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THE JOHNS HOPKINS UNIVERSITY

HOPKINS POPULATION CENTER

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April 4, 1986

Mr. Anselmo Bernal
S&T/POP/IT Room 806 SA-18
Office of Population
U.S. Agency for International Development
Washington, D.C. 20523

APR ~~1986~~

APR 10 1986

Dear Al,

Enclosed is a copy of Greg Christenson's trip report to Nigeria, in case you may not have received a copy yet from CDC. You may recall that Greg's trip was in response to our request for collaboration in developing evaluation mechanisms for JHU/PCS activities in Nigeria as well as looking at the current data collected from various States.

You will note that Greg has withheld analytical comments on the data pending clarifications on a number of items. Indeed, we sympathize with Greg. The quality of clinic data in Nigeria leaves much to be desired. Over the long run, the problem of distinguishing between old and new acceptors will be a serious one. In the meantime, however, even as efforts will have to be mobilized on a cooperative basis with other cooperating agencies in Nigeria to address the clinic data issue, we believe certain indications could be gleaned from various data generated, particularly in Kwara State.

In Kwara State, unlike other states, the forms being used as of three months ago include a question about referral. This question was made more specific by JHU/PCS by stamping the forms with the names of specific mass media which were not previously included. These data are now available for the October-December 1985 quarter. On the basis of both the Kwara State Family Health Project's 1985 third (July-September) and fourth (October-December) quarter reports (Greg's data cover only the third quarter) there seems to be an upsurge in the number of new acceptors,* specifically a rise of about 111 percent (513 to 1087) from the second to the third quarter. Excluding the number of new acceptors in six newly operated clinics, the increase is still a hefty 46 percent. Almost all clinics experienced a jump in new acceptors. This sudden increase does not appear to be a fluke as the fourth quarter data (October-December) indicate that the trend has been maintained although the increase (at about 27 percent, 1087 to 1377) has not been as dramatic.

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* Figures are corrected from mathematical inaccuracies in the two Kwara reports.

It is also significant to point out that the newly-collated data on source of referrals for October-December 1985 reveal that: 18 percent of new acceptors were referred by radio; 15 percent, by the PCS-supported field worker; and 12 percent, by TV. The method mix is also encouraging: pills, 45 percent; condoms, 31 percent; IUCD, 16 percent; and injectables, 6 percent. Please see enclosed referrals. We have asked the Kwara State staff to collate data on media referrals for the two preceding quarters also, if possible.

Kwara was the first State in Nigeria to officially launch FP in day-long ceremonies last June 28, 1985. The launching was widely covered by the media, including a generous treatment in the TV network news. Following the State launching, radio exposures averaging about four spots a day were launched. About two months thereafter TV spots averaging about 2-3 times a day were aired. Only one TV spot was used sporadically during the start of the radio campaign. TV exposures have continued until the end of February. Newspaper ads were also run sporadically.

In Kwara, JHU/PCS provided funds for radio and TV air time (and newspaper space) in order to control the number of exposures and ensure airing at peak times. Substantial discounts were negotiated.

Although a cause and effect relation between the IEC campaign and the increase in new acceptors cannot be drawn with any scientific certainty, the upsurge in the number of new acceptors coincided with the time period of the campaign. The events do seem to indicate that there is some form of connection.

In Ogun State, in contrast to Kwara, JHU/PCS did not provide funds for airing the radio and TV materials developed under the mass media component of the first phase of JHU/PCS assistance. Very limited exposures were negotiated between the Health Ministry and the radio and TV stations. Although the Ogun State data, as gathered by Greg, are incomplete, no significant impact of the media campaign can really be expected. JHU/PCS is now negotiating with radio and TV stations for discounted air time rates in Ogun.

In Plateau State, the data gathered could serve as a useful baseline in assessing the results of a media campaign expected to be launched this second quarter of 1986.

We will be exploring with Keys MacManus several alternatives to improve the quality of clinic data when she comes to attend the JHPIEGO course for Nigerians starting April 28. Definitions of new and old acceptors and, resumers if you will, will have to be clarified in the minds of the nurses filling out the forms. Greg has raised this in his report. Of more interest to us is the installation of a relatively bias-free entry of sources of referrals in the forms. There may be a need to train nurses to refrain from asking leading questions, but at the same time able to probe clients (e.g., if you were referred by your friend, where did your friend hear about FP?). We will discuss these issues further with Keys when she is here.

We shall keep you informed of other interesting developments in Nigeria. Many thanks for the support you have extended to us.

With warmest regards,

Sincerely,

Patrick L. Coleman
Project Director
Population Communication Services

JGR/ch

KWARA STATE MINISTRY OF HEALTH
FAMILY PLANNING SERVICE
QUARTERLY REPORT: OCTOBER TO DECEMBER, 1985

C. NEW CLIENTS AND SOURCES OF REFERRAL

No	Clinic	Total New Client	Sources of Referral							
			Field Worker	Clinic Staff	Friend	Relative	Radio	Television	Newspaper	Others
1.	DHU Ilorin	221	87	25	5	8	45	39	2	10
2.	Okelele Mat.	102	15	40	12	13	5	16	-	1
3.	Pakata Mat.	58	14	7	4	4	15	10	-	4
4.	BHC Ogidi	66	27	12	-	5	3	9	1	9
5.	BHC Shao	19	-	-	4	-	10	-	-	5
6.	BHC Oke-Oyi	15	-	10	1	-	3	-	-	1
7.	RHC Koko	2	-	-	-	-	2	-	-	-
8.	DHU Afon	19	3	5	2	3	4	-	-	2
9.	DHU Offa	136	-	73	32	3	8	20	-	-
10.	RHC Erinle	34	-	9	2	-	12	3	7	1
11.	DHU Omu-Aran	133	-	100	2	-	16	10	-	5
12.	Gen. Hosp. O/Aran	40	-	20	1	3	6	10	-	1
13.	DHU Share	1	-	-	1	-	-	-	-	-
14.	M/C I/Oro	15	8	2	-	-	-	5	-	-
15.	RHC Omupo	33	4	14	1	1	10	-	-	3
16.	DHU Kabba	-	-	-	-	-	-	-	-	-
17.	Gen. Hosp. Okene	79	-	24	8	4	26	9	3	5
18.	Gen. Hosp. Lokoja	27	-	3	14	-	10	-	-	-
19.	DHU Lokoja	78	4	16	21	6	14	9	4	4
20.	GH Isanlu Oyi	134	-	50	11	16	25	9	3	10
21.	1st A/C MOH	~~5067~~	-	~~2215~~	-	-	7	~~146~~	-	7
22.	Spec. Hosp. Sobi	50	-	22	-	-	7	14	-	7
23.	DHU Lafiagi	48	-	22	-	2	20	-	-	4
	Total	1377	20	469	122	68	248	169	21	78
	Percentage	100%	14.7%	34%	8.9%	4.9%	18%	12.3%	1.5%	5.7%

Total New Last Quarter - ~~1144~~ 1087 Total New this Quarter - 1377

Total Old Last Quarter - 1,433 Total Old this Quarters - 2328

Percentage Increase of the New Acceptors over last quarter - ~~16.9%~~ 26.6%

Percentage Increase of the Old Client over the last quarter - 38.4%

4

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control

Memorandum

Date February 24, 1986

From Gregory M. Christenson, Ph.D., Scientist, Behavioral Epidemiology and Evaluation Branch, Division of Health Education, Center for Health Promotion and Education (CHPE)

Subject International Trip Report (AID/RSSA): Nigeria, November 14--December 1, 1985 Evaluation of Information, Education, and Communication Campaign

To James O. Mason, M.D., Dr.P.H.
Director, CDC
Through: Assistant Director for Science, CHPE

I. DATES AND PLACES OF TRAVEL
II. PURPOSE OF TRAVEL
III. PRINCIPAL PERSONS CONTACTED
IV. FINDINGS AND RECOMMENDATIONS
V. GENERAL COMMENTS
APPENDIX: FIGURES 1-15

I. DATES AND PLACE OF TRAVEL

Nigeria, November 14--December 1, 1985, at the request of AID Affairs Office/Nigeria to assist the JHU/PCS and health officials in Ogun, Kwara, Plateau, Kaduna, and Oyo assess the impact of Information, Education, and Communication (IEC) campaigns and discuss evaluation projects in those States. This travel was in accordance with the Resource Support Services Agreement (RSSA) between the Office of Population, AID, and DRH/CHPE/CDC.

II. PURPOSE OF TRAVEL

In response to a request from the Division of Reproductive Health, the Division of Health Education provided technical assistance to The Johns Hopkins University/Population Control Services group for the evaluation of an Information, Education, and Communication (IEC) project currently underway in Nigeria. The specific consultation had two objectives: (1) to examine existing information in three States where IEC programs are currently underway, and (2) assess the likelihood of succesfully evaluating the IEC project.

III. PRINCIPAL PERSONS CONTACTED

A. USAID Affairs Office (AAO), Lagos
1. Ms. Keys MacManus, AID Affairs Officer

B. Johns Hopkins University/Population Communication Services (JHU/PCS)
1. Jose G. Rimon, II, Regional Program Coordinator, PCS
2. Kim Winnard, Assistant Regional Program Coordinator, PCS

C. Ogun State
1. Mrs I. V. Mako, Director of Nursing, MOH
2. Mrs. A. O. Taiwo, Course Coordinator, School of Family Planning
3. Dr. S. A. Onadeko, Director of Medical Services, MOH

D. Kwara State
1. Dr. David Olubaniyi, Project Director, Director of Medical Services
2. Ms Florence Tolushe, Project Coordinator
3. Ms. A. Adebayo, Project Supervisor
4. Ms. M. B. Omiyide, Assistant Project Supervisor
5. Ms. M. L. Babaturde, Assistant Project Supervisor
6. Mr. G. Adeseko, Training Coordinator
7. Dr. Fakeye, Ilorin Teaching Hospital

E. Plateau State
1. Mr. Usaini Inji Samaila, Planned Parenthood Federation Nigeria State Secretary
2. Mr. Bola Kusemiju, PPFN Lago IEC Coordinator
3. Mrs. Zipporah Guabo Mafuia, Family Planning State Coordinator
4. Mrs. S. O. Dung, Primary Health Care Coordinator
5. Mr. M. D. Kwon, PPFN Jos Chairman
6. Rebecca Goton, Principle Health Sister
7. Helen Mandieng, Adult Education Officer, Minister of Education

F. Kaduna State
1. Dr. Suleiman Sani, Perm. Sec.
2. Hajia Bilksu Abdurhawau, Chief, Health Education
3. Dr. Y. Madaki, Director, Medical Services
4. Dr. P. Y. Katung, Assistant Health Education Officer

G. UCH/IBADAN
1. Dr. E. O. Otolorin, Consultant, Department OB/GYN

IV. FINDINGS AND RECOMMENDATIONS

Objective 1--Two Nigerian States (Kwara and Ogun) have implemented and carried out the first phases of their IEC campaigns. A third State, Plateau, is currently in the process of developing materials, both print and audio, for their campaign. Additionally, Plateau has conducted a personal interview survey of current contraceptive practices in several communities in the State for use in assessing the impact or effect of the IEC campaign.

Data on new and old acceptors from all three States were available at the time of our visit. For Kwara and Ogun States, these data were available for both the entire year 1984 and of the first three quarters of 1985. For Plateau State, the data from 1983 and 1984 were available. The 1985 data had not been tabulated at the time of our visit; therefore, only data for 1983 and 1984 is presented. These data are presented in graphic form in Figures 1 through 17.

At this time, I prefer to withhold analytical comments on the data and will instead present some factors which need clarification prior to interpretation of these data. However, one general comment from the data may be in order. While there appears to be an increasing trend in the total number of contraceptive users, whether old or new acceptors, the absolute numbers are very small given the total population of Nigeria.

Point one is that there is confusion in my mind about what old and new acceptors mean. The new acceptor nomenclature is somewhat clearer in that I think it indicates any person who accepts any form of contraception at a point in time. What isn't clear to me, and from my discussions with people in the three projects to them, is whether a person who accepts condoms in month 1 and IUCD in month 2 is counted as an acceptor twice. Another issue which isn't clear to me is whether a person accepting once, who then discontinues visits to the clinic or goes somewhere else for contraception for a period and then later comes again to a clinic, is counted as accepting twice. I'm convinced that these issues can be clarified and doing so would make the numbers collected by each project more meaningful. It should be noted that there appears to be differential difficulty with this data problem. The people in Ogun State appear to be much clearer in their definitions and more skilled in their data collection than the other States visited.

The old acceptor concept is a bit more difficult for me to filter out. On several occasions, clinic personnel indicated that these might be both persons who were practicing contraception and were continuing to visit the clinic, and/or they were persons who were not practicing contraception but were coming to the clinic for counseling or other noncontraceptive contact. In any event, I'm not clear whether on a monthly basis that one individual may be counted as an old acceptor once, twice, or a number of times. Likewise, it seems possible that one person might be counted as both a new acceptor and an old acceptor in the same month. These issues make any interpretation of these data difficult; therefore, I think it might serve JHU/PCS, AID, and CDC for both me and someone from DRH/CDC to meet with the JHU/PCS Nigeria staff to discuss these and other relevant issues prior to finalizing any statements made from these data.

Another general concern I have with the clinic data is an accuracy of reporting issue. This problem may be of particular importance in the population we are dealing with in these projects. It appeared to me that clinic staff could easily bias reported results by leading respondents in their questioning concerning when and through what communications medium the client had received the family planning message. If this problem exists to the extent that I believe it may, the data collected in the various projects has little meaning. Data collection through interviewing is difficult and requires training to avoid the introduction of interviewer bias. An example from a visit to one clinic, Ilorin, may demonstrate what I mean. When asking the nurses questions, one usually received an answer that parrotted your questions. For instance, if you were to ask, "Have you had more acceptors since the campaign?", you would get back, "Yes, more acceptors since the campaign." If you then followed with, "Did they tell you they heard about Family Planning on the radio or T.V.?", you would get back, "Yes, the radio and T.V." Conversation such as this makes me wonder about the reliability of

the data. It may be that what has been collected is simply a reflection of the clinic's staff telling us what they think we want to hear. For these reasons, caution should be exercised in the interpretation of any data which has been collected to this point in the projects.

Recommendations

It seems that some training in data management, data collection and evaluation would benefit program and project people. This training need not be complex but instead should be focused and practical, providing field workers with simple, easy, and useful techniques which they can use in documenting program/project effects. It has been brought to my attention that several training sessions related to these issues have been discussed and are currently being planned. I would hope that these training sessions would be structured to provide practical skills. We don't need Ph.D. trained evaluators. What appears needed is systematic and useful data collection and management from which evaluation would subsequently benefit. In this regard, it would be wise to contact INTRAH as soon as possible to determine the content of their planned course and make suggestions about what would be helpful in the assessment of IEC programs.

Objective 2. In order to address the likelihood of successfully evaluating the Nigerian IEC projects, it may be useful to briefly describe issues pertinent to the conduct of any program evaluation. Program evaluations are usually designed to do one of two things: (1) to improve existing program(s), or (2) to test the differences between programs. No matter which of the approaches the evaluation is structured to use, the most critical early design issue is to determine whether the evaluation can in fact document precisely whether the intended program actually has been implemented as planned. In other words, one cannot assume that just because a program is designed and written in a specific way that it is in fact implemented in a community exactly as intended. It is precisely this lack of clear understanding of the specifics of intended interventions that accounts for much of the misunderstanding and lack of significance in health education and health promotion evaluation research.

Specifying the intervention is a particular concern in information/communication (media) campaigns that are dependent on free- or low-cost time slots being made available for the audio or video messages. Such interventions are generally weak to begin with in respect to changing people's behavior or motivating them to act. Without a specific documented plan to maximize message saturation in a community, such messages probably will have even less effect than would normally be expected. To attempt to measure the impact of such a campaign without knowing precisely when, how, where, and how frequently the messages are presented would probably lead to frustration on the part of program developers, as well as the evaluator, and would more than likely result in an inability to specify program effects from the campaign.

To prevent some of the problems from occurring, better control of the projects and community interventions could be accomplished if someone representing JHU/PCS were available in Nigeria on a full-time basis. While my personal bias is that the person should be a data evaluation person, that may not be

possible. Therefore, I would hope for, and advocate, a person who has some evaluation expertise (many M.P.H people have such expertise) and a real appreciation for documenting the effects of the IEC project. Clearly, an advocate for evaluation and IEC would be ideal.

While it may seem a bit presumptuous of me following a single visit to Nigeria to advocate an in-country project coordinator, intuitively and through my observation of the communication and transportation systems, such an approach seems to makes sense. JHU/PCS has a number of projects in several States with additional projects in other States being added continually. In order to provide adequate communication with and monitoring of so many projects, a JHU/PCS representative who is available on a continuous basis would be helpful.

Regarding my bias for evaluation expertise in such a person, I recall that during our briefing held in Baltimore October 28, 1985, Jim Herrington mentioned that INTRAH was preparing a course on evaluation to be taught in Nigeria in the spring of 1986. If this is the case, it might be worthwhile for JHU/PCS to try and have people from their project sites attend the session. If JHU/PCS were able to provide persons at each of their project sites with some appreciation and skills in evaluation, it might in the longrun enhance specific site program assessments and, therefore, the overall IEC project evaluation. This is just a thought, but I do believe it is worth pursuing. As for the full-time in-country project(s) manager, I can't be helpful. All I can do is see the inherent logic to having such a person.

V. GENERAL COMMENTS

Two additional States were visited by me on this trip. Each had the possibility of developing IEC projects with JHU/PCS. These were Oyo and Kaduna. In each of these States, I was impressed by the staff we talked with. At Ibadan University in Oyo, there appeared to be an already existing interest in tracking and plotting the training of nurses in insertion and the number inserted. Such interest suggests that independently these people are concerned about program effects. Such interest might be nurtured and supported and could result in a systematic assessment of the IEC program, possibly using a quasi-experimental design with control groups for comparison of IEC effects on family planning adaption.

A similar atmosphere appeared to exist in Kwara State with the Chief of Health Education and the newly appointed Permanent Secretary. Promoting the evaluation component early in the projects' development in this State may facilitate getting important effects data. This also holds true for the Plateau State project.

Another general comment is that complex evaluation of Family Planning IEC is not needed in Nigeria at this time. More monitoring and data management would seem to be most important with any need to ascribe specific cause and effect from IEC to come later. I make this statement based on the proliferation of agencies doing a large number of activities in the same country and often the same States with little coordination. In the current situation, to filter out what program has had what specific effect would be an enormous task, very

expensive, and at this point, impossible. On the other hand, the strategy to provide as much service as possible hoping something will take hold and grow, doesn't really call for ascribing cause and effect. One thing is clear; no matter what program or programs are introduced, the problems are so many and varied that it seems you can't help but have some positive effect. While this shotgun approach may not be the most efficient or cost-effective way of going about things, it may be the best approach possible at this time. An overall process assessment through monitoring general indicators may be the most important evaluation technique that can be used this early in the Nigerian experience. However, continued effort should be made to ensure that documemtation of specific program effects will eventually come about.

These are my preliminary thoughts on the evaluation consultation. Additional discussions with the JHU/PCS staff should allow me to finalize the data included in Attachment 1.

Gregory M. Christenson, Ph.D.

Appendix 1-15

FIGURE 1

OGUN STATE 1984-1985 CONTRACEPTIVE PILL USERS

New Acceptors

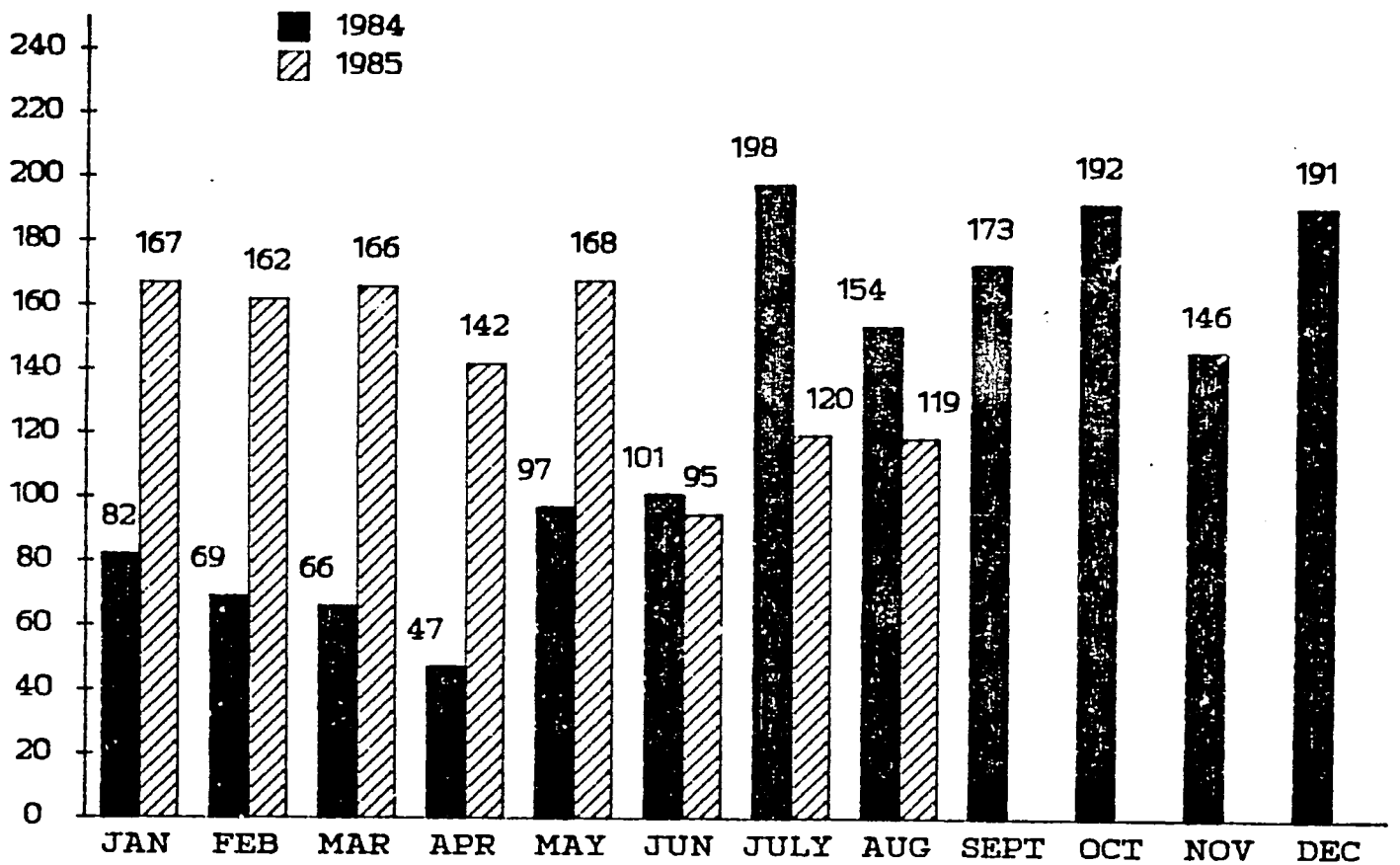


FIGURE 2

OGUN STATE 1984-1985 CONTRACEPTIVE I.U.C.D. USERS

New Acceptors

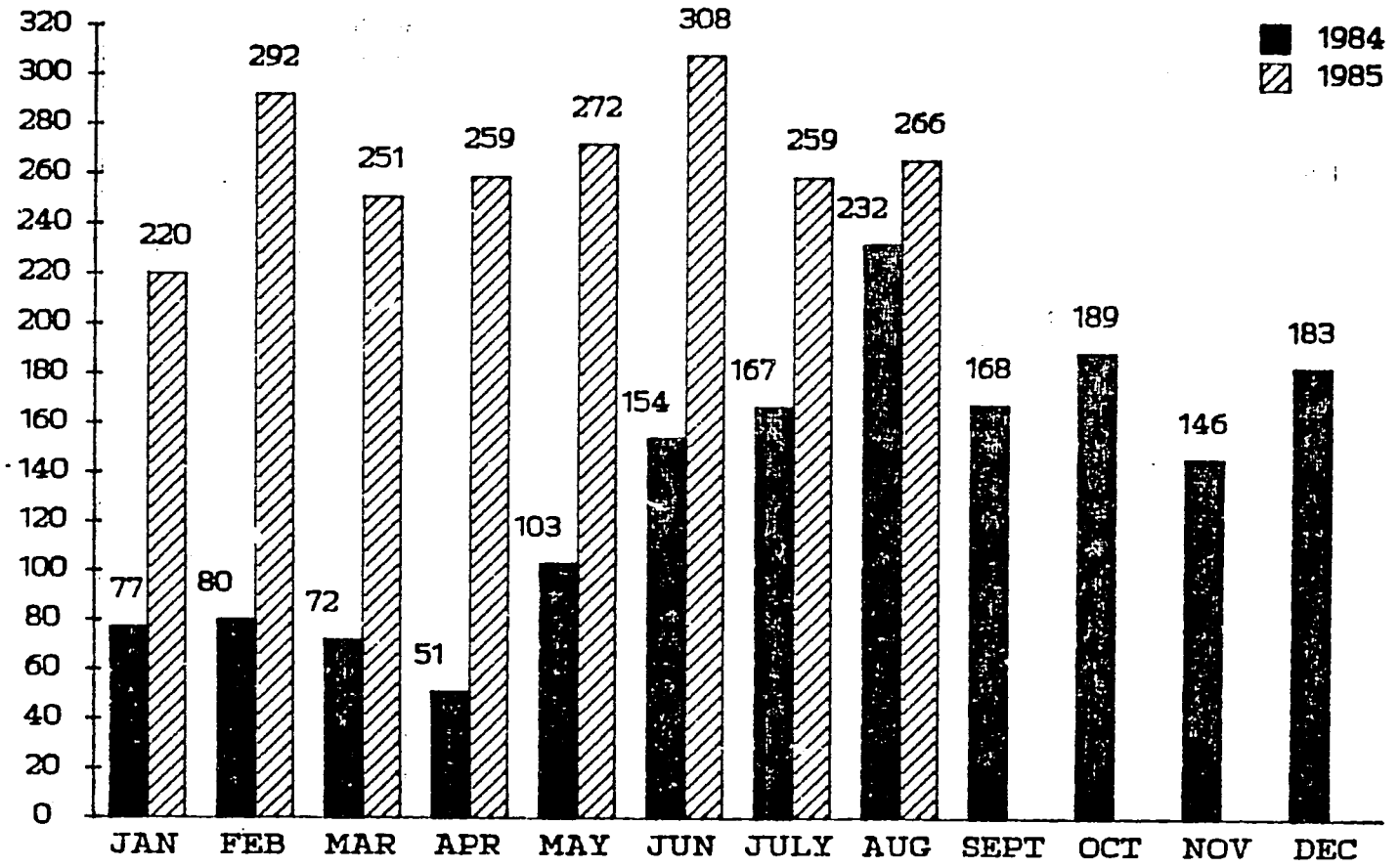


FIGURE 3

OGUN STATE OTHER CONTRACEPTIVE USERS

1985 Condoms; 1984 Injectables + Others

New Acceptors

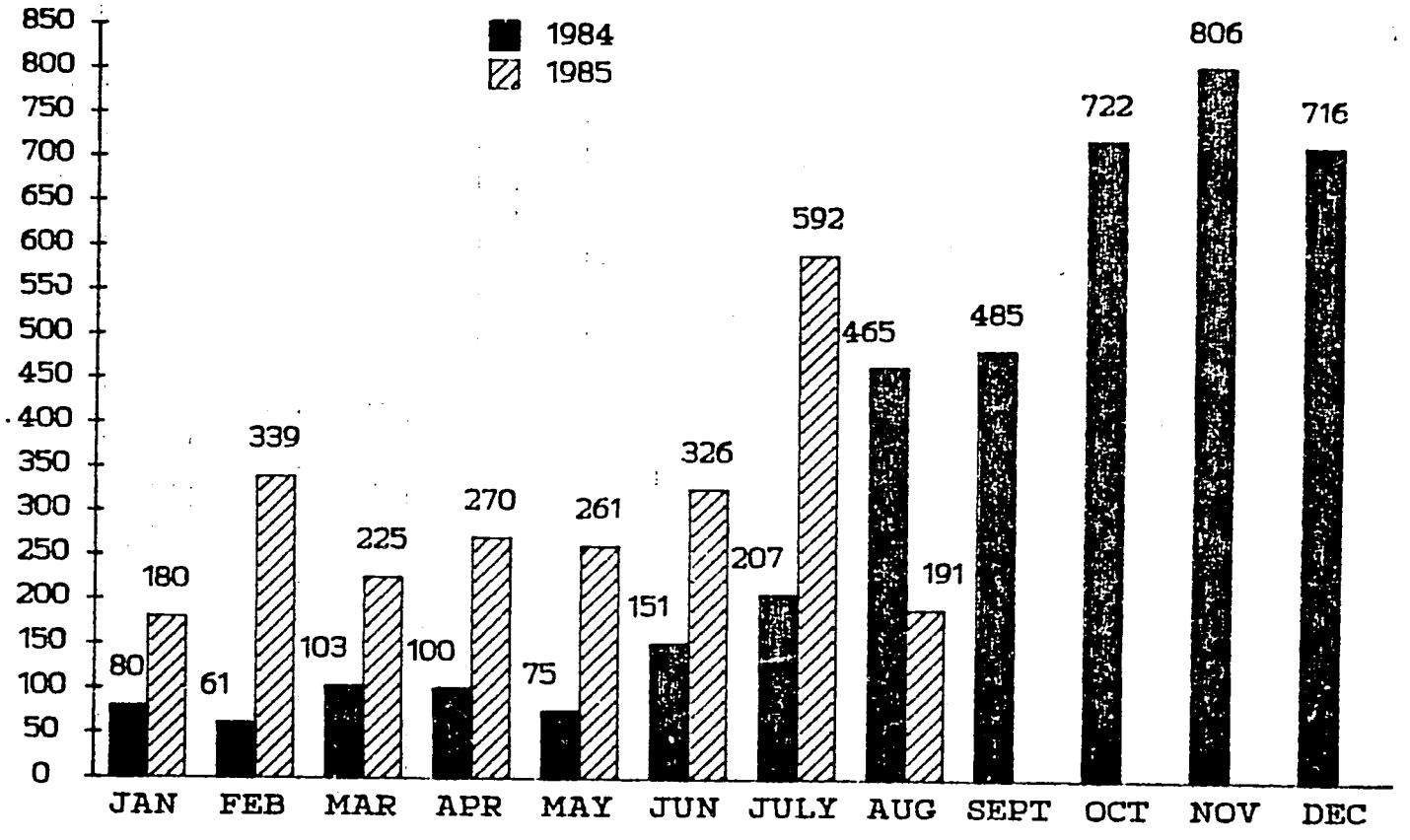


FIGURE 4

OGUN STATE CONTRACEPTIVE USERS -1985

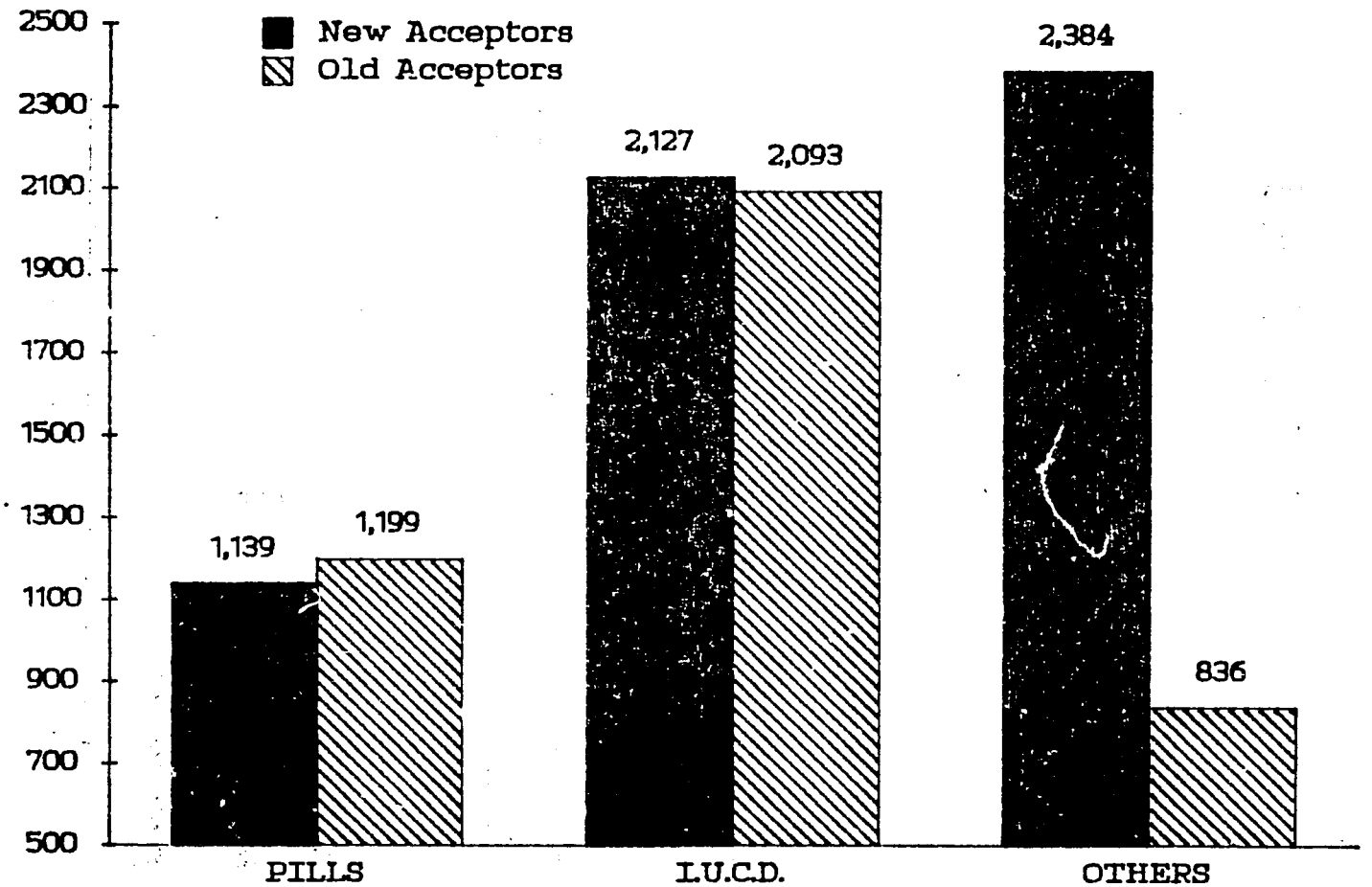


FIGURE 11

KWARA STATE FAMILY PLANNING

NEW CONDOM ACCEPTORS

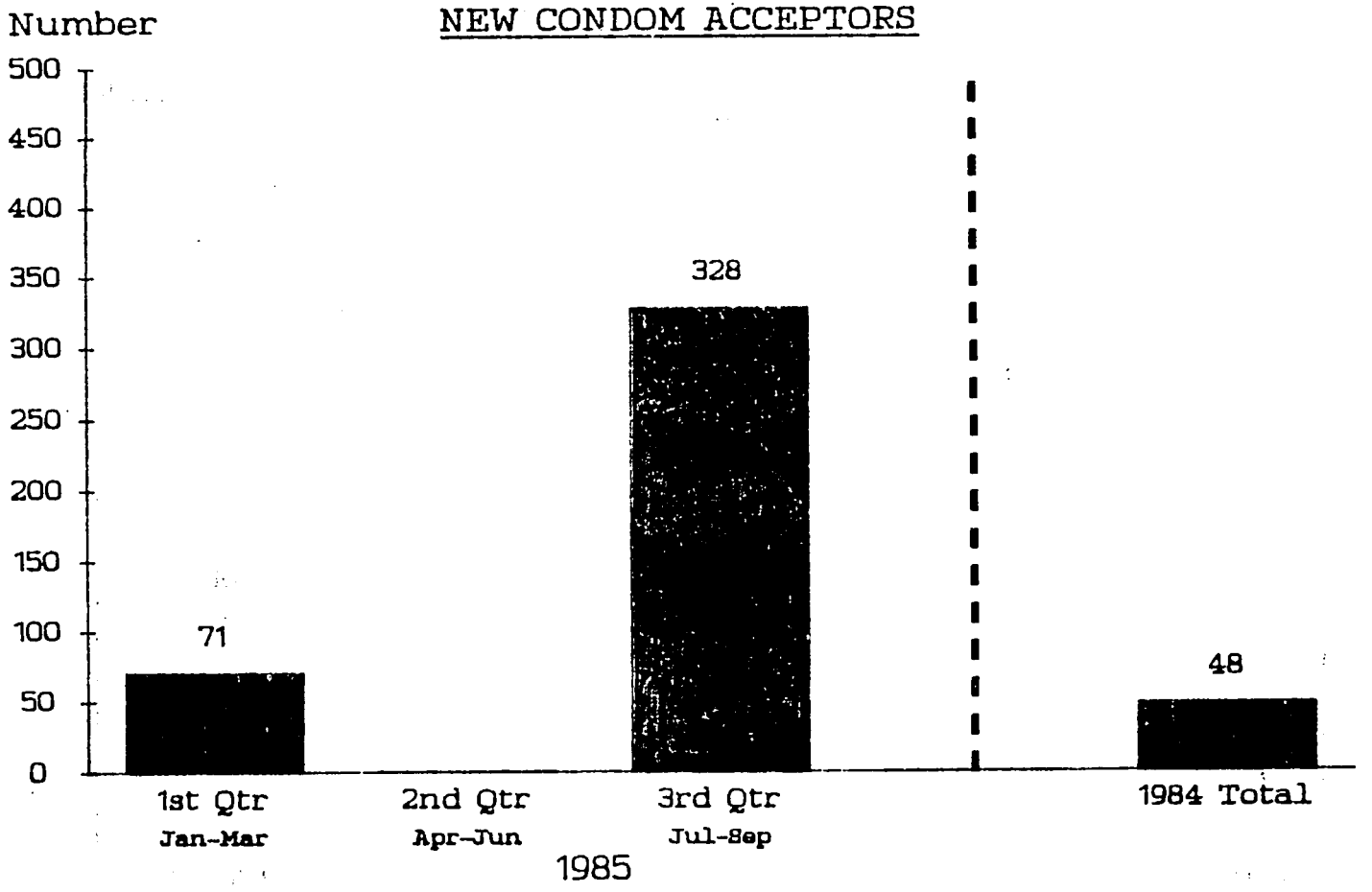


FIGURE 12

PLATEAU STATE CONTRACEPTIVE USE (1983-1984)

New Plus Old Acceptors

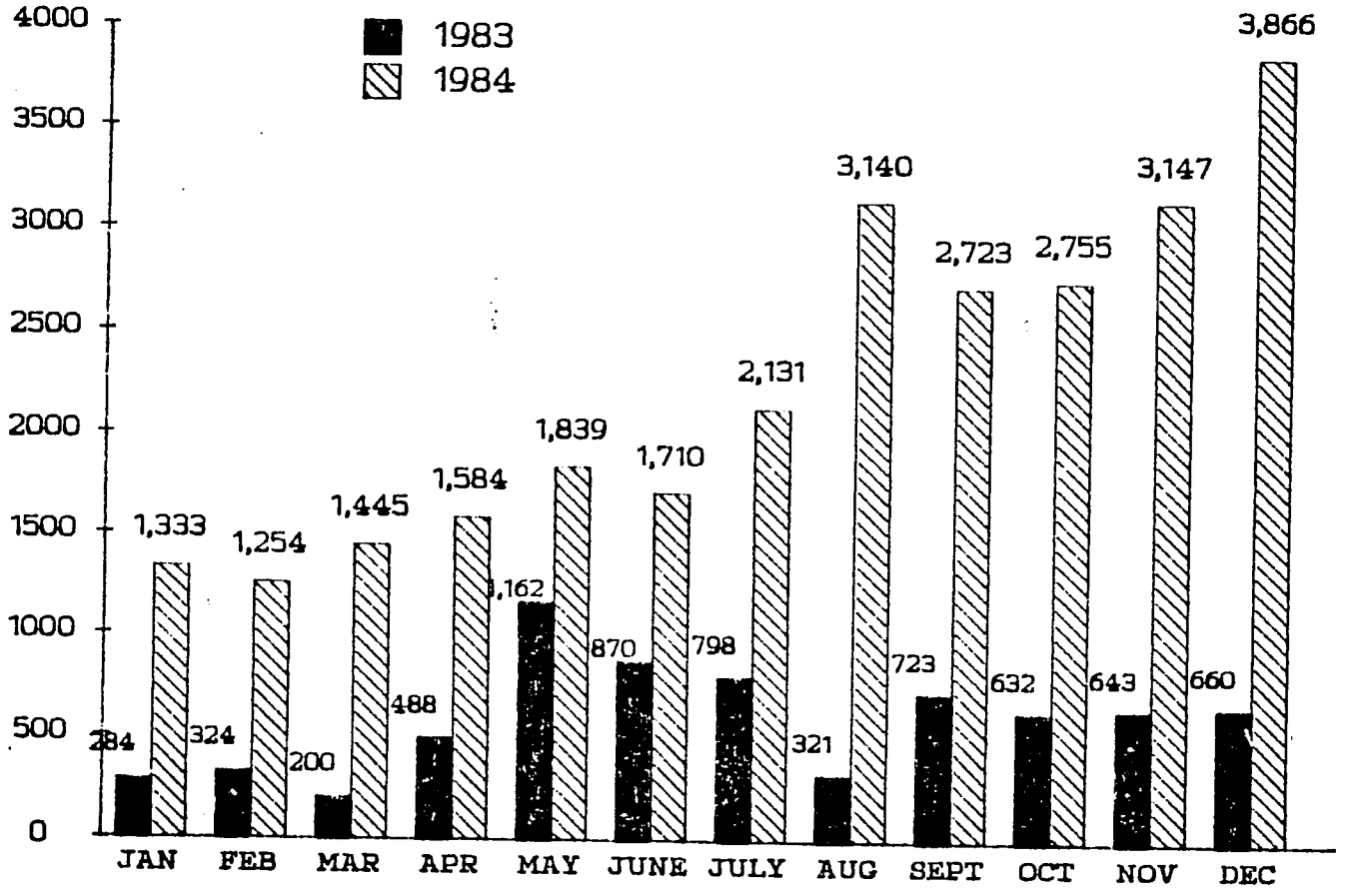


FIGURE 13

PLATEAU STATE CONTRACEPTIVE USERS

1983-1984 New Acceptors

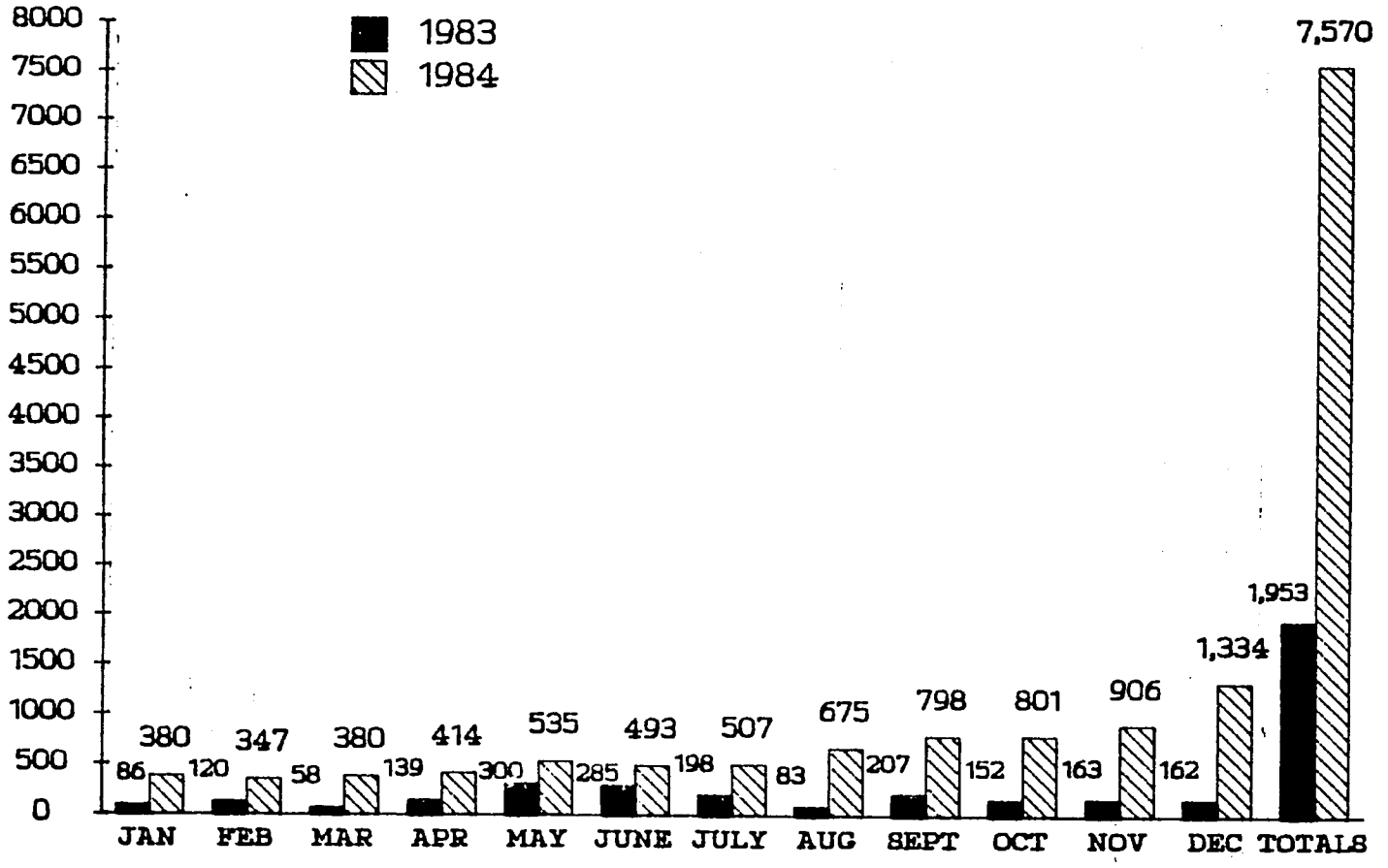


FIGURE 14

PLATEAU STATE CONTRACEPTIVE USERS (1983-1984)

Old Acceptors

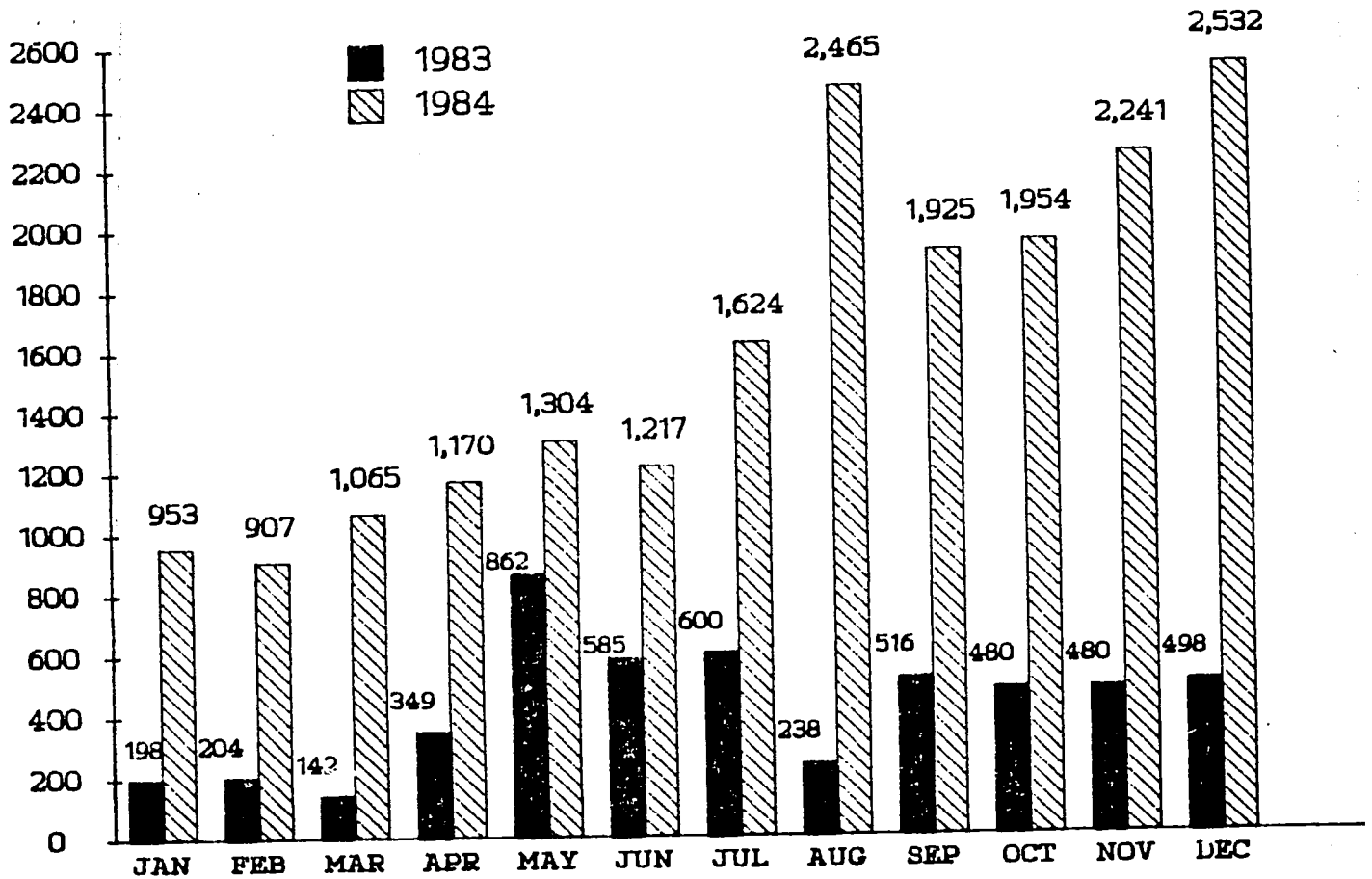


FIGURE 15

PLATEAU STATE CONTRACEPTIVE USERS

1983-1984 New Acceptors

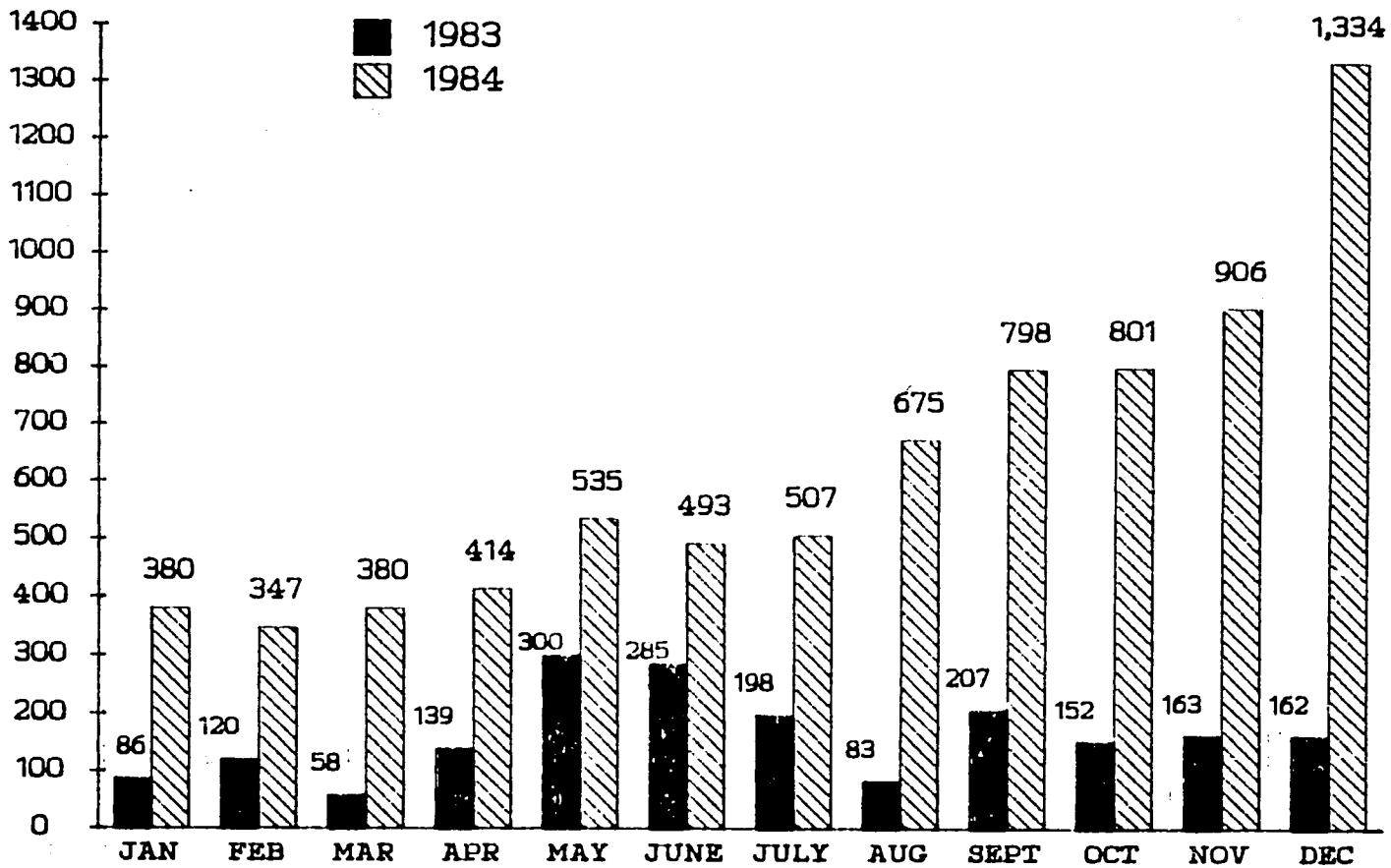


FIGURE 5

KWARA STATE FAMILY PLANNING

Number of Clinics by Quarter 1985, Total 1984

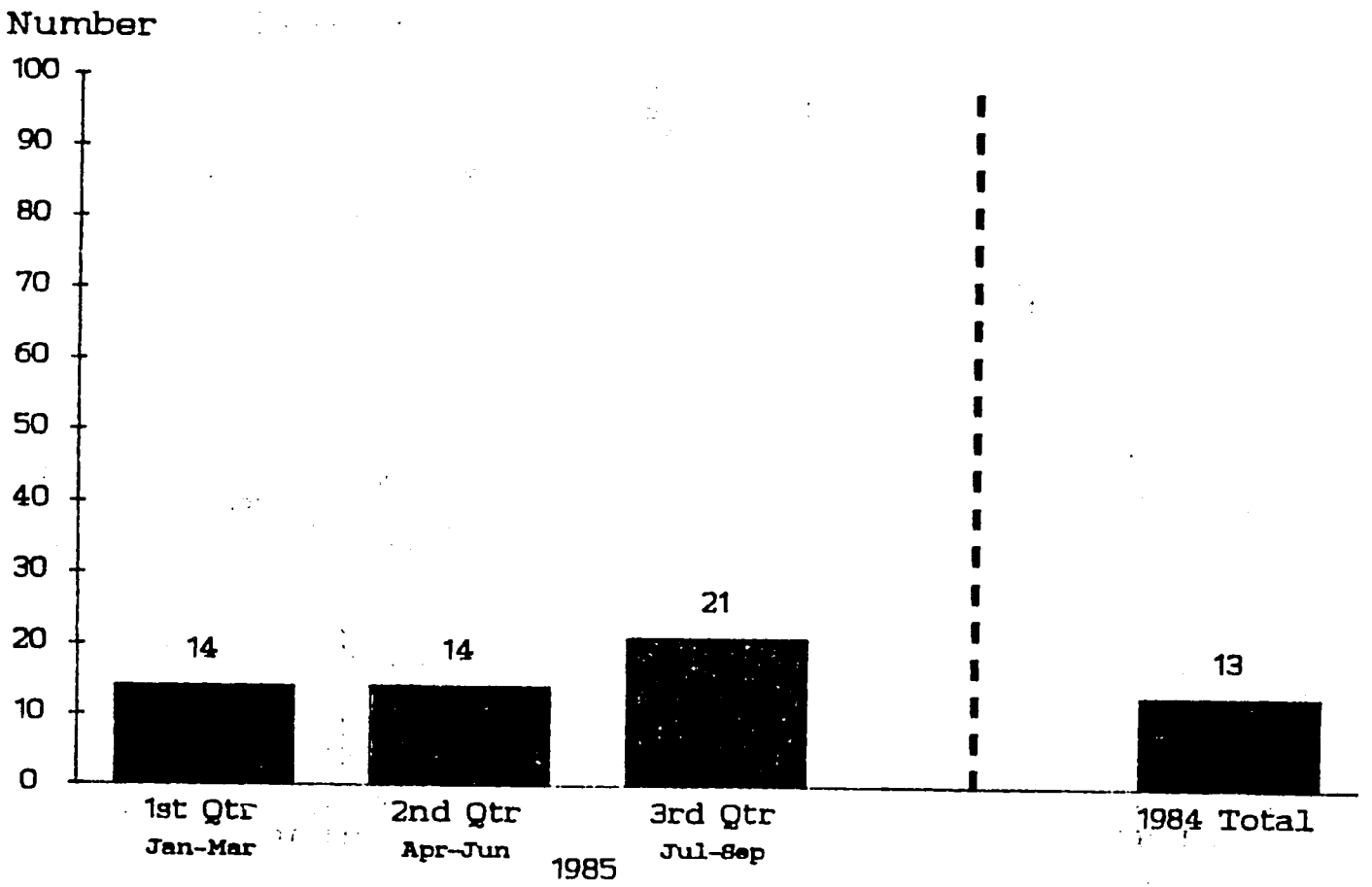


FIGURE 6

KWARA STATE FAMILY PLANNING

Average Number of New Acceptors Per Participating Clinic

By Quarter 1985

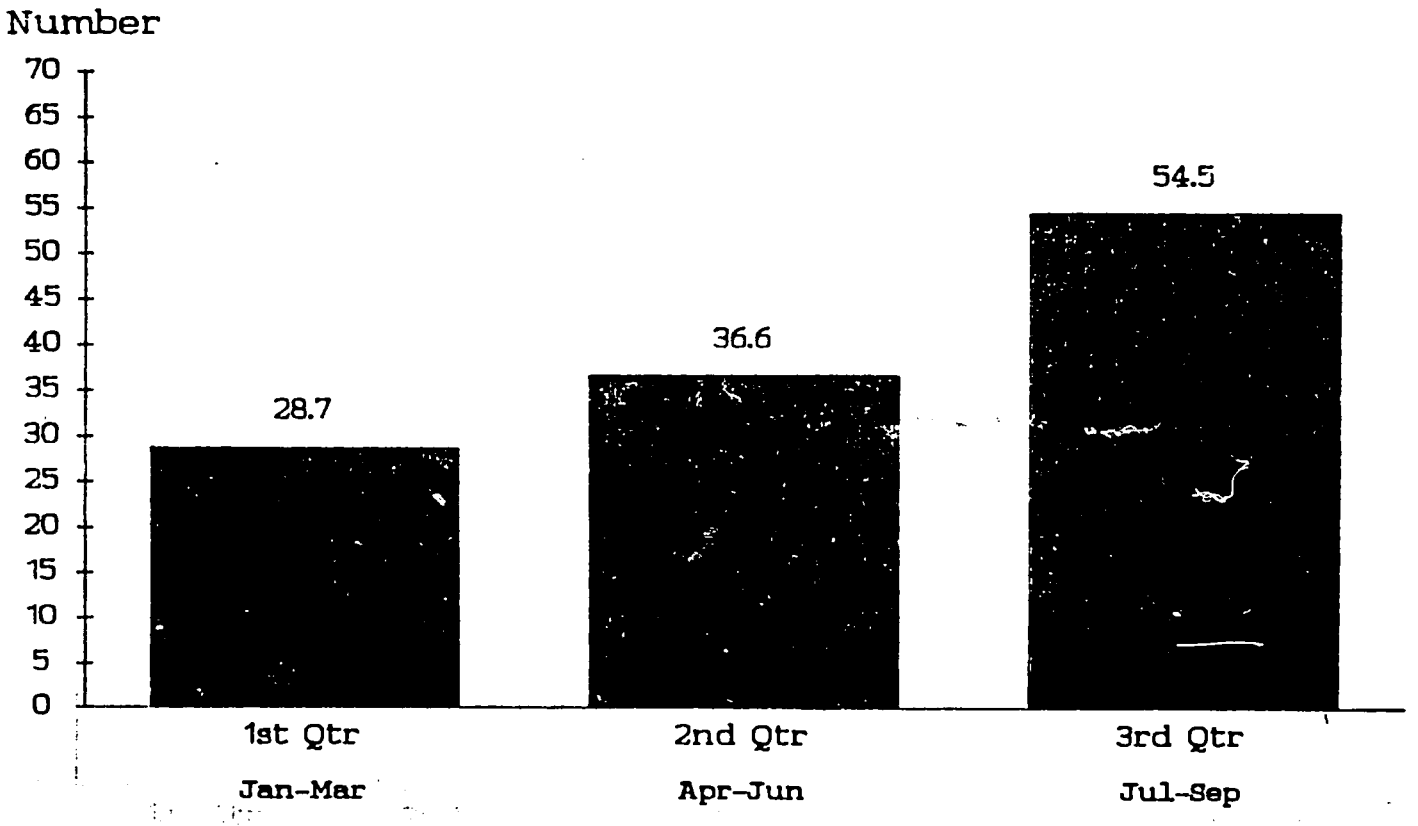


FIGURE 7

KWARA STATE FAMILY PLANNING

NEW ACCEPTORS

First 3 Quarters of 1985 and Total 1984

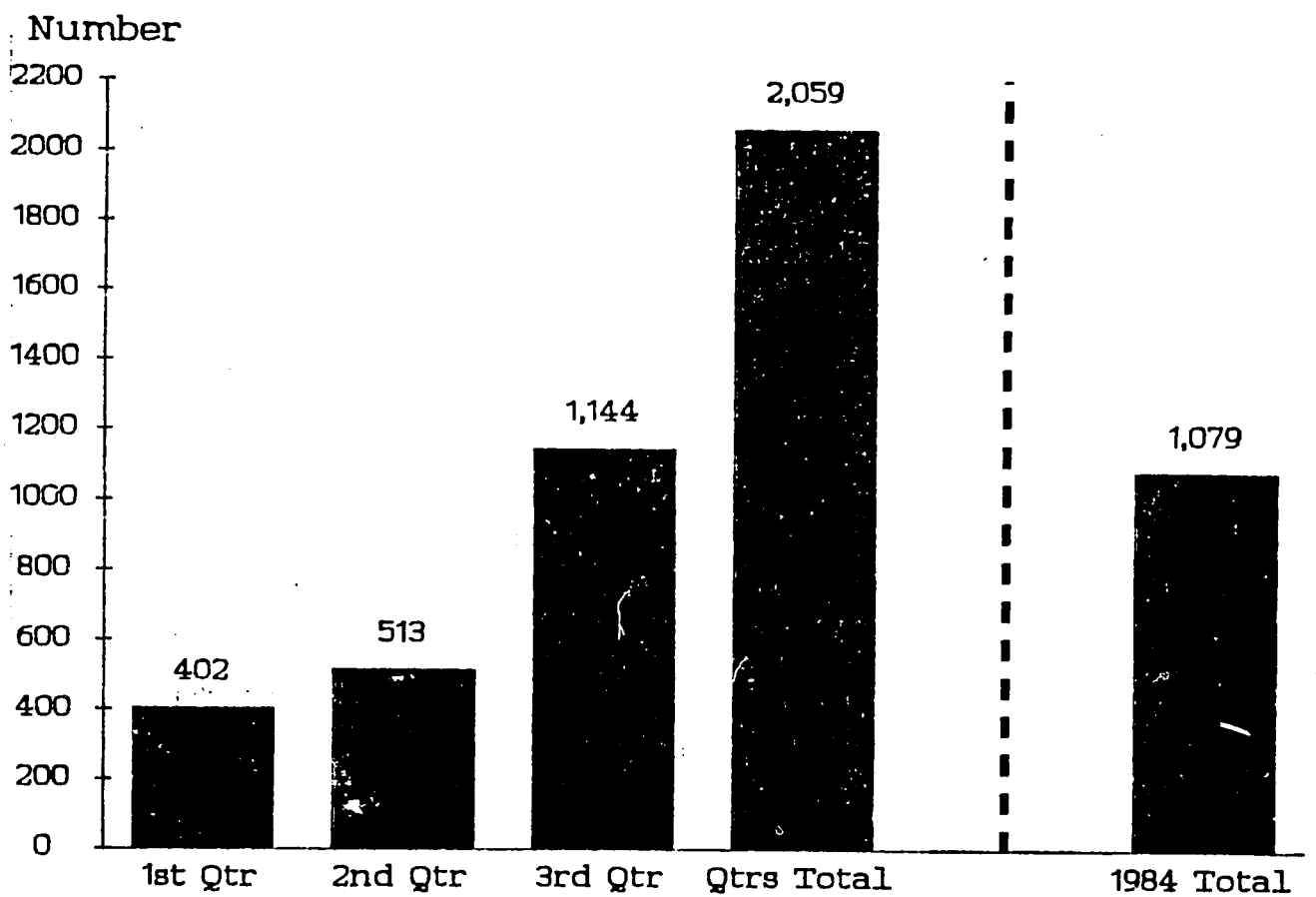


FIGURE 8

KWARA STATE FAMILY PLANNING

NEW DEPO ACCEPTORS

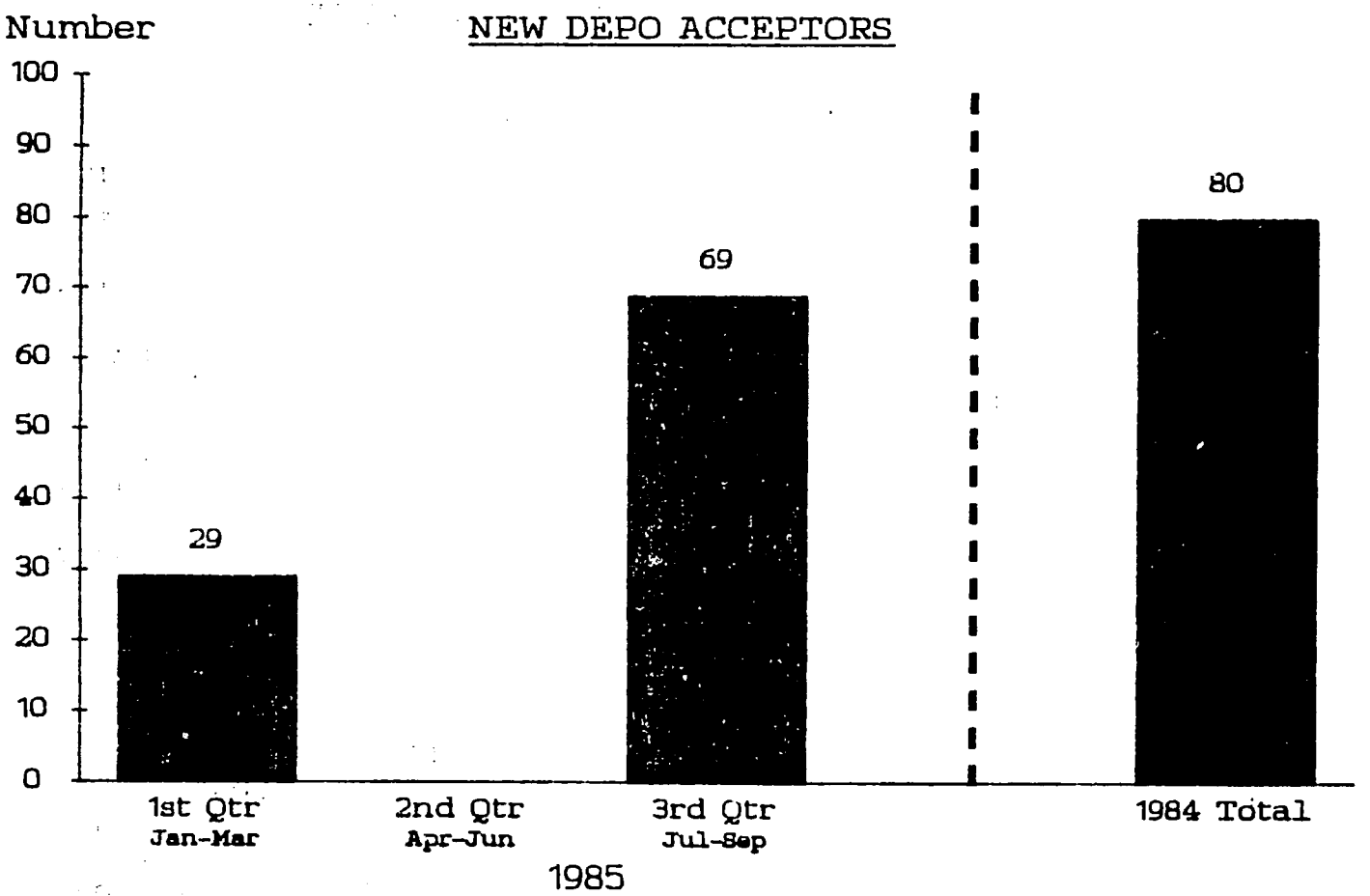


FIGURE 9

KWARA STATE FAMILY PLANNING

NEW PILL ACCEPTORS

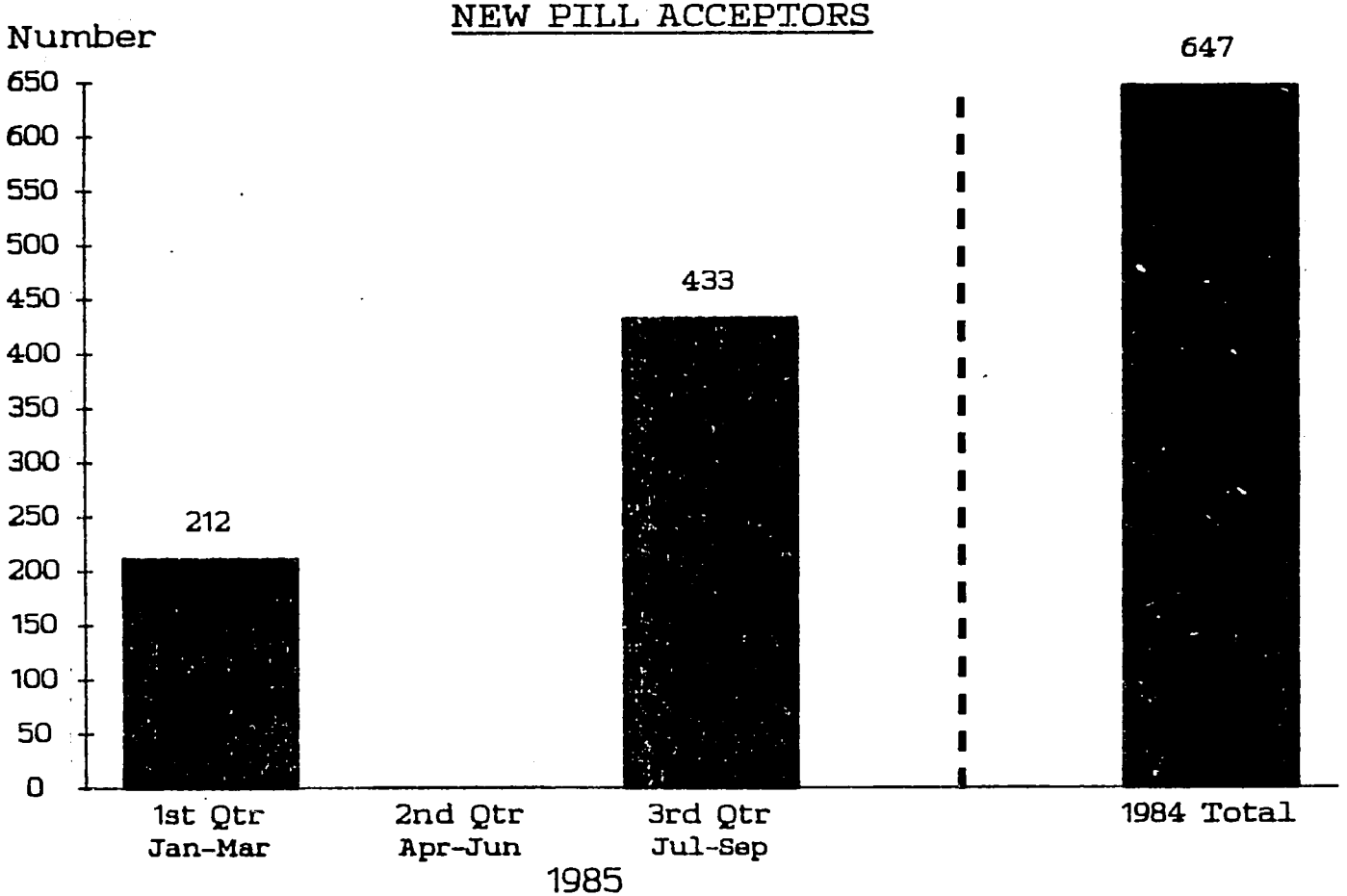
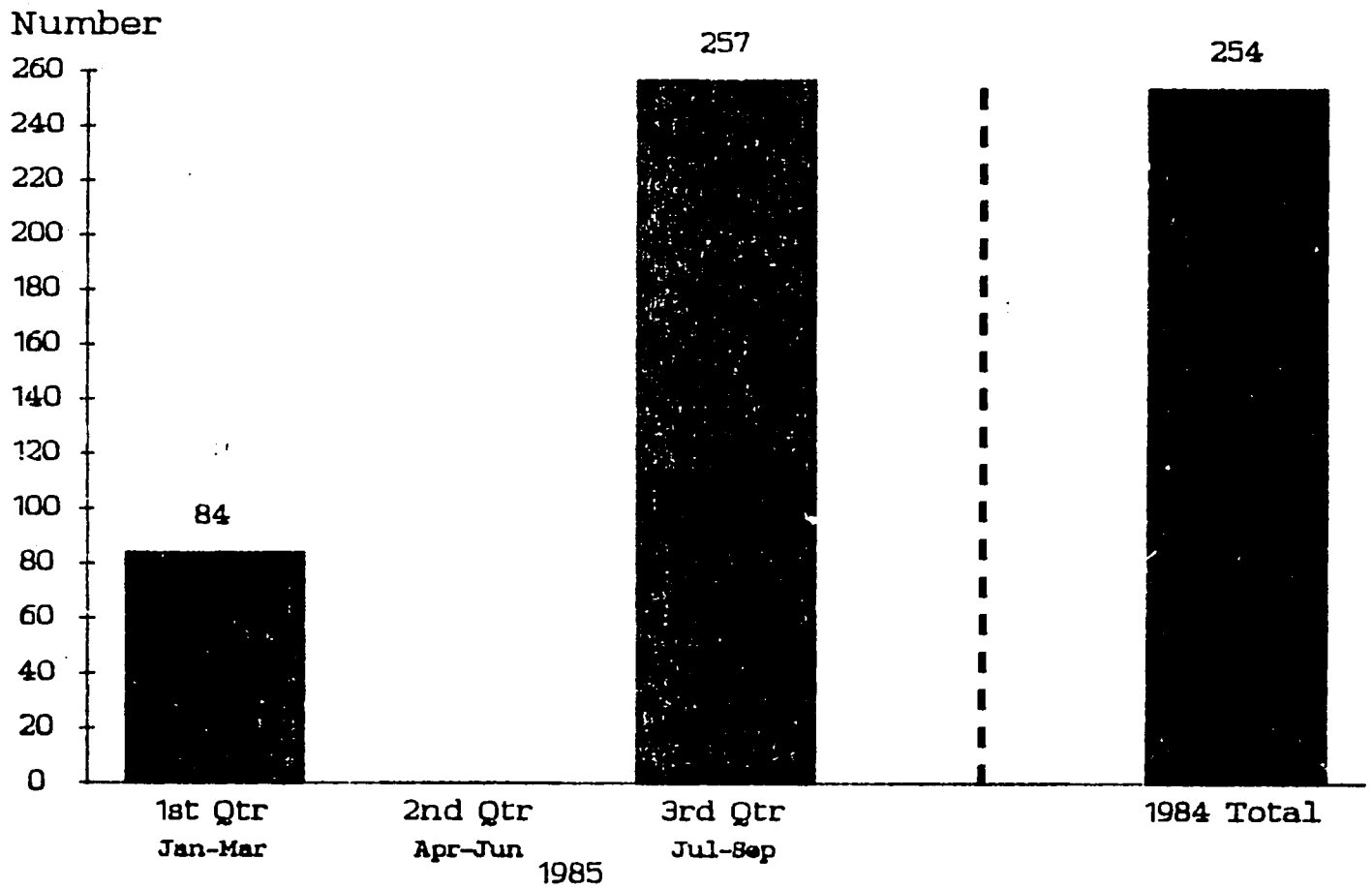


FIGURE 10

KWARA STATE FAMILY PLANNING

NEW I.U.C.D. ACCEPTORS