



## *Ananda Marga Universal Relief Team*

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### **Safe Motherhood program in Burkina Faso, November 2007**

Dear Friends, namaskar

Hope that you are all well. I am writing to summarize about where we stand in the Burkina Faso Safe Motherhood project.

We just returned from the village on Thursday night with the evaluation team from APAIB Burkina. They sent a six member evaluation team, two midwives, two nurses, and an administrator in the health department and a journalist with the leading newspaper in Burkina Faso, Sidawaya. The team also included two translators we found in Gorom Gorom, one for Fulfulde (the language of the Peuhl/Fulanis) and one for Tamasek (the language of the Bellas). Every day we used two vehicles and motorcycles. From AMURT, Numero Une, the coordinator in Deou, Rasa the Ouaga coordinator and myself and two drivers joined the team. We got further assistance from guides and agents from the three clinics in the project area, Deou, Gandafabou and Boulekessi. So all in all we had about close 20 people involved in the evaluation exercise. Twelve of us stayed at the AMURT compound in Deou. It was like a big family with good harmony and understanding.

The team divided itself in two most days, and visited altogether 40 communities, thirty seven villages with trained village midwives, plus Deou, Gandafabou and Boulekessi.

We will get the evaluation report by the end of the month. From what we could observe things are looking very positive. Most of the midwives responded very well when interviewed and during the meetings with the villagers the people spoke very positively about AMURT and the current Safe Motherhood program. Everybody seemed to know AMURT very well, and in most villages the communities recounted the work done during Dada Rudreshvaranandaji's time, like building hospital, digging wells, helping to start vegetable gardens, cooperatives, cereal banks, literacy training, reforestation, and even building bridges on the road to Djibou! One village, Boulekessi, spoke about Dada Rudreshvaranandaji in such an affectionate way, it was very touching. I promised to send the message to Dada's mother.

The terms of the reference for the evaluation were quite extensive, and the report will touch on a lot of areas, including finance, communication, reporting, government liaison, etc. . I think the most interesting points, and what the evaluation team spent more time, was to understand the effectiveness of the training, and also what, if any, changes the program had brought amongst the population. We have independent audits for 2005 and 2006, and our books and records for at 2006 and 2007 are in quite good shape.

The evaluation team was excited and deeply touched to see this remote corner of their country for the first time. Seeing the different tribal culture and the communities still living grass huts, and subsisting on millet and milk in the 21st century affected all. The people still appeared quite harmonious, it was clear that they felt they belonged and very few, if any at all, talked about wanting to live anywhere else.

The village midwives responded very well. It was clear that those who were very new, that is those trained in 2007 or even some from 2006, were yet to understand certain aspects well, and some had not yet had the confidence (or had not yet gained the confidence of the local people) to start doing deliveries. Amongst those who had been trained in 2002 to 2005 most were active, making deliveries and sensitizing the women and general population in their communities. The staff at the CSPS's in Deou, Gandafabou and Boulekessi, spoke, from what I could hear, very well about the program, and in some cases were able to produce statistics showing the effect of the program, like an increase in the number of women coming for Pre-Natal-Consultation. In general, the population spoke about several changes brought by the program : reduction in the practice of female genital mutilation and the improved health of mothers and children.

Many of the village midwives had been very active in sharing what they had learnt at the training with the communities, and pregnant women now came to them for advice and help. It was inspiring to see these women emerging as leaders in an area where the conservative culture and traditions keep women suppressed; there are very few female leadership role models.

The evaluators also asked what the village midwives and the population needed, and what help they wanted from AMURT. Almost all requested a donkey cart – when complications arise during pregnancy or during the delivery, the women are unable to mount the donkey or camel, or walk the long distance to the nearest clinic. Donkeys are easily available, but only few have carts and are hesitant to lend it. This could be a life saver. A donkey cart cost about USD 245. Some also requested bi-cycle and more medicines to distribute. Almost all also requested more training in women's health and midwifery and some requested literacy training.

The main problem in the area is the lack of water, personal hygiene is very close to impossible during the dry season. Many of the communities asked AMURT to help with wells, dams or dugouts. (This work requires careful technical research, and although I am interested in it, I feel at this point, we can't make any additional commitments.)

Another suggestion which we have had in mind for a long time, is the construction of a small building in each village that could be used for deliveries, and consultations. We have trained male village health promoters in 12 of the communities, they could also share the building for their work. (We might decide to train more male village health promoters in 2008) When the SMI Mobile team come for pre-natal consultation and check ups and training, they could also use this building as their base. As it is now, they have to beg to borrow the grass huts of the locals, where you can't even stand up-right. Or use a shade, where there is no privacy. As we know it's not good to spend money too easily in community development work, so it will depend on the readiness of the communities to contribute communal labour and materials to the construction. According to the ASV's and some communities that were asked, they will be ready to commit. I plan to study about this more on my next visit. It is something we will look into.

Another big need is proper ambulance, specially for Deou and Gandafabou. Deou is using an old ambulance given by AMURT in 2005. Dada Rudreshvaranandaji combined the working parts of two broken vehicles, the old AMURT Pick-up and the old ambulance of Deou hospital that had been parked for years, and made on vehicle. However, it keeps breaking all the time. And it is also the car for the SMI, the mobile maternal clinic, where the CSPS staff, do weighing and pre-natal-consultation and health education in the villages. Because the area is so remote, from Deou, it takes two hours to reach the nearest hospital in Gorom Gorom, from some of the far away villages, it can take up to 2 or 3 hours to reach Deou. To buy a second hand car for this area with no roads and very difficult terrain, is not a good idea. It would be great if we could help raise funds for new vehicles. They could save lives.

Around the 25th we will get a draft of the evaluation report. We will review it to check if there are any major mistakes or misunderstandings, and then they will give us the final report. It will be in French, we will take it to the official translators, that will certify the translation into English. It should be ready sometime before the 10th of December.

Also in early December there will an article in Sidawaya, the most important newspaper in Burkina Faso, about AMURT, the project and the evaluation.

Of course we can expect that the team will have found different aspects of the program that needs to be improved and corrected. We will have to humbly acknowledge that indeed there are many aspects of the program that needs to be improved. But in general, from our conversations with the team, and from what we heard ourselves from the village midwives, the population and the health department people, it will be a positive report for us.

We are very well placed now to expand and improve this work, and really make a difference. We will have to decide how ambitious we want to be. We can continue on a modest level, or we can expand hire qualified people for better training and monitoring. We can make efforts to help with donkey carts, bi-cycles or even with more vehicles, or the construction of village level centres for medical consultations and deliveries.

I feel very inspired to expand and improve this work. We can't stop or turn back now, the health department, and more importantly, the communities are counting on us to follow up and take the work further.

There is no doubt that this is among the most isolated and neglected areas on the face of the planet, there are hundreds of NGO's in Burkina Faso, but none other are working in the health sector in Deou department. We are dealing with tribal people, where the illiteracy amongst women is very close 100 %, and amongst the men the literacy is also in the single digits. Our program is primarily one of health education, and as such it's huge challenge. Things are expensive in Burkina Faso, vehicles and vehicle maintenance is very expensive, diesel is 580 CFA/1 liter, which will mean about USD 5.80 per gallon. A huge part of our budget has been vehicle maintenance and fuel, and it's likely to continue like that. However, as we are working remote parts, where nobody else are ready to work, we must accept this, although it may not look so inspiring in the budget.

In the last year, the quality of the training of the midwives has improved very much. AMURT in Ouagadougou made contact with a group of experienced midwives. They understand very well key elements of development work, and are able to apply creative and effective methods of instructions that are appropriate to the illiterate women in the project area. Of the three government clinics that we work with in the project, only one has a female staff member, and she is an 'accoucheuse auxilliaire', that means a midwife without full qualifications. Because it's so hard to find women to

accept postings in the remote districts, the government of Burkina Faso has a policy of training male midwives (maiettiens), We found that the male staff during the training, while trying their best, were not able to communicate in a way that facilitated learning for the midwives. Their teaching technique was too theoretical, magisterial: while we like to have the teaching more participative, practical, interactive, making use of visual aids donated by AMURTEL US and teaching aids such as the special mannequins donated from AMURT/AMURTEL UK. The female teachers from Ouaga is doing this.

I am mentioning these women trainers, as I think they will play an expanded role in the new program that we will make. They have been charging 55,000 CFA per day, that is about USD 55. So it will cost money. It could be an idea to hire one of these women full time, it would be best if we could find someone who spoke either Ffulfulde or Tamasek. However, as it will be near impossible to find someone to stay in Deou full time, to bring in the resource persons just for the training is probably a better idea.

It is likely that we will change the way we organize and schedule the training sessions. We will probably have shorter sessions with smaller groups, where only one language group at a time is present. The problem with having training with translation into three languages is just too inefficient. We will have to get better translators also.

We are also looking for someone who can do literacy training on a similar format, that is in smaller groups, for shorter periods. The official government training program we have been using has been totally ineffective. For this reason we did not do literacy training in 2007, we are on the track of finding out how to do this.

From 2002 until today, we followed the same structure and budget for the training and supervision work as given to us by the Provincial head of the Health Department in 2001. We would like to make some changes to this, but we don't know how this will be received by the health department. The program has given welcome extra income to the workers in the remote clinics, if we start relying on more qualified outside trainers, and reduce their role, they may not like it. They might even have in mind increasing their pay from the project. So after we decide what we would like to see, before we can submit the budget and final proposal to prospective donors, we have to come to some agreement with the health department. This could be difficult, they may come to the table with their own proposals. They might have some different ideas, or maybe even some better ideas. In some countries we could just move, but in Burkina Faso we can't by-pass or side step the authorities. It could jeopardize our position here. I think it will work out, it could be tricky, but probably we could work out a compromise. We have no choice, as our program needs to be in line with the government. .

We have to decide what components to include in our program, and if we need to break it up into several proposals, to be submitted to several donors. I very much like to hear your ideas and suggestions. I will be going to Ghana on Monday 19th November, and expect to be back in Burkina Faso for about two weeks starting 20th December.

Components that could be separated from the main Safe Motherhood Project, could be training of supervision of male village health promoters, literacy training, ambulances, building of birth/health centres in the villages, donkey carts, bicycles. Or if we could find a big donor and put most of this in one package, that would of course be great!

The funding from Norway is finished at the end of this year. And we don't have any funds yet for 2008. I am hoping to scrape together donations from here and there so that we can maintain salaries, and operating expenses at a minimum for the time it takes to secure new funding. We will have to reduce the regular activities for some time. Any ideas or help in this regards are also very welcome. I will write about finance and the finer point of budgeting in Burkina Faso in more details later on. Here in Burkina Faso, AMURT since the beginning, has been giving all benefits to employees, that is social security health insurance, vacation pay, special per diem for travel etc. So it adds up, and does not look so inspiring in the budget or on the finance report. Still in the long run, if we wish to establish AMURT as serious NGO, it's better we do it like this, rather than cutting corners.

My feeling is to be bold with this project, and try to take this project to the next level. This means a bigger budget and increased activities. I feel to limit the work to Deou department, that is we will not expand our project area. There are not many uncovered villages, some midwives might need to be replaced, so some new ones need to be trained. The focus will be on building on work done so far; more extension into the villages, more training to those who have been trained and who are active., and to strengthen the health care infrastructure in the villages.

Thanks for all support and for taking time to read this. Hope to hear from you when you have time.

Brotherly,

Dada Daneshananda