**Meredith Gilbert: IH790**

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## Class Reflections

Week 1
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**6 July 2010**

5 hour class, 30 minute meeting with Wolffy, 35 minute bus ride, World Cup game (boo, South America is out), report for work, 6:00 Skype test call with the Boston side of my virtual team, case report reading, need to be up at 5:50 AM to talk to the full virtual team. What happened to my summer?!

That said, first class was very interesting. It was nice to get right into things and the class seems full of very interesting people. In particular, it was interesting to be broken into the blue team with a new MPH student and a very business oriented professional. Apparently we won which just proves that different backgrounds can come together FOR THE WIN!

Also, I miss Iceland. I took these photos last week on my last night there:

**7 July 2010**

5:50AM alarm. Just enough time to clear the sleep out of my throat and brush my teeth before our attempted Skype call with our virtual team in Afghanistan. The communication challenge (multiple dropped calls, lag time, poor sound quality) came hand in hand with a management challenge, of course. Although my Boston team had practiced Skyping the evening before, we never established who would "lead" the conversation and with the lag time things got really complicated when more than one of us broke the silence at once. This was a beast of our own making since we opted to each stay at home for the call instead of meeting at BUSPH where we would be able to use non-verbal communication to indicate who should speak. Lesson learned! We are going to meet to discuss how to improve the communication and management of the call before the next one. On a positive note, the rest of our team seems great and quite organized which should make working with them a lot easier.

I have been reflecting a bit on my management style at work now that I am there only a fraction of my previous hours due to this class, yet responsible for the same tasks. One of my job responsibilities is to manage 6 HIV+ adolescents (late teens, early twenties) who work as mentors for younger HIV+ youth. It's a great program and I've been working with the youth for several years so at this point I'm basically on autopilot which I fear has led to complacency in some areas. When I interviewed for the position the woman linked to that program was thrilled that I had had experience working with HIV+ youth in Africa. She loved my tough love attitude towards kids here who take their medications and opportunities for granted. Her approval helped me get into a good groove with the youth where I was a committed and tough, but forgiving, boss. I'm also very very laid back when I'm at the center where they work which definitely throws them for a loop, particularly since they only somewhat believe I'm 29 years old (many thought I was in high school based off how I look). Now that I'm not there to meet with them in person and check in I've already become even more laid back... too laid back? I was assuming everything was fine and then got a frantic call from the center because the youth collectively all forgot when timesheets were due without me there to remind them. And one of them entered a homeless shelter because she forgot her case manager's name *and* my phone number in the past two days. Clearly I need a bit more micromanagment in my style!

Which leads me to another reflection that I hope to revisit in future entries. I am obsessed with my grass. Quick back story is that the small plot of land in front of my Cambridge apartment came with a bunch of dead yellow grass and a dead bush. I recently became motivated enough to attack the whole patch with one of my roommates, a rake, a hoe, and a lot of water (we chose one of the hottest days of the year to do this). Once it was cleared and mostly flattened I invested in a type of grass seed that comes with mulch and seed and fertilizer all mixed up to make things super easy on myself. My roommates have offered to help water the grass which needs to happen at least twice a day and I have refused. Instead I compulsively check on it (the soil changes color when it needs to be watered, part of the mix's dummy proof system), gaze at it, double check on it. Nobody else is allowed to touch the hose or the sprinkler. How did I develop such micromanagement in such an odd sphere of life?! It really baffles me. I've never been micromanaged professionally (if anything I am more used to managing up) or even by my parents growing up. My grass must hate this strange human who frowns and frets over its lack of progress and becomes overly rewarding and happy with signs of improvement. I'm attaching a photo where you can see there's some length but not a lot of thickness. We'll see how it goes.

**8 July 2010**

Today's Pandora simulation is the most interesting and relevant coursework that I've done at BUSPH. I was on the donor team which was an interesting perspective, particularly having just taken Professor Bicknell's class that is full of criticism of the donor process. It was a relief that we appeared to be part of a donor team that was motivated to represent the goals of the country to the headquarters. I found myself really thinking a lot about my Peace Corps experience where I was much more on the tribal level with a dash of donor perspective. The bulk of my firsthand donor knowledge was due to the serendipitous fact that the UNICEF country director in Swaziland was my college roommate's father and he and his wife (empty nesters) immediately "adopted" me. I certainly remember how unheard the people of my village felt within the Swaziland bureaucracies and how alienating it was for them to have to deal with agencies in English which many people in my village didn't know. For some reason I forgot all of this during the simulation where I (as a donor) ignored the villagers due to lack of time and because they didn't reach out first. Feeling a bit ashamed now...

I also wanted mention that I was extremely inspired by Joan and Morsy's discussion about motivating front line staff. I've seen that lack of attention paid that the organization where I currently work (even with middle managers like myself!) and it pollutes the quality of output of the entire agency. It's amazing how such an overlooked and simple thing is generally the last thing on the minds of upper managers. Today I was in the elevator with a top level consultant in my 50 person division and she thought I was the receptionist who just started working downstairs. This consultant and I have both been here for 3 years and have even worked together on a project before. Clearly a morale buster.

**9 July 2010**

It's amazing that this first week is over! This has been such a fulfilling experience so far and I can't wait to delve further into these topics and get going on our challenge model. My group sat down during class to hammer out hopes, expectations, and to get to know each other better. We all have so many common interests and desires for the

# Session Reflections

Our First Class
Pandora
ARI-CDD
Integrating Measles Immunization and Malaria in Zambia
MSF Malnutrition and Micronutrient Workshop in Bihar India
Bidders Conference 2010
PMTCT Workshop for District Hospital Program Managers, Lusaka
Safe Motherhood and Neonatal Health Technical Workshop Marrakech Morocco
Job Interview Debrief and Introduction to Logic Models
Goals, Objectives, and Activities
Monitoring and Evaluation Plus
Presentation Day at MSH

Today our class was invited to participate in a workshop to consider issues and develop potential strategies for improving nutrition and micronutrient deficiency in Bihar, India. The workshop was prepared to train volunteers for work with Doctors without Borders and was developed and conducted by Fareesa, Sarah, Taryn, Lianna, and Lauren.

The workshop design was elegant. It began with an introduction and overview of the scope of the problems of under nutrition in Bihar. Participants were then separated into two groups. Within each group, participant pairs were provided information about the growth, diet, and social situation of a child. Each of the two groups rotated through two breakout sessions, one on malnutrition and the other on micronutrient deficiency. At the end of the workshop the groups came together to consider root causes of malnutrition and micronutrient deficiency and identify interventions to address these root causes at the household and community level.

For the cases used in the breakout sessions click here.

The objectives, quickly laid out for the participants, by the training team were ambitious, but the team led the participants through a series of interactive exercises that provided an opportunity for everyone to learn about this expansive topic.

The workshop objectives were:

- To understand what malnutrition is
- To learn why malnutrition is a problem
- To learn what different ways to measure under nutrition
- To learn the difference between stunting and wasting
- To learn what the different micronutrient deficiencies are
- To learn how to treat under nutrition
- To learn ways to prevent under nutrition
- To learn about the different interventions to combat under nutrition

Taryn covered the basics. Malnutrition is defined as lack of proper nourishment. It is a serious global problem caused by inadequate or unbalanced or excessive intake of food

and nutrients, or by an inability to absorb or utilize what is consumed. Malnutrition thus includes both inadequate nourishment (under nutrition) and excessive intake of nutrients (obesity). Taryn explained that this workshop would focus exclusively on under nutrition.

In India which has a population of 1.15 billion people, twenty five percent of the population lives below the poverty line. Up to a third of the world's undernourished children are Indian. Forty-six percent of Indian children under 3 years old are underweight and 38% are stunted. There are large variations in the incidence of malnutrition within India and within states. The state of Bihar where the MSF program is located is one of the worst affected by under nutrition. Girls are more affected than boys. About one-third of adult women are underweight. Under-nutrition begins early. Up to 25% of infants are born with low birth weight, predisposing them to under-nutrition and increased vulnerability to disease throughout life.


Taryn explained that Bihar State, the 9th largest state in nation had the second largest population in India, about 83 million people with only 10.5% living in urban areas. Female literacy in Bihar is low, about 33%. Male literacy is higher, about 60%. The main agricultural crops and industries are rice, paddy, wheat, jute, maize, oil seeds. There are many rice mills, sugar mills, and edible oil mills. Agricultural production includes many vegetables such as cauliflower, cabbage, tomato, radish, carrot, beet, sugarcane, potato, barley.

Some of the key nutritional issues for this population of young children and women in their child bearing years in Bihar were inadequate food, iron deficiency, Vitamin A deficiency, and iodine deficiency. There are many government programs focusing on nutrition education, ongoing nutrition monitoring and surveillance, distribution of iodized salt, semiannual Vitamin A distribution to children, and provision of iron-folic acid tablets to pregnant women. A 2008 study showed that government attempts were not sufficient to address the multiple nutritional issues successfully.

After the introduction to Bihar and a quick review of the scope of the nutrition problems, the participants rotated through two breakout sessions.

The under nutrition breakout session was facilitated by Lauren, Taryn and Fareesa. Lauren explained the breakout session objectives for the participants. She carefully articulated that participants would learn how to recognize different manifestations of under nutrition, identify an undernourished child, and utilize several ways of measuring child growth.

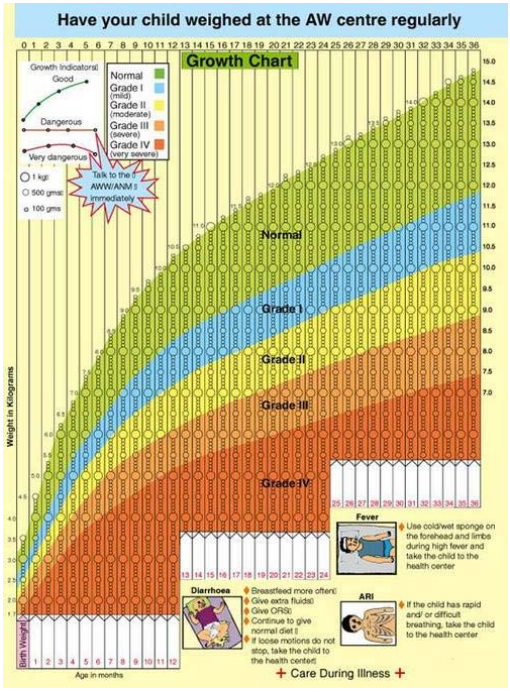
She then introduced the growth chart and explained that it provided an excellent way to monitor child growth. She noted the different ways a child's growth could be plotted on a growth chart and explained how to interpret the chart.

- Weight-for-Age detects underweight children
- Weight-for-Height detects wasting
- Height-for-Age detects stunting

She noted the curves on the graph represented Z-Scores with
- 0 to -1 = Normal

- -1 to -2 = Moderate
- -2 to -3 = Severe
- >-3 = Very Severe

A child with a weight for Age Z score would be underweight. This might be from stunting or wasting. If weight for height Z core was below the normal range then the child would be wasted. If height-for age Z score was below the normal range the child would be stunted.




Participants plotted their cases on the growth charts the team had provided and Taryn and the team discussed the growth of the children that the participant pairs had plotted.

Fareesa then explained that the mid-upper arm circumference, MUAC, could also be used to detect stunting. She showed how to place it on the arm, half way between the tip of the shoulder and the elbow and noted that it could be used at any age since the mid-arm circumference does not change much with age. Participants were given the MSF paper arm bands and practiced using them on each other's wrist.

In the discussion participants noted the growth promotion required growth monitoring with interventions to respond to nutritional problems when they were identified by plotting the child's weight for age over time. Facilitators emphasized looking at the growth over time, every 3 – 4 months, rather than a single measurement at one point in time.

For the power point for used in the breakout session click here.

The micronutrient breakout session facilitated by Sarah and Lianna was occurring simultaneously. In that session Sarah provided a primer for the major micronutrient deficiencies covering the sources of micronutrients and the clinical manifestations of deficiency. She discussed iodine, Vitamin A, B's, C, D, iron, and zinc.

Participants then were asked to look at their own case study and identify the nutritional/micronutrient issues in their children. Interestingly, this case analysis was complicated because of multiple micronutrient deficiencies and often underlying malnutrition either from inadequate food intake or concurrent or persistent infection.

For details on different micronutrient deficiencies see the power point from the session.

Lianna then asked for solutions to the nutritional and micronutrient issues that were uncovered in the analysis of the cases. The group had many suggestions including mother-child feeding support groups, community gardens, exclusive breastfeeding promotion and support. There was lots of discussion on how to improve mother's health and nutritional intake with suggestions of focusing on girl's in school with school feeding

programs and education programs. The need to address the nutrition issues of girls throughout the life cycle was particularly emphasized.

Positive deviance was also identified by the group as an important strategy for improving child nutrition. Lianna then noted the results of a positive deviance study in Bihar in (2005). This study provided an interesting look at a community-based nutrition program. In this program positive deviance identified poorest children with best nutritional outcomes and showed that the success of positive deviance program activities were not dependent on household resources. They noted other successful interventions included behavior change efforts for complementary feeding, hygiene coaching, increase Sprinkles usage, and introduction of informal education and literacy activities for mothers.

Check out the film on the use of Positive Deviance in the community.

When the breakout sessions were completed all the participants reassembled and divided into working groups made up of participant pairs with different cases. Fareesa asked each group to think the root causes of inadequate nutrition in their specific households basing their reflection on what they had discussed in their case studies and the breakout sessions. She advised the groups to brainstorm some ideas on interventions that could be developed to improve the nutrition in the community.

Working groups considered:

- the resources that would be needed
- the challenges to implementing these interventions
- the most vulnerable children in the community who may not have been identified in this exercise
- the possible strategies that could overcome barriers to accessing nutrition programs

The groups identified the root causes of inadequate nutrition as:

- Poverty
- Inadequate knowledge about nutrients, food, vegetables
- Lack of access to food
- Food availability and geography (limitation in what can be grown)
- Mixed feeding (breastfeeding and introducing foods before 6 months)
- Co-morbidity with other infectious disease
- Cultural Barriers to introducing a new diet or different foods
- Habits
- Physical access to food (wartime / peace)

They identified many interventions for improving child nutrition at the individual and family level including:

- Community based therapeutic programs using Ready to Use Therapeutic Foods (Plumpy Nut)
- Exclusive Breast Feeding
- Home-based Micronutrient Supplements
- School feeding programs
- Strategies identified through positive deviance
- Community gardens including garden sharing – square foot gardening to support diversity of agriculture in small spaces
- Hand washing and hygiene

- Salt Iodization
- Conditional cash-transfers or community cash transfer
- Microcredit programs
- Community nutrition education
- Mother-to-mother support group
- Supplementation with micronutrient sprinkles
- Folate, Calcium, and iron supplementation for pregnant women
- Policy recommendations – encouraging governments to get involved
- Community meals
- Education – to improve knowledge

For a list of evidence based interventions at all levels see Maternal and Child Under nutrition 3, What works? Interventions for maternal and child under nutrition and survival

Many thanks to our facilitation team for an excellent training workshop.

**Catherine Mezzacappa at BU SPH** site map



# Evidence-Based Program Design

**Proposal Development - Reproductive Health in Mali**
Introduction
Project IMPACT
Context
Intervention Logic Model
Goal and Objectives
Programs and Operations
Long-Term IMPACT
Intervention Costs
**The Process**
Skills
Reflections

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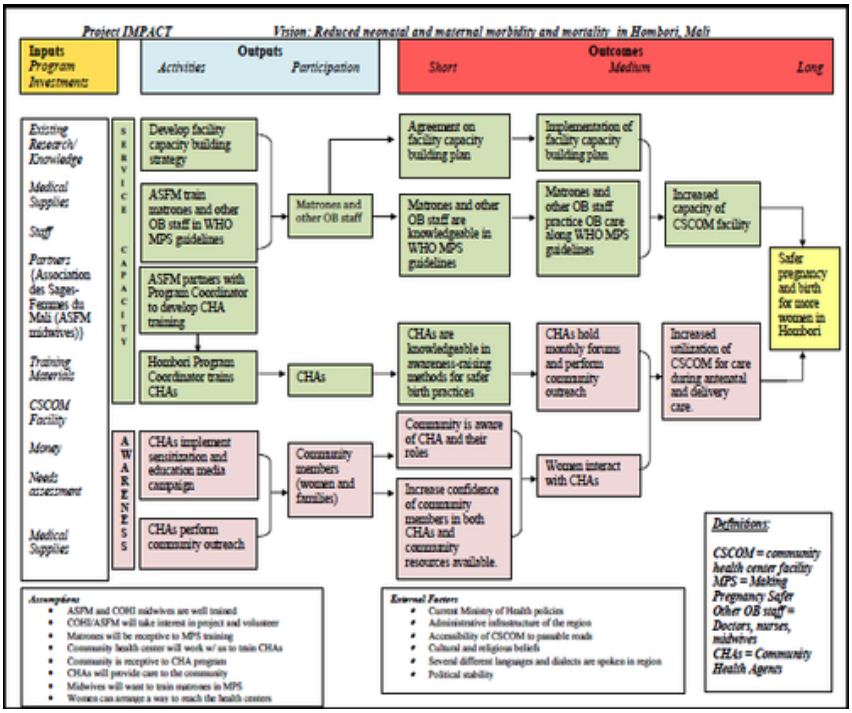
**Monitoring and Evaluation - Handwashing in India**
Program Design
Objective and Indicators
Monitoring and Evaluation Forms
Results Monitoring Framework
Presentation, Dissemination and Use of Results




The long term goal of Project IMPACT is to provide safer pregnancy and birth to women in Hombori, Mali. In order to do so, based on the current barriers facing the community, the approach to achieve this goal must come from two separate sources: 1) Increased capacity of the CSCOM facility in Hombori, and 2) Increased utilization of the CSCOM for care during both antenatal and delivery periods.

Increasing the capacity of the CSCOM facility requires safer birthing practices of the matrones and other obstetrics (OB) staff at the CSCOM. While all OB staff at the CSCOM has had some formal training and qualify as "Skilled Birth Attendants" as defined by the WHO, the majority of births are attended by the lowest trained members: the matrones. Additionally, many staff have been working in this isolated and rural community for several years without any continuing education. Therefore, Project IMPACT will increase their capacity to delivery safer antenatal and delivery care by training them in guidelines developed from the WHO's Making Pregnancy Safer Program

guidelines. The training program will be developed by a midwife consultant from the Association des Sages-Femmes du Mali (ASFM) to assure the training is both relevant and appropriate for the matrones' education level, which is generally no higher than a grade 8 level.

Additionally, the facility will have its capacity built by strengthening the equipment and supplies necessary to assist with providing safer birth. The matrones and other OB staff will work in conjunction with COHI to create a plan after performing an initial needs assessment when the project begins in order to investigate missing but crucial materials for providing increased antenatal and delivery care at the CSCOM.

Increasing the utilization of the CSCOM requires a behavior change by the community members themselves. In order to bridge the gap between the CSCOM and the women and families in the communities, Project IMPACT will utilize Community Health Agents (CHAs) to act as liaisons to women and households in Hombori. The CHAs will hold monthly open forums in addition to interacting directly with women. To assure the CHAs are capable of sufficiently hosting these forums, they will be trained by the Hombori Program Manager in awareness-raising methods for safer birth practices. The HPM will work in conjunction with ASFM to develop an effective training for the CHAs.

Once the CHAs are sufficiently trained, they will assure the women in the community interact with them by creating an awareness and sense of confidence in both their roles as community health liaisons as well as in the resources available to community members at the CSCOM. As creating confidence and awareness can be challenging, especially in a rural population, the CHAs will implement a sensitization and education media campaign. Additionally, the CHAs will also perform community outreach directly to a vast number of households throughout the area.

By following these steps and guidelines, Project IMPACT will be able to both effectively raise awareness of and demand for safer antenatal and delivery care while also providing an increased capacity of the CSCOM to provide that higher level of care.

Take a look at the evolution of Project IMPACT by browsing through previous drafts of our logic model:

Logic Model updated 052610.doc
Logic Model updated 052510.doc
Logic Model updated 052410.doc
Logic Model updated 052110.doc
Logic Model updated 052010.doc
Logic Model updated 051910.doc

## Leading Organizations to Achieve the MDGs

## Rubric for Assessment of the e-portfolio

| Criteria | Outstanding | Adequate | Needs Improvement |
|---|---|---|---|
| **Collects evidence of professional practice that demonstrates competencies in project design** | Evidence selected powerfully demonstrates competence in all aspects of leadership | Evidence selected demonstrates competence in some aspects of leadership | Evidence selected is incomplete and does not clearly demonstrate competence in leadership |
| **Integrates academic work with previous work and life experience** | Many portfolio reflections insightfully link leadership experience in this class with other academic work and life experience | Some portfolio reflections link leadership experience in this class with other academic work and life experience | Portfolio reflections do not may a strong link between the leadership experience in this class and other academic work and life experience |
| **Selection of content aligned with public health career goals and objectives** | E-portfolio provides many examples of how work in this course is connected to public health career goals and objectives | E-portfolio provides some examples of how work in this course is connected to public health career goals and objectives | E-portfolio does not show how work in this course is connected to public health career goals and objectives |
| **Uses multimedia to powerfully convey ideas and information** | Frequent use of multimedia powerfully communicates ideas and information in e-portfolio | Some use of multimedia to convey ideas and information in e-portfolio | Poor or limited use of multimedia to convey ideas and information in e-portfolio |
| **Promotes and demonstrates reflection** | E-portfolio provides a reflection that reveals a clear professional, realistic, and informed understanding of the challenges of leadership | E-portfolio provides a reflection that reveals a limited professional, realistic, and informed understanding of the challenges of leadership | E-portfolio does not provide a reflection that reveals a professional, realistic, and informed understanding of the challenges of leadership |
| **Creativity** | Highly creative, captivating and interesting | Presents appropriate information clearly but is not compelling or exciting | Poor creative effort; dull, drab and uninspiring |