

AWARE II Endline Assessment Report

AWARE II

May 2012

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ACTION FOR WEST AFRICA REGION (USAID AWARE II)

FINAL EVALUATION REPORT FOR COMMUNITY FAMILY PLANNING, MATERNAL, NEONATAL AND INFANT HEALTH INTERVENTIONS IN TOGO

< May 2012 >

This report was produced for review by the United States Agency for International Development. It was prepared by Dr TCHAGAFU M. Country Consultant for the USAID AWARE II Project in Togo.

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Summary

The Action for West Africa Region Project (AWARE II) is a three-year flagship project of USAID/West Africa spanning July 2009 and September 2012. It seeks to adopt an innovative and holistic approach in the quest to strengthen family planning, maternal, neonatal and child health and HIV AIDS best practices in twenty countries in West and Central Africa. Proposed activities over the three-year period were expected to contribute to strengthening the common vision adopted in the first year through a district-level approach to integrated and synergic service provision which will enhance the expected impact considerably. To demonstrate the usefulness of this approach, USAID and the AWARE Project II commit to conducting research based on the following hypothesis “*Given adequate political and technical support from health infrastructure and from communities, community health agents are able to provide a set of services in sufficient quantity and acceptable quality to significantly increase health coverage of target populations in rural West Africa*”. In order to demonstrate the impact of this project, an initial survey was conducted in two selected districts in Togo (Blitta and Haho) as well as in one comparative district (Wawa) between March and June 2011. The package of activities was operationalized between July 2011 and May 2012. Given that the project ended in May 2012 in the two districts, and in order to demonstrate the verifiability of the research hypothesis, an evaluation was conducted in the three preceding districts between April and May 2012.

The survey methodology (study area, data collection tools, collection procedures, entry format, data analysis plan or method) was similar to that of the 2011 study, such that the results of the two evaluations are comparable. The main targets were the Community Health Agents (CHAs), women of child-bearing age, health trainers and pharmaceutical products depots. The CHA sample size was 123 although only 116 were actually interviewed, out of which 103 were drawn from the project area. Women of child-bearing age were interviewed in their homes. At the end of the data collection, 1200 households were interviewed with 1419 women of child-bearing age interviewed. The health facilities captured in the final evaluation were 30 in number while pharmaceutical depots were 29. In relation to the CHAs, the final evaluation showed that their level of education was almost the same as that of the initial evaluation. However, Blitta and Hahoo districts CHAs mastered contraception perfectly. They were able to identify eligible women for oral and injectable contraceptives. They also mastered the depo-provera injection technique which had been selected for distribution in the communities. Proportions vary between 90-100% at all levels in terms of contraception administration and monitoring of participating women.

CHAs in the two districts exhibited adequate knowledge of malaria, diarrhoea and acute respiratory infections (ARI) management in Under-5 children. They were able not only to identify the signs of malaria but also to manage it. For example, in the Blitta District, 91.1% of CHAs were able to manage the AM+LM posology as against 58.6% in the initial study.

However, the same indicators declined in the Wawa District (65.4% - 50%). The trend is similar in respect of the other two targeted diseases (diarrhoea and pneumonia). The performance of CHAs was confirmed by parents of Under-5 children. For example, 56.1% of women of child-bearing age in Haho District said that their children who contracted diarrhoea in the two weeks preceding the study were treated by CHAs. This figure was only 3.4% in the same district at the beginning of the project. CHA knowledge of the ideal interval between pregnancies and the advantages of spaced birth, also improved. They were able to recognise danger signs in pregnant women and in neonates. For example, the proportion of those who could identify danger signs in new-born babies rose from 0% to 75.6%.

Women of child-bearing age in the two project districts knew the ideal pregnancy interval and the advantages of spaced birth. The results of the evaluation show that the proportion of women who knew the IIG increased significantly from 7.2% to 47% in Blitta District, while the figures for Haho and Wawa Districts rose from 11.0% to 31.1% and 6.4% to 53.0% respectively. The proportion of women who knew the various contraceptive methods increased significantly in Blitta and Haho and in all the districts. This probably could be the result of the awareness-creation effort of CHAs. The proportion of women who said they were currently on contraceptives is 55.6% as against 22.9% in the initial study in Blitta District and 37.2% as against 16.9% in Haho. The most widely used method is the injectable (59.2% as against 29.2 in Blitta and 72.6 as against 41.6 in Haho). Regarding the treatment of under-5 children, it was the parents who provided information both on the health of their children and on facilities where they sought primary care. It is remarkable that between the two evaluations, the number of women who sent their children to CHAs for primary care rose considerably to the detriment of the dispensary. For example, the proportion of parents who had their children treated by CHAs for diarrhoea rose from 4.7% to 66.2% in Blitta, 3.4% to 56.1% in Haho and 1.4% to 1.6% in Wawa. In conclusion, although the project implementation time was short (7 months in Haho and 2 months in Blitta), the experience in treating infections of under-5 children such as coughs, diarrhoea and malaria and the provision of modern contraceptive methods (pill and injectable) by CHAs was very promising. This can help reverse current trends in respect of contraceptive prevalence in West and Central Africa. However, it must be recognized that it was important to apply the criteria for the selection of localities, to involve civil societies in the monitoring of CHAs and to ensure regular technical supervision.

It is recommended that community members could contribute effectively to achieving the Millennium Development Goals 4 and 5 in respect of child and maternal health although the necessary means will have to be provided. The following recommendations are addressed to field actors (NGOs and districts), development partners and the Ministry of Health:

1. involvement of sectors related to the health sector in sensitizing community leaders to project activities and to the selection of CHAs (administrative authority, religious leaders and NGOs)
2. clearly spell out CHA duties and responsibilities in their community and inform community leaders on the limits of CHAs
3. rigorously apply CHA selection criteria as stipulated in the normative documents and share them with community leaders during sensitization
4. Develop training aids and service provision tools for CHAs during training and immediately after.
5. immediately provide CHAs with working material soon after training in order to help them practicalize their training in the shortest possible time after training
6. Ensure that both local NGOs and health authorities of PCU, districts and the central government regularly monitor CHAs in their community. Apart from being a source of motivation for CHAs, this also clothes them with legitimacy in the eyes of the community
7. clearly establish drug distribution circuits for the management of diseases affecting under-5 children (diarrhoea, malaria and pneumonia)

Recommendations to development partners

8. Provide districts with the means to supply CHAs with initial stocks of drugs for the management of under-5 children illnesses (IMNCD-C products).
9. contribute to give the state contraceptive products taking needs into account so as to maintain the free distribution of these products within the community distribution process
10. Put in place an effective mechanism for monitoring the management of field actor resources.

Recommendations to the Ministry of Health

11. Develop, in collaboration with national governments, motivation criteria for various actors depending on their level of performance.
12. put in place a normative framework for community service providers and disseminate them at all levels

13. provide political and financial support for this initiative which aims to bridge the gap in the most remote areas
14. Develop a permanent consultative framework among the various actors in order to curb excesses.

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ACCRONYMS AND ABBREVIATIONS

ADESCO	Community Health Development Support
AFD	Agence Française de Développement
MIUA	Manual Intra-Uterine Aspiration
AM-LM	Artéméther/Luméfantrine
AS/SR	State of Reproductive Health Analysis
CHA	Community Health Agent
ATBEF	Togo Association of Family Well-being
AWARE II	Action for West Africa Region II (USAID project)
AfDB	African Development Bank
WB	World Bank
EGDPC	Essential and Generic Drugs PurCHAIing Centre
CBC	Communication for Behavioural Change
PH	Préfectoral Hospital (District Hospital)
CHR	Regional Hospital
CHU	Teaching Hospital
NOC	National Orthopedic (Fittings) Centre
CNLS	National AIDS Council
CBTC	National Blood Transfusion Centre
PNC	Post-Natal Consultation
ANC	Ante-Natal Consultation
TRC	Togo Red Cross
CSPRO	Census and Survey Processing system
ACT	Artemisinin-based Combination Therapy
IUD	Intra Uterine Device
FHD	Family Health Division
DFT	District Framework Team
TPHS	Togo Population and Health Survey
WCA	Women of Child-bearing Age
GF	Global Fund for HIV, Tuberculosis and Malaria
IMF	International Monetary Fund
HF	Health Facility
AMTL	Active management of Third-Phase of Labour
GM	Drug management
DH	District Hospital
IEC	Information, Education and Communication

INH	National Institute of Hygiene
ARI	Acute Respiratory Infections
STI	Sexually Transmitted Infections
PARM	Participative Action Research Method
EGD	Essential and Generic Drugs
ITN	Insecticide Treated Net
MICS 3	Multiple Indicators Cluster Survey 3
LRM	Least Risk Motherhood
MNCH	Maternal, Neonatal and Child Health
MSH	Management Sciences for Health
OCB	Primary Community Organisation
OCDI	Organisation for Charity and Total Development
WHO	World Health Organisation
MDG 4	Millennium Development Goal 4
NGO	Non- Governmental Organisation
IMCD	Integrated Management of Childhood Diseases
IMNCD	Integrated Management of Neonatal and Child Diseases
PF	Family Planning
NHDP	National Health Development Plan
NMCP	National Malaria Control Programme
NTCP	National Tuberculosis Control Programme
PMCT	Prevention of Mother- to-Child Transmission
PIDAR	Population Impact on Development Analysis Resource
PAC	Post-abortion Care
AIDS	Acquired Immuno- Deficiency Syndrome
MIH	Maternal and Child Health
MNICH	Maternal, Neonatal, Infant and Child Health
KMC	Kangaroo Mother Care
MNIH	Maternal, Neonatal and Infant Health
EONC	Emergency Obstetric and Neonatal Care
ECONC	Emergency Complete Obstetric and Neonatal Care
EBONC	Emergency Basic Obstetric and Neonatal Care
SPSS	Statistical Package for the Social Sciences
RH	Reproductive Health
O RS	Oral Rehydration Salt/Solution
RDT	Rapid Diagnostic Test
MCT	Mother-to-Child Transmission

IMR	Infant Mortality Rate
TMIJ = TM5	Infant and Child Mortality Rate or Under-five mortality Rate
EU	European Union
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
PCU	Peripheral Care Unit
HIV	Human Immunodeficiency Virus

INTRODUCTION

The Action for West Africa Region Project (AWARE II) is a three-year beacon project (July 2009-September 2012) of USAID West Africa seeking to introduce an innovative approach and holistic view of strengthening better family planning, maternal, neonatal and child health (MNCH) practices, as well as HIV and AIDS in 21 West and Central African countries. The AWARE II project is implemented by Management Sciences for Health (MSH) in collaboration with Engenderhealth and Futures Group. The strategic objective of AWARE II is aimed at creating a favourable environment to enable countries of the region plan and adopt a number of high impact health service interventions.

The programme comes to crown three years of activities which have contributed to the strengthening of the common vision upon which a district-approach to integrated and synergic service provision would considerably increase the expected impacts.

The AWARE II project service provision programme includes:

1. an integrated package providing best practices in family planning, maternal, neonatal and infant health, improvement of the political environment, capacity building in 4 project countries (Burkina Faso, Togo, Mauritania and Niger)
2. improved access and availability of reproductive health products through a supply chain and an effective management system in the 14 countries where USAID does not operate¹
3. Identify, engage and meet the needs of the populations which are most vulnerable to AIDS in the 21 countries² where there is proven need.

In Togo, the project was implemented in 2 health districts (Blitta and Haho) in collaboration with local NGOs. The Togo Association of Family Well-being was in Haho District while *Appui de developement de la Sante Communautaire* was in Blitta. The project reinforced the continued going from the community to health infrastructure with an integrated intervention package aspect of family planning, maternal, neonatal and infant health. This major action in favour of the community benefitted from a support policy and from targeted awareness creation activities to ensure the promulgation of necessary laws, regulations and protocol.

To demonstrate that the package of activities would yield clear, measurable and verifiable results, the AWARE project II conducted an initial evaluation between March and April 2011 in

¹ Burkina, Mauritania, Togo, Niger, Eq. Guinea, Gabon, Cameroun, Sao Tome, Sierra Leone, Chad, Gambia, Ivory Coast, Cape Verde, Guinea Bissau.

² The 15 ECOWAS countries plus Cameroun, Chad, Mauritania, Equatorial Guinea, Gabon and Sao Tome and Principe.

order to determine the level of the various project monitoring indicators. This evaluation was conducted in 2 pilot districts (Blitta and Haho) and in a third comparative district (i.e. Wawa).

At the end of the project, the same study was reproduced in the same district between April and May 2012. After processing the various data collected this report was written in order to help consign the results obtained. It articulates around the following principal points: the state of child health in Togo, the main actions undertaken by the project in these intervention areas, the research hypothesis, the objectives, research methodology, the analysis of data collected, difficulties encountered and the major findings. The main findings show a comparison of the initial situation, the situation as at the final evaluation and the degree.....

CONTEXTE GENERAL

1. TOGO – AN OVERVIEW

1.1 Geographic and administrative capital

Situated in West Africa on the Gulf of Guinea, Togo has a total land area of 56,600km² stretching 600km length-wise and between 50 and 150km breadth-wise. To the north, it shares borders with Burkina Faso, the Atlantic Ocean to the south, Benin to the East and Ghana to the West. The capital of Togo is Lome. Togo has 2 climatic zones, namely, an equatorial climate in the south of the country with 2 dry seasons and 2 rainy seasons, and a moist tropical climate over the northern half which has only one rainy season and 1 dry season.

Administratively, Togo is divided into 5 economic regions. These are from south to north, Maritime, the Plateau, Central, Kara and Savanne. The capital towns of the five economic regions are respectively Tsevie, Atakpame, Sokodie, Kara and Dapong. Each region is sub-divided in prefectures. Some regions have sub-prefectures. The last administrative reforms divided the regions into 35 prefectures and one sub-prefecture. However, this reform is yet to come into effect.

In terms of health, Togo is divided into 6 regions namely; Lome, Maritime, Plateau, Central, Kara and Savanne.

1.1.1 Demographic information³

The population of Togo stood at 6,191,155 at the end of 2010 with an average annual growth rate of 2.84%. Of this figure, 51.4% were women while men accounted for 48.6%. Most of the people (62.3%) live in rural areas. The percentage of the population under 15 years old was 42.0% while the sexually active population (15-49 years) accounted for 47.5%.

1.1.2 Economic information⁴

Togo is a low income country with an annual per-capita income of 330 US dollars in 2004. Per capita GNP was 190,067 F CFA in 2007. The Togolese economy is essentially agrarian although there is also the mining sector dominated by phosphate mining. Due to the fall in the price of raw material, the devaluation of the FCFA in 1994 without any accompanying measure as well as the structural adjustment programmes and the prolonged social and political crisis resulting in the suspension of international public and development aid (especially the EU, World Bank, IMF, ADB and USAID), the Togolese economy is in serious crisis with the following effects

- worsening of internal and external debt situation

³ Source : Rapport définitif du RGPH de décembre 2011

⁴ Source : Plan sectoriel de lutte contre le VIH/Sida du ministère de la Santé 2009-2013

- drastic fall in purchasing power
- impoverishment of the most vulnerable sections of the population especially women and children
- a high tendency, especially of young girls, to engage in risky sexual behaviour in order to survive

International financing mechanisms such as the HIPC Initiative provides Togo the opportunity to mobilise resources to strengthen the health sector.

1.2 Structure of the Health System

The health system in Togo is organised in a three-stage pyramid in line with the three-phase health development framework recommended by the WHO. These three levels are the peripheral or operational level, the intermediary or regional level and the central or national level.

1.2.1 The peripheral or operational level

The peripheral level consists of 31 health districts (prefecture) and their health infrastructure (prefectural health directorate or district health directorate, prefectural/district hospitals, peripheral care units and private care providers) and the basic communities. This level constitutes the operational ground for implementing of health intervention driven by policies and guidelines from the central level. It is responsible for implementing health interventions and for ensuring community participation. The peripheral level prioritises interaction among health system partners (public, private NGOs).

Its work is facilitated by a framework team which is in charge of planning and supervising the interventions whose capacity has to be enhanced within the framework of the “reach every district” approach. The peripheral structures, which are the first point of contact, ensure universal access to disease prevention and treatment services. At this level, relations are established with community service providers such as the CHAs.

NB: Blitta, Wawa and Haho Districts. The sites of the study belong to this level of the health pyramid

1.2.2 The Intermediary or Regional Level

The intermediary level consists of 6 health regions, each of which has a regional health directorate together with its related units, a regional hospital and region-wide private care providers. It is the responsibility of the regional level to support, monitor and evaluate the operational level in terms of national health policy guidelines implementation. The existence of a decentralised structure responsible for monitoring and evaluating operational activities, decentralised organs, especially the regional framework teams, the regional therapeutic

committees and regional referral structures (regional hospitals) constitute a springboard for providing technical support to the district in respect of national health strategies implementation

1.2.3 The Central or National Level

The central level consists of the Ministry, the public health general directorate and its central directorate divisions and units as well as national interest structures (CHG, INH, CNAO, CNPS and Health Training Schools). The central level also comprises nation-wide private service providers. It is responsible for defining and monitoring the implementation of the broad policy guidelines in respect of health. It sets the norms and standards in respect of health development and ensures coordination of health action nation-wide while controlling all health interventions. It has over-sight responsibility for defining and applying national health strategies in general.

2. OVERALL STATE OF MATERNAL, NEONATAL AND CHILD HEALTH

2.1 Neonatal and Infant health

In the current context, achieving child health objectives is in line with the attainment of the millennium development objective 4. It would be recalled that MDG 4 aims at reducing infant mortality among under-five children by two thirds between 1990 and 2015. According the third MDG monitoring report on Togo, reduction in mortality rates especially infant and infant-child mortality rates is a pre-requisite for harmonious population growth and for human resource which is indispensable to national economic growth.

The findings of various studies conducted in Togo since 1961 have shown a high rate of child and infant-child mortality. A comparison of the 2010 MICS 4 and MICS 3-2006 data (representing the mortality rate of 2001), shows that there has been no improvement in the infant and infant-child mortality rates, which were respectively 77 and 123 per thousand.

Disparities exist between settlement areas with a higher probability of a baby dying in rural areas (83% as against 66% in urban areas). The same trend pertains to under-five children (133% as against 102%)

The infant and child mortality rate has fallen a lot faster than the infant mortality rather although a lot more needs to be done in order to meet MDG targets. Infant and child mortality rate data shows that by 2015, all things being equal, the current rates will be higher than expected. Togo must therefore make more effort in order to meet these targets by 2015. In respect of infant mortality rates, available information shows that the reversal of trends which was necessary in 2005 in order to attain the MDGs has not been actualised. Togo is therefore on the path of extremely infant mortality rates as compared to MDG targets if nothing is done in respect of this indicator. Regarding neonatal mortality, the rate is estimated at 42% according to the 1998 EDST. Although there is no recent data, the Emergency Obstetric and Neonatal Care survey

conducted in 2006 showed an early neonatal fatality rate of 12.6%, the still-birth rate of 19% and peri-natal mortality rate of 31%.

Children die from several diseases. Prevention, especially through vaccination, plays an important role in eradicating certain diseases in under-five children. The government has embarked on several nation-wide vaccination campaigns. These actions have significantly reduced child morbidity and mortality (linked to diseases targeted by the extended vaccination programme).

The achievement of MDG4 objectives would have required a child and infant-child mortality rate of about 87.4% since 2006 instead of 123% in 2010 in order to meet the 2015 target. It is therefore necessary to accelerate the fight against infant mortality by strengthening the achievements of previous actions in the area and by full implementation of actions captured in the national health development plan including the integrated management of child and neonatal diseases with particular emphasis on the community level.

2.2. Maternal Health

Like neonatal and infant health, maternal health aims at achieving MDG 5 whose targets are the following:

- a. reduce maternal mortality rates by three quarters between 1990 and 2015
- b. provide universal access to reproductive health by 2015

Nationwide, maternal mortality rate is still far from the 120 per 100,000 birth threshold expected in 2015. Although the current rate is unknown, the 1998 Togo Population and Health Survey showed a rate of 478 death per 100,000 births. The percentage of births assisted by qualified health personnel, which was 49% in 1998⁵, increased by only 1% between 2005⁶ and 2006⁷ (respectively 61% and 62%);. The proportion of mothers who had prenatal consultations reduced slightly, from 83.8% in 2006 to 72% in 2010. Modern contraceptive methods coverage which stood at 11% in 2006 rose to 13.2% in 2010. (*Source: 1998 Togo Population and Health Survey, MICS 3 and 4, Ministry of Health 2006 and AS/AR 2003*). This figure is lower in rural areas (11.8%) as compared to urban areas (15.4%). Nationwide, un-met contraceptive needs are estimated at 31.0%, of which 30.8% are in rural areas and 31.4% in urban areas in 2010.

⁵ EDST 1998

⁶Analyse de la situation de la SR au Togo

⁷ EDST 1998

The fight against maternal mortality hinges on access to health services. However, major regional disparities exist in Togo in terms of access to primary health services, particularly prenatal consultations and births assisted by qualified health personnel. Lome residents have greater access to health centres with over 84% of them living less than three kilometres from the nearest health centre. In the Savanne Region, this proportion is 45%.

Access to health services may be considered a determining factor for birth assisted by qualified health personnel. According to MICS 3 and 4 reports, the number of women who gave birth in a health institution increased by about one point between 2006 and 2010⁸ (60% as against 67.0%). Pre-natal care coverage is higher in urban areas than the rural areas (76% in 2006 as against 59.9% in 2010). However, , progress made in terms of births assisted by qualified health personnel is still modest.

With a 1% progress in the rate of births assisted by health personnel within a period of three years (between 2003 and 2006), the 100% target in 2015 may not be attained if significant steps are not taken to improve this rate which stood at only 60.1% in 2010

2.3- MATERNAL AND CHILD HEALTH INTERVENTIONS

2.3.1- General interventions for reducing infant and infant-child mortality: IMNCD

Reducing child mortality and morbidity have always been a major concern to the Togolese government. As early as the 1990s, a “child survival” project was initiated **with** financial and technical support of USAID. This project involved the fight against malaria, diarrhoea and malnutrition in under-five children. In 1996, Togo adopted the childhood diseases integrated management programme as an appropriate care strategy for children. Training modules were crafted based on a WHO generic and provided training and work documents which helped improve the skills of health agents. Starting 2007, a neonatal management aspect was introduced into this program which then became known as the IMNCD. This approach was three-pronged, namely, a clinical aspect which was provided by PCU health service providers., a community aspect which was implemented by households and the community through the CHAs known as community IMNCD and lastly, the health system.

There are high-impact interventions targeted at the maternal, neonatal, child and infant-child mortality reduction. These are a package of activities defined on the basis of recognised and scientifically proven international observations which must be implemented in their preventive, curative and promotional phase, both in the community and at the health centres. IMNCD takes incorporates most of these high-impact interventions.

2.3.1.1 The fight against malaria

⁸ MICS 4

The fight against malaria is enhanced through community-based service networks responsible for distributing insecticide treated nets. The proportion of under-five children sleeping under treated nets stood at 38.4% (MICS 3). Between 2003 and 2009, there was a positive trend in terms of the proportion of households with insecticide treated nets, that of children sleeping under treated mosquito nets, and under-five mortality rates linked to malaria (Table 1).

Table 1 : Trends of major prevention indicators in under-five children from 1990 to 2010

Indicators	MICS I 1990	MICS II 2000	MICS III 2006	MICS IV 2010
% of households with at least one insecticide treated mosquito net	Unknown	Unknown	40	56,4
% of under-five sleeping under insecticide treated mosquito net	Unknown	18	38	56,9
Under-five mortality rate	141‰	143‰	123‰	123‰

2.3.1.2 Appropriate home care

This category of IMNCD aims at enhancing skills in home the management of childhood diseases. It includes feeding of sick children, appropriate early home treatment of diseases (malaria, pneumonia, diarrhoea, etc), injury and accident prevention measures, child abuse and neglect prevention and the participation of men in child care.

The correct home use of antibiotics for pneumonia treatment, the use of ACT for malarial treatment and oral ORS associated with Zinc in treating diarrhoea are all proven high-impact interventions for reducing infant mortality. Oral rehydration therapy with oral rehydration salt, (the former high osmolarity formular) was widely administered in all health centres at all levels of the pyramid. For example, according to the 2006 MICS 3 report, the use of oral rehydration therapy stood at twenty one percent and increased to 23.5% in the 2010 MICS 4.

Since 2007, in the framework of the community IMNCD implementation, and according to the new recommendations, diarrhoea has been managed with the new low-osmolarity ORS formula and Zinc. Although this practice has been tested in communities in ten districts, it has not been sufficiently implemented in health facilities due to lack of training or information.

2.3.1.3 Seeking care outside households

This section empowers the community to identify signs of serious illnesses and to refer children to health facilities. The quality of care provided in the health facilities is a testimony of the continuous improvement in the skills of health agents in terms of the correct management of child and neonatal diseases.

Clinical management of malaria, diarrhoea and severe malnutrition in health facilities have proven have concrete impact on infant-child mortality reduction.

2.3.1.4 Maternal and neonatal care

This section provides families with the capacity to help every woman take advantage of adequate antenatal care while at the same time being monitored for danger signs during child-birth and the post-partum period,. It also ensures that every new-born receives adequate care.

In order to reduce neonatal mortality rate significantly, it is necessary to implement the following activities:

- post-partum care of new-born babies
- kangaroo mother care (KMC)
- neonatal emergency management
- promotion of instant care for ailing new-born babies

2.3.2 Maternal health general interventions

The government has always developed maternal and child health care activities in its desire to reduce maternal and neonatal mortality. In order to assess the efforts made, several studies have been conducted with the view to measure maternal and neonatal mortality. Each time, these studies have enabled the readjustment of strategies to reduce maternal and neonatal mortality rates.

2.3.2.1 Births assisted by qualified personnel

Births assisted by qualified personnel are key to the reduction of maternal mortality. Even with proper antenatal consultation, most maternal deaths occur as a result of obstetrical complications. The strategy for improving the quality of assisted birth hinges on the use of the partogram, the active management of third phase labour and a review of maternal deaths. In Togo, the proportion of assisted births in 2009 was 62% (MICS 3). This figure is low as compared to the targeted ANC coverage of 82%⁹.

The partogram is an indispensable tool for monitoring women in labour, detecting anomalies and timely decision making. It is estimated that 23% of service providers have been trained in the use of this tool. According to a service provider's monitoring programme conducted by FHD in

⁹ 2009 Family Health Division Report

2007, there has been a break from the WHO modified partograms, owing to lack of rigour in partogram processing.

2.3.2.2 Emergency obstetric and neonatal care

Emergency obstetric and neonatal care includes a set of interventions capable of ensuring not only the survival of women during pregnancy and delivery, but also the survival of the healthy new-born baby. This includes post-abortion care, partogram use, active management of third-phase of child delivery, ventouse obstetrics application and management of birth-related complications.

2.3.2.3 Post-abortion care

Post-abortion care through the practice of manual intra-uterine aspiration was introduced in Togo in 2006. It was taught to service providers drawn from 28 public facilities, mostly teaching hospitals, regional hospitals and district hospitals. Five private facilities provide this service in Lome, Sokode and Kara.

2.3.2.4. Active management of third-phase of child birth

It seeks to prevent haemorrhage during child delivery. It comprises three basic actions:

- oxytocin injection after the expulsion of the baby
- umbilical cord controlled traction
- uterus massage

2.3.2.5- Managing birth-related complications

This form of management is done through emergency basic obstetric and neonatal care or emergency complete obstetric and neonatal care health services. In Togo, emergency obstetric and neonatal care regulations are flouted. According to data from the 2006 Emergency Obstetric and Neonatal Care Survey, there was poor quality and inadequate numbers of emergency obstetrics and neonatal care structures (0.18 emergency basic obstetric and neonatal care as against 4 recommended by WHO for 500,000 people). However, availability of complete emergency obstetric and neonatal care is 0.9 as against 1 for 500, 000 people. Inadequate care is the result of inadequate funding and shortage of qualified human resource base.

Post-partum haemorrhage constitutes the first cause of maternal death (2006 Emergency Obstetric and Neonatal Care Survey). However, infrastructure for harvesting and storing fresh blood and blood derivatives are inadequate and so there is always a shortage of blood products.

Caesarean sections help reduce maternal mortality in case of dystocic delivery. However, it is geographically and financially inaccessible to most people. The rate of caesarean sections is

1.6% (emergency obstetric and neonatal care survey). Efforts are being made to subsidize the management of major delivery-related complications.

The inability to recognize pregnancy and birth related danger signs is a contributing factor to maternal and neonatal deaths. A care continued system has also been initiated in the low risk motherhood and emergency obstetric and neonatal care programme (**LRM** and emergency obstetric and neonatal care). This strategy requires the intervention of CHAs.

2.3.2.6- Provision of Family Planning Services

National Reproductive Health Policy allows the use all contraceptive methods. Between 2000 and 2010, it is estimated that 386 service providers trained in basic contraceptive technology (pill, injectable and barrier method). The number of persons trained in IUD insertion and retrieval is 468 and 458 for the insertion and retrieval of sub-cutaneous implants. Modern contraceptive method prevalence rate rose from 3.1% in 1998 (EDST 1) to 11% in 2006 (MICS 3) and 13.2 in 2010 (MICS 4).

3- EXECUTION OF USAID AWARE II PROJECT IN THE 2 DISTRICTS

Over the last three years, Togo has benefitted from several interventions within the framework of the USAID AWARE II project, all of which have high impact in the fight against maternal infant mortality. Although the thrust of the project was on community-based activities undertaken by the CHA, health facilities were also strengthened.

3.1- Strengthening of Health Institutions

Service providers of the two project beneficiary districts were trained in various areas such as emergency obstetric and neonatal care (EONC), integrated management of neonatal and childhood diseases (IMNCD) as well as supervision.

3.1.1- Emergency Obstetric and Neonatal Care (EONC)

After adapting the generic guide to the Togolese context, 16 people from the two districts (Haho and Blitta) were trained as emergency obstetric and neonatal care (SONU) trainers. With the support of national trainers, these district trainers trained heads of peripheral care units and mid-wives. A total of 55 people were trained for Haho District and 40 for Blitta. Key elements of this training were:

- active management of third-phase of labour
- treatment of eclampsia with magnesium sulphate
- resuscitation of the new-born

- care of babies born under-weight i.e kangaroo mother care practices (KMC)

3.1.2- Integrated Management of Neonatal and Infant Diseases (IMNID)

In this framework too, heads of health institutions in the two districts including some members of framework teams underwent a training of trainers with a total of 26 trainers for Haho and 21 for Blitta, who subsequently trained and supervised the CHAs.

3.1.3- Community Training in Family Planning Techniques

In the area of community family planning, mid-wives and birth attendants of the two districts were also trained as trainers in association with district, regional and NGO framework teams. A total of 44 people were trained: 24 for Blitta District and 20 for that of Haho.

3.1.4- Training in Facilitating Supervision Techniques

The aim of facilitating supervision techniques training is to strengthen the capacity of peripheral care unit heads in CHAs training and supervision. The training catered for agents of the two partner NGOs. Thus, 25 people were trained in Haho District and 29 in Blitta.

3.1.5- Other forms of Health Sector Support

During the two preliminary years of implementation, the project supported the national fight against AIDS and STDs within the framework of mother-to-child transmission (MCT) prevention programme. The first strategic plan was evaluated and another was drawn up for 2011-2015. In collaboration with the National AIDS Council (CNLS), advocacy documents (AIM) were prepared nation-wide and particularly for religious groups. These documents were distributed in the two intervention districts.

With regard to reproductive health, advocacy documents (Population Impact on Development Analysis Resource) were also drawn up and distributed nation-wide and in the two districts (Blitta and Haho).

3.2- Major Project Activities at the Community Level

At the community level, activities of the project mostly consisted of the integrated family planning package implementation, integrated management of neonatal and infant diseases, maternal health and the fight against HIV/AIDS infection in Haho and Blitta Districts. Activities kicked off in Haho and Blitta in October 2011 and January 2012 respectively. The main partner NGOs were the Togo Association of Family Well-being (ATBEF) in Haho and the Community Health Development Support (ADESCO) in Blitta. This implementation centred mostly on sensitization of community leaders, election of CHAs by the people, training of CHAs, official launch, CHAs certification and monitoring of CHAs activities.

In the area of family planning, CHAs were introduced to modern contraception initial administration methods such as the pill and injectable. In terms of integrated management of neonatal and infant diseases - (IMNCD-C), they were responsible for the three childhood “killer” diseases – fever, diarrhoea and pneumonia.

In order to cater for villages with 500 or more inhabitants situated over 5km from a primary health unit, the project trained 250 CHAs in Haho and 182 in Blitta. The table below shows the number of women and children who benefitted from CHAs services in the two districts and the quantity of products distributed.

Table 2 : Number of project villages, CHAs and clients served by CHAs in the two districts

Indicators	Health Districts		Total
	Haho ¹⁰	Blitta ¹¹	
Number of project villages	86	70	156
Number of CHAs agents trained by the project	250	182	432
Number of new clients given oral contraception by CHAs during the project	1195	287	1482
Number of new clients given injectable contraceptives by CHAs during the project	4994	1591	6585
Number of under-five children treated for malaria by CHAs with CAT during the project	1362	960	2322
Number of under-five children treated for diarrhoea by CHAs with ORS during the project	1282	641	1923
Number of under-five children treated for pneumonia by CHAs with antibiotics during the project	1284	122	1406
Number of children born under-weight monitored by the CHAs using the kangaroo mother care method (KMC)	22	0	22

¹⁰ Implementation period considered in this report is 7 months (October 2011 to April 2012)

¹¹ Implementation period considered in this report is 2 months (March and April 2012)

Table 3 : Quantity of products distributed by CHA within the project framework by district and by type of product including contraceptive products CYP

Indicators	Health Districts		Total	CYP
	Haho	Blitta		
Number of oral contraceptive strips distributed by CHAs	2 272	392	2 664	178
Number of bottles of injectable contraceptives distributed by CHAs	8 353	1 787	10 140	2 535
Quantity of condoms distributed by CHAs	51 907	119 446	171 353	1 422
Quantity female condoms distributed by CHAs	390	123	513	-
Quantity of antibiotics distributed by CHAs	26 419	191	26 610	
Quantity of ACT packets distributed by CHAs	4 311	1 211	5 522	
Quantity of ORS sachets distributed by CHAs	2 634	1 064	3 698	
Quantity of Zinc tablets distributed by CHAs	00	632	632	
Total				4 135

**FINAL INTERNAL EVALUATION
METHODOLOGY**

4. EVALUATION METHODOLOGY

Interventions implemented by the USAID AWARE II project in Blitta and Haho district for which this internal evaluation provides end-of-project indicators are based on the following hypothesis: *“Given adequate political and technical support from health infrastructure and from communities, community health agents are able to provide a set of services in sufficient quantity and acceptable quality to significantly increase health coverage of target populations in rural West Africa”*.

4.1 Objectives

The final internal evaluation of USAID West Africa AWARE II project had two sets of objectives, namely the general objective and specific objectives

4.2 General Objective

The evaluation seeks to determine the final level of project performance indicators for family planning and maternal, neonatal and infant health, including the performances of pharmaceutical products supply chain for family planning and maternal and infant health in the AWARE II project pilot zone (Blitta and Haho) and the comparative zone of Wawa in Togo.

4.3 Specific Objectives

The specific objectives of the project are:

1. To determine the capacity of CHAs to :
 - a. make initial oral and injectable contraceptive prescriptions
 - b. properly identify and treat malaria, diarrhoea and acute respiratory infections
 - c. give adequate advice about child-birth spacing
 - d. demonstrate the kangaroo mother care method in the districts
2. To determine the level of knowledge of women of child-bearing age in terms of the ideal birth interval and its benefits for pregnancy spacing and also the danger signs for mothers and neonates
3. To determine the extent to which women of child bearing age use family planning methods at home and at health and community centres
4. To determine under-five children access to treatment for malaria, diarrhoea, ARI at home and at health and community centres

5. To determine the performances of performances of pharmaceutical products supply chain for family planning and maternal and infant health in the four target countries
 6. To make appropriate recommendations
- 5. methodology of the finale survey**

5.1. Implementation framework

The finale intervention in the USAID AWARE project intervention districts was conducted in partnership with the Ministry of Health and specifically with the Family Health Division of Togo. The entire process involved three main actors:

- Health Ministry which, by its position of principal beneficiary, is the supervising authority and head of the entire appropriation process with the view to scaling
- Survey technical and financial partners: the AWARE II project mobilises the expertise required to support the Health Ministry in respect of processes agreed upon by all. It also assumes technical responsibility for the process. USAID West Africa is the financier of the project
- The local technical team ensures the technical aspect of the finale evaluation process. The team is made up of the USAID AWARE II project consultant and his team.

5.2. Administrative preparation, ethical considerations, information and sensitisation

Within the framework of this evaluation, the process below was put in place with the view to ensure efficient implementation:

- an introduction letter signed by the Health Ministry was sent to administrative and local authorities of the selected areas informing them and soliciting their cooperation and support in respect of the project implementation
- Informed and voluntary consent was obtained from each survey participant
- Sensitisation of sample-villages was done through resource persons of partner NGOs and CHAs in Blitta and Haho Districts. However, in the comparative district of Wawa, peripheral care unit officials and traditional channels especially village chiefs spearheaded the sensitisation campaign.

5.3- Sampling

5.3.1- Survey area

The survey area comprises the two health districts of Blitta and Haho which constitute the area of intervention as well as the health district of Wawa which was the comparative district during the first evaluation. In all three districts, the area of intervention was within 5 kilometres or more of

a health facility and has a population of at least 500. Sample villages were identical to those of the initial study conducted between March and April 2011

5.3.2- Targets

Three population categories were studied in the target villages, namely, Community Health Agents (CHAs), women of childbearing age (WCA) and officials of health facilities catering for the selected villages.

5.3.3- Sampling frame

5.3.3.1- Surveying CHA and health facilities

The evaluation team was meticulous in surveying the CHAs. CHAs are men and women identified by the community and trained by the districts who conduct various health activities in the community. All CHAs from selected villages in a given health district were surveyed. Health facilities were also deeply involved in the survey. On the one hand, all district hospitals and all health structures (including drug depots) serving selected villages in a particular district were systematically sampled. Respondents were either health facility officials or their well-informed representatives.

5.3.3.2- Surveying households

In all, the survey sampled 1200 ordinary households (400 in each district) which were typical of the three health districts under evaluation

The sampling frame comprised the list of all villages located 5 kilometres or more from a health facility (medico-social centres, dispensaries, hospitals) with a population of at least 500. A long list of villages was compiled for each district which showed the size of the village in population terms, number of households, distance from the nearest health facility, the number of CHA and the adjoining health facility.

5.3.3.2.1- selection of Households

In order to have stable indicators up to the district health level, a representative sample of 20 clusters per district were proposed, with 20 households per cluster, from which 400 households were interviewed.

The selection procedure included the following: 2-degree stratified, areolar draw. The basic survey unit also known as cluster was the village or part of the village if the village is large. The first degree sample was taken independently in each health district while the second degree sample was also taken in each basic unit drawn in the first degree.

In the first degree survey, 60 clusters were selected, 20 clusters per district in a systematic draw with probability proportional to size. The size of the village was the number of households or persons.

During data collection, all compounds were listed and households identified by compounds. Only one household was randomly drawn in each compound. Members of the selected household were identified through household questionnaire and every woman aged between 15 and 49 in the household was also interviewed with an individual woman questionnaire.

The main respondents to the household questionnaire was the household head or any other person authorised by him. Every adult person who is a member of the household can be a respondent or provide additional information during the filling of the household questionnaire. Information provided in the household questionnaire basically helped eligible women to be interviewed individually. Only eligible women aged 15-49 were qualified to respond to the individual woman questionnaire. This questionnaire comprises a cover page similar to that of the household questionnaire and carries household information, the results of the interview which helped calculate survey coverage rate, field and office control as well as seven sections for recording information on the following topics:

- socio-demographic characteristics
- number of children and birth background limited to the previous five years
- knowledge and use of contraceptive methods
- assisted delivery and place of delivery
- fever in under-five children in the two preceding weeks and treatment
- coughs in under-five children in the preceding two weeks and home treatment sought outside.
- Diarrhoea in under –five children in the two preceding risks and problems
- Current marital status
- Fertility properties

CHA questionnaire elicited the following information

- Skills acquired,
- CHAs child survival activity
- Women’s health activity
- Contraceptive methods provided

Health facility Questionnaire elicited the following information

- Available staff
- *Services provided by the facility*
- *Collaboration with CHAs*
- *Data collected by CHAs*
- *Products supply chain*
- *Risk of shortage*

Generic Drug depot questionnaire

- Available drugs
- Product shortage over the last three months
- Cause of shortage

The five questionnaires came with manuals or guide which recalled study concepts and definitions, objectives, summary of the methodology, mode of contacting authorities and households, the way questions were asked and the way answers were recorded and the manner of checking information provided. Field working conditions were also consigned (group life, discipline, management and distribution of work). This document served not only as a teaching aid during the training, but also as field reference document for field investigators as well as a useful data analysis source. Other documents were also drawn up for technical management (performance/progress of each collecting personnel, work distribution, pace of work, management of team material and logistic resources). Each of these questionnaires was nearly entirely pre-coded, a fact which facilitated administration and processing. Some questions and modalities marked as “OTHERS” were left open.

5.4.1 Validation of data collection aids

The process of finalising and validation went through the following stages:

- The standard versions used during the 2011 initial validation
- Version 1 updated to accommodate issues arising out of project implementation and validated by the USAID AWARE II project office for the pilot survey (version 2)
- Version 2 updated during the training and pre-test by the country consultant and approved and validated by the USAID AWARE II project office for the main survey training (Version 3-final version)

5.4.2 Data Collection Aids Pre-test Methodology

In spite of the remarkable similarity between these questionnaires and those approved for other surveys, it was necessary to test the underlying aids and concepts in order to ensure that questions are relevant, well put, well understood and well answered.

In this evaluation, the pre-test which was light was made in villages outside the sample area but very similar to sample villages. It was done while collection agents were being trained.

The areas earmarked for questionnaire pre-testing were identified early enough and residents informed through health facility officials, NGO resource persons and CHAs. Based on the lessons learned, the aids were updated. Some methodological readjustments were made in terms of the pace of household selection. The resulting aid versions were used in the main data collection exercise.

5.4.3 Translation of questionnaires

Given that most investigators did not speak local languages, the field collection aids were translated into French. However, during the training sessions, local languages (Ewe, Mina, Kotokoli, Kabye, Losso, Ouatchi, Agnangua, Adja and Fon) were the preferred languages for familiarizing the collection agents with the appropriate wording of each question.

5.5 Collection Agents Recruitment and Training Approach

For every health district in the intervention zone, two five-man teams were recruited. Of the five people, four were collection agents (at least three of whom were women responsible for surveying households) and one was team leader.

Given the sensitive nature and the target-specificity of the survey, the professionalism of field personnel was key to the success of the operation. Thus preference was given to agents who participated in the 2011 initial survey. Thus a four-day training program proved to be adequate. In all, 23 people were trained out of which 20 were sent to the field while 3 stayed in the office to check the filled questionnaires. The training, which was organised in Notse, was administered by members of the oversight team (namely the country consultant, the assistant consultant and the head of the Family Health Division).

Although the field questionnaires were in French, the training was conducted in the major local languages (Akposso, Ewe, Mina, Kotokoli, Kabye, Losso, Ouatchi, Agnagua, Adja and Fon) to acquaint agents with the proper wording of questions. The capacity of agents to execute this task, which was very important for household surveys, informed their final selection and assignment to the field. Team leaders received enhanced training before and during that of collection agents in order to master the survey methodology and their responsibilities.

At the end of the training, the 20 agents (4 team leaders and 16 female investigators) selected for field work¹² were put into four teams of 5 field agents. The team leader was responsible for ensuring the quality of the work and the administrative and logistic management of the team. Collection agents were tasked with surveying households and individual women. In addition to their quality control and management tasks, team leaders were exclusively tasked with surveying health facilities and CHA.

5.6- Data collection methodology

5.6.1- Survey duration

Data collection lasted 18 days. This period allowed agents to better understand targets, rectify any errors on the field and have the time to sharpen their skills for collecting quality data.

5.6.2- Field and mobile teams

Data collection agents were put in 4 teams comprising 4 female investigators and 1 team leader. Factors that informed the composition of the teams were languages spoken by members and knowledge of site among others.

¹² *The best among the last 3 were put on a waiting list in case of withdrawal or resignation.*

Two teams were dispatched to each health district of the intervention area (Blitta/Haho). Villages, health facilities, essential and generic drugs depots and CHAs in the intervention areas were assigned to the teams. However, given that the exercise required team work, all teams were mandated to cover the entire sample, working hand in hand if necessary.

Within the team, tasks were assigned by the leader on a daily basis with the help duty description forms. Duty description forms were filled based on the household identification forms. At the beginning of activities, a deployment plan was drawn up. Understandably, this plan was modified in consultation with management to suit the realities on the ground.

5.6.3- Quality control within the team

Questionnaires filled by team members were checked and corrected by team leaders. Interviews were checked by team members with each investigator and working sessions were frequently organised with all team members with the view to strengthen the training received and to correct all data collection errors.

5.6.4- Transfer of files to the survey central office

Transfer of completed dossiers to the central office to feed personnel responsible for questionnaire data processing was done by supervisory missions. The first supervisory mission, which was undertaken between April 24 and 27 2012, helped return dossiers of fifteen (15) clusters, that is 5 clusters of three teams. A second field visit was made on May 4 which allowed the consultant to discuss the modalities for transferring teams to the controlling district and for returning the dossiers from the last clusters of the intervention area to the central office in Lome.

5.6.5- Logistics and security of field personnel

The proper implementation of this investigation required adequate security and logistic means in order to better master the overall timeline and ensure strict compliance with quality standards. To this end, each team was given a vehicle to facilitate movement. For villages with unmotorable roads, motorcycles were used.

Still on the subject of the security of field agents, insurance cover was provided during the entire period of their field work. All equipment, supplies, logistics and communication means, working documents (cluster dossiers, questionnaires, manuals, technical and management fiches, etc) necessary for the proper rollout of the work were provided.

Every team was given a vehicle together with a driver and fuel while provision was also made for telephone bills. Besides, to facilitate work organisation (working hours, control and verification) and strengthen team spirit, some PCU officials contributed to help personnel eat and sleep together. Others were provided with funds for accommodation.

5.6.6- Team administrative dossier

At the time of going to the field, agents were given administrative dossiers which included a travel order issued by the Consultant, a letter of introduction from the Ministry of Health and all correspondence exchanged with the view to informing and sensitising target populations and authorities.

5.6.7- Methodology for data verification and investigator performance control

Given that the quality of the survey was largely determined on the ground, steps were taken to ensure very strict control during the entire period of data collection. Thus, each team had a leader who ensured quality control. Additionally, team spirit ensured that all team members worked regularly with team leaders to cross-check data

Given that the limited time allotted for field survey hindered supervisory visits, permanent contact was maintained between the central office and field personnel in order to obtain premium quality data. Regular telephone conferences were held entre office supervisors and field personnel.

All measures were taken to ensure that interviews were conducted in languages perfectly spoken by both the interviewer and the interviewee. In some exceptional cases, interpreters were called in to facilitate communication.

5.7-Voluntary consent and Confidentiality of responses

5.7.1- Confidentiality

Information collected is confidential and shall not be disclosed for any reason (the statistics secrecy law). Several formal and practical measures were put in place to guarantee confidentiality.

- formally :
 - Every questionnaire was conspicuously labelled ‘‘STRICTLY CONFIDENTIAL’’. This instruction was complied with.
 - also, during training, collection agents were informed and sensitised on the confidential nature of survey statistics ;
 - at the end of the training, each collection agent had to sign a confidentiality charter in order to be definitely recruited into the survey team
- practically :
 - during the field survey, only team members could comment interview responses, and this, away from all unauthorised persons
 - The « number of blank questionnaires received = number of (filled or blank) questionnaires returned » rule applied during the field survey. This means that it was forbidden to lose, destroy or discard any questionnaire, whether filled or blank
 - access to the data processing units was strictly controlled ;
 - names of respondents were omitted in the course of data processing;
 - at the end of data processing all questionnaires and other filled documents were archived
 - in the course of data analysis, all survey results were aggregated. It is therefore impossible to trace any response to any particular person

5.7.2- Informed consent

One of the roles of the collection agent was to clearly explain to the interviewee the purpose of the survey while allowing him the right to participate in the survey or not. The informed consent document appears on the first page of every questionnaire.

5.8- Data processing

Based on pre-test questionnaires Cs Pro data entry frames and verification programmes were designed by the statistician recruited by project consultant in Togo. The latter worked in synergy with the programme designer to update the frames as and when aids wrap-up activities unfolded. Data entry operatives and editors were recruited and trained for a day. The questionnaires were filled and checked, packaged and sent to the central office where they underwent the following processes:

- another thorough check
- the sampling procedure was checked for proper application
- quality and coding check
- filing and recording
- conveyed to the entry office

In relation to open questions and some “other” responses, they were entered alphabetically and recoded following analysis of frequencies after entry and before the final addition of data.

An entire organisation was put in for data entry, verification and archiving. The integral double entry method was applied for all questionnaires (households and women). Editing of data (removal and correction of error messages) was done simultaneously with entry.

Computer processing (entry and purging) was done with Cs Pro). This task was done by a team of three-man operators over a period of four weeks and an editor under the responsibility of a supervisor who is in charge of the entry.

Data editing consisted of checks in terms of plausibility, external and internal coherence. All errors detected during editing were corrected with reference to field questionnaires. An editor was recruited and assigned to this task. After all errors were corrected and data analysed using SPSS and STATA

5.8.1 Organisation and archiving of documentation

All documentation on the survey (questionnaires, guides and manuals, databases, reports, etc.) were organised and archived on CDROM and handed over to AWARE II

5.9. Chronogram of Activities

Survey activities were conducted over a period of about two months from April to May 2012.

Analysis of Data the Collection

Field data collection lasted for three weeks i.e. two weeks in the intervention area with two teams for each district and one week in the comparison zone where four teams work together. Table 4 and 5 show the quantitative characteristics of data collected.

Table 4 : Number of households and women selected, identified and interviewed and response rate by area for Blitta, Haho and Wawa districts, 2012

Survey	Blitta intervention Zone	Haho intervention Zone	Wawa comparison Zone
Household survey			
Number of households selected	400	400	400
Number of households identified	517	453	504
Number of households interviewed	400	400	400
Rate of household response ¹ (%)	77,3	88,3	79,3
Individual Woman Survey			
Number of eligible women	485	459	456
Number of eligible women interviewed	459	442	441
Response rate of eligible women interviewed ² (%)	94,6	96,2	96,7
Health Facilities Survey			
Number of health facilities identified	11	12	07
Number of health facilities surveyed	11	12	07
Response rate of health facilities ³ (%)	100	100	100
Drug management survey			
Number of depots/drug management centres identified	11	12	07
Number of depots/drug management centres surveyed	11	12	07
Response rate of depots/drug management centres ⁴ (%)	100	100	100
CHA Survey			
Number of CHAs identified	46	62	15
Number of CHAs interviewed	43	54	13
Response rate of CHAs ⁵ (%)	93,4	87,0	86,6
Notes :	1. Relationship between "number of households interviewed" and "number of households identified" 2. Relationship between "number of women interviewed" and "number of eligible women" 3. Relationship between "number of health facilities surveyed" and "number of eligible women" 4. Relationship between " depots/drug management centres surveyed" and "number of depots/drug management centres identified" 5. Relationship between "number of CHAs interviewed" and "number of CHAs identified"		

Table 5 : Field Survey Results Quantitative Analysis by Questionnaires

Type of questionnaire	Percentage							
	Refusal	Long absence	Partially filled	Incapacitated	Travelled	Filled	Total	Num
Household Questionnaire	0,0	0,0	0,0	0,0	0,0	100,0	100,0	120
Women Questionnaire	0,5	0,0	0,1	0,4	3,9	95,1	100,0	141
CHA Questionnaire	0,0	0,0	0,0	0,0	0,0	100,0	100,0	116
DM Questionnaire	0,0	0,0	0,0	0,0	0,0	100,0	100,0	29
HF Questionnaires	0,0	0,0	0,0	0,0	0,0	100,0	100,0	30

6.1. Strong points

The final internal evaluation of the USA AWARE II family planning, maternal, neonatal and infant health intervention project was easier to prepare because initial evaluation questionnaire were already available and samples were known. The majority of data collection agents already had experience.. The evaluation was favorably welcomed in the three districts./ District officials, those of the peripheral care units and agents of partner NGOs contributed effectively in sensitizing target communities. Wherever the collection agents went, whether in the health facilities or in the communities, they were warmly received. Collaboration with CHA, village chiefs and community leaders was perfect. Women who participated in the study displayed perfect appropriation and provided the required information.

6.2 Difficulties encountered

In the course of the whole project, the main difficulties encountered at each state are as follows:

6.2.1 Data collection phase

Access to some villages proved to be the major problem during the data collection phase. This was because of the onset of the rainy season which made certain roads unmotorable. Secondly, residents of most sample villages were dispersed over large areas. This did not allow for the random selection of compounds as intended.

Furthermore, the number of CHAs encountered especially in the comparison zone was lower than expected given that initial estimates had put the number of CHAs as 2 per village in these districts. Unfortunately, there were villages where there was no CHAs for the following reasons:

- Some CHAs recruited by the national anti-malaria programme and its partners were sacked for poor performance. Other CHAs resigned for low or inadequate remuneration. In some cases, CHAs were not resident in their duty villages.

6.2.2- Data processing

The double entry of data proved to be a tedious task. A comparison of entries generated errors which had to be corrected progressively, a process which required referral data collection forms.

6.2. Quality of data collected

Questionnaire response rate was 100% for household questionnaires and 95.1 for women questionnaires. In the case of women questionnaire, the absence of targets at home largely explains the gap (4.9%). One can safely conclude that the field data collection exercise was successful. In respect of data entry, it is the double entry method which was applied with agents ensuring data harmony and, where necessary, making corrections with reference to collection forms.

**RESULTS OF THE DISTRICT
SURVEY FINAL INTERNAL
EVALUATION**

Results of this evaluation presented in this report according to plan :

- Sociodemographic characteristics of targets (CHAs, women of child bearing age and under-five children)
- State of CHAs with respect to different indicators
- State of women in relation to different indicators
- State of under-five children in relation to different indicators
- State of health facilities and pharmaceutical depots visited

Data resulting from the analysis are presented by health district (Blitta, Haho and Wawa). In each table (Table 4 and 5), there is a comparison of results between initial the evaluation conducted a year ago and those of this final internal evaluation.

For each variable, the co-efficient z is immediately calculated to determine whether differences between the two evaluations are significant. Table 6 below shows z values, its interpretations and relationship with p.

Table 6 : Z valeurs, meaning and relationship with p

Signs of Z	Meaning of Z	Relationship with p
Ns	Insignificant	$p \geq 0.05$
*	Very insignificant	$0.01 \leq p < 0.05$
	Significant	
**	Significant	$0.001 \leq p \leq 0.01$
***	Very significant	$p \leq 0.001 \approx 0.000$

7- SOCIODERMOGRAPHIC CHARACTERISTICS OF TARGETS

7.1 Characteristics of household members

7.1.1 Blitta District

Out of a total of 2387 persons counted in the various households visited during collection, 49.8% were male while 50.2% were female. In the initial evaluations these proportions were 48.1% as against 51.9% respectively. The distribution of household members by sex in Blitta District is 51.9% males and 48.1% females. In terms of age distribution, under-five children constituted the largest age-group (22.7%).

7.1.2 Haho District

In Haho District, households visited had a total number of 2344 members, 50.6% of whom were male and 49.4% female. This distribution is diverges from the initial evaluation which showed 51.6% females and 48.4% males. The largest age group is that of children between the ages of 5 - 9 (21.2%).

7.1.3 Wawa District

In Wawa District, a total of 2265 people were counted in all households visited with 51.0% males as against 49.0% females. The situation is almost identical to the initial evaluation (50.9% males as against 49.1% of females). The most represented age group was children between the ages of 5-9 (22.3%).

Table 7 : percentage distribution of household members by district, sex and age group in Blitta and Haho Districts, 2012

Age Group	Haho District			Blitta District			Wawa District		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
< 5	19.5	19.9	19.7	23.8	21.6	22.7	17.0	20.4	18.7
5-9	20.8	21.6	21.2	20.1	18.9	19.5	24.7	19.9	22.3
10-14	14.7	15.0	14.8	12.2	12.0	12.1	13.0	13.2	13.1
15-19	8.9	4.2	6.6	7.5	4.5	6.0	8.3	4.2	6.3
20-24	3.4	6.3	4.8	5.6	8.6	7.1	4.4	5.7	5.0
25-29	4.6	9.0	6.8	4.5	9.3	6.9	4.2	9.3	6.7
30-34	5.7	9.5	7.6	5.2	6.8	6.0	5.3	7.8	6.5
35-39	6.1	6.1	6.1	5.0	6.2	5.6	5.4	7.1	6.2
40-44	6.7	4.0	5.4	4.9	4.2	4.5	5.4	5.2	5.3
45-49	2.9	1.3	2.1	4.5	1.5	3.0	5.2	2.2	3.7
50-54	2.6	1.3	2.0	2.8	2.4	2.6	3.3	2.2	2.7
55-59	0.8	0.5	0.7	1.5	1.2	1.3	1.8	1.1	1.5
60-64	1.9	0.8	1.3	0.8	1.3	1.0	1.0	0.9	1.0
65-69	0.5	0.1	0.3	0.7	0.5	0.6	0.3	0.5	0.4
70-74	0.3	0.3	0.3	0.3	0.5	0.4	0.4	0.3	0.4
75-79	0.2	0.2	0.2	0.3	0.3	0.3	0.1	0.0	0.0
80 and +	0.4	0.0	0.2	0.4	0.3	0.4	0.2	0.2	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	1186	1158	2344	1190	1197	2387	1157	1108	2265

7.1.4 Characteristics of household heads

Household heads of sampled villages were mostly male in the three health districts. In Blitta District, the proportion of male household heads was 89.3% as against 92.7% in the initial study. In Haho District, male household heads accounted for 90.5% as against 84.4% in the initial

study. The proportion of male household heads in Wawa District was 89.0% as against 90.2% in the initial study. Average number of household members was 6 in the three districts (Table 8)

Table 8 : percentage distribution of household heads by sex, and number of habitual members per household

Socio-demographic Characteristics	Haho	Blitta	Wawa
<u>Sex of members</u>			
Male	90.5	89.3	89.0
Female	9,5	10,8	11,0
Total	100,0	100,0	100,0
Number	400	400	400
<u>Number of habitual members</u>			
1	0,0	0,3	0,3
2	2,5	1,5	4,0
3	10,3	10,5	9,8
4	17,8	16,3	15,5
5	18,5	20,5	21,0
6	18,8	16,3	20,0
7	14,8	12,3	13,8
8	6,3	10,0	8,0
9 and more	11,3	12,5	7,8
Total	100,0	100,0	100,0
Number	400	400	400
Average household size	6	6	6

7.2- Community Health Agents (CHA)

This finale internal evaluation covered 116 CHAs as against 85 during the initial evaluation (Table 9). 38.8% were identified in Blitta District, 50% in Haho and 11.2% in Wawa. The figures of the initial study for Blitta, Haho and Wawa were respectively 35,3%, 34,1% et 30,6%. Increases in the number of CHAs reached in Haho and Blitta were the fruit of training programs provided under the project.

The finale evaluation showed that the distribution by sex of CHAs in Blitta and Haho was nearly the same, that is, 53.3% men as against 46.7% women in Blitta while Haho recorded 56.9% men as against 43.1 women. In Wawa, men accounted for 84.6%, which represented the general trend

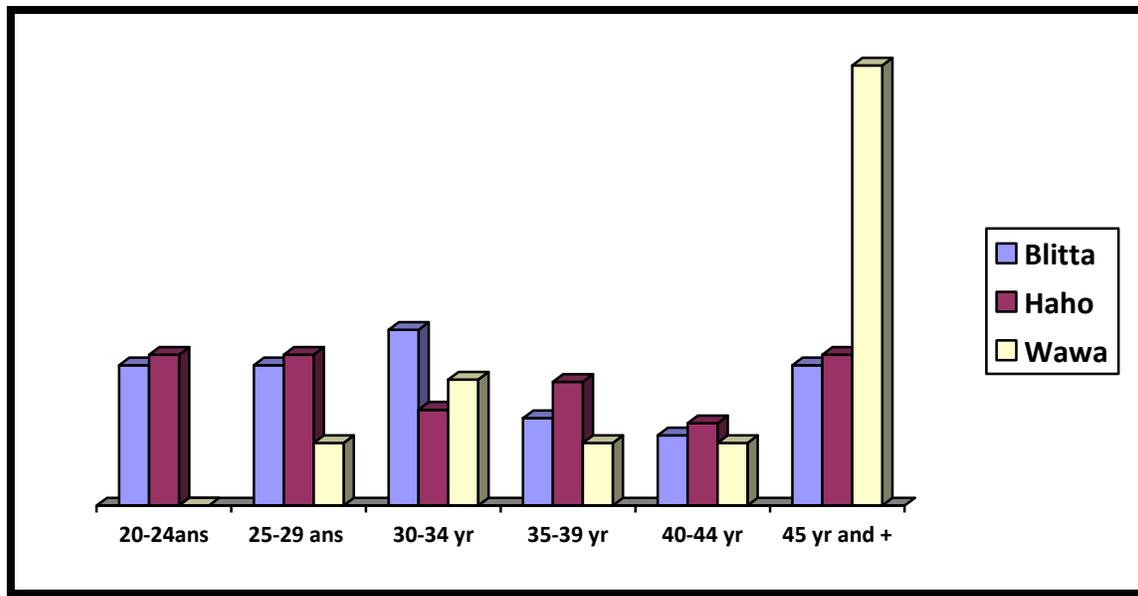
in the three districts during the initial evaluation (88.6%). The increase in the number of female CHAs was a stated objective of the project in line with its gender parity policy. Although the two districts did not score 50%, there was a significant increase in the number of women (Table 9).

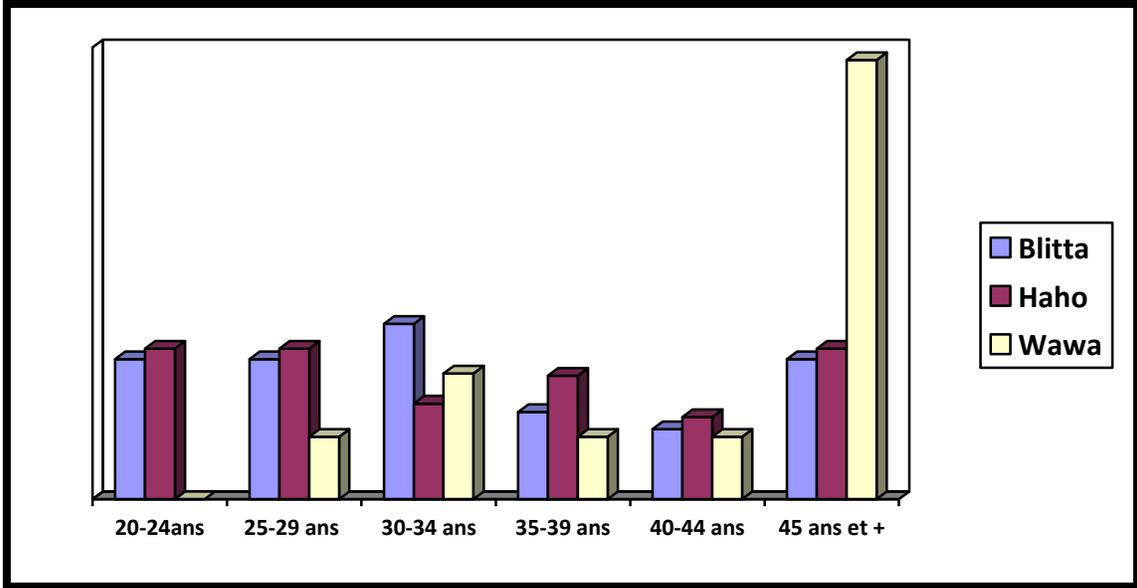
Average age of CHAs, which was 37 in the first evaluation, now stands at 34.8. Blitta and Haho CHAs appear younger as those who are 45 or more account for about 20% in the two districts while this age group accounted for 58% in Wawa.

As in the base study, nearly all CHAs were married (100% in Blitta and Wawa and 93% in Haho). Figures in respect of the level of education were also similar to those of the base study with 100% of CHAs having completed basic education in Blitta, 86.2% in Haho and 92.3% in Wawa. In the base study however, roughly the same numbers of CHAs were Secondary School leavers with an average figure of 84.7% in all districts combined.

Depending on the number of years of experience, more than half of CHAs in Blitta and Haho had been working for less than one year (51.1% for Blitta and 58.6% in Haho). Their first assignment was with the USAID AWARE II project. On the other hand, Wawa District CHAs had all been in the job for more than one year.

Thus the project’s desire to recruit young and educated CHAs of both sexes was achieved, which is why most of the CHAs are new to the project. The fact that the project activity constituted new terrain for the CHAs turned out to be very useful since they sought to go the extra mile to provide their communities with quality service. Additionally, the fact that CHAs were elected also played a critical role as they were mindful not to lose the trust of their communities through poor performance





Graphique 1 : Répartition des ASC des trois districts en fonction des tranches d'âge
Graph 2 : Distribution of CHAs in the three districts by age

Table 9 : percentage distribution of CHAs by major sociodemographic characteristic such as sex, age, marital status, level of education, number of years of practice

Characteristics	Intervention Districts		Comparison District
	Blitta	Haho	Wawa
<u>Sex</u>			
Male	53.3	56.9	84.6
Female	46.7	43.1	15.4
Total	100.0	100.0	100.0
Number	45	58	13
<u>Age (yr)</u>			
20-24 yr	18.6	20.0	0.0
25-29 yr	18.6	20.0	8.3
30-34 yr	23.3	12.7	16.7
35-39 yr	11.6	16.4	8.3
40-44 yr	9.3	10.9	8.3
45 and more	18.6	20.0	58.3
Total	100.0	100.0	100.0
Number	43	55	12
<u>Marital status</u>			
Married/co-habiting	100.0	93.1	100.0
Divorced	0.0	5.2	0.0
Single	0.0	1.7	0.0
Total	100.0	100.0	100.0
Number	45	58	13
<u>Level of Education</u>			
Uneducated	0.0	13.8	7.7
Primary	100.0	86.2	92.3
Total	100.0	100.0	100.0
Number	45	58	13
<u>Number of years of practice as CHA</u>			
Less than a year	51.1	58.6	0.0
1-5 yr	22.2	17.2	76.9
6-10 yr	20.0	17.2	15.4
More than 10 year	6.7	6.9	7.7
Total	100.0	100.0	100.0
Number	45	58	13

7.3- Women of Child- Bearing Age

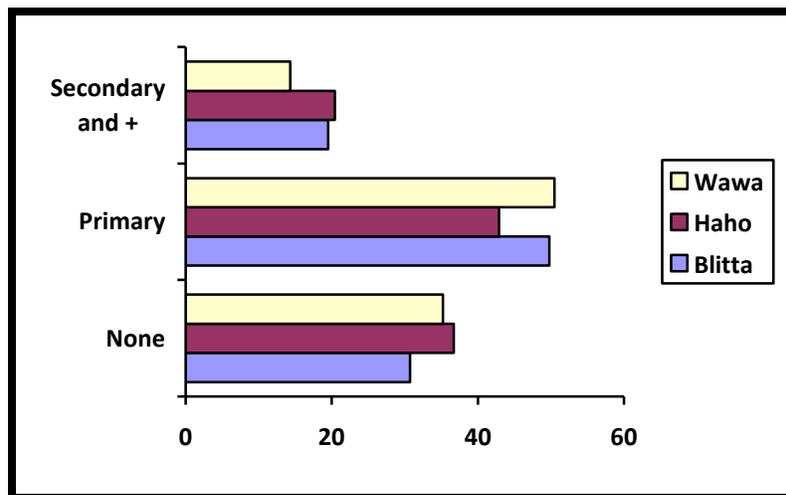
7.3.1- Age, religion, ethnic group and number of children

In all three health districts, 1350 women of child bearing age were met as against 1464 women met during the initial evaluations, Age distribution showed that on the whole, women between the ages of 25 to 29 were more represented, However, in Haho, majority of women were between the ages of 30 and 34 (24,5%), This distribution is identical to that of the initial evaluation, The average age of women was 30,

In respect to level of education, majority of the women had completed primary school (42,9% in Haho, 49,8% in Blitta and 50,5% in Wawa), In all districts more than 50% of women said they were Christians (56,8% in Haho, 54,1% in Blitta and 71,8% in Wawa, There was no significant difference between the same characteristics during initial studies,

In Blitta District, the majority of women were Kabyses(31,5%), In Haho District Ewes were the majority (32,0%) while in Wawa, Akebou women accounted for 48,4%. Percentages in the initial evaluation were: Kabye in Blitta District (33,3%), Adja in Haho (27,2%) and Akebou in Wawa District (48,2%),

Majority of the women in the three districts had 6 children or more, They exceeded 30% in all three districts (Table 10),



Graph 3 : Distribution of women of child bearing age by district and by level of education

7,3,2- Marital Status of women

Women of child bearing age in ours ample were married (76,4% in Haho, 73,6% in Blitta and 75,7% in Wawa, Unmarried women represented 10,6% in Haho, 12,2% in Blitta and 12,0% in Wawa,

Table 10 : Percentage distribution of women of child bearing age by socio-demographic characteristics

Characteristics	Intervention zone		Comparison zone
	Haho	Blitta	Wawa
<u>Ages of women</u>			
15-19 yr	9.0	10.3	8.2
20-24 yr	16.7	21.5	13.6
25-29 yr	22.3	22.7	23.2
30-34 yr	24.5	17.4	18.9
35-39 yr	14.4	15.2	17.7
40-44 yr	9.9	9.4	13.0
45-49 yr s	3.2	3.4	5.5
Total	100.0	100.0	100.0
Number	444	466	440
<u>Religion</u>			
Muslim	3.6	10.1	11.6
Christian	56.8	54.1	71.8
Animist	32.4	31.8	13.6
None	7.2	4.1	3.0
Total	100.0	100.0	100.0
Number	444	466	440
<u>Ethnicity</u>			
Ewe	32.0	3.6	9.3
Kabye	24.5	31.5	21.4
Tem	0.7	1.7	8.4
Losso	3.4	27.7	0.2
Akposso	1.4	0.0	10.7
Akebou	0.0	0.4	48.4
Ouatchi	0.7	0.0	0.2
Fon	0.0	0.0	0.2
Agnanga	0.0	4.5	0.0
Other	37.4	30.5	1.1
Total	100.0	100.0	100.0
Number	444	466	440
<u>Total Number of births</u>			
Less than 2 births	18.0	20.2	19.3
2 births	11.7	15.5	9.5
3 births	10.4	12.0	9.8
4 births	12.8	12.0	14.5
5 births	14.4	10.1	13.6
6 births	32.7	30.3	33.2

Total	100.0	100.0	100.0
Number	444	466	440

Table 11 : Percentage distribution of women by their marital status

Characteristics	Intervention Zone		Comparison Zone
	Haho	Blitta	Wawa
<u>Currently in relationship</u>			
Yes currently married	76.4	73.6	75.7
Yes living with a man	13.1	14.2	12.3
No not in relationship	10.6	12.2	12.0
Total	100.0	100.0	100.0
Number	444	466	440
<u>Married or ever lived cohabitated</u>			
Was married	17.0	21.1	28.3
Lived with a partner	14.9	7.0	17.0
No	68.1	71.9	54.7
Total	100.0	100.0	100.0
Number	47	57	53
<u>Current marital status</u>			
Widow	53.3	37.5	45.8
Divorced	6.7	6.3	8.3
Separated	40.0	56.3	45.8
Total	100.0	100.0	100.0
Number	15	16	24
<u>Husband/partner currently lives with her or elsewhere</u>			
Lives with her	88.7	84.6	85.3
Lives elsewhere	11.3	15.4	14.7
Total	100.0	100.0	100.0
Number	397	409	387

7.3.3- Distribution of level of education by socio-demographic characteristics

Tables 12 and 13 illustrate the co-relations between the level of instruction and certain socio-demographic characteristics on the one hand, and on the other hand, participation in any literacy programme. For example, it is evident from table 12 that adolescents and the youth were in the majority in terms of school attendance and were on a higher level on the educational ladder (Secondary). There were more unschooled Muslim women than older women (34.0% in Blitta, 62.5% in Haho and 62.7% in Wawa). In addition to the fact that the women did not go to school, they had also not participated in any literacy programme (Table 13).

Table12 : Percentage distribution of women aged 15-49 depending on the highest level of education attained or completed based on some sociodemographic characteristics per area- Blitta, Haho and Wawa health District, 2012

Sociodemographic characteristics	Intervention zone								Zone control			
	Blitta				Haho				Wawa			
	None	Primary	Secondary +	Total	None	Primary	Secon +	Total	None	Primary	Secon +	Total
Age groups												
15-19	14.6	41.7	43.8	100.0	35.0	45.0	20.0	100.0	25.0	36.1	38.9	100.0
20-24	14.0	54.0	32.0	100.0	58.1	33.8	8.1	100.0	23.3	60.0	16.7	100.0
25-29	28.3	50.0	21.7	100.0	63.6	28.3	8.1	100.0	28.4	53.9	17.6	100.0
30-34	40.7	46.9	12.3	100.0	70.6	24.8	4.6	100.0	33.7	53.0	13.3	100.0
35-39	38.0	59.2	2.8	100.0	79.7	18.8	1.6	100.0	46.2	48.7	5.1	100.0
40-44	56.8	40.9	2.3	100.0	86.4	13.6	.0	100.0	49.1	43.9	7.0	100.0
45-49	43.8	43.8	12.5	100.0	78.6	7.1	14.3	100.0	45.8	45.8	8.3	100.0
Religion												
Muslim	34.0	55.3	10.6	100.0	62.5	37.5	.0	100.0	62.7	27.5	9.8	100.0
Christian	22.2	51.6	26.2	100.0	56.7	32.9	10.3	100.0	28.2	55.1	16.8	100.0
Animist	41.9	45.3	12.8	100.0	84.0	13.2	2.8	100.0	45.0	48.3	6.7	100.0
Without religion	47.4	47.4	5.3	100.0	71.9	28.1	.0	100.0	53.8	38.5	7.7	100.0
Ethnic group												
Ewe	47.1	35.3	17.6	100.0	63.4	29.6	7.0	100.0	29.3	58.5	12.2	100.0
Kabye	28.6	49.7	21.8	100.0	53.2	39.4	7.3	100.0	18.1	61.7	20.2	100.0
Tem	37.5	50.0	12.5	100.0	33.3	66.7	.0	100.0	70.3	21.6	8.1	100.0
Losso	25.6	50.4	24.0	100.0	40.0	40.0	20.0	100.0	.0	.0	100.0	100.0
Akposso				.0	16.7	50.0	33.3	100.0	19.1	63.8	17.0	100.0
Akebou	.0	100.0	.0	100.0				.0	41.8	46.5	11.7	100.0
Ouatchi				.0	33.3	66.7	.0	100.0	100.0	.0	.0	100.0
Fon				.0				.0	.0	100.0	.0	100.0

Agnanga	38.1	42.9	19.0	100.0				.0				.0
Other	34.5	51.4	14.1	100.0	84.3	11.4	4.2	100.0	20.0	40.0	40.0	100.0
Marital status												
Single	9.8	34.1	56.1	100.0	31.3	46.9	21.9	100.0	13.8	48.3	37.9	100.0
Married	30.6	52.8	16.6	100.0	69.6	24.5	5.9	100.0	35.1	53.8	11.1	100.0
In relationship	37.9	48.5	13.6	100.0	70.7	24.1	5.2	100.0	42.6	40.7	16.7	100.0
Divorced/Separated	60.0	40.0	.0	100.0	57.1	42.9	.0	100.0	30.8	38.5	30.8	100.0
Widower	50.0	16.7	33.3	100.0	75.0	25.0	.0	100.0	63.6	18.2	18.2	100.0

Tableau 13 : Percentage distribution of women aged 15-49 per education level attained and level of participation in a literacy programme, based on some sociodemographic characteristics per area- Blitta, Haho, and Wawa health District, 2012

Sociodemographic characteristics	Intervention Zone						Control area		
	Haho			Blitta			Wawa		
	Took part in a literacy programme.	Did not participate in a literacy programme	Total	Took part in a literacy programme	Did not participate in a literacy programme	Total	Took part in a literacy programme	Did not participate in a literacy programme	Total
Age groups									
15-19	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
20-24	1.8	98.2	100	0.0	100.0	100	0.0	100.0	100
25-29	1.3	98.7	100	0.0	100.0	100	0.0	100.0	100
30-34	2.3	97.7	100	0.0	100.0	100	0.0	100.0	100
35-39	1.7	98.3	100	0.0	100.0	100	0.0	100.0	100
40-44	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
45-49	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Ethnic group									
Ewe	2.0	98.0	100	0.0	100.0	100	0.0	100.0	100
Kabye	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Tem	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Losso	12.5	87.5	100	0.0	100.0	100	0.0	100.0	100
Akposso	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Ouatchi	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Other	1.3	98.7	100	0.0	100.0	100	0.0	100.0	100
Marital status									
Single	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Married	1.8	98.2	100	0.0	100.0	100	0.0	100.0	100
In relationship	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100

Divorced/Separated	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Widower	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Education level									
None	1.7	98.3	100	0.0	100.0	100	0.0	100.0	100
Primary	0.0	100.0	100	0.0	100.0	100	0.0	100.0	100
Together	1.4	98.6	100	0.0	100.0	100	0.0	100.0	100

7.4- Under- 5 Children

1460 under-5 children were sampled in the 2011 baseline evaluation as against 1370 in the final evaluation. The average age was 22 months for all three districts. In all, most represented age group was 1 to 2 years old accounting for 36.0% at Blitta, 42.7% at Haho and 42.2% at Wawa).

The distribution of children by gender revealed that there were more boys in Blitta and Haho representing 52.6% and 50.3% respectively whilst they constituted 47.1% in the control district. Gender distribution in all three districts was 50-50 (Table14).

Table 14 : Percentage distribution of under-5 children by district, gender, And type of birth

Characteristics	Health district		
	BLITTA district	HAHO district	WAWA district
<u>Age</u>			
Under 1	26.0	22.8	15.8
1-2	36.0	42.7	42.2
3-4	38.0	34.5	42.0
Total	100.0	100.0	100.0
Number	511	447	412
<u>Gender</u>			
Boy	52.6	50.3	47.1
Girl	47.4	49.7	52.9
Total	100.0	100.0	100.0
Number	511	447	412
<u>Type of birth</u>			
Single	95.7	94.0	92.7
Multiple	4.3	6.0	7.3
Total	100.0	100.0	100.0
Number	511	447	412

8- CURRENT WORK CONDITIONS OF THE CHA

8.1- Training and retraining

The last training session or update received by the CHAs before the survey addressed the following themes: family planning, treatment of malaria, diarrhoea and pneumonia (100% of Blitta CHAs and 96.9% of those in Haho against 7.7% in Wawa). Although this proportion has not changed in Wawa, (7.7% in the baseline study), the differences in Blitta and Haho remain highly significant (table15). Considering FP, the proportion of CHAs trained in this area

increased from 3.3% to 100% in Blitta and from 6.9% to 96.6% in Haho District. The differences are the same for child care.

8.2- Intervention areas

During the baseline evaluation, fewer than 2 CHAs out of 10 were involved in the management of ARI and diarrhoea, representing 18.8% and 16.5% respectively. Those who intervened in FP were accounted for only 12.9%. Currently, the same trend is observed in Wawa district where no activity was conducted by the project. All the CHAs interviewed in the other two districts said they have expertise in FP, malaria, diarrhoea and pneumonia service provision. The proportion of the CHAs treating children with malaria in children in Wawa decreased marginally the baseline study and the final evaluation (88.5% as against 69.2%) although this variation was statistically insignificant.

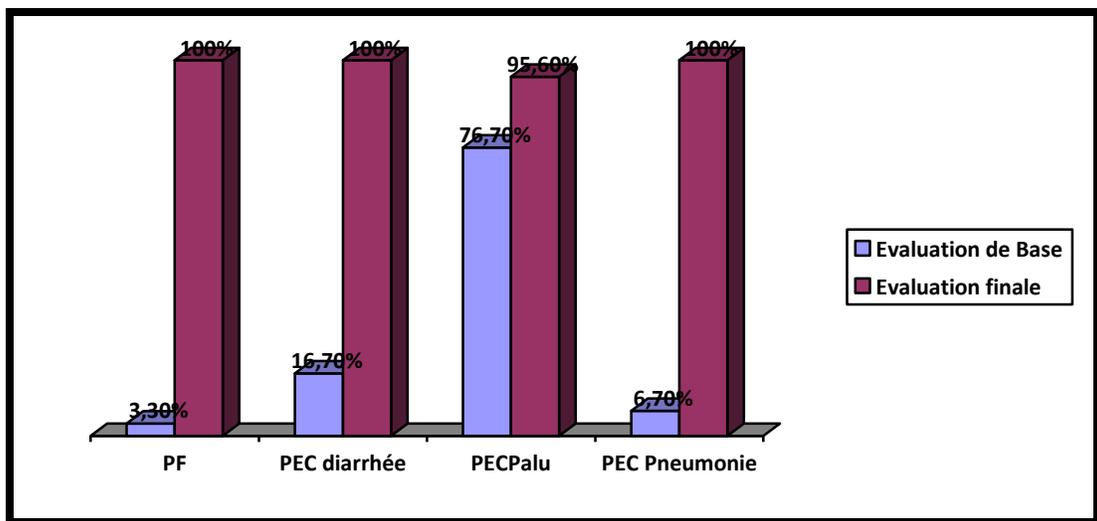


Figure 4 : Comparison of the proportion of CHAs engaged in project key areas during the baseline and final evaluation (for example, Blitta District)

8.3- Material resources available for the work

For example, in Blitta district, the majority of CHAs had:

- Activity report forms; 7 CHAs out of 10 (76.7%) in the baseline evaluation as against 97.8% in the final evaluation;
- Thermometer ; 6 CHAs out of 10 (63.3%) in the baseline evaluation as against 95.6% in the final evaluation;
- CHAs Technical guide; 5 CHAs out of 10 (50.0%) in the baseline evaluation as against 93.3% in the final evaluation;
- IEC/CBC support; 7 CHAs out of 10 (66.7%) in the baseline evaluation as against 95.6% in the final evaluation.

Regarding means of transport (bicycle), only 2 CHAs out of 10 (16.7%) had access to bicycles in the Blitta District during the baseline evaluation. Currently, 97.8% of CHAs have bicycles.

8.4- Technical support partners

The National Malaria Control Programme and the National Tuberculosis Programme (NMCP/NTP) were the most cited by the CHAs during the baseline study. However, during this study, the USAID AWARE II project was the most cited in the Blitta and Haho Districts with 97.8% and 100% respectively, followed by Plan Togo which is leading the fight against malaria at the community level. Togo organisation was the cited in Wawa with 92.3%.

Tableau 15 : Percentage distribution of the CHA under the themes of the last refresher course/training, areas of intervention, available resources and technical partners supporting the Community component.

9- CAPACITY OF CHA TO PROVIDE HOME CARE FOR WOMEN OF CHILD-BEARING AGE AND UNDER- 5 CHILDREN

10- 9.1- Contraceptives

9.1.1- Knowledge of contraceptive methods

In the baseline evaluation, the percentages of CHAs interviewed (Table16), who had knowledge of condoms was 46.7% in Blitta, 79.3% in Haho and 61.5% in Wawa. However, at the end of the project, these numbers have increased to 97.8% in Blitta and 98.3% in Haho. In Wawa, the proportion of CHA who had knowledge of condoms fell to 38.5%. The proportion of women who had knowledge of injectable contraceptives also increased generally (Blitta: 91.1% currently as against 13.3% in the beginning, Haho: 98.3% against 75.9% and Wawa: 15.4% against 50%). In respect of oral contraceptives, all CHAs in the areas of intervention knew them with the exception of Wawa district (Blitta 100% against 36.7% at the base; Haho 98.3% against 62.1% and Wawa 15.4% against 46.2%) (Cf. Table 16).

9.1.2- Identification of prospective women candidates for oral contraceptives

Out of four items proposed in the questionnaire, it was suggested that CHAs knew a woman candidate for oral contraceptive if he/she could list all the items. On this basis, the level of knowledge remains very high to all intents and purposes. 92.3% of CHAs were able to identify candidates for oral contraceptives during the baseline evaluation in Blitta district as against 100% this evaluation. In Haho the proportions were 88.9% during the baseline study and 100% in the final study. In Wawa the percentage fell from 83.3% in the baseline study to 80.0% in the final evaluation (Table16). Although it is possible to attribute the higher numbers in Haho and Blitta to training, it is difficult to understand the decline in Wawa. CHAs interviewed at the beginning may probably not be the same during this evaluation.

9.1.3- Identification of oral contraceptives contraindications

In this section, it was accepted that a CHAs was able to identify the contraindications of contraceptive methods if they he/she could list all contraindications linked to contraceptives methods with the help of training aids. In the two districts of the intervention there was a total reversal of trends (Blitta: 0% in the baseline study as against 100% in the final evaluation, Haho 7.4% against 100%). In Wawa district the trend is reversed: 5.6% as against 0%.

9.1.4- Signs of complications women taking oral contraceptives requiring referral to a health centre

CHAs interviewed were required to list the complication signs or warning signs. It was shown during the initial study that in this respect too, less than 2 CHAs out of 10 (17.2%) were able to identify these signs (Table 16). More CHAs were able to identify the complication signs numerous in the Haho District (22.2%).

After the project intervention, the proportion of CHAs who could identify the warning signs has increased in Blitta (7.7% at the initial stage against 51.1% at the end) and in Haho (22.2% at the initial stage against 98.3% at the end).

9.1.5- Instructions for oral contraceptives use

Almost all CHAs knew how to use oral contraceptives. All CHAs in Blitta and Wawa (100%) and 92.6% of CHAs in Haho were at least able to provide women candidates with oral contraceptive use instructions (Table 16).

In the two intervention districts, proportions remained the same (93.3% in Blitta and 93.1% in Haho).

9.1.6- Eligibility of women of childbearing age for oral contraceptives use

The ability to identify both female candidates and contraindication signs qualified CHAs to identify an eligible woman. In the baseline study, 0% of CHA in Blitta, 7.4% in Haho and 5.6% in Wawa were able to identify eligible women (Table16).

After the final evaluation 100% of CHAs in Blitta and Haho could identify eligible women.

It should be noted that by using the working documents to answer questions or to simulate the work of service providers during data collection, CHAs in Blitta and Haho were able to answer questions well by reason of the priority accorded them. On the other hand, CHAs in Wawa had no reference during the final evaluation. In the baseline study, some CHAs emphasised the fact that they had just been trained in FP service provision, which could have accounted for the good results obtained.

9.1.7- InjeACTble contraceptives

This section had not been treated during the baseline study because while the study was ongoing the government had not yet given permission to the project for the practise of injeACTble contraceptives in DBC.

9.1.7.1- Identification of women candidates for injeACTble contraceptives

CHAs in the intervention districts gained expertise in the implementation of this method. All community health workers, both in Haho or in Blitta (100%), were able to identify eligible women for the injeACTble contraceptive. Only 50% in Wawa were able to identify these women (table17).

9.1.7.2- Identification of contraindications of injeACTble contraceptive methods

If in Wawa all the CHAs (100%) were not able to identify the contraindications of injeACTble contraceptives, it is quite the opposite in the intervention districts of Blitta and Haho). It appeared that they were 100% who could identify the contraindications (Table 17).

9.1.7.3- Complication signs requiring referral to a health centre for women under injeACTble contraceptives.

These were warning signs for women taking InjeACTbles. In the intervention area 75.6% in Blitta and 94.5% in Haho identified the warning signs as opposed to none in the Wawa.

9.1.7.4- Instructions for injeACTble contraceptives use

InjeACTble contraceptives use instructions capture injection guidelines and techniques. The evaluation revealed that 75.6% in Blitta practised the injection technique properly and also gave use instructions correctly as against 82.8% in Haho.

9.1.7.5- Eligibility of women of child- bearing age for injeACTble contraceptives use

Table17 shows that 100% of CHAs in Blitta and Haho could identify women of child -bearing age eligible for injeACTble contraceptives use.

This evaluation also confirmed that CHAs could initiate both oral and injeACTble contraceptives provided they were well trained and regularly monitored. NGOs were therefore assigned the task of monitoring CHAs in this context.

Technical supervision with officials from the PCU is necessary but it can only be periodic for fear of emptying health care structures for long. Only NGO workers can really ensure the near-daily monitoring which involves product replenishment.

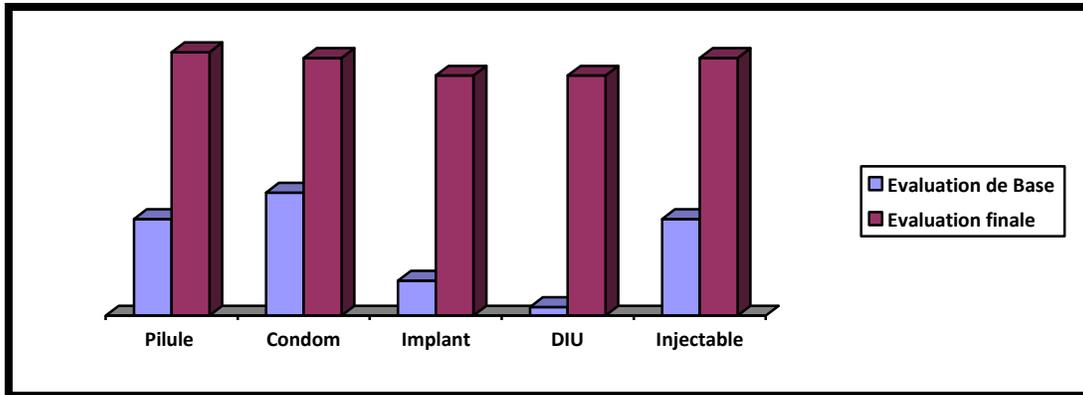


Figure 5 : Proportion of CHAs in relation to already existing methods during the baseline evaluation and the final evaluation of the project in the Blitta health district of the Central Region

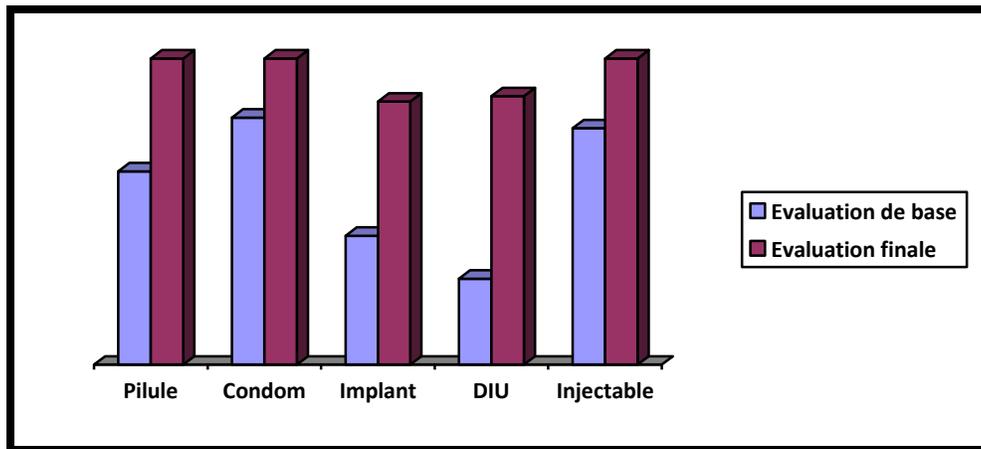


Figure 6 : Proportion of CHAs in relation to existing methods during the baseline evaluation and the final evaluation of the project in Haho health district of Plateaux Region.

Table 16 : Percentage distribution of CHAs by level of knowledge of contraceptive methods and ability to identify eligible women for oral contraceptives use

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Existing contraceptives methods</u>									
Contraceptive Pills	36.7	100.0	- 6.2***	62.1	98,3	-4.6***	46.2	15,4	1.9 ns
Condom	46.7	97.8	- 5.2***	79.3	98,3	-3.1**	61.5	38.5	1.4 ns
Implants	13.3	91.1	- 6.7***	41.4	84,5	-4.1***	38.5	7.7	2.0 ns
Intrauterine device (IUD)	3.3	91.1	- 7.5***	27.6	86,2	-5.5***	30.8	15.4	1.0 ns
InjeACTbles	36.7	97.8	- 5.9***	75.9	98,3	-3.4***	50.0	15.4	2.1*
Other	3.3	46.7	- 4.0***	10.3	29,3	-2.0 ns	11.5	0.0	1.3 ns
Number	30	45		29	58		26	13	
<u>Identification of women candidates for oral contraceptives</u>									
Do not know women candidates	7.7	0.0	1.9 ns	11.1	0,0	2.6*	16.7	20.0	-0.2 ns
Know women candidates	92.3	100.0	-1.9 ns	88.9	100,0	-2.6*	83.3	80.0	0.2 ns
Total	100.0	1000		100.0	100,0		100.0	100.0	
Number	13	45		27	58		18	5	
<u>Identification of contraindication signs for oral contraceptives</u>									
Do not know contraindication signs	100.0	0.0	7.6***	92.6	0,0	8.7***	94.4	100.0	-0.5 ns
Know contraindication signs of contraceptives	0.0	100.0	- 7.6***	7.4	100,0	-8.7***	5.6	0.0	0.5 ns
Total	100.0	100.0		100.0	100,0		100.0	100.0	
Number	13	45		27	58		18	5	
<u>Identification of complication signs requiring referral for a woman under oral contraceptives</u>									
Do not know the complication signs	100	48.9	2.8**	100	1,7	7.5***	83.3	100.0	-1.0 ns
Know the complication signs	0	51.1	-2.8**	0	98,3	-7.5***	6.5	0.0	1.0 ns
Total	100.0	100.0		100.0	100,0		100.0	100.0	
Number	13	45		27	58		18	5	
<u>How to use oral contraceptives</u>									
Do not know the recommendations	0.0	6.7	-1.0 ns	7.4	6.9	0.1 ns	0.0	100.0	-4.8***

Know the recommendations	0	93.3	1.0 ns	0	93.1	-0.1 ns	0	0.0	4.8***
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	13	45		27	58		18	5	
<u>Identification of women eligible for oral contraceptives</u>									
Identify women eligible for the FP	3.5	100.0	-	6.9	100.0	-8.7***	3.8	0.0	0.5 ns
Unable to identify eligible women	77	0.0	7.6***	11.1	0.0	2.6*	16.7	20.0	-0.2 ns
Number	13	45		27	58		18	5	

Table 17 : Percentage distribution of CHAs, by ability to identify women candidates for injeACTbles and to give instructions for proper contraceptives use.

Characteristics	Heath district		
	BLITTA	HAHO	WAWA
<u>Identification of women candidates for injeACTble contraceptives</u>			
Do not know women candidates	0.0	0.0	50.0
Know women candidates	100.0	100.0	50.0
Total	100.0	100.0	100.0
Number	45	58	4
<u>Identification of contraindication signs</u>			
Do not know contraindication signs	0.0	0.0	100.0
Know contraindication signs for contraceptives	100.0	100.0	0.0
Total	100.0	100.0	100.0
Number	45	58	13
<u>Identification of signs for complications requiring referral</u>			
Do not know complication signs	24.4	5.2	100.0
Know complication signs	75.6	94.8	0.0
Total	100.0	100.0	100.0
Number	45	58	13
<u>How to use injeACTble contraceptives</u>			
Do not know the recommendations	24.4	17.2	100.0
Know the recommendations	75.6	82.8	0.0
Total	100.0	100.0	100.0
Number	45	58	13
<u>Identification of women eligible for the FP (injeACTble)</u>			
Identify women eligible for FP (InjeACTble)	100.0	100.0	0.0
Unable to identify eligible women (InjeACTble)	0.0	0.0	15.4
Number	45	58	13

9.2- Malaria treatment in under-5 children

9.2.1- Identifying signs of malaria

CHAs intervening in the survey area were community actors in the fight against malaria. The proportion of CHAs who cited fever as a sign of malaria varied depending on the districts in the baseline evaluation (Blitta 86.7%, Haho 69.0% and Wawa 88.5%). The figures for the final evaluation were 100% in Blitta and Haho while Wawa scored 92.3%. (Table18). Only the changes in Haho and Blitta districts were statistically significant.

9.2.2- What to do when one has malaria

CHAs were declared as qualified to manage malaria if they were able to describe correctly how to manage malaria in under-5 children: identify signs of fever, make a rapid diagnostic test (RDT), administer artemisinin-based combination therapy (ACT) if the test proves positive. Going by this criterion, 72.4% of CHAs in Blitta, 53.8% in Haho and 53.8% of CHAs in Wawa knew how to treat malaria in the baseline study (Table 18).

At the end of the project, proportions are 97.8% in Blitta, 89.3% in Haho and 91.7% in Wawa. It is worth noting that CHAs in Wawa were mostly involved in malaria treatment activities in collaboration with Plan Togo funded by the Global Fund against AIDS, malaria and tuberculosis.

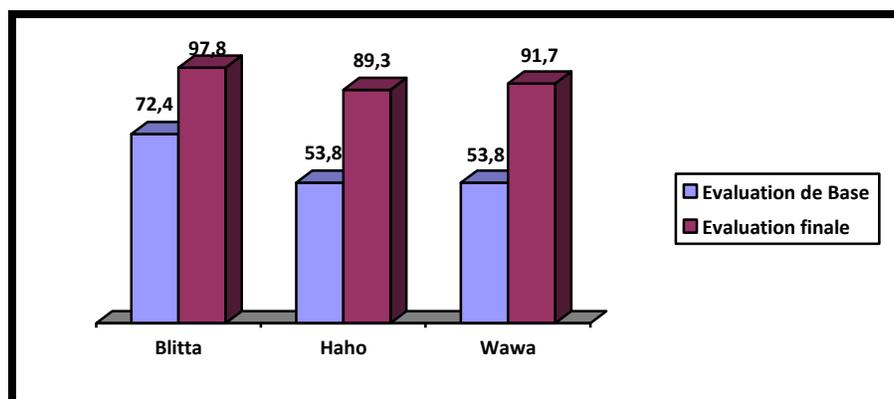


Figure 7 : Comparison of the proportion of CHAs able to describe exactly what to do in case of fever in under- 5 children, between the initial evaluation and the final evaluation in all three districts

9.2.3- Treatment Dosage

artemether/Lumefantrine combination (AM-LM) was considered as basic treatment because it is the first-line drug recommended by the National Malaria (NMCP). The ability to describe correctly AM-LM treatment dose in children aged between 6 months to 3 years constituted a criterion for assessing CHAs skills. CHA who could explain this dosage were among the best performers. The results of the baseline evaluation revealed that 58.6% of CHAs in Blitta, 50.0% in Haho and 65.4% in Wawa mastered the dosage.

At the end of the project, the proportions of those who master the dosage are 91.1% in Blitta, 37.5% in Haho and 50.0% in Wawa. For unknown reasons, lower figures were recorded in Haho and Wawa although this fall was not statistically verifiable.

9.2.4- Identifying serious signs and what to do

CHAs in Haho districts were among those who could readily identify signs of severity. They were a little more than 5 out of 10, that is, 53.8% in the baseline study. Blitta had 27.6% and Wawa 50.0%. At the end of the project, 80.4% of CHAs in Haho cited signs of severe malaria, 91.1% of those in Blitta and still 50.0% in Wawa.

In terms of what to do in case of severe malaria, almost all the CHAs, both in the baseline evaluation and the final study (9 CHAs out of 10 representing 96,3%), affirmed the need to refer patients to the nearest health centre (table 18).

Table 18 : Percentage distribution of CHAs by district, level of knowledge and ability to treat malaria in under-5 children.

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Malaria signs in a child under 5 years of age</u>									
Fever	86.7	100.0	-2.5*	69.0	100.0	-4.4****	88.5	92.3	-0.4 ns
Fever mixed with diarrhoea	23.3	2.2	2.9**	41.4	24.1	1.6 ns	26.9	30.8	-0.3 ns
Fever mixed with cough	3.3	4.4	-0.2 ns	17.2	20.7	-0.4 ns	11.5	7.7	0.4 ns
General fatigue without fever	6.7	6.7	0.0 ns	24.1	27.6	-0.3 ns	3.8	15.4	-1.3 ns
Child feels cold, shivers and wants cover	16.7	35.6	-1.8 ns	24.1	39.7	-1.4 ns	23.1	0.0	1.9 ns
Child in alternate sweats and cold bouts	3.3	20.0	-2.1*	10.3	13.8	-0.5 ns	0.0	0.0	
Other	43.3	13.3	2.9**	58.6	29.3	2.6*	73.1	53.8	1.2 ns
Number	30	45		29	58		26	13	
<u>What to do when malaria symptoms show up</u>									
Do not know what to do when symptoms appear	27.6	2.2	3.3**	46.2	10.7	3.6****	46.2	8.3	2.3*
Know what to do when symptoms appear	72.4	97.8	-3.3**	53.8	89.3	-3.6****	53.8	91.7	-2.3*
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	29	45		26	56		26	12	
<u>Dosage (AM+LM)</u>									
Masters dosage	58.6	91.1	-3.3**	50.0	37.5	1.1 ns	65.4	50.0	0.9 ns
Do not master dosage	41.4	8.9	3.3**	50.0	62.5	-1.1 ns	34.6	50.0	-0.9 ns
Total	100.0	100.0		100.0	100.0		100	100.0	
Number	29	45		26	56		26	12	
<u>Knowledge of severe symptoms</u>									
Do not identify symptoms	72.4	8.9	5.6****	46.2	19.6	2.5*	50.0	50,0	0.0 ns
Identify symptoms	27.6	91.1	-5.6****	53.8	80.4	-2.5*	50.0	50,0	0.0 ns
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	29	45		26	56		26	12	
<u>What to when severe symptoms appear</u>									
Administer C AT immediately and watch	6.9	0.0	1.8 ns	15.4	1.8	2.4*	7.7	0.0	1.0 ns
Administer paracetamol immediately	0.0			3.8			0.0		
Visit the child the next day	3.4	0.0	1.3 ns	0.0	8.9	-1.6 ns	0.0	0.0	
Send child to health centre	93.1	100.0	-1.8 ns	100.0	89.3	1.7 ns	96.2	91.7	0.6 ns

Other	0.0	0.0	7.7	5.4	0.4 ns	7.7	8.3	-0.1 ns
Number	29	45	26	56		26	12	

9.3- Diarrhoea treatment in under-5 children of age

9.3.1- Identification of diarrhoea signs

The CHAs of all three districts know, at a rate of about 7 CHAs out of 10 (67.1%), the signs of diarrhoea (Table 19). The highest proportion was 73.1% (Wawa) and the lowest was 58.6% (Haho), Blitta had 70.0%. At the end of this project, the proportions of CHAs who know the signs of diarrhoea was 91.1% in Blitta, 87.9% in Haho and 53.8% in Wawa.

9.3.2- ORS dosage

Knowledge about ORS dosage in children aged 0 to 2 years old and those over 2 years. About 2 CHAs out of 10 (18.8%) knew the dosage in under-2 children while about 3 CHAs out of 10 (29.4%) knew the dosage over-2 children (Table 19).

The proportions have increased in Blitta (100% of CHAs for both age groups) and in Haho (87.9% for under-2 children and 93.1% for over-2 children). In Wawa District, there was substantial increase with regard to the dosage under-2 children (50.0%), unlike that of over-2 children where CHA knowledge decreased (16.7%).

9.3.3- Functions of ORS in a child's body

The proportions of CHAs who thought that ORS stops diarrhoea (Table 19) were high in Blitta District (56.7%), Wawa (42.3%) and Haho (27,6%). These proportions were 26.7% in Blitta, 39.7% in Haho and finally 46.2% in Wawa at the end of the project. Only Blitta District recorded a significant.

CHAs who believed that ORS replaces lost water and mineral salts loss accounted for 40.0% in Blitta, 34.5% in Haho and 26.9% in Wawa. The final evaluation showed the proportions to be 64.4% in Blitta, 81.0% in Haho and 0% in Wawa. This reflects generally good trends in terms of perceptions in the two intervention districts especially in Haho.

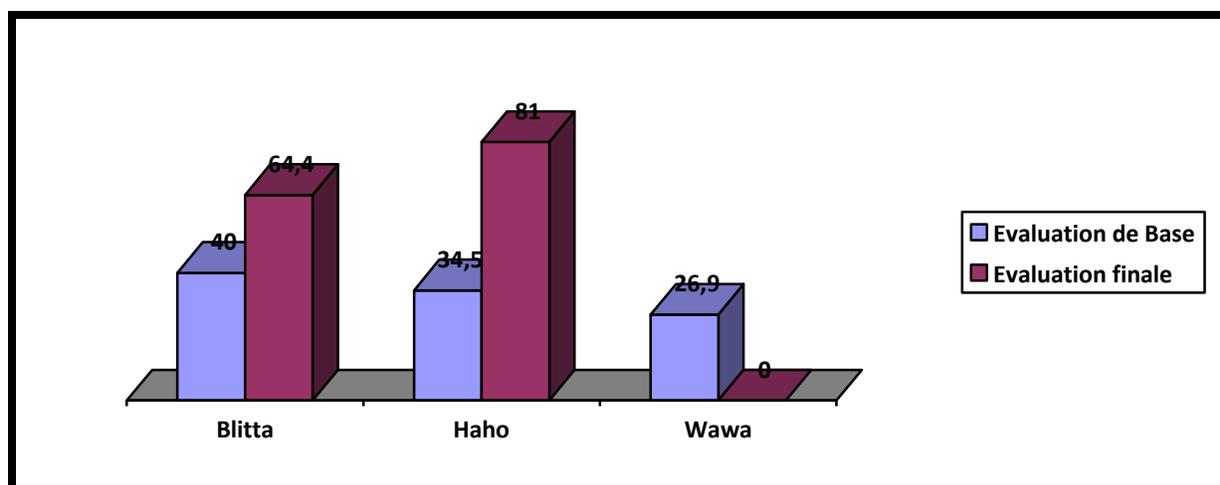


Figure 8 : Proportion of CHAs who know ORS replaces lost water and mineral salts in Blitta, Haho and Wawa health districts during the baseline and final evaluations

Table 19 : distribution of CHAs by district and by ability to treat diarrhoea in under-5 children

Characteristics	Health district									
	BLITTA District			HAHO District			WAWA District			
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z	
<u>Signs of diarrhoea in under-5 children</u>										
Do not know the signs		30.0	8.9	2.4*	41.4	12.1	3.1**	26.9	46.2	-1.2 ns
Know the signs		70.0	91.1	-2.4*	58.6	87.9	-3.1**	73.1	53.8	1.2 ns
Total		100.0	100.0		100.0	100.0		100.0	100.0	
Number		30	45		29	58		26	13	
<u>Dosage of ORS in under- 2 children</u>										
Do not master dosage		76.7	0.0	7.1**	86.2	12.1	6.8***	80.8	50.0	1.6 ns
		0	100/0	-	13.8	87.9	-	19.2	50.0	-1.6 ns
				7.1**			6.8***			
Master dosage				*						
Total		100.0	100.0		100.0	100.0		100.0	100.0	
Number		30	45		29	58		26	6	
<u>Dosage of ORS in +/- 2children and over</u>										
Do not master dosage		76.7	0.0	7.1**	69.0	6.9	6.1***	65.4	83.3	-0.9 ns
				*						
				-			-			
				7.1**						
Master dosage		0	100.0	*	0	93.1	6.1***	0	16.7	0.9 ns

Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	
Number	30	45	29	58		26	6		
<u>Function of ORS in child's body</u>									
Replaces lost water and salts	40.0	64.4	-2.1*	34.5	81.0	-4.3***	26.9	0.0	2.1*
Stops diarrhoea	56.7	26.7	2.6*	27.6	39.7	-1.1 ns	42.3	46.2	-0.2 ns
Other	3.3	4.4	-0.2 ns	37.9	6.9	3.6***	30.8	0.0	2.2*
Number	30	45		29	58		26	13	

9.4- Management of acute respiratory infections (ARI) or pneumonia.

As part of the management of pneumonia or ARI, almost all CHAs interviewed were not able to identify the symptoms in the proportion of 9 CHAs out of 10 representing 94.1%). For the sections labelled *drug dosage and signs of severity of ARI*, the proportions of those who knew them were nil.

9.4.1- Identifying pneumonia symptoms in under-5 children

After the implementation of project, the CHAs in the intervention districts were able to identify symptoms of pneumonia based on the number of breaths:

- 37.8% of CHAs in Blitta and 81.0% in Haho knew the maximum number of breaths per minute in children aged 0-2 months,
- 100% of CHAs in Blitta and 96.6% in Haho knew the maximum number of breaths per minute in children aged 2-12 months,
- 100% of CHAs in Blitta and 93.1% of those in Haho knew the maximum number of breaths per minute in children aged 12-59 months.

In Wawa District all CHAs knew nothing about the management of lung diseases in children.

9.4.2- Knowing antibiotics dosage

The first-line antibiotic is amoxicillin in Togo at the IMNCD cell level. The majority of CHAs in the Blitta and Haho districts knew the dosages of amoxicillin depending on the age of the under-5 children (Table 20). The proportions of those who knew the dosages are higher in Blitta district than those of Haho. It is certain that the CHAs in Haho district did not want to refer to their documents during data collection.

9.4.3- Knowing signs of severe pneumonia

In most cases, the CHA cited high respiratory rate (75.6% in Blitta and 80.7% in Haho), the intercostal indrawing representing (80.0% in Blitta and 82.5% in Haho), the child becomes increasingly ill (64.4% in Blitta and 36.8% in Haho).

Table 20 : distribution of CHAs by district and by pneumonia management care for under-5 children.

Characteristics	Health district		
	BLITTA District	HAHO District	WAWA
<u>Symptoms of pneumonia/ARI in a child</u>			
Frequency of breaths higher or equal to 60 per minute in a new-born aged 0 to 2 months	37.8	81.0	0.0
Frequency of breaths higher or equal to 50 per minute in infants aged 2 to 12 months	100.0	96.6	0.0
Frequency of breaths higher or equal to 40 per minute in infants aged 1 to 3 years	100.0	93.1	0.0
Total	45	58	13
<u>Dosage of amoxicillin in children aged 2 to 4 months</u>			
Do not master dosage	15.6	43.9	
Master dosage	84.4	56.1	
Total	100.0	100.0	
Number	45	57	
<u>Dosage of amoxicillin in children aged 5 to 11 months</u>			
Do not master dosage	6.7	38.6	
Master dosage	93.3	61.4	
Total	100.0	100.0	
Number	45	57	
<u>Dosage of amoxicillin in children aged 12 to 29 months</u>			
Do not master the dosage	11.1	38.6	
Master of dosage	88.9	61.4	
Total	100.0	100.0	
Number	45	57	
<u>Dosage of amoxicillin in children aged 30 to 59 months</u>			
Do not master dosage	11.1	38.6	
Master dosage	88.9	61.4	
Total	100.0	100.0	
Number	45	57	
<u>Signs requiring urgent referral of children suffering from pneumonia</u>			
Frequency of high breath in relation to age	75.6	80.7	
High temperature	44.4	45.6	
Circulation between ribs	80.0	82.5	
Flaring of nose	57.8	28.1	
Has difficulty drinking	26.7	31.6	
Illness worsens	64.4	36.8	
Other	6.7	28.1	
Number	45	57	

9.5- Kangaroo Mother Care (SMK)

When the project started, almost all CHAs did not know what to do to combat hypothermia in new-born babies (98.8%) throughout the data collection area. The proportions as per districts were: Blitta (100.0%), Haho (96.6%) and Wawa (100.0%). It is the same for the advantages of SMK. More than 9 CHA out of 10 (96.5%) did not know the advantages. They are 100% in Blitta, 93.1% in Haho and 96.2% in Wawa (Table 21).

In both Haho and Blitta districts, the data have shown a positive development. The proportion of those who knew the use of SMK increased from 0.0% to 91.1% in Blitta, from 3.4% to 69.0% in Haho. The proportion of those who know the advantages followed the same trend in the two districts (from 0.0% to 95.6% in Blitta and from 6.9% to 91.4% in Haho). The various changes were statistically significant. The CHAs training in the project had emphasized the practice of SMK for the CHA to keep track on low-birth weight children in the rural area (Table 21).

9.6- Ideal interval for birth spacing

The baseline evaluation revealed that more than 9 CHAs out of 10 representing (94.1%) were unaware of the interval of ideal birth spacing of 24 months between delivery and a new pregnancy or three years between births (Table 21). Compared with districts, the proportion of those who were unaware of the interval is 100% in Wawa and Blitta, then 82.8% in Haho.

Yet the advantages of ideal birth spacing were well known by about 7 out of 10 CHAs (67.1%). The proportion of those who knew it was 79.3% in Haho, 73.1% in Wawa, and 50.0% in Blitta.

Data in this evaluation project of the end of project reveal that 88.9% of CHAs in Blitta and 82.8% of CHAs in Haho knew the ideal interval of pregnancy. In Wawa this proportion was only 46.2% against 0.0% at the onset. The advantages were also well known by the CHAs (100% of CHA in Blitta, 93.1% of CHAs in Haho).

9.7-Danger Signs during pregnancy.

It was expected that the CHAs knew the warning signs during pregnancy and in the newborn baby so that they can refer patients to health care facilities on time. On this principle, a little more than 2 CHAs out of 10 representing 22.4% knew the warning signs during pregnancy (Table 21) before the activities of the project. The highest proportion of the CHAs who knew these signs were obtained in Haho with 41.4%, Blitta had 10.0% and Wawa 15.4%.

At the latter end of project evaluation, the proportions are 93.3% in Blitta, 82.8% in Haho and 0.0% in Wawa.

9.8- Warning signs in new-borns

All the CHAs did not know the danger signs in new-born (Table 21). Generally, the proportion of those who did not know the signs is more than 9 CHAs out of 10 (97.6%), including 100% in both Blitta and Wawa, and 93.1% in Haho. The proportion of CHAs who knew the warning signs in the newborns at the end of project were 75.6% in Blitta, 60.3% in Haho and 7.7% in Wawa.

Figure 21 : Percentage distribution of CHAs who know the Kangaroo Mother Care, the ideal interval for child spacing and warning signs in pregnant women, during delivery and in the newborn baby

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Demonstration of Kangaroo method</u>									
Do not know	100.0	8.9	7.8***	96.6	31.0	5.8***	100.0	100.0	
Know steps to avoid fall in temperature	0.0	91.1	-7.8***	3.4	69.0	5.8***	0.0	0.0	
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	30	45		29	58		26	13	
<u>Advantages of Kangaroo methods</u>									
Do not master advantages of SMK	100.0	4.4	8.2***	93.1	8.6	7.7***	96.2	100.0	-0.7 ns
Master advantages of SMK	0.0	95.6	-8.2***	6.9	91.4	7.7***	3.8	0.0	0.7 ns
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	30	45		29	58		26	13	
<u>Perfect knowledge of the IIG</u>									
Do not know IIG	66.7	11.1	7.6***	55.2	17.2	5.9***	100.0	53.8	3.8***
Know the IIG	33.3	88.9	7.6***	44.8	82.8	5.9***	42.3	46.2	3.8***
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	30	45		29	58		26	13	
<u>Advantages of birth spacing</u>									
Do not know advantage	50.0	0.0	5.3***	20.7	6.9	1.9 ns	26.9	53.8	-1.7 ns
know advantages	50.0	100.0	-5.3***	79.3	93.1	-1.9 ns	73.1	46.2	1.7 ns
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	30	45		29	58		26	13	
<u>Danger signs during pregnancy</u>									
Do not know danger signs	90.0	6.7	7.2***	58.6	17.2	3.9***	84.6	100.0	-1.5 ns
Know danger signs	10.0	93.3	-7.2***	41.4	82.8	3.9***	15.4	0.0	1.5 ns
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	30	45		29	58		26	13	
<u>Danger signs in newborns</u>									
Do not know signs	100.0	24.4	6.4***	93.1	39.7	4.7***	100.0	92.3	1,4 ns
Know signs	0.0	75.6	-6.4***	6.9	60.3	4.7***	0.0	7.7	-1,4 ns
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	30	45		29	58		26	13	

9.9- Inventory management for products tracers by the CHAs

9.9.1- Contraceptives Products

At the baseline evaluation, most of CHAs in the three districts (Table 22) had never received oral contraceptives in their pharmacy box (9 CHA out of 10 representing 91.8%). Those who experienced stock-outs represent less than one CHA out of 10 (7.1%). Condoms were available to about 3 CHAs out of 10 (31.8%). During data collection, 2 CHAs out of 10 (24.7%) run out of condoms.

With project support, the CHAs of the districts of Blitta and Haho received contraceptives products such as injection, pills, femidoms, and condoms. None of them experienced stock-outs during the last six months (Table 22).

9.9.2- Antibiotics

At the baseline evaluation, antibiotics which should have been available in pharmacies of CHAs were amoxicillin or erythromycin for the treatment of Pneumonia. It appears that 8 CHA out of 10 representing 82.4% have never received amoxicillin, 9 CHAs out of 10 that is 92.9% had never received erythromycin. The proportion of those who has run out of amoxicillin represents 13.3% in Blitta, 17.2% in Haho, and 3.8% in Wawa (Table 22).

After the implementation of the project and given the availability at the central pharmacies (CAEGD and OCDI), the CHAs in the district of Blitta and Haho received erythromycin to treat pneumonia cases. Over 90% of CHAs in the two districts have never run out of stock. But there is great concern about the sustainability of the present system.

9.9.3- ACT, TDR and MII

In the sample of CHA interviewed (Table 22), 8 out of 10 representing 81.2% received the ACT but 6 CHAs out of 10 experienced stock-outs (60.0%). For insecticide-treated bednet (MII), about CHAs out of 10 (77.6%) received it but 60.0% have run out of stock. The proportion of CHAs having experienced MII stock-outs is the same proportion as the CHAs that run out of ACT. The proportion of CHAs having RDT is the same as that of those that had the ACT and MII. But as regards TDR, the proportion of CHAs that had run out of stock is 38.8%.

As part of the project, the CHAs did not receive the MII and the RDT. They all received ACT of artesunate amodiaquine type of fixed combination. Until the evaluation day, the proportion of those who did not run out of stock was 97.8% in Blitta, 87.9% in Haho and 15.4% in Wawa. As part of the project, and in collaboration with district officials, the re-supply system was functional. Just as with the antibiotics, efforts must be made to clarify the responsibilities so as to maintain the re-supply system.

9.9.4- ORS and Zinc

As part of the fight against diarrhoea about 8 CHAs out of 10 (Table 22) never received ORS and almost the totality of CHAs never received Zinc (97.6%). During the project, all CHAs received

ORS. Those of Blitta district received zinc. To date, there has not yet been a stock-out for these two products.

Table 22 : Percentage distribution of CHAs with or without shortages of tracer product for the health of under-5 children and family planning.

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Oral contraceptives</u>									
Stock-out	10.0	0.0	2,2*	10,3	3.4	1,3 ns	0	0.0	
			-						
No Stock-out	00	100.0	8.7***	0	96.6	-8.9***	3.8	0.0	0.7 ns
Never received	90.0	0.0	8.0***	89.7	0.0	8.6***	96.2	100.0	-0.7 ns
Total	100.0	100.0		100	100.0		100	100.0	
<u>ACT</u>									
Stock-out	53.3	0.0	5.5***	65.5	8.6	5.6***	61.5	69.2	-0.5 ns
			-						
No Stock-out	20.0	97.8	7.0***	24.2	87.9	-5.9***	19.3	15.4	0.3 ns
Never received	26.7	2.2	3.2**	10.3	3.5	1.3 ns	19.2	15.4	0.3 ns
Total	100.0	100.0		100	100.0		100	100.0	
<u>ORS</u>									
Stock-out	23.3	0.0	3.4**	17.3	1.7	27**	3.8	15.4	-1.3 ns
			-						
No Stock-out	00	100.0	8.7***	10.3	98.3	-8.4***	7.7	0.0	1.0 ns
Never received	76.7	0.0	7.1***	72.4	0.0	74***	88.5	84.6	0.3 ns
Total	100.0	100.0		100	100.0		100	100.0	
<u>Zinc</u>									
No Stock-out		0,0			1.8	-0.7 ns		0.0	
			-						
Never received	3.3	100.0	8.4***	3.4	3.5	0.0 ns	0	0.0	
	96.7	0.0	8.4***	96,6	94,7	0,4 ns	100	100.0	
Total	100.0	100.0		100	100.0		100	100.0	
<u>Amoxicillin</u>									
Stock-out	13.3	0.0	2.5*	17.2	40.0	-2.1*	3.8	0.0	0.7 ns
No stock-out	3.4	4.4	-0.2 ns	6.9	12.7	-0.8 ns	7.7	0.0	1.0 ns
Never received	83.3	95.6	-1.8 ns	75.9	47.3	2.5*	88.5	100.0	-1.3 ns
Total	100.0	100,0		100	100,0		100	100.0	
<u>Erythromycin</u>									
Stock-out	10.0	2.2	1.5 ns	3.4	8.6	-0.9 ns	3.8	0.0	0.7 ns
			-						
No stock-out	0.0	97.8	8.4***	3.5	91.4	-8.0***	0	0.0	
Never received	90.0	0.0	8.0***	93.1	0.0	8.8***	96.2	100.0	-0.7 ns

Total	100,0	100,0		100	100,0		100	100,0	
MII									
Stock-out	43.3	6.7	3.8***	79.3	0.0	7.9***	57.7	23.1	2.0*
No stock-out	26.7	2.2	3.2**	3.5	1.7	0.5 ns	23.1	7.7	1.2 ns
			-						
Never received	30.0	91.1	5.5***	17.2	98.3	-7.9***	19.2	69.2	-3.1**
Total	100,0	100,0		100	100,0		100	100,0	
RDT									
Stock-out	46.7	0,0	5.1***	24.1	0.0	3.9***	46.2	76.9	-1.8 ns
No stock-out	26.7	2.2	3.2**	62.1	1.7	6.4***	34.6	15.4	1.3 ns
			-						
Never received	26.6	97.8	6.6***	13.8	98.3	-8.1***	19.2	7.7	0.9 ns
Total	100,0	100,0		100	100,0		100	100,0	
Condoms									
Stock-out	33.3	0.0	4.2***	34.5	5.2	3.6***	3.8	0.0	0.7 ns
			-						
No stock-out	3.4	97.8	8.2***	6.9	931	-7.9***	11.5	0.0	1.3 ns
Never received	63.3	2.2	5.9***	58.6	1.7	6.2***	84.7	100.0	-1.5 ns
Total	100.0	100.0		100	100.0		100	100.0	
Number	30	45		29	58		26	13	

9.10- Evaluation of CHAs with regard to project

The CHAs in Haho and Blitta district admitted to have benefited from some activities of the project. These activities include training, grant for equipment and products, monthly premiums and supervisions. The proportions of CHAs that cited these activities exceeded 95% in Blitta and 85% in Haho. There was a disagreement over discounts on products because the practice was not yet systematized in the two districts. These discounts are applicable only for the IMNCD products.

All the CHAs were satisfied with the project, with over 50% reporting to have been very satisfied with the implementation process. Most of the people wish to update their work, have more financial resources to maintain their bicycles.

Table 23 : Percentage distribution of CHAs by district based on activities they benefited from, general evaluation, suggestions to improve on the project.

Characteristics	Health district		
	BLITTA	HAHO	WAWA
<u>AWARE II Project activities benefiting CHA</u>			
Supervision	97.8	50.0	0.0
Grant for products and equipment	100.0	98.3	30.8
Community FP training	97.8	93.1	0.0

IMNCD-C training	100.0	86.2	0.0
Discounts on sale	95.6	58.6	0.0
Monthly motivation premiums	100.0	94.8	0.0
Other	0.0	15.5	15.4
Number	45	58	13
<u>General evaluation of CHA project</u>			
Very satisfied	51.1	50.0	0.0
Satisfied	48.9	50.0	85.7
Not satisfied	0.0	0.0	14.3
Total	100.0	100.0	100.0
Number	45	58	7
<u>CHA Suggestions for improving project services</u>			
Higher motivation premiums for CHAs	20.0	55.2	0.0
Subsidies for equipment maintainance	24.4	55.2	7.7
Retraining of CHAs	42.2	62.1	0.0
Other	933	55.2	38.5
Number	45	58	13

10- Knowledge and abilities of women of child bearing age in FP and integrated management of diseases of under-5 children.

10.1- Ideal birth spacing and advantages

Women who recognised the interval of ideal birth spacing of at least 24 months accounted for less than one in 10 women (8.2%) at the baseline evaluation. By districts, there was 7.2% in Blitta, 11.0% in Haho and 6.4% in Wawa. The final evaluation results noted a significant increase in the three districts namely (Blitta 47.0%, Haho 31.1% and Wawa 53.0%). These increments were not simply the work of the project in Wawa.

As part of the advantages of birth spacing, women who mastered it represented, in the study base, a proportion of 51.0% in Blitta, 56.7% in Haho and 58.3% in Wawa. At the end of the project, the proportions have increased significantly in the three districts- Blitta 83.3%, Haho 83.8% and Wawa 76.1% (Table 24). In this area, women would have gathered enough information at the time when the project was implemented.

10.2- Needs not met in FP

The proportion of married women or in relationship who wanted a contraception but did not use it during the collection period accounted for 28.4% in Blitta, 29.4 in Haho and 37.5 in Wawa at the baseline evaluation. These rates increased in the intervention districts (Blitta 39.3% and Haho 30.2%). It is slightly down in the Wawa (35.5%). The various rate changes between the baseline evaluation and the final evaluation were not statistically significant. The current rates were very close to the national average rate of needs not met in FP 31% according to MICS 4 of 2010.

Table 24 : distribution (%) of women of child bearing age who know the ideal birth spacing with the related advantages and unmet FP needs

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Perfect Knowledge of IIG</u>									
Know IIG (24 months)	7.2	47.0	13.9***	11.0	31.1	7.6***	6.4	53.0	15.6***
Do not know IIG	92.8	53.0	13.9***	89.0	68.9	7.6***	93.6	47.0	15.6***
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	489	466		492	444		483	440	
<u>Advantage of birth spacing</u>									
Master advantages	0	83.3	10.4***	0	83.8	8.8***	0	76.1	-5.6***
Do not master advantages	49.0	16.7	10.4***	43.3	16.2	8.8***	41.7	23.9	5.6***
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	447	466		439	444		412	440	
<u>Needs not met in FP</u>									
Wish to use a contraceptive method but do not use it	28.4	39.3	-2.1*	29.4	30.2	-0.2 ns	37.3	35.5	0.3 ns
Do not wish to use a contraceptive	71.6	60.7	2.1*	70.6	69.8	0.2 ns	62.7	64.5	-0.3 ns
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	116	364		102	328		118	304	

10.3- Contraception

10.3.1- Knowledge of methods

InjeACTble contraceptives were the best known methods by women in the three districts. Their proportion has changed between the beginning and end of project. In Blitta it increased from 60.3% to 95.1%, in Haho from 63.6% to 93.5% and in Wawa from 75.4% to 78.6%.

Then followed by the proportion of women who know the condom. It increased from 67.3% to 68.0% in Wawa, from 59.3% to 87.8% in Haho and from 44.6% to 90.6% in Blitta. The proportion of women who know the pills has also increased from 45.8% to 89.7% in Blitta and from 46.5% to 87.8%. For all other methods, the increments were observed and were statistically significant in the districts of intervention (Table 25).

10.3.2- Source of information about contraceptives

In the early interventions, information on the contraceptive methods for women was obtained in health centres. They remain the leading centres for Wawa district (59.1% at the initial stage and 65.1% at the end of project). Using CHAs as a source of information for FP has increased significantly in the Haho and Blitta districts. The proportion of women claiming to have information from these CHAs was 52.2% against 3.9% in Blitta and 65.6% against 2.1% in Haho and 65.6% against 2.1% in Haho (Table 25).

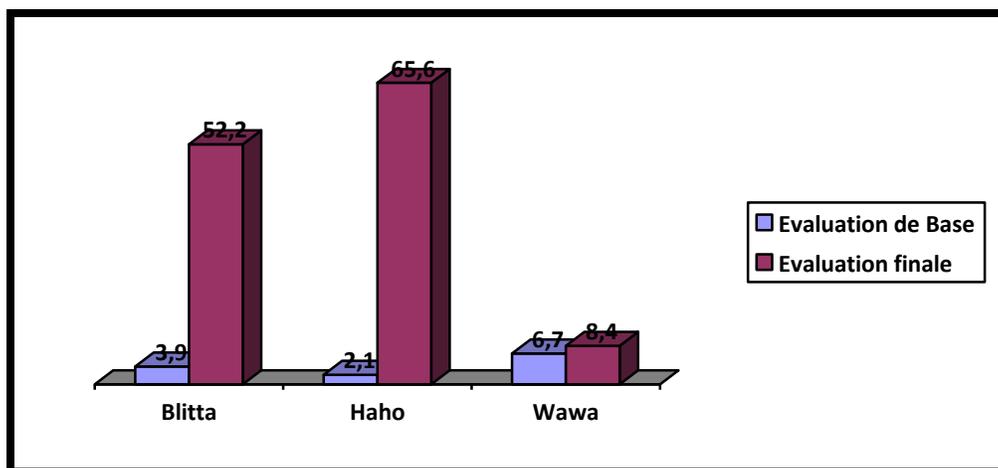


Figure 9 : proportion of FAP which declared sourcing FP information from CHAs in the three districts in the baseline and final evaluation.

Tableau 25 : Percentage distribution of women of child bearing age by existing FP and source of information.

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Existing contraceptive Methods</u>									
Female sterilization	0.4	15.2	-8.6***	24.4	27.7	-1.2 ns	19.9	8.9	4.7***
Male sterilization	0.4	14.4	-8.3***	7.3	23.0	-6.8***	6.8	5.9	0.6 ns
IUDs	8.2	29.8	-8.6***	24.4	36.7	-4.1***	30.4	18.0	4.4***
						-			
Injection	60.3	95.1	-12.8***	63.6	93.5	11.0***	75.4	78.6	-1.2 ns
Implants	32.1	56.0	-7.4***	45.7	51.4	-1.7 ns	58.0	47.0	3.3***
						-			
Pill	45.8	89.7	-14.4***	46.5	87.8	13.3***	67.5	64.1	1.1 ns
Male condom	44.6	90.6	-15.1***	59.3	87.6	-9.7***	67.3	68.0	-0.2 ns
						-			
Female	12.5	63.3	-16.2***	20.5	59.0	12.1***	22.6	46.4	7.6***
MAMA	0.8	7.9	-5.4***	16.3	23.9	-2.9**	13.7	11.6	1.0 ns
Rythm method	7.6	14.4	-3.4***	30.9	18.7	4.3***	33.3	21.6	4.0***
Withdrawal	1.0	2.1	-1.4 ns	23.4	12.4	4.4***	18.8	6.8	5.4***
Morning-after pill	0.8	2.4	-1.9 ns	13.4	5.6	4.0***	12.6	3.9	4.8***
Other	2.7	1.7	1.0 ns	3.3	1.6	1.7 ns	1.4	2.0	-0.8 ns
Number	489	466		492	444		483	440	
<u>Place where women got information on FP for the first time</u>									
Structure/ Health personnel	69.6	33.0	10.4***	40.0	18.2	6.9***	59.1	65.1	-1.7 ns
						-			
CHA	3.9	52.2	14.8***	2.1	65.6	18.9***	6.7	8.4	-0.9 ns
Husband /spouse/Partner	0.9	0.0	2.0*	1.0	0.2	1.4 ns	0.2	1.0	-1.5 ns
Family Member	1.9	0.4	2.0*	2.9	1.4	1.5 ns	1.7	1.8	-0.1 ns
Friend/female friend	12.5	5.0	3.9***	34.8	7.2	9.8***	16.2	14.5	0.7 ns

Other	11.2	9.3	0.9 ns	19.2	7.4	5.0***	16.1	9.2	3.0**
Total	100.0	100.0		100.0	100.0		100.0	100.0	
Number	359	460		385	433		421	392	

10.3.3-Using methods

The proportions of women using contraceptive methods were more improved than the baseline study in the project districts. For evidence, there was 7.6% against 16.9% in Haho and 55.6% against 22.9 % in Blitta. In the Wawa district, the change is low and insignificant accounting for 26.2% against 25.8% (Table 26).

The methods that women claim to have used were mostly injections (Table 26). The proportions increased from 41.7% to 72.6% in Haho, from 37.4% to 54.4% in Wawa and from 29.2% to 59.2% in Blitta.

The majority of women got their methods from the public health centres (Table 26),(58.5% in Blitta, 45.1% in Haho and 68.3% in Wawa). At the end of the project, the great proportion of women received methods from CHAs in Blitta and Haho with proportions of 72.5% in Blitta and 79.5% in Haho.

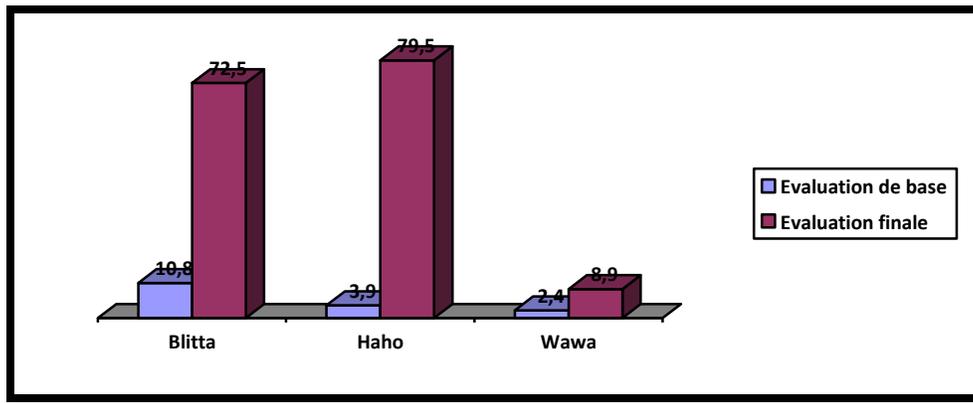


Figure 10 : Proportion of women who were introduced to contraceptive methods by CHAs in the baseline and final evaluations in the three districts

Table 26 : Percentage distribution of women of child birth age by use of contraceptive methods, methods used, source of information, motives for choosing method

Characteristics	Health district								
	BLITTA district			HAHO district			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Use of contraceptive methods</u>									
Women under methods currently	22.9	55.6	8.9***	16.9	37.2	6.2***	25,8	26.2	-0.1 ns
Women not using methods currently	77.1	44.4	8.9***	831	62.8	6.2***	74,2	73.8	0.1 ns
Total	100.0	100.0		100.0	100.0		100,0	100.0	
Number	315	419		355	393		384	344	
<u>contraceptive Methods used</u>									
Female sterilisation	0.0	0.4	-0.6 ns	5.0	0.0	2.7**	1,0	0.0	1.0 ns
IUD	1.4	1,7	-0.2 ns	1.7	0.7	0.7 ns	2,0	2.2	-0.1 ns
Injections	29.2	59.2	4.5***	41.7	72.6	4.2***	37,4	54.4	-2.4*
Implants	16.7	10.7	1.4 ns	10.0	4.1	1.6 ns	11,1	16.7	-1.1 ns
Pill	18.1	12.4	1.2 ns	16.7	8.2	1.8 ns	24,2	14.4	1.7 ns
Condom	29.2	13.7	3.0**	10.0	4.1	1.6 ns	7,1	11.1	-1.0 ns
Female Condom	0.0			0.0			1,0		1.0 ns
Rythm method	9.7	0.9	3.9***	13.3	0.0	4.5***	17,2	1.1	3.8***
Withdrawal	0.0			5.0		2.7**	1.0		1.0 ns
Number	72	233		60	146		99	90	
<u>Source of method</u>									
public hospital	15.4	1.3	4.9***	5.9	55	0.1 ns	6.1	3.3	0.9 ns
Public health Centre	43.1	17.6	4.3***	39.2	8.2	5.2***	62.2	68.9	-0.9 ns
FP Clinic	0.0	0.4	-0.5 ns	3.9	0.7	1.6 ns	0.0	0.0	
Mobil/ Public Clinic	0.0	0.4	-0.5 ns	3.9	0.7	1.6 ns	0.0	2.2	-1.4 ns
Other Public Sector	1.5	0.4	0.9 ns	2.0	0.0	1.7 ns	8.5	0.0	2.8**
Hopital/clinic/private office	0.0	0.4	-0.5 ns	5.9	0.7	2.3*	0.0	0.0	
Private pharmacy	0.0	0.9	-0.7 ns	0.0	1.4	-0.8 ns	2.4	0.0	1.5 ns
Community health worker/ village	10.8	72.5	9.0***	3.9	79.5	9.5***	2.4	8.9	-1.8 ns
Shop	20.0	3.4	4.6***	15.7	0.0	4.9***	7.3	8.9	-0.4 ns
Other areas	7.7	2.1	2.2*	9.8	1.4	2.8**	7.3	4.4	0.8 ns
Number	65	233		51	146		82	90	
<u>Reasons for the choice of a method</u>									
Free	8.3	5.2	1.0 ns	5.0	19.9	-2.7**	4.0	5.6	-0.5 ns
Cheaper	34.7	1.7	8.3***	8.3	2.7	1.8 ns	10.1	67	0.8 ns
More available	2.8	6.4	-1.2 ns	26.7	5.5	4.3***	9.1	5.6	0.9 ns

Was prescribed	4.2	12.4	-2.0*	5.0	0.7	2.0*	2.0	2.2	-0.1 ns
			-			-			
More effective	11.1	41.6	4.8***	3.3	24.7	3.6***	25.3	33.3	-1.2 ns
No adverse effects	13.9	9.4	1.1 ns	8.3	6.2	0.6 ns	11.1	14.4	-0.7 ns
The only existing method	2.8	0.9	1.3 ns	3.3	2.1	0.5 ns	7.1	1.1	2.0*
On recommendation	6.9	11.6	-1.1 ns	18.3	11.6	1.3 ns	15.2	20.0	-0.9 ns
Other	13.9	9.9	10 ns	21.7	21.2	0.1 ns	16.2	8.9	1.5 ns
Number	72	233		60	146		99	90	

10.4- Using the mass media

As observed in the baseline study, radio stations were the most influential media. State media come in first among districts. In Blitta the three radios with the widest audience were- Radio Kara, Radio Etincelle, and Radio Lomé, in Haho the order is Radio Lomé, Moisson Finale and Radio Kara, while listeners in Wawa preferred the two public radios: Kara and Lomé. (Table 27).

Tableau 27 : Percentage distribution of women of child bearing age by frequency of reading newspapers, types of newspapers read, frequency of listening to radios, preferred radio stations, frequency of watching TV and TV channels watched.

Characteristics	Health district								
	BLITTA district			district HAHO			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Frequency for newspapers reading</u>									
Almost every day	0.8	0.4	0.7 ns	0.2	0.2	-0.1 ns	0.4	0,2	0.5 ns
At least once a week	1.5	0.0	2.7**	1.2	0.2	1.7 ns	1.4	0,2	1.9 ns
Less than once per week	0.8	0.0	1.9 ns	1.6	0.5	1.7 ns	1.4	0,0	2.5*
Not at all	96.9	99.6	-3.1**	97.0	99.1	-2.3*	96.8	99,5	-3.1**
Total	100.0	100.0		100.0	100.0		100.0	100,0	
Number	489	466		492	444		483	440	
<u>Newspapers or magazines read</u>									
Togo Presse	40.0	100.0	-1.6 ns	53.3	50.0	0.1 ns	31.3	100,0	-1.9 ns
Private newspapers	26.7		0.8 ns	13.3		0.8 ns	6.3		0.4 ns
International Magazine	33.3	0.0	1.0 ns	33.3	50.0	-0.6 ns	62.5	0,0	1.7 ns
Number	15	2		15	4		16	2	
<u>Frequency of listening to radio</u>									
Almost everyday	29.2	29.0	0.1 ns	40.0	28.4	3.7***	33.5	21,1	4.2***
At least once a week	28.6	24.5	1.4 ns	23.2	14.2	3.5***	21.3	15,9	2.1*
Less than once a week	4.7	1.1	3.3***	5.9	5.0	0.6 ns	5.2	3,4	1.3 ns
Not at all	37.5	45.5	-2.5*	30.9	52.5	6.7***	40.0	59,5	-5.9***
Total	100.0	100.0		100.0	100.0		100.0	100,0	
Number	489	466		492	444		483	440	
<u>Radio stations listened</u>									
Radio Lomé	35.6	34.6	0,2 ns	78.8	77.7	0.3 ns	87.6	86,5	0.3 ns
Radio Kara	71.9	66.9	1,3 ns	22.1	10.0	3.7***	36.2	41,0	-1.0 ns
Novissi	0.3	0.4	-0.2 ns	65.0	67.3	-0.6 ns	0.7	0,0	1.1 ns
Moisson finale	0.3	0.4	-0.2 ns	14.4	8.5	2.0*	1.0	0,6	0.5 ns
Sky FM	3.6	2.8	0.6 ns	1.2	2.4	-1.0 ns	1.7	3,4	-1.2 ns
Etincelle	41.2	53.1	-2.8**	0.0	0.9	-1.8 ns	16.6	9,6	2.1*
Cosmos	18.0	9.4	2.9**	0.6	0.5	0.2 ns	0.0	0,0	
Adja Hloma	0.3	0.4	-0.2 ns	21.2	171	1.2 ns	0.7	0,6	0.2 ns
Other	23.5	19.7	1.1 ns	30.9	28.9	0.5 ns	38.3	31,5	1.5 ns
Number	306	254		340	211		290	178	
<u>Frequency of using TV</u>									
Almost everyday	0.8	0.6	0.3 ns	3.9	1.4	2.4*	1.0	0,2	1.5 ns
At least once a week	7.2	3.2	2.8**	3.1	3.8	-0.6 ns	4.8	0,9	3.5***
Less than once a week	1.8	0.9	1.3 ns	2.8	1.4	1.5 ns	0.4	0,2	0.5 ns
Not at all	90.2	95.3	-3.0**	90.2	93.5	-1.8 ns	93.8	98,6	-3.8***

Total	100.0	100.0		100.0	100.0		100.0	100,0	
Number	489	466		492	444		483	440	
<u>TV channels more watched</u>									
Télévision Togolaise									
(TVT)	18.8	50.0	-2.7**	91.7	89.7	0.3 ns	36.7	50,0	-0.6 ns
LCF	12.5	9.1	0.4 ns	12.5	3.4	1.3 ns	13.3	0,0	0.9 ns
TV5	6.3	4.5	0.3 ns	14.6	6,9	1.0 ns	3.3	16,7	-1.3 ns
France 24	6.3	0.0	1.2 ns	16.7	0,0	2.3*	3.3	16,7	-1.3 ns
Africa 24	4.2	4.5	-0.1 ns	14.6	0,0	2.2*	0.0	16,7	-2.3*
LC2	2.1	9.1	-1.3 ns	6.3	0.0	1.4 ns	6.7	0,0	0.7 ns
Canal 3	6.3	4.5	0.3 ns	6.3	0.0	1.4 ns	0.0	0,0	
Other	75.0		5.8***	16.7		2.3*	53.3		2.4*
Number	48	22		48	29		30	6	1,2 ns

10.5- Media exposure

The number of women of child bearing age in the three districts exposed to the media was very small. The only media listened to once a week was the radio.

10.5.1 Women's profile

Table 28 : Proportion of women aged 15-49 who usually read a newspaper, listen to the radio and / or watch television at least once a week, by selected sociodemographic characteristics, Blitta health district, 2012

Sociodemographic Characteristics	Read a newspaper at least once a week	Listen to the radio at least once a week	Watch TV at least once a week	The three media at least once a week	No media at least once a week	Total
<u>Age of women</u>						
15-19	0.0	20.8	8.3	0.0	77.1	48
20-24	0.0	25.0	3.0	0.0	72.0	100
25-29	0.0	27.4	2.8	0.0	70.8	106
30-34	0.0	22.2	3.7	0.0	74.1	81
35-39	0.0	26.8	2.8	0.0	70.4	71
40-44	0.0	15.9	0.0	0.0	84.1	44
45-49	0.0	37.5	0.0	0.0	62.5	16
<u>Woman's ethnic group</u>						
Ewe	0.0	17.6	0.0	0.0	82.4	17
Kabye	0.0	26.5	2.0	0.0	72.8	147
Tem	0.0	25.0	12.5	0.0	62.5	8
Losso	0.0	31.0	6.2	0.0	64.3	129
Akebou	0.0	0.0	0.0	0.0	100.0	2
Agnanga	0.0	4.8	0.0	0.0	95.2	21
Other	0.0	20.4	2.1	0.0	77.5	142
<u>Marital status</u>						
Single	0.0	19.5	7.3	0.0	75.6	41
Married	0.0	23.3	2.0	0.0	75.2	343
In relationship	0.0	34.8	7.6	0.0	59.1	66
Divorced/Separated	0.0	10.0	0.0	0.0	90.0	10
widower	0.0	33.3	0.0	0.0	66.7	6
<u>Level of education</u>						
none	0.0	21.0	1.4	0.0	77.6	143
Primary	0.0	25.0	3.0	0.0	73.3	232
Secondary +	0.0	28.6	6.6	0.0	65.9	91
Together	0.0	24.5	3.2	0.0	73.2	466

Tableau 29 : **Proportion of women aged 15-49 who usually read a newspaper, listen to the radio and / or watch television at least once a week, by selected sociodemographic characteristics, Haho health district, 2012**

Characteristics	Read a newspaper at least once a week	Listen to the radio at least once a week	Watch TV at least once a week	The three media at least once a week	No media at least once a week	Total
<u>Age of women</u>						
15-19	0.0	25.0	5.0	0.0	72.5	40
20-24	0.0	12.2	1.4	0.0	86.5	74
25-29	1.0	8.1	5.1	0.0	88.9	99
30-34	0.0	13.8	4.6	0.0	85.3	109
35-39	0.0	18.8	1.6	0.0	79.7	64
40-44	0.0	15.9	4.5	0.0	81.8	44
45-49	0.0	14.3	7.1	0.0	78.6	14
<u>Ethnicity of woman</u>						
Ewe	0.7	17.6	3.5	0.0	80.3	142
Kabye	0.0	12.8	1.8	0.0	86.2	109
Tem	0.0	0.0	0.0	0.0	100.0	3
Losso	0.0	26,7	6.7	0.0	66.7	15
Akposso	0.0	0.0	0.0	0.0	100.0	6
Ouatchi	0.0	0.0	0.0	0.0	100.0	3
Autre	0.0	12.0	5.4	0.0	85.5	166
<u>Marital status</u>						
Single	0.0	28.1	3.1	0.0	71.9	32
Married	0.3	13.6	4.4	0.0	83.8	339
In relationship	0.0	10.3	0.0	0.0	89.7	58
Divorced/Separated	0.0	14.3	14.3	0.0	85.7	7
widower	0.0	12.5	0.0	0.0	87.5	8
<u>Level of education</u>						
none	0.0	11.8	4.7	0.0	85.9	297
Primary	0.0	17.1	0.9	0.0	82.9	117
Secondary +	3.3	26.7	6.7	0.0	66.7	30
Together	0.2	14.2	3.8	0.0	83.8	444

Table 30 : Proportion of women aged 15-49 who usually read a newspaper, listen to the radio and / or watch television at least once a week, by selected sociodemographic characteristics, Wawa health district, 2012

Characteristics	Read a newspaper at least once a week	Listen to the radio at least once a week	Watch TV at least once a week	The three media at least once a week	No media at least once a week	Total
<u>Age of women</u>						
15-19	0.0	8.3	0.0	100.0	91.7	36
20-24	0.0	18.3	0.0	100.0	81.7	60
25-29	0.0	15.7	0.0	100.0	84.3	102
30-34	0.0	18.1	0.0	100.0	81.9	83
35-39	0.0	16.7	3.8	100.0	79.5	78
40-44	0.0	15.8	1.8	100.0	84.2	57
45-49	4.2	12.5	0.0	100.0	83.3	24
<u>Ethnicity of woman</u>						
Ewe	0.0	17.1	2.4	100.0	82.9	41
Kabye	0.0	17.0	0.0	100.0	83.0	94
Tem	0.0	21.6	0.0	100.0	78.4	37
Losso	0.0	0.0	0.0	100.0	100.0	1
Akposso	0.0	14.9	4.3	100.0	80.9	47
Akebou	0.5	13.6	0.5	100.0	85.4	213
Ouatchi	0.0	0.0	0.0	100.0	100.0	1
Fon	0.0	100.0	0.0	100.0	0.0	1
Other	0.0	40.0	0.0	100.0	60.0	5
<u>Marital status</u>						
Single	0.0	17.2	0.0	100.0	82.8	29
Married	0.0	16.8	1.2	100.0	82.3	333
In relationship	0.0	13.0	0.0	100.0	87.0	54
Divorced/separated	0.0	0.0	0.0	100.0	100.0	13

widower	9.1	18.2	0.0	100.0	72.7	11
<u>Level of education</u>						
None	0.0	13.5	0.6	100.0	85.8	155
Primary	0.0	17.6	0.9	100.0	82.0	222
Secondary and +	1.6	15.9	1.6	100.0	81.0	63
Together	0.2	15.9	0.9	100.0	83.2	440

Table 31 : Percentage distribution of women aged 15-49 per district in terms of media exposure, based on certain socio-demographic per zone, Blitta and Wawa Health Districts 2012.

Features	BLITTA District				HAHO District				WAWA District			
	Afternoon	Before noon	Total	Number	Afternoon	Before noon	Total	Number	Afternoon	Before noon	Total	Number
<u>Age brackets</u>												
15-19 years	100,0	0,0	100,0	48	97,5	2,5	100,0	40	94,4	5,6	100,0	36
20-24 years	93,0	7,0	100,0	100	97,3	2,7	100,0	74	93,3	6,7	100,0	60
25-29 years	97,2	2,8	100,0	106	96,0	4,0	100,0	99	97,1	2,9	100,0	102
30-34 years	96,3	3,7	100,0	81	94,5	5,5	100,0	109	94,0	6,0	100,0	83
35-39 years	91,5	8,5	100,0	71	95,3	4,7	100,0	64	94,9	5,1	100,0	78
40-44 years	95,5	4,5	100,0	44	97,7	2,3	100,0	44	98,2	1,8	100,0	57
45-49 years	87,5	12,5	100,0	16	100,0	0,0	100,0	14	91,7	8,3	100,0	24
<u>Ethnic group of the women</u>												
Ewe	100,0	0,0	100,0	17	97,9	2,1	100,0	142	87,8	12,2	100,0	41
Kabye	92,5	7,5	100,0	147	94,5	5,5	100,0	109	95,7	4,3	100,0	94
Tem	100,0	0,0	100,0	8	100,0	0,0	100,0	3	86,5	13,5	100,0	37
Losso	95,3	4,7	100,0	129	100,0	0,0	100,0	15	100,0	0,0	100,0	1
Akposso					100,0	0,0	100,0	6	100,0	0,0	100,0	47
Akebou	100,0	0,0	100,0	2					96,7	3,3	100,0	213
Ouatchi					100,0	0,0	100,0	3	100,0	0,0	100,0	1
Agnanga	95,2	4,8	100,0	21								
Fon									100,0	0,0	100,0	1
Other	96,5	3,5	100,0	142	95,2	4,8	100,0	166	100,0	0,0	100,0	5
<u>Marital status</u>												
Single	100,0	0,0	100,0	41	96,9	3,1	100,0	32	89,7	10,3	100,0	29
Married	94,5	5,5	100,0	343	95,3	4,7	100,0	339	94,9	5,1	100,0	333

Cohabitation	93,9	6,1	100,0	66	100,0	0,0	100,0	58	98,1	1,9	100,0	54
Divorced/Separated	100,0	0,0	100,0	10	100,0	0,0	100,0	7	100,0	0,0	100,0	13
<u>Level of education</u>												
Widow	100,0	0,0	100,0	6	100,0	0,0	100,0	8	100,0	0,0	100,0	11
None	97,2	2,8	100,0	143	96,6	3,4	100,0	297	94,8	5,2	100,0	155
Primary	93,5	6,5	100,0	232	96,6	3,4	100,0	117	95,0	5,0	100,0	222
Secondary +	95,6	4,4	100,0	91	90,0	10,0	100,0	30	96,8	3,2	100,0	63

11- TREATING CHILDREN FOR MAJOR DISEASES

11.1- Malaria Treatment of

Fever was the main symptom associated with malaria in the community. To treat fever in an under-5 child, community health agents or health agents must conduct a RDT and administer an ACT. In all, very few children had fever during the two weeks preceding the final survey. Out of these, 30.3% occurred during the final evaluation as against 37.7% at the beginning of the Blitta project. Haho District recently recorded 25.7% as against 43% at the beginning. Wawa District had 29.9% at the end of the survey as against 39.9% at the beginning.

Table 32 : Percentage distribution of under-5 children with symptoms of fever and treated for malaria.

Features	Health District								
	BLITTA District			HAHO District			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Children below 5 years who have had fever in the last 2 weeks</u>									
Have had fever	37,7	30,3	2,5*	43,0	25,7	5,5***	39,3	29,9	3,0**
Have not had fever						-			-
	62,3	69,7	-2,5*	57,0	74,3	5,5***	60,7	70,1	3,0**
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	486	511		486	447		488	412	
<u>TDR test on children Test</u>									
Blood sample taken									
from the thumb	6,22	20,6	0,3 ns	1,04	13,9	1,2 ns	2,53	7,3	2,8**
			-0,3						-
No sample taken	78,1	79,4	ns	80,9	86,1	-1,2 ns	81,2	92,7	2,8**
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	183	155		209	115		192	123	

11.2- Treating diarrhoea

The proportion of children with reported cases of diarrhoea reduced in all the districts (Table 33). The figure dropped from 33.1% to 19.2% in the Blitta District, from 30.2% to 17.0% in the Haho District and from 26.4% to 22.3% in the Wawa District. Treatments administered in Haho and Wawa, during the baseline survey were mostly ORS-based. At Blitta, 44.9% of children were treated with ORS and zinc as against 2.3% at the beginning of the project. This reduction in diarrhoea cases could be attributed to the hand washing campaign by conducted CHAs.

Most malaria cases were treated by CHAs and not at health facilities as was the case in the baseline survey. 66.2% of the children were treated by CHAs as against 4.7% in the baseline

survey. Haho District recorded 56.1% as against 3.4% while most diarrhoea cases in Wawa were treated in health facilities.

Table 33 : Percentage distribution of under-5 children who reported with symptoms of diarrhoea and received an ORS and Zinc-based treatment

Features	Health District								
	BLITTA District			HAHO District			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Diarrhoe in children below 5 years in the last 2 weeks</u>									
Children who reported with diarrhoea	33,1	19,2	5,0***	30,2	17,0	4,7***	26,4	22,3	1,4 ns
Children who did not have diarrhoea	66,9	80,8	5,0***	69,8	83,0	4,7***	73,6	77,7	-1,4 ns
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	486	511		486	447		488	412	
<u>Solutions used to treat diarrhoea</u>									
ORS	20,8	13,3	1,5 ns	8,8	35,5	4,9***	12,9	16,3	-0,7 ns
ORS + ZINC	2,3	44,9	8,8***	0,7	7,9	-2,9**	1,7	5,4	-1,5 ns
Water and sugar solution	7,5	0,0	2,8**	2,7	3,9	-0,5 ns	3,4	1,1	1,1 ns
Ordinary drinking water	32,4	12,2	3,7***	34,5	21,1	2,1*	24,1	34,8	-1,7 ns
Other	49,1	36,7	2,0 ns	55,4	38,2	2,4*	57,8	53,3	0,7 ns
Number	173	98		148	76		116	92	
<u>Place of consultation/ treatment</u>									
Public hospital	3,8	1,4	1,0 ns	1,1	4,9	-1,3 ns	1,4	3,3	-0,7 ns
Public health centre.	33,0	1,4	5,2***	18,4	4,9	2,1*	18,6	19,7	-0,2 ns
Public health post.	5,7	8,1	-0,6 ns	8,0	19,5	-1,9 ns	10,0	9,8	0,0 ns
Community health agent	4,7	66,2	8,9***	3,4	56,1	6,9***	1,4	1,6	-0,1 ns
Other public sector	0,9	0,0	0,8 ns	1,1	2,4	-0,6 ns	1,4	0,0	0,9 ns
Private hospital/clinic	0,9	4,1	-1,4 ns	0,0	0,0		0,0	0,0	
Pharmacy	1,9	0,0	1,2 ns	0,0	2,4	-1,5 ns	0,0	3,3	-1,5 ns
Mobile clinic	0,0	0,0		0,0	2,4	-1,5 ns	1,4	0,0	0,9 ns
Health worker	0,0	0,0		3,4	0,0	1,2 ns	4,3	1,6	0,9 ns
Other medical service. Private	1,9	0,0	1,2 ns	2,3	2,4	0,0 ns	1,4	3,3	-0,7 ns
Chemist	15,1	12,2	0,6 ns	21,8	12,2	1,3 ns	31,4	42,6	-1,3 ns
Traditional healer	13,2	1,4	2,8**	8,0	0,0	1,9 ns	4,3	1,6	0,9 ns
Market	23,6		4,5***	14,9		2,6*	22,9		4,0***
Other	4,7	8,1	-0,9 ns	20,7	4,9	2,3*	5,7	13,1	-1,5 ns
Number	106	74		87	41		70	61	

11.3- Effect of ORS and feeding of sick children

Less than a woman out of every 10 (5.8%) knew that the ORS replenish the body fluids and mineral salts lost due to diarrhoea (Table 34). A greater number of women (41.9%) know that the ORS helps deal with diarrhea. This trend did not change after the intervention. In the Blitta district alone, it was realized that the number of parents, who gave unusually high volumes of water to their children suffering from diarrhoea, had increased from 24.3% to 36.7%.

Table 34 : Percentage distribution of children whose mothers attested to the usefulness of ORS and to feeding of sick children.

Features	Health District								
	BLITTA District			HAHO District			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Effect of the ORS according to the women</u>									
Replace water and mineral salts	6,4	8,2	-0,5 ns	5,4	9,2	-1,1 ns	1,7	5,4	-1,5 ns
Stops the diarrhoea	56,1	66,3	-1,6 ns	33,8	51,3	-2,5*	31,0	39,1	-1,2 ns
Other	38,7	27,6	1,9 ns	62,8	44,7	2,6*	68,1	59,8	1,2 ns
Number	173	98		148	76		116	92	
<u>Volume of liquid given to the child</u>									
Much less	17,3	2,0	3,7***	10,8	9,2	0,4 ns	7,8	13,0	-1,2 ns
A little less	26,0	28,6	-0,5 ns	21,6	23,7	-0,4 ns	19,8	25,0	-0,9 ns
About the same volume	26,6	28,6	-0,3 ns	29,1	52,6	3,5***	31,0	34,8	-0,6 ns
More than usual	24,3	36,7	-2,2*	33,1	14,5	3,0**	37,1	26,1	1,7 ns
Nothing to drink	4,1	4,1	0,0 ns	4,1	0,0	1,8 ns	3,4	1,1	1,1 ns
Do not know	1,7		1,3 ns	1,3		1,0 ns	0,9		0,9 ns
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	173	98		148	76		116	92	
<u>Quantity of food given to the child</u>									
Much less	22,5	13,3	1,9 ns	12,8	11,8	0,2 ns	12,1	15,2	-0,7 ns
A little less	34,7	36,7	-0,3 ns	33,8	35,5	-0,3 ns	33,6	28,3	0,8 ns
About the same quantity	27,2	26,5	0,1 ns	35,2	42,1	-1,0 ns	35,3	40,2	-0,7 ns
More than usual	5,2	6,1	-0,3 ns	8,1	0,0	2,6*	6,9	7,6	-0,2 ns
Stopped feeding	5,8	4,1	0,6 ns	8,1	3,9	1,2 ns	7,8	4,3	1,0 ns
Have never given food	4,6	12,2	-2,3*	2,0	6,6	-1,8 ns	4,3	4,3	0,0 ns
NSP		1,0	-1,3 ns		0,0			0,0	
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	173	98		148	76		116	92	

11.4- Treating ARIs

The number of children with acute respiratory infection dropped as was the case for diarrhoea and fever (Table 35). According to parents whose children had diarrhea, community health agents were very helpful in treating acute respiratory infections. In Blitta, 68.8% of cases were treated by community health agents as compared to 0.9% in the baseline survey. A similar scenario was recorded in Haho where parents confirmed that their children were treated by CHAs as against 0% in the baseline survey.

Table 35 : Percentage distribution of under-5 children with symptoms of ARI in the two weeks preceding the ARI Survey.

Features	Health District								
	BLITTA District			HAHO District			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
Children with symptoms of ARIs during the last 2 weeks									
Presence of ARI symptoms	22,2	9,4	5,6***	21,8	12,3	3,8***	19,5	7,3	5,3***
Absence of ARI symptoms	77,8	90,6	-5,6***	78,2	87,7	-3,8***	80,5	92,7	-5,3***
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	486	511		486	447		488	412	
Causes of respiratory difficulties									
Only chest	11,8	18,8	-1,2 ns	12,2	16,4	-0,7 ns	9,7	26,7	-2,3*
Only nose	58,2	58,3	0,0 ns	51,9	43,6	1,0 ns	62,4	53,3	0,9 ns
Nose and chest at the same time	25,5	14,6	1,5 ns	34,0	40,0	-0,8 ns	22,6	20,0	0,3 ns
Do not know	4,5	6,3	-0,5 ns	1,9	0,0	1,0 ns	5,3	0,0	1,3 ns
Other		2,1			0,0			0,0	
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	110	48		106	55		93	30	
Place of consultation/treatment									
Public hospital	0,9	0,0	0,7 ns	0,9	0,0	0,5 ns	0,9	5,3	-1,6 ns
Public health	25,7	16,7	1,2 ns	20,8	6,9	1,7 ns	10,4	18,4	-1,3 ns
Public health post	9,7	2,1	1,7 ns	3,8	10,3	-1,4 ns	11,3	21,1	-1,5 ns
Mobile clinic	0,0	4,2	-2,2*	0,9	0,0	0,5 ns	0,9	0,0	0,6 ns
Health Agent	6,2	2,1	1,1 ns	3,8	6,9	-0,7 ns	5,7	0,0	1,5 ns
Other public (sector)	1,8	2,1	-0,1 ns	2,8	0,0	0,9 ns	2,8	0,0	1,0 ns
Pharmacy	1,8	0,0	0,9 ns	0,0	3,4	-1,9 ns	0,0	0,0	
Community health agent	0,9	68,8	-9,5***	0,0	62,1	-8,7***	4,7	2,6	0,5 ns
Other medical services	7,1	0,0	1,9 ns	2,8	3,4	-0,2 ns	5,7	7,9	-0,5 ns
Chemist	17,7	4,2	2,3*	25,5	6,9	2,2*	21,7	34,2	-1,5 ns
Traditiona healer	6,2	0,0	1,8 ns	3,8	6,9	-0,7 ns	5,7	0,0	1,5 ns
Market	19,5			24,5			17,9		
Other	8,0	0,0	2,0*	13,2	0,0	2,1*	12,3	10,5	0,3 ns

Table 36 : Percentage distribution of children by volume of liquids and food received during the ARI episode.

Features	Health District								
	BLITTA District			HAHO District			WAWA		
	Initial	Final	Z	Initial	Final	Z	Initial	Final	Z
<u>Volume of liquid given to the child</u>									
Much less	20,7	1,6	3,6** *	11,1	14,0	-0,5 ns	9,9	1,6	2,2*
A little less	22,3	23,8	-0,2 ns	28,8	30,2	-0,2 ns	28,7	29,7	-0,2 ns
About the same volume	32,1	44,4	-1,8 ns	35,4	41,9	-0,8 ns	39,1	45,3	-0,9 ns
More	21,7	27,0	-0,9 ns	19,2	14,0	0,8 ns	19,8	23,4	-0,6 ns
Nothing to drink	2,7			2,0			1,5		
Do not know	0,5	3,2	-1,7 ns	3,5	0,0	1,2 ns	1,0	0,0	0,8 ns
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	184	63		198	43		202	64	
<u>Quantity of food given to the child</u>									
Much less	22,3	14,3	1,4 ns	11,7	7,0	0,9 ns	13,9	15,6	-0,3 ns
A little lesser than usual	30,4	36,5	-0,9 ns	35,9	51,2	-1,9 ns	34,2	40,6	-0,9 ns
About the same quantity	30,4	30,2	0,0 ns	40,4	34,9	0,7 ns	39,1	28,1	1,6 ns
More than usual	5,4	11,1	-1,5 ns	4,0	2,3	0,5 ns	4,0	7,8	-1,2 ns
Has stopped feeding	7,6	1,6	1,7 ns	4,5	2,3	0,7 ns	6,3	3,1	1,0 ns
Has never given food	3,3	6,3	-1,1 ns	1,5	2,3	-0,4 ns	1,0	4,7	-1,9 ns
Do not know	0,6			2,0			1,5		
Total	100,0	100,0		100,0	100,0		100,0	100,0	
Number	184	63		198	43		202	64	

12- STATE OF HEALTH FACILITIES

12.1- Types of health training

During the baseline survey, data was collected in 31 health training centers as compared to 30 in the final survey. As pertained in the commencement of the project, most were dispensaries and the care system was operational at 80% and 100% of the centers in Blitta and Haho respectively. Only 50% of centers in Wawa had a child care facility (Table 37). The two surveys revealed that almost all the health facilities are open 7 days a week with an average of 7 working hours a day. All health facilities closed at around 1700 GMT.

Table 37 : Percentage distribution of health facilities by type of health training, personnel category, health care system, training received by the personnel, number of years in operation and population served.

Features	BLITTA District		HAHO District		WAWA District	
	Base	Final	Base	Final	Base	Final
<u>Types of health facilities visited</u>						
Health post/dispensary	0	72,7	0	90,0	2,5	71,4
Dispensary	72,7	9,1	83,4	10,0	6,25	0,0
CMS	18,2	9,1	8,3	0,0	312,5	28,6
DPS	9,1	9,1	8,3	0,0	312,5	0,0
Total	100	27,3	100	10,0	100	28,6
Number	11	11	12	12	8	7
<u>Hospital admission system</u>						
YES	40	88,9	90	100,0	50	100,0
NO	60	11,1	10	0,0	50	0,0
Total	100	100,0	100	100,0	100	100,0
Number	5	9	10	9	4	7
<u>Population served</u>						
Less than 5000 inhbt	-	18,2	-	0,0	-	0,0
5000-9999 inhbt	-	54,5	-	40,0	-	71,4
10000-14 999 inhbt	-	18,2	-	30,0	-	28,6
15000-19 999 inhbt	-	9,1	-	20,0	-	0,0
20000 inhbt plus	-	0,0	-	10,0	-	0,0
Total	-	100,0	-	100,0	-	100,0
Number	-	11	-	12	-	7
<u>Years of operation by the centre</u>						
Less than 5 years	27,3	18,2	0	0,0	25,0	0,0
5-9 years	0	9,1	16,6	16,7	0	14,3
10-14 years	18,2	9,1	16,7	16,7	0	0,0
15 years plus	54,5	54,5	66,7	50,0	75,0	57,1
NSP	-	9,1	-	16,7	-	28,6
Total	100	100,0	100	100,0	100	100,0

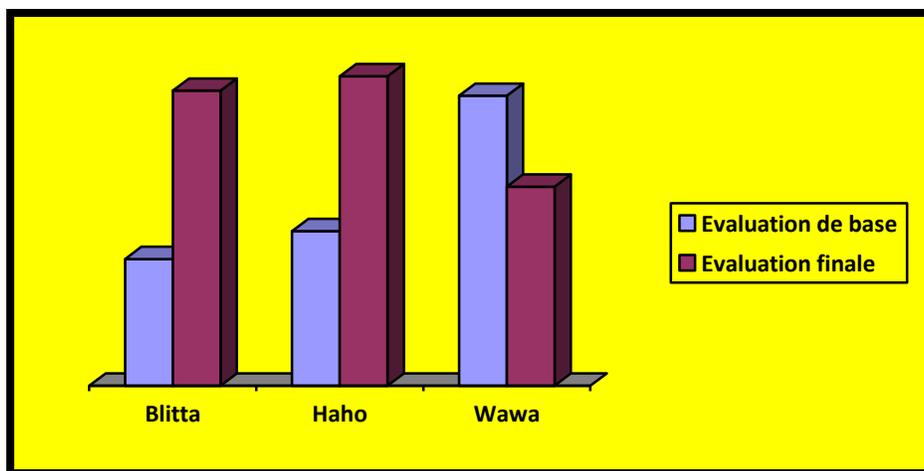
Number	11	11	12	12	8	7
<u>Average number of working days per week</u>	7	7	7	6	7	7
<u>Average working hours at the centre</u>	7	7	7	7	7	7
<u>Average closing time at the centre</u>	17	17	17	17	17	17

12.2- Services offered by health facilities

All health facilities provided PNC, child delivery and health care services (Table 38). Thanks to the USAID RESPOND Project, 100% of the health facilities visited in Blitta and Haho had FP services as against 90.9% and 91.9% respectively at the onset. The post-partum Kangaroo mother care method (KMC) was not a popular practice at the beginning of the project (18.2% in Blitta, 75% in Haho and 37.5 in Wawa). At the end of the project however, 90.9% of health facilities in Blitta, 83.3% in Haho and 42.9% in Wawa could carry out KMC demonstrations as against 37.5% at the onset. The high number of centres using the KMC method in Haho is as a result of AFD Project interventions in the districts. However, the success chalked at the end of the project is thanks to the USAID AWARE II Project. Indeed, during the project, service providers benefitted from this training as part of ENOC practices.

Practices such as Controlled Cord traction and massage of the uterus to prevent post-partum hemorrhage were more popular practices in health facilities, than at the beginning of the project (90.9% as against 18.2% in Blitta and 91.7% as against 58.3% at Haho in terms of controlled cord traction) (Table 38).

The distribution of centres by types of FP methods used shows that at the beginning of the project almost all the centres provided all FP methods. The most frequently-used methods were the injeACTble and the pill. The project and its partners have strengthened health facilities such that they are able to provide implant and the IUD services, which explain the significant increase in the use of these two long term methods. The ratio of health facilities providing IUD services increased from 27.3% to 63.3% in Blitta and from 33.3% to 66.7% in Haho (Table 38). In Wawa, the number decreased from 62.5% at the onset to its current 42.9%. This decrease is the result of transfers.



Graph 11 : Proportion of health facilities providing IUD as a Family Planning method in the three districts at the commencement and end of the Project

Table 38 : Distribution (5) of health facilities by type of activity, KMC and hemorrhage prevention practices, types of methods available, number of years of collaboration with the CHAs and CHA activities

Features	BLITTA District		HAHO District		WAWA District	
	Baseline	Final	Baseline	Final	Baseline	Final
<u>Main activities of health training</u>						
Primary healthcare	100	100,0	91,7	100,0	100	85,7
CPN	100	100,0	100	100,0	100	85,7
Delivery	100	100,0	100	100,0	100	85,7
CPON (Post natal consultation)	100	100,0	91,7	100,0	75,0	85,7
Family Planning	90,9	100,0	91,7	100,0	87,5	85,7
Vaccination	81,8	100,0	100	100,0	87,5	85,7
Workforce	11	11	12	12	8	7
<u>Hypothermia prevention (SMK)</u>						
Carefully dry the newborn and cover it with a warm and dry cloth.	100	90,9	91,7	100,0	87,5	71,4
Keep the newborn away from any air current	36,4	72,7	33,3	75,0	12,5	71,4
Give the newborn to the mother for a skin to skin contact	18,2	90,9	75,0	83,3	37,5	42,9
Check the feet every 15 minutes to verify the temperature	9,1	18,2	8,3	25,0	12,5	0,0
Other	9,1	9,1	0	8,3	12,5	0,0
Workforce	11	11	12	12	8	7
<u>Prevention of bleeding after delivery</u>						
Administration of uterotonics (Oxytocin or Ergometrin)	90,9	90,9	75,0	91,7	75,0	57,1
Uterine massage	63,6	100,0	66,7	75,0	75,0	71,4
Controlled cord traction	18,2	90,9	58,3	91,7	50,0	57,1
Other	0	9,1	16,7	8,3	37,5	0,0
Workforce	11	11	12	12	8	7
<u>Available contraceptive methods</u>						
Pills	90,9	90,9	58,3	100,0	87,5	85,7
InjeACTbles	90,9	90,9	91,7	100,0	87,5	85,7
Implants	27,3	72,7	33,3	75,0	75,0	57,1
IUD	27,3	63,6	33,3	66,7	62,5	42,9
Loop	18,0	18,2	16,7	41,7	12,5	14,3
Other	27,3	27,3	50,0	58,3	50,0	0,0
Workforce	11	11	12	12	8	7

12.3- Collaboration between the health training centres and CHAs.

Almost all the health trainings collaborated with the CHAs (Table 39). This collaboration has lasted for more than 6 years. In almost all health facilities, CHAs presented Activity Reports every month (100%). Training of CHAs was provided by health training managers and members of the district framework team. This situation, which prevailed before the project, has remained even after the project completion with the exception of drug supplies where the NGOs have taken a more active part within the project framework to prevent shortage of supplies.

Table 39 : Percentage distribution of health facilities by type of activity, KMC practice, hemorrhage prevention, types of methods available, number of years of collaboration with the CHAs, CHA activities and main topics of interaction

Features	BLITTA District		HAHO District		WAWA District	
	Base line	Final	Base line	Final	Base line	Final
<u>Frequency of report transmission by CHAs</u>						
Monthly	100	100,0	100	100,0	87,5	100,0
Total	100	100,0	100	100,0	--	100,0
Workforce	11	11	12	12	8	7
<u>Person in charge of training CHAs</u>						
Senior in-house Nurse or district team	63,6	72,7	75,0	83,3	75	28,6
National IMNCD Coordination	0	54,5	--	50,0	--	0,0
ECR	--	90,9	--	58,3	--	14,3
DSF	--	54,5	--	25,0	--	0,0
Member of an ECD	45,5	81,8	41,7	100,0	25	57,1
Member of an NGO	54,5	63,6	41,7	66,7	25	71,4
Workforce	11	11	12	12	8	7
<u>Persons responsible for the supervision of CHAs</u>						
Senior in-house Nurse	81,8	100,0	100	100,0	100	57,1
Member of DCT	9,1	81,8	8,3	50,0	0	14,3
Member of an NGO	18,2	36,4	58,3	50,0	12,5	71,4
Other	9,1	0,0	8,3	0,0	0	14,3
Workforce	11	11	12	12	8	7
<u>Institution responsible for supplying CHAs with drugs</u>						
EGD Pharmacy of the district	9,1	27,3	16,7	0,0	12,5	0,0
Pharmacy of the NGO	9,1	90,9	8,3	58,3	25,0	42,9
District depot	--	9,1	--	33,3	--	0,0
Depot of the health post	72,7	54,5	66,7	50,0	50	85,7
Other	9,1	0,0	0	25,0	0	0,0
Workforce	11	11	12	12	8	7

The CHAs referred cases to the health trainings. The average number of such referred cases was much higher for malaria, in the last three months, while the average number of women referred for FP came in the twentieth position (Table 40). During the final project evaluation, the number of referred clients for FP had dropped. This was expected because the CHAs were able to administer the most popular FP method in Togo; the InjeACTble. A similar situation was recorded in the case of children below 5 years referred for malaria.

The trend was however different in the case of the ARIs. There was an increase in referred cases in the two project districts. This situation was acceptable because parent found it difficult to diagnose the infection and ascertain the gravity.

Table 40 : Number of clients (women and children below 5 years) referred by the CHAs to health trainings in a month per district.

Features	BLITTA District		HAHO District		WAWA District	
	Baseline	Final	Baseline	Final	Baseline	Final
<u>Number of women referred by CHAs for FP in the last three months</u>						
Total number of women referred	55	25	94	15	6	0
Average number in the last three months	6	8,2	13	1,4	2	0,0
<u>Number of children below 5 years referred by CHAs for acute malaria in the last three months</u>						
Total number of children referred	217	91	74	31	11	0
Average number of the last three months	24	8,3	12	3,1	3	0,0
<u>Number of children below 5 years referred by the CHAs for severe dehydration in the last three months</u>						
Total number of children referred	5	12	25	7	0	0
Average number in the last three months	1	1,1	6	0,7	0	0,0
Total number of children referred	1	10	0	18	2	0
Average number in the last three months	0	0,9	0	1,8	1	0
<u>Number of interactive sessions organised in the last three months</u>						
Total number of interactions	155	253	335	348	161	87
Average number in the last three months	19	23,0	38	29,0	20	17,4
<u>Number of health trainings</u>	11	11	12	12	8	7

13- STORAGE OF ESSENTIAL AND GENERICI DRUGS

13.1- Types of facilities and stock management supports

During the final evaluation, 29 pharmaceutical depots were visited as against 32 during the baseline survey. This was because the survey did not take the Generic and Essential Drugs Purchasing Unit (CAEGD) and the Atakpame and Sokode regional supply pharmacies into account. As in the final evaluation, the primary clients of these depots were patients from the health facilities while CHAs came in second position (Table 41).

Stock management files were available in almost all depots at the outset of the project. This was however not the case in the Blitta District where files were available in only 18.2% of depots. The initial evaluation showed that about 5 depots out of 10 (54.5%) had updated stock management files. As at this final evaluation, 50% of the files in the Blitta and Wawa depots had been updated while 75% had been updated in Haho.

Table 41 : Percentage distribution of pharmacies and depots by type, qualification of manager(s), clients of depots, existence of various collection aids.

Features	Health District					
	District BLITTA		District HAHO		WAWA	
	Initial	Final	Initial	Final	Initial	Final
<u>Qualification of the manager</u>						
Pharmacist	8,3	18,2	0	16,7	0	33,3
Chief storekeeper	0	81,8	23	33,3	14,2	66,7
Pharmaceutical depot manager	91,7	0,0	30,8	50,0	42,9	0,0
Others	0		46,2		42,9	
Total	100	100,0	100	100,0	100	100,0
Number	12	11	13	12	7	6
<u>Clients of the EGD depots</u>						
Patients from the Centre	83,3	100,0	92,3	100,0	85,7	83,3
CHAs	75	63,6	7,7	75,0	28,6	50,0
Health posts / peripheral health care units	16,7	27,3	30,8	25,0	28,6	50,0
Others	0	0,0	30,8	8,3	0	16,7
Number	12	11	13	12	7	6
<u>Availability of stock management files</u>						
Yes.	100	18,2	76,9	100,0	71,4	33,3
No	0	81,8	23,1	0,0	28,6	66,7
Total	100	100,0	100	100,0	100	100,0
Number	12	11	13	12	7	6
<u>Updated stock management files</u>						
Yes.	71,4	50,0	50	75,0	40	50,0
No	28,6	50,0	50	25,0	60	50,0
Total	100	100,0	100	100,0	100	100,0
Number	7	2	10	12	5	2

<u>Availability of daily stock movement registers</u>						
Yes.	100	100,0	76,9	58,3	71,4	50,0
No	0	0,0	23,1	41,7	28,6	50,0
Total	100	100,0	100	100,0	100	100,0
Number	12	11	13	12	7	6
<u>Updated daily stock movement register</u>						
Yes	50	63,6	50	57,1	40	100,0
No	50	36,4	50	42,9	60	0,0
Total	100	100,0	100	100,0	100	100,0
Number	12	11	10	7	5	3

13.2- Management of contraceptive stocks at the depots

It was realized at the commencement of the Project that the Wawa, Blitta and Haho districts had an average of 11,126 and 150 cycles of oral contraceptives (Microgynon and ovrette) respectively (Table 42). More than 6 depots out of the 10 had experienced shortage lasting more than 90 days. In about 2 of these depots, the shortage was due to poor estimates.

Current average quantities of these contraceptives, consisting of microgynon only, is 37 in Wawa, 21 in Blitta and 30 in Haho Districts. Shortage was experienced only in the Haho district over an average period of 12 days. The main cause of this shortage was poor estimates (66.7%).

The average quantity of condoms available in the districts in 2011 were 1021, 39 and 602 units in the Blitta, Wawa and Haho districts respectively. About 8 depots out of the 10 had experienced shortage of these contraceptives for more than 90 days.

In 2012, the average quantity of contraceptives in each district was very low; 202 in Blitta, 106 in Haho and 1 in Wawa. Blitta, Haho and Wawa each experienced an average period of 7, 17 and 30 days of shortage respectively. Shortage of contraceptives remained a problem between mid-2011 till the end of the year.

Table 42 : Percentage distribution of EGD depots with oral contraceptives and condoms by quantity and stock management problems.

Features	Health District					
	BLITTA		HAHO		WAWA	
	Initial	Final	Initial	Final	Initial	Final
<u>Average quantity of oral contraceptives available</u>	126	21	1791	30	11	37
<u>Average period of shortage of oral contraceptives</u>		0		12		0
<u>Cause of shortages of oral contraceptives stocks</u>						
Poor estimation	33,3	-	0	66,7	33,3	0
Shortage at the main depot						100
Incompetence		-		33,3		0
Other	0		14,3		66,7	
Number	6	0	7	3	3	1
<u>Average quantity of condoms available</u>	1021	202	2771	106	1699	1
<u>Average period of shortage of condoms stocks</u>		7		17		30
<u>Cause of shortage of condom stocks</u>						
Poor estimation	0	-	0	33,3	20	0
Other	0	-	0	0	20	100
Number	6	0	10	3	5	1

Quantities of subcutaneous implants and IUDs available in the various depots of the three districts were lower than in 2011 (Table 43). Injectables were also available in all the districts in normal average quantities.

Table 43 : Distribution (%) of EGD depots which have implants and IUD by quantities and stock management problems.

Features	Health District					
	BLITTA		HAHO		WAWA	
	Initial	Final	Initial	Final	Initial	Final
Average quantity of implants available	26	4	8	5	3	10
Average period of shortage of implants		7		0		40
Cause of shortages of implant stocks						
Poor estimation	100	100	0	-	0	100
Number	1	1	5	0	3	1
Quantity of IUDs available	17	6	4	5	1	2
Average period of shortage of IUD stocks		5		0		0
Cause of shortage of IUS stocks						
Poor estimation	0	100	25	-		-
Other	16,7		25			
Number		1	6	0	4	0
Average quantity of injeACTble available	598	50	249	94	36	38
Average period of shortage of injeACTbles		0		3		0
Cause of shortage of injeACTble stocks						
Poor estimation	0	-	0	100	50	-
Number	5	0	9	1	2	0

13.3- Management of tracer drugs

In 2011, average quantities per district were 400 for Blitta, 846 for Haho and 350 for Wawa (Table 44). The main drugs were Artemether/Lumefantrine in 24 tablet strips. Shortage of these products at the depots was as a result of shortage at the central point.

There were large quantities of ORS sachets in Haho; about 830 of them compared to 327 in the Blitta district (Table 44). There were also 20 blisters of Oxytocin in Haho, 18 in Wawa and 46 in the Blitta district (Table 44).

All these products were still available during the 2012 data collection though in smaller quantities as compared to 2011. The long periods of shortage pertained ACT for which there was erratic supply nationwide (Table 44).

Table 44 : Percentage of EGD depots with ACT, ORS and oxytocin by quantities and stock management problems.

Features	Health District					
	BLITTA		HAHO		WAWA	
	Initial	Final	Initial	Final	Initial	Final
<u>Average quantity of ACT</u>	400	165	846	319	350	62
<u>Average period of shortage of ACT stocks</u>		120		23		15
<u>Cause of shortage of ACT stocks</u>						
Poor estimation		18,2		0		16,7
Shortage at the Central unit	70	9,1	76,9	0	0	0
Other	0	9,1	30,8	8,3	0	16,7
Number	10	3	13	1	4	1
<u>Average quantity of ORS</u>	327	500	831	649	331	81
<u>Average period of shortage of ORS stock</u>		30		-		60
<u>Cause of shortage of ORS stock</u>						
Lack of financial resources	0		0		25	
Poor estimation		9,1		0		16,7
Number	7	1	11	0	4	1
<u>Average quantity of oxytocin</u>	46	21	20	56	18	38
<u>Average period of shortage of oxytocin</u>						
<u>Cause of shortage of oxytocin</u>						
Poor estimation	0		0		25	
Shortage from the central unit	0		28,6		25	
Other	0		14,3		25	
Number	7		7		4	
Lack of competence		-		-		100
<u>Oxytocin storage conditions</u>						
Open air	60		61,5		50	16,7
Refrigerator	40		38,5		33,3	
Others (specify	0		0		16,7	
Number	10		13		6	1

Table 45 : Comparison of indicators between the initial and final evaluation in respect of family planning, maternal, neonatal and infant health/AWARE II Project ((2011 & 2012)

INDICATOR N°	DESCRIPTION OF THE INDICATOR	BLITTA		HAHO		WAWA	
		Baseline	Final	Base	Final	Baseline	final
Indicator 1	Proportion of trained CHAs capable of correctly identifying clients eligible for oral contraceptives	3,5	100	6,9	100	3,8	0
Indicator 2	Proportion of trained CHAs capable of correctly explaining how to use oral oral contraceptives	0	93,3	0	93,1	0	0
Indicator 1 Bis	Proportion of trained CHAs capable of correctly identifying clients eligible for injeACTbles	0	100	0	100	0	0
Indicator 2 Bis	Proportion of trained CHAs capable of correctly how to use injeACTbles	0	75,6	0	82,8	0	0
Indicator 3	Proportion of trained CHAs capable of correctly identifying clients using oral contraceptives who need to be referred.	0	51,1	0	98,3	6,9	0
Indicator 3 Bis	Proportion of trained CHAs capable of correctly identifying clients using injeACTbles who need to be referred.	-	75,6	-	94,8	-	0
Indicator 4	Proportion of trained CHAs capable of correctly identifying and treating malaria in under-5 children.	3,3	97,8	0	89,3	0	91,7
Indicator 5	Proportion of trained CHAs capable of correctly identifying and treating diarrhoea in under-5 children	0	100	0	93,1	0	16,7
Indicator 6	Percentage of trained CHAs capable of correctly identifying and treating pneumonia in under-5 children	0	88,9	0	61,4	0	0
Indicator 7	Percentage of trained CHAs capable of demonstrating the Kangaroo method.	0	91,1	3,4	69,0	0	0

Indicator 8	Percentage of trained CHAs who know the ideal interval/spacing between births	33,3	88,9	44,8	82,8	42,3	46,2
Indicator 9	Proportion of trained CHAs who know much about FP, malaria, diarrhoea, pneumonia, Kangaroo and the ideal birth spacing intervals (all indicators from 1 to 8).	0	26,7	0	15,5	0	0
Indicator 10	Percentage of women of child-bearing age who know the ideal birth spacing interval.	7,2	47,0	11,0	31,1	6,4	53,0
Indicator 11	Percentage of women of child-bearing age who know at least 2 advantages of birth spacing	0	83,3	0	83,8	0	76,1
Indicator 12	Percentage of women of child-bearing age who know at least 3 warning signs for pregnant women after childbirth and for the newborns	0	3,0	0	4,1	0	3,6

INDICATOR N°	DESCRIPTION OF THE INDICATOR	BLITTA		HAHO		WAWA	
		Basel ine	Final	Baseli ne	Final	Basel ine	Final
Indicator 13	Number of women using (old and new) contraceptive methods every quarter in the last 2 years, by district and health centre						
Indicator 14	Percentage of women of child-bearing age who use modern contraceptive methods (contraceptive prevalence)	14,7	43,1	12,2	28,8	20,3	16,4
Indicator 15	Percentage of women of child-bearing age who intend to use a contraceptive method but do not use it(Contraceptive needs not met)	28,4	26,3	29,4	21,4	37,3	23,9
Indicator 16	Number of under-5 children treated for malaria per district per health centre/USP/PS/CSI/Case every quarter of the last 2 years per district and health facility						
Indicator 17	Number of under-5 children treated for diarrhea per district per health centre/USP/PS/CSI/Case every quarter of the last 2 years per district and health facility						
Indicator 18	Number of under-5 children treated for ARIs per district per health centre/USP/PS/CSI/Case every quarter of the last 2 years per district and health facility						

Indicator 19	Percentage of under-5 children treated for malaria (among children who reported malaria symptoms)	6,22	20,6	1,04	13,9	2,53	7,3
Indicator 20	Proportion of under-5 children treated for diarrhoea (among children who reported diarrhoea symptoms)	31,79	58,2	22,30	43,4	24,14	21,7
Indicator 21	Proportion of under-5 children treated for coughs with fast respiration (among children with symptoms of cough with fast respiration)	26,36	77,6	14,15	79,3	11,83	39,5

INDICATOR N°	DESCRIPTION OF INDICATOR	TYPES OF PRODUCTS	BLITTA		HAHO		WAWA	
			Baseline	Final	Baseline	Final	Baseline	Final
Indicator 22	Average period of shortage of contraceptives, oxytocin, magnesium sulphate and cotrimoxazole at drug depots over a period of 6 months at the depots of the health training centres.	Oral contraceptives	0	0	1	0,2	1	0
		InjeACTble contraceptives	0,6	0	0	0,01	0,9	0
		Condoms	1	0,03	0	0	2	0,22
		Implant	1	0,4	4	0	0	1,3
		IUD	0	0,02	4	0	5	0
		ACT	0	2	24	0,12	34	0
		ORS	0	0,16	0,64	0	0,64	0,3
		Oxytocin	0	--	3,8	--	9,7	--
		Magnesium sulphate	50	0,16	41	0,16	50	0
		Cotrimoxazole ¹³	5	0	5	0	4	0
		Amoxicilin	0	0	0	0,07	0	0
		Erythromicin	0	0	0	0,16	0	0,6

¹³ Galenic formula : Cotrimoxazol tablets for childred

INDICATOR N°	DESCRIPTION OF THE INDICATOR	TYPES OF PRODUCTS	Blitta	Haho	Wawa	Central	
						Base	Final
Indicator 23	Average period of shortage of contraceptives, oxytocin, magnesium sulphate and cotrimoxazole/amoxycilin/erythromycin at the depots over a period of 6 months	Oral contraceptives				52	0
		Injectable contraceptives				14	0
		Condoms				67	0,3
		ACT				516	0
		Oxytocin				100	100
		Magnesium sulphate				100	100
		Cotrimoxazol				0	0
		Amoxycilin				0	0
		Erythromycin				0	0