2002	PC, CT, MNH
Reinforce collaboration between HCM and VHC (village health committee)	Organize regular meetings between HCM and VHC	HCM President	March 2002	Quarterly
	Discuss CHWs' motivation with HCM	MCD	March 2002	PC PSE
VILLAGE HEALTH COMMITTEE				
Implement VHC in all villages	Organize community discussions on the subject	CF	April 2002	
	Assist technically in the implementation in villages which express the need	CF	May 2002	
	Train CHWs on CS interventions	CF	June 2002	