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TRIP REPORT:
VISIT TO ASSIST
NIGERIA PLATEAU STATE COUNTRY PROJECT
TO DEVELOP RESEARCH AND MONITORING COMPONENT

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NIGERIA

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EXECUTIVE SUMMARY

From July 23 to August 3, 1985, Gerald Hursh-Cesar, Vice President of Intercultural Communication, Inc., visited the JHU/PCS project in Jos, Plateau State, Nigeria as a consultant. The purpose of his visit was two-fold:

1. To assist the PPFN with the development of the research and evaluation component of the PPFN/JHU project in Plateau State.
2. To prepare a draft research/evaluation plan including draft questionnaires, as may be needed.

Given the unavailability of key PPFN staff in Lagos and in Jos, it was agreed that the consultant would devote his time almost exclusively to developing for later consideration a research and evaluation plan of action for the PPFN/JHU project in Jos.

However, in the light of the absence of PPFN and PPFN/JHU project managers, the action plan (see Appendix A.) can be considered a draft set of recommendations only.

A number of adverse conditions make cause-and-effect inferences very hazardous for this project. Consequently, both the monitoring and the research activities recommended in the action plan seek to capitalize on (1) ways in which the project distinguishes itself from other IEC activities; and (2) settings in which the project has the best chance of distinguishing its impact.

The plan of action details concepts and operations involved in quantitative monitoring/evaluation and qualitative village-level research as follows:

- o Monitoring: Several features make evaluation of project impact on Acceptors highly problematic. The team was advised to concentrate mostly on developing an accountability system, using baseline data from MCH clinics which sometimes have records in combination with local government hospitals and village dispensaries.

Given few resources, time pressure, and rural logistical problems, the monitoring system that was proposed involves only about a dozen rural MCH clinics and a handful in Jos.

- o Village Research: Research on the target audiences for project materials had not been contemplated and/or was thought to be the singular responsibility of the PAL advertising agency, which has just recently been contracted by PPFN/Lagos.

Like the monitoring activity, this qualitative study has been confined to a small number of (perhaps 8) villages. The action plan includes a group-discussion topical guide, interviewing procedures, and data recording and summarizing procedures.

A time schedule for both monitoring/evaluation and research activities was developed that would produce by November 1st the monitoring system in place and verified and a final report on village research for material development. The schedule tries to take advantage of the complementary nature of activities in the field and reduce their impact on other project functions.

The consultant had opportunities to meet key members of the Project Advisory Committee. The project is considered very important to government population programming and it has high visibility. However, because of the lack of materials produced by the project and the urgent felt-need for them, the project could lose much credibility if it doesn't produce something soon. Members were advised not to expect material production for at least three months while basic research is undertaken.

Acroynms and Abbreviations

FP	-	Family Planning
IEC	-	Information, Education and Communication
JHU/PCS	-	Johns Hopkins University/Population Communication Services
MOH	-	Ministry of Health
MCH	-	Maternal-Child Health clinics
PPFN/Lagos	-	Planned Parenthood Federation of Nigeria/Lagos
PPFN/Jos	-	Planned Parenthood Federation of Nigeria/Jos
PPFN/JHU	-	Planned Parenthood Federation of Nigeria/Johns Hopkins University project
USAID	-	United States Agency for International Development

INTRODUCTION:

This report summarizes the visit to Plateau State, Nigeria during the period of July 16 to 23, 1985 by Gerald Hursh-Cesar, Intercultural Communication Inc., acting as a consultant for JHU/PCS.

During the visit, the consultant's attention focused on three activities:

1. Developing with PPFN/Jos staff a draft plan for monitoring and evaluating the "probable" impact of the IEC activities of the PPFN/JHU project in motivating new contraceptive acceptors in Plateau State (see Appendix_A.).
2. Developing with PPFN/Jos staff a draft plan for qualitative village-level research as a basis for IEC materials development by the project and by PAL, the advertising agency contracted with the project (see Appendix_A.).
3. Providing draft questionnaires for both the monitoring and qualitative research activities (also in Appendix_A.).

Because of confusion regarding my dates in-country, I was unable to meet with Dr. Abayomi Fajobi, PPFN Executive Director, and Mr. Marc A. Okunnu, PPFN, Programme Director, both of whom were traveling while I was in Lagos and at a national PPFN conference in Kaduna during the time I was in Jos. Further, Mr. Christopher Nwosu, PPFN Research Specialist, was available only for one day in Lagos and two days in Jos. Likewise, Mr. Samaila I. Usaini, PPFN/Jos Field Supervisor, was available only for two days in Jos.

Additionally, I was able only to speak with Dr. MacManus (USAID) by phone, as she was traveling during most of the time I was in Lagos.

While I met the objectives of the mission to produce a specific plan of action for the monitoring/evaluation and qualitative research activities, the plans can only be drafts in light of the unavailability of the above key individuals to respond to the plans.

However, because of the necessity in the absence of these principals to produce essentially a "record" of my recommendations, I spent virtually all of my time at field sites gathering information and writing the action plans. Consequently, contacts with outside state officials and agencies were limited to meetings with three members of the Project Advisory Committee.

PLANNED PARENTHOOD FEDERATION OF NIGERIA/LAGOS (PPFN/LAGOS):

In the absence of the top officers, my orientation to the PPFN/JHU project was confined to one afternoon with Mr. Nwosu. He detailed the external FP/IEC activities already in Plateau State and the planned project IEC activities.

Additionally, Ms. Susan Rich, Population Crisis Committee, provided a brief but helpful orientation to research in Nigeria.

From these discussions, it seemed apparent that separating the impact of PPFN/JHU project IEC activities from other programs and media campaigns would be difficult at best.

PLANNED PARENTHOOD FEDERATION OF NIGERIA/JOS (PPFN/JOS):

From outward appearances and perhaps only temporarily, the PPFN/JHU project appears understaffed and with insufficient resources -- e.g., vehicle, travel funds -- to mount an effective state-wide IEC program in the near future:

- o Staff: Mr. Christopher Nas, PPFN/Plateau State Secretary, is no longer able to assist the project; the Secretary/Typist has just been replaced; and the Project Coordinator is based in Lagos. All of which leaves the Field Supervisor, Mr. Usaini, and his Administrative Assistant, Mr. Malo, as the only professionals in charge of all project activities: planning, supervision, field visits, lectures, government liaison, materials development, et al.

In light of the above, it is not surprising that the project's IEC outreach activities have been slow-starting. To-date, Mr. Usaini has held only one lecture in Jos, although he and others have traveled on reconnaissance to the rural areas. However, work is in progress on certain material development for booklets and for curricula and A/V aids for lectures, seminars, meetings.

- o Equipment: PPFN/Lagos provides a vehicle for PPFN/JHU use when not in conflict with PPFN needs. The vehicle is in poor operating condition: dangerously cracked windshield, bald tires, worn brake linings. Its periodic unavailability and hazardous driving condition are a real constraint on project mobility. Frequently, the staff uses public transportation to go to rural areas.

Funds: For many lectures and seminars in the rural areas, it most likely will not be possible for project staff to go and return in one day. But the (approx.) \$36 allotted per speakers' bureau is not enough, they say, to cover transportation, hotel lodging, meals, rentals, etc. Moreover, there is no provision for travel or expenses as inducements for participants (e.g., Agric. Extension Workers, Health Aides) to come to the rural seminars.

Time/Research: PPFN/Jos staff uniformly feel that the two-year time period for the project is too short to demonstrate the effectiveness of their efforts. And they feel that the budget for research and evaluation (approx. \$3600.) is too small for a project of this size and potential importance and for the mission of the research: to provide a basis for many IEC materials and to evaluate the impact of these motivational materials on Acceptors over time.

Regardless of facts, the perceptions of problems associated with the project -- and especially the rural lectures and seminars -- may be real obstacles to its conduct.

In terms of my mission, the implication seems clear that if the PPFN/JHU project begins any serious research/evaluation activity, it can only be at the expense of other project IEC objectives. Mr. Usaini carries a significant burden and cannot alone take on the research enterprise without giving up some of his programming activities.

PPFN/JHU PROJECT ADVISORY COMMITTEE:

I met separately with three members of the Project Advisory Committee: Mr. M.D. Kwon, Ministry of Works and Committee Chairman; Mrs. Zippora Mafuyai, Ministry of Health; and Mr. London Wadak, Plateau Radio and Television. The following are the observations which they shared unanimously:

- o Importance: The Government of Plateau State considers this project of very great importance. The Government "counts on this project" because it has no motivators working in the rural areas.
- o Credibility: Particularly because of the national economic crisis, the demand for FP services is at an unprecedented high and the need for IEC materials is crucial. However, while the need is great and the visibility of the project is high, the project stands to lose credibility soon if it does not produce something. The project is seen as understaffed, over-promised, and late getting started.
- o Resources: The project also is seen as under-committed: the project "needs vehicles, it can't reach the villages where the need is greatest and FP ignorance highest"; and its "time is too short....it's like planting a flower and then (after two years) taking away the water supply." Two members (and project staff) also felt that the project needs tape recorders for proper material development.

- o Materials: Materials are the "bottleneck." The demand for IEC materials is so high that: "Just give me the materials, I'll get them used." Not all members realized that the Advisory Committee is empowered to approve project materials. All felt this was necessary and important to "customize" materials for local use in Plateau State. None was aware that the contract had been signed with PAL, Ltd. advertising agency for material production. In any event, all felt strongly that the Advisory Committee must see the materials, because in the past some produced outside Plateau State have been of poor quality and misunderstood.
- o Rural: Unanimously, the three Committee members felt that the most urgent need for IEC materials was in the rural areas which are largely unreached by FP services and where the people suffer most. NOTE: Here, the three agreed with a sentiment expressed by all project staff: provide vehicles w/loudspeakers to take mobile services to the inaccessible rural areas and the Acceptor rate will increase dramatically.
- o Media Representatives: The lack of representation by local media on the Advisory Committee is viewed as shortsighted. The mass media will use FP materials given to them, but more representation is required to get the materials into the media on a day-to-day basis.
- o Local Integration: While it may have high visibility, clearly the project is only at the periphery of the professional/governmental FP network in Jos. I urged Mr. Usaini and Mr. Malo to increase their traffic with the relevant FP agencies; to get into the information stream.
- o Lagos: There is a concern among Committee members for the distant role that PPFN/Lagos will play in directing the materials and activities of the Jos-based project. Members are concerned for having too little control over materials going out. It is felt that a Jos agency with modern advertising/production facilities (e.g., the Plateau State Radio and Television Corporation) would have been preferable to and more economical than a Lagos-based ad agency.

Speaking to Committee members' primary concern, I advised each not to expect production of materials for at least three months while the team undertakes the research base for material development.

MONITORING AND EVALUATION:

Appendix A gives full details on my recommendations for the design of project (1) monitoring/evaluation and (2) qualitative village research. So, I won't labor over too many specifics here. The following is a brief summary of the recommendations given to the PPFN/JHU project staff for monitoring/evaluation:

- o Accountability: Several elements (small budget, unspecified end-of-project evaluation, complex media environment, nature of available data, and focus on behavioral indicators) dictate that project allocate most resources to monitoring and an accountability scheme.
- o Project Impact: Similarly, several elements (little time, no budget for large-scale surveys, poor extant baseline data, and multiple external conditions -- other media, services, programs, actions) make cause-and-effect inference extremely hazardous. Thus, the best chance of inferring project impact is to discern:
 - (a) how the project differs from other activities, and focus on those differences in measurement; and
 - (b) where do we have the best chance of distinguishing project effects, and concentrate most resources on those areas.

The above considerations led to the theme incorporated into the monitoring and village-research questionnaires and to an emphasis on data gathering in rural areas.

- o MCH Clinic Monitoring: After reviewing the types, periodicity, and probable reliability of FP Acceptor data from several sources (ministries, churches, projects, extension workers, retail outlets, village dispensaries) it was concluded (as the JHU-PCS team had previously concluded) that the 42 rural and 21 urban MOH Maternal-Child Health Clinics are the only real alternative for monitoring.

In a given Local Government compound, there may be a mixture of clients and records kept by the General Hospital, MCH Clinic, or Village Dispensary. But, invariably, all women (regardless of age or reproductive status) who go to the Dispensary become clients of the MCH. All records kept by the Dispensary are kept by the Clinic. This leaves only men as a data-capture problem between hospitals and clinics. This is manageable.

- o Implementation: Of necessity, the number of monitoring sites has to be few -- e.g., 8 to 12 rural and 3 to 4 in Jos. Specific guidance was given to the project staff regarding selection of sites, questionnaire items, frequency of measurement, verification, training, and recording historical events.

Regretfully, acting project leader Mr. Usaini, to whom my memo was addressed, returned only on the evening of the day before my departure. We discussed the monitoring and research activities only in broad terms, as he had had no chance to read the memo.

I exhorted him to initiate these activities without delay, stressing their importance to the accountability of his project and to the much-needed development of IEC materials. He understands that any effort he puts into research/evaluation will result in a sacrifice of other project activities.

VILLAGE-LEVEL QUALITATIVE RESEARCH:

In the brief time that Messrs. Nwosu and Usaini and I had together in Jos, we noted this topic only in passing. We concentrated on monitoring (and the elusive evaluation baseline) and on project resources, staffing, and logistics needed to carry out field data-gathering.

As a result, I have almost no idea of their thinking, except that Mr. Usaini clearly favors village-level research for material development but is not clear as to how this research complements or duplicates the "pretesting" and "research" to be done by the PAL advertising agency. No distinction is made in the project budget.

The following are recommendations made for village research:

- o Group Discussions: MCH Clinic staff were very encouraging on the question of "outsiders" convening groups of villagers to discuss FP issues openly. Since MCH staff have to be relied on to make the village appointments, one problem will be to keep them out of the group discussion.
- o Number of Villages: For reasons mentioned above, the number of villages that can be covered is, of necessity, small: perhaps 8. Logistically, the most sensible schedule is to combine these villages with visits to MCH Clinics when training in monitoring is conducted.
- o Respondents: Discussants will be solely "Non-acceptors," including ex-users. Most will be women and traditional leaders, and some men. Groups of 8 to 12 will be convened per village.

- o Discussion Topics: Concentrating on only a few, essential questions, the topical guide is organized around questions (with suggested probes) on (a) FP awareness/perception, including media exposure; (b) FP attitudes -- primarily the themes of the project's IEC motivational materials; (c) FP practices, including conversations and recommendations to others.
- o Interviewing: Several pages of advice were given on techniques of leading discussions, probing responses, recording data, and summarizing main themes.

TIME SCHEDULE:

The last pages of the memo (Appendix A.) propose a time schedule for both monitoring and village research activities.

It indicates high correspondence between the needs of the two activities, meaning that by November 1st all preparation (sampling, questionnaire designs), training, interviewing, verification, and report-writing (for research) can be concluded.

The field schedule is proposed in a way to give Mr. Usaini and staff fairly light field assignments on alternate weeks.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID):

While only able to speak with Dr. MacManus by telephone, it is clear that she has very high expectations for the PPFN/JHU project. In turn, among project staff and government officials I talked with, Dr. MacManus is very highly esteemed for her professional skills and for her commitment to FP programming in the country.

CONCLUSIONS AND RECOMMENDATIONS:

The following are conclusions and recommendations coming out of my visit to the PPFN/JHU project in Jos, Nigeria:

- o PPFN/Lagos Support: With PPFN/Lagos, JHU should review its budget commitment to support of the Jos project. A frank review might produce the basis for a discussion of the needs of PPFN/Jos (conceptual, staffing, logistical), and -- if it seems warranted -- encourage PPFN/Lagos to strengthen its support of the Jos project. Clearly, at the moment, the Jos team does not have enough upper-level professional staff to meet the project's objectives.

- o Vehicle: Of course, complaints about project logistical support are among the most common variety of distress signals sent by field teams everywhere. In the case of the PPFN/JHU project in Jos, the lack of a project vehicle and the use of a manifestly hazardous vehicle when available are, in my view, critical impediments to the project's field success. Although ignorant of the latitude for renegotiating budget line items, I would urge that strong consideration be given to the Jos project's dilemma.
- o Budget/Time: Like logistics, equally common staff concerns are those about the level of funding. But, in this case, I raised the questions out of my own conviction that the amount of money for research and evaluation is too small and that the time for the project to demonstrate its IEC impact on Acceptors is too short.

Since it is unlikely that more research funds will be forthcoming, I would recommend that JHU closely look into the research funds apparently allocated for PAL's pretesting and other research activities. There may be useful opportunities here to bring divergent research interests together with the same funds.

End-Project Evaluation: Despite strong reservations that the project's life is too short, my memo to the PPFN/JHU staff addresses the problems of trying to infer project impact. To this end, JHU should now begin seriously planning the nature of the evaluation at the end of the project.

I have tried to give the project an accountability rationale and scheme by which it can meet future demands for an accounting. No one, however, is clear about the terminal evaluation. Of course, it should not be done by the project team. On the other hand, JHU with PPFN/Lagos and /Jos, should begin immediately to stipulate the activities and indicators (quantity, quality, timing, and cost) that will be revealing of project impact.

Naturally, some of these will change over time. But the point of getting clarity now on what should produce "success" is that these criteria will aid JHU's ongoing evaluation of project performance. I recommend this in the belief that results of an end-project evaluation will be otherwise inconclusive.

- o Revised Time Schedule: Being cognizant that there will be an appreciable decline in PPFN/JHU's IEC activities as the team takes up the research and monitoring problem, JHU should revise its time schedule. Allow 2 - 3 months slippage in present IEC activities in Jos.

- o Communication: Without becoming burdensome, JHU should increase its specific, directed communication with PPFN/Lagos and /Jos. General quarterly reports are not enough to keep up with the ebb and flow of project fortunes.
- o Advisory Committee: JHU should urge that representatives from all variety of Jos media be added, in one capacity or another, to the Advisory Committee.
- o Professional Integration: To implement the bulk of its activities and products, the project has to work within the established FP framework. JHU should, based on its experiences in several countries, prepare guidance for the Jos team on ways in which the project can become more centrally integrated into the professional/governmental FP network in Jos.

The present lack of integration has resulted in a lack of information about the project, misperception of its activities, concern over its direction, and misunderstanding of the Advisory Committee's role vis-à-vis the project.

APPENDIX A

TO: USAINI INJI SAMAILA
FROM: GERALD HURSH-CESAR
SUBJECT: DRAFT EVALUATION PLAN

This memo presents for your consideration a draft plan for research and evaluation for PPFN-JHU project in Plateau State.

Given the conflicting schedules which limited our time together - as well as with Christopher Nwosu, PPFN - Lagos, this memo can only summarize our discussions from my own perspective. As such, the memo should be viewed as a set of recommendations, and not as a definitive plan of action. Although we agree there must be action soon.

The memo has four parts: -

- I. BACKGROUND: the special set of problems that surround any effort to evaluate the impact of this family planning IEC public awareness project.
- II. MONITORING: the design, questions and implementation of a village-level monitoring scheme.
- III. QUALITATIVE VILLAGE DATA: the design, questions and implementation of a study of different male and female groups in a small number of rural villages.
- IV. TIME SCHEDULE: a suggested time schedule.

As soon as you have had time to consider the feasibility of the plan given here, you should get together with Chris. I suspect that a high degree of involvement for both of you is essential to the further development and implementation of the project's evaluation effort.

I. BACKGROUND:

The following points summarize the issues which make evaluation of the PPFN/JHU project (NGA 03) both imperative and difficult:

- A. BUDGET AND ACCOUNTABILITY: The project budget has provided large sums of money for IEC material development. Inherent in the development of materials by the advertising agency is an unspecified amount of audience pretesting of materials. But other materials are already starting production - such as, speakers bureaus, radio jingles, pre-debate lectures, booklets, seminar, etc.

As a result, many project materials are being developed without any research on the audience the materials are intended to reach.

Under "evaluation", ₦3,000.00 (three thousand Naira) has been designated for a small-scale KAP survey and related costs. This ₦3,000 would also have to cover any project monitoring that may be undertaken.

To meet the needs of the project, ₦3,000.00 will provide only minimal insights into audience characteristics (demography, levels of awareness, attitudes, and family planning (FP) practice). Moreover, given the nature of available data and the project's focus on behavioral indications (i.e., member of acceptors), it would seem that the ₦3,000.00 would have to be divided in some rough proportion favoring the monitoring activity which would focus on Acceptors and gather other audience data as well.

Further, the project provides unspecified funds for an unspecified evaluation to be carried out at the two-year end of the project by staff or outside evaluations. For this reason, too, the project should develop the strongest accountability scheme it can, on the basis that it is better to have insight into one area than to have no insight into two.

This argument follows from the contention that the project is only able to demonstrate convincingly its "efficiency" in the production and distribution of materials, and not able to demonstrate its "effectiveness" in changing urban/rural attitudes or behavior (see below).

- B. MEASURING PROJECT IMPACT: It is a considerable distance between early research on audience characteristics and later research on audience effects. While we must have even qualitative information now on audience information, attitudes, and behavior as a basis for material production, we must also attempt, to the extent possible, to develop some kind of quantitative baseline measurement for the purpose of inferring the probable impact of the project on urban/rural areas of Plateau State. If a good baseline can be established, then, it is imperative to do so in order to assess project impact. However, if only an imperfect baseline can be devised, then we should still attempt to do so in order for the project to muster the most persuasive accountability data it can on the "probable" results of its activities - on contraceptive acceptors.

In our project, only an imperfect baseline can be devised for charting broad movement in the numbers of urban/rural people who adopt some form of family planning. That is to say:

1. A better baseline could be made, but we cannot afford it.
2. That which we can afford will permit only a general, not specific, view of changes within the total population and of population sub-groups.
3. Whatever we do will be largely confined to statements about the usual areas, not urban.

The last point above is one of the problems that limits our ability to measure "cause and effect" relationships; that is, to measure project impact.

We cannot afford large-scale sample surveys, so we cannot build a data baseline composed of individual urban/rural residents for pre-post-test measurement. And even if we could, the multiplicity of family planning programmes, campaigns, and media (especially in the urban areas) from different sources makes it very improbable that we could even sort out the effects of this PPFN/JHU project and the effects of other sources.

In our discussions, for example, at least the following sources were described as active in FP service and/or communication:

1. Ministry of Health
2. Church of Christ in Nigeria
3. INTRAH
4. Evangelical Church of West Africa
5. Ministry of Agriculture, Economics Division
6. University of Jos, Centre for Fertility Studies
7. Planned Parenthood Federation of America
8. USAID, and of course,
9. PPFN, the fine work of your own organization.

While the activities of these groups focus mainly on service delivery, such services are invariably accompanied by an information exchange, exhortation,

motivational efforts, as well as often printed and visual materials distributed. Evidence of this point is that Plateau State is currently being exposed to posters, booklets, newspaper advertisements, pamphlets, radio spots, debates, lectures, visual aids for demonstrations, etc. on family planning. These kinds of activities have been underway since about 1971, and are gaining momentum today. Apparently, such IEC efforts produce tangible effects--especially since Plateau State has the highest number of contraceptive users in the country, yet, when you ask people the reason for the increase in adoption, the answer usually is that it is due to:

1. The economic crisis in the country, and
2. The positive attitude of the present administration toward family planning.

With such a mixture of new services, communication efforts, government action, and external conditions impinging on any "cause and effect" relationship in family planning, it would be difficult to determine project impact under the best of circumstances. We could make a case, with a blanket evaluation of the entire system, for the synergistic (multiplier) effect of the project's interaction with other parts of the FP system. This would be, at best, a questionable inference, and would require an historical analysis of all other FP activities (government and non-government) during the life of the project. This we are not able to do either. However, an historical record of other major events and activities (e.g. new MOH program started, new Government decree issued, etc.) should be maintained in any case. More about this later.

The best chance we have for inferences (weak but probably not misleading) about the project's impact on the rate of contraceptive adoption is to determine that:

1. It concentrates solely on IEC and does not deliver services.
2. It has entirely a complementary role in that it is aimed at fortifying attitudes largely imparted by others. (This is not necessarily to our advantage.)
3. It stresses new themes: male responsibility, religious compatibility, modern methods of FP, and the social and economic consequences of high birth rates.

To the extent that the project is to play a leading role in motivating people with "new" kinds of messages, something of its impact may be discernible.

On the second point, the urban areas offer little hope to small-scale efforts to evaluate our project. Both private and public sector activities are concentrated in the cities and larger towns. Rather, the rural areas offer the best chance of inferring whether the project is reaching the target audience effectively.

- C. TYPES OF DATA AVAILABLE: For Plateau State, no urban/rural data base exists that helps us except for the limited records of acceptors reported by some 40 MOH clinics throughout the State. Centralized records are said to be probably misleading because of problems of keeping track of the records. The World Fertility Survey of Nigeria and the Contraceptive Prevalence Survey do not have enough cases to extrapolate down to the State level. Other kinds of research are small-scale, unable to extrapolate upward. So it appears that we have to use the clinic records as a starting place.

In summary, what the project can do well is demonstrate its own efficiency in producing and distributing materials. What it (or outside evaluation) cannot do well is demonstrate its effectiveness in producing population changes.

Evaluation aside, we are very soon to invest heavily in media materials directed at audiences about whom we know very little. Ideally, we would want attitude surveys, media-usage studies, and KAP baseline surveys in order to develop our media campaign. We won't have these; but we need something--fast.

Despite low resources, we have to act on both fronts: Accountability of project activities and audience research for IEC materials development. But because of low resources, we are limited on both fronts.

What we must do seems dictated by these points made above:

1. Rural: Confine research and monitoring largely to rural areas.
2. Baseline: Capitalize on the one reporting system that works, and capitalize at its source: the MOH clinic.
3. Acceptors: For reporting purposes, focus largely on behavioral measures: the number of new contraceptive users, new clients for other FP services, repeat visits, etc.
4. Themes: In getting feedback on audience response, focus on the themes that distinguish the project.
5. Qualitative: With a shortage of time and money, conduct only thematic qualitative research in villages (e.g., group discussions) aimed at insights into what FP attitudes exist, why the attitudes are held, what are other obstacles to FP, what can be done about them, how important are village leaders for FP decisions?
6. Small Numbers: With ₦3,000.00 budget for both activities, confine the baseline-monitoring system to a few, but respectable, number of clinics and to a few villages.

7. Links: To save money, tie together village qualitative research with those clinics used for monitoring acceptors.
8. History: Keep historical account of the activities of all major sources in the FP system.
9. Circumspection: Be cautious in attributing project effects. In all reports, warn the readers of the danger of concluding falsely from small numbers.

Below, based on our few discussions and my discussions with others and visits to three rural areas, are recommendations for the monitoring system and small-scale qualitative village studies.

II. MONITORING

The information for this section emerges from our discussions and from my visits to three rural health clinics in Akwanga, Barkin Ladi, and Pankshin. Altogether, there are 42 such MOH clinics supported by the local government which provide mainly maternal-child health (MCH) care. Each clinic has a FP unit.

As I understand it from Mrs. Musa, local governments have the best organization of usual services and are very keen on family planning. This is to our advantage, because the project needs strong liaison with rural FP services. So, I assume you would be looking more to the local governments than to, for example, women's associations or rural cooperatives.

Typically, each local government has two MCH clinics (as well as one general hospital). Each clinic is supported by five or six dispensaries, each of which serves two or three villages.

A. MONITORING THE MCH CLINIC

The purpose of visiting the clinics was to learn more about the actual and potential information flow between rural clinics, dispensaries and villages. This was done primarily in the interest of project monitoring, but I was interested as well in learning more about relations between clinic staff and nearby villages for the purposes of our doing some qualitative village-level research.

In either case, I tried to look at the FP system from two points of view:

1. Who carries information to the villages, and therefore might disseminate or collect information?
2. Who receives information from the villages, and therefore might provide information?

The purpose of these questions was to learn where we could feasibly establish a research and monitoring system by taking advantage of existing information -- exchange activities, asking: At what level is information recorded? How often? With what verification? And at what probable cost to us for existing or augmented data?

Of various rural extension services, only the MOH clinics offer serious promise for project monitoring. Of the others:

1. Women's Association - not sufficiently organized to cover villages uniformly.
2. Ministry of Agriculture - extension workers are not likely to cooperate in all areas.

3. Church and mission projects - too small and localized.
4. Rural cooperatives - not sufficiently organized.
5. Social Development Officer - not likely to cooperate in all areas.
6. Ministries of Education and of Information - not involved enough in rural areas.
7. Chemists and other private outlets - not much influence in rural areas, will not keep records, likely to suspect we are prying into their affairs.

This review leads to the obvious conclusions that, first, clinics are the only low-cost way to get uniform monitoring data over time; and, second, unless we attempt "surrogate" interviewing of clinic staff (using them as "reporters" on village FP characteristics), the only acceptable source of qualitative data on villages are villagers themselves. On the last point, there simply is no alternative to doing some small-scale village research (for example, group discussions).

For a brief time, it seemed that village dispensaries would be our best monitoring source. But events in Barkin Ladi and Pankshin overturned that idea. In these areas, dispensaries do not keep records of FP acceptors, but refer all clients to the general hospital (especially men seeking contraceptives and advice) or to the MCH clinic (especially pregnant women and mothers with children from 0 to 6 years of age). The dispensaries mainly serve as referrals to higher level medical facilities and treat low-grade problems, like minor injuries. Given the apparent contradiction, the project should investigate the kinds of clients served and the kinds of records kept at the hospital (usually one for each local government area), at the MCH clinic, and at the village dispensary. Records on male and female acceptors may be complementary or duplicate. Conceivably, you could use

only the MCH clinic at most places and some combination of the three services in other places.

Finally, the following information is very encouraging for use by MCH clinics for monitoring:

1. Clinic staff frequently visit village dispensaries and villages.
2. Where dispensaries keep records, the records are retrieved once a month and are checked for accuracy.
3. But any client seen by the dispensary is also seen by the clinic or the hospital where records are kept.
4. Clinics (and dispensaries) could and willingly would record additional information for this project.
5. Clinics also serve all women other than those pregnant or with young children. So their female records are complete.
6. Clinics and/or the general hospital serve men. So the records exist between the two sources.

With this background, let's turn to implementing the monitoring scheme.

B. IMPLEMENTING THE MONITORING SYSTEM

Although MCH staff do visit rural villages as frequently as possible, their visits are irregular. Due to low budgets, lack of transport, long distance, and inaccessible roads, outside contact with the villager is not systematic. Outside contact, unless paid, cannot be relied on for the purpose of monthly or bi-monthly monitoring of villages.

In your own case, lack of funds prevent you from undertaking any large-scale venture. Thus, the number of sites will be small and, moreover, the villagers will have to come to us for counting. Fortunately, it seems that they will and do. MCH staff consistently maintain that when women or men adopt family planning, very little can prevent them from keeping their appointments. Repeatedly, staff say, "the people are ready." (Of course, staff also say that if they had vehicles, they would do much more.) I recount this because normally I would doom to failure any reporting system based on volunteerism. Here, I believe the system will work.

The following are recommendations for the monitoring system:

1. Number of Sites: You will not be able to achieve a large sample of the 42 rural clinics nor of the 21 clinics in Jos. Nonetheless, the locations must be sufficiently spread out through Plateau State, to assure a reasonable diversity (see below). Knowing that the average distance between clinics is about 100 kms, achieving such diversity will not be difficult. On the other hand, average distance between sites also suggests that you will not be able to manage more than a few, unless you have more money, staff, and vehicles. Since new resources are unlikely, I would recommend that you "cost out" the expense of maintaining 10-12 rural sites and 3-4 Jos sites. Maintaining sites means visits to each to train MCH staff (see below) and periodic return visits to verify the records.
2. Type of Sites: Obviously, we cannot choose the most accessible sites. They must resemble the range of characteristics of clinic locations in rural and urban areas. The following is a brief set of criteria to consider in selecting sites:
 - a. Population size.

- b. Institutional development - including churches, chemists, and other retail outlets as well as other institutions of commerce and government.
- c. Access - distance and type of access roads.
- d. Major language - Hausa, local dialects, English.
- e. Ethnic groups.
- f. Religion - Moslem, Christian, others.

The University of Jos, perhaps the Centre for Fertility Studies, is said to have good maps for helping you make these geographic and socio-economic determinations. The criteria by which you might select Jos clinics is probably best known to you. If the city is clearly divided into ethnic neighborhoods or economic zones, these would be useful criteria. Construct a typology (or different categories) of sites and purposely choose your "sample." With so few sites, you are likely to pick a better sample deliberately than randomly.

3. Questions: The MCH clinic already keeps some useful records for our use. We cannot add greatly to their burden. We should not ask more than a single page of a few, essential questions. Probably 10-15 would be enough. Presently, the clinic records this information:

Name _____

Address _____

Ethnic group _____

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Age _____

Education _____

Religion _____

Occupation _____

Service required (contraception, others) _____

Contraceptive history _____

Marital status _____

Marital history _____

Monogamous/Polygamous marriage _____

Source of referral _____

Pregnancy history _____

Live children history _____

Medical history of pregnancy _____

Medical examination data _____

Type of contraceptive provided _____

To this set of data, we could add the following kinds of questions of FP knowledge, attitude, and practices:

Awareness:

- a. What does family planning mean? (This is also an attitude question.)
 - b. How did he/she first learn about FP?
 - c. How else has he/she learned about FP?
4. For all sources not mentioned in Question 2 or Question 3, ask: Has he/she ever heard about or read about FP in any of these sources:

Booklets	Cinema	Friends
Pamphlets	TV	Relatives
Posters	Radio	Spouse
Demonstrations	Lectures	Leaders
Newspapers	Discussions	Clergy, etc.

NOTE: Once you have a complete list of sources, it could be used for Questions 2, 3, and 4.

Attitude:

- a. Why has he/she come to FP? Examples:
 - Bad economic conditions
 - Poor health
 - Can't feed or clothe children
 - Village leader told us
 - Husband told me, etc.
- b. How many children does she/he want to have? (This is mainly for use in a re-test at the end of the project.)

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- c. How many children does his/her spouse want to have?
- d. What relationship does he/she see between high birth rates and national socio-economic development?
- e. What does he/she see as the male's responsibility for FP?
- f. How safe is FP? What is unsafe about FP practice?
- g. Why are many people in the village against FP?

___ Against God's will

___ Unsafe

___ Children are parent's old age security

___ Ignorant of what FP is

___ Against our traditions

NOTE: Many attitude items could be asked. We can only ask a few, and should link them to project themes.

Practices:

- a. Ever talk to others about FP? Who? How often?
- b. Ever recommend FP to others? Who? How often?
- c. FP Status:

First visit for contraception?

____ Repeat visit for contraception? (Number of visits)

____ First visit for other MCH/FP services?

____ Repeat visit for other MCH/FP services? (Number of visits)

NOTE: The first two questions are specifically related to project IEC behavioral objectives.

A questionnaire form would have to be printed, showing both questions and coded responses on one side (hopefully) of the paper. In the clinic, the staff would staple each completed form to its counterpart already used by the clinic.

It is essential that you "preview" the form with some clinic staff in the field to ensure that it will work as intended (e.g. that the questions mean what you want them to mean.)

5. Number of Measurements

Of course, we want to keep records on all clinic (or hospital or dispensary, as the case may be) clients who come for FP services. There is no sampling here, we simply take all we can get.

Records should be collected by PPFN staff on the same monthly or bi-monthly basis as at present. It is better for you to collect the forms periodically than to wait until the end of the project. We should not make their safe-keeping the continuing responsibility of the clinic.

Despite the cost involved and the fact that you do not have computer-processing facilities, I would recommend that you try to interview again

toward the end of the project all or a sample of MCH clients who were interviewed in, say, the first six months of the project. This would permit you to see, in addition to general trends over time, specific individual-based changes in FP awareness, media exposure, attitudes, and communication behavior. This requires, of course, that you keep careful track of the forms from the first interview.

Again, the lack of machine or computer facilities is an important consideration. In your deliberations, why not investigate the possible free access of data processing equipment at, for example, the University of Jos. This would be your surest information that, during the project period, there have been significant increases in the number of FP sources perceived, the frequency of family planning conversations, and recommendations of FP to others.

6. Verifications:

Early in the monitoring phase, you would want to visit each site once to verify that the forms are being completed correctly. Thereafter, verification checks and problem-solving could be done on visits corresponding with Mrs. Musa's field visits. Probably, in time, she will be able to take responsibility for all verification.

7. Training:

Hopefully, Mr. Nwosu will be involved with you in designing the questionnaire (reporting form) as well as training MCH staff in its use. As you know, training always sounds simpler than it is. With a questionnaire, you have to play two roles in designing it and in training others to use it: the role of the respondent and the role of the interviewer:

- The Respondent is prone to misunderstand and misperceive questions, or generally not to know what is expected of him or her. These are errors in "decoding" information. Worse, the respondent often gives answers that he/she feels the interviewer wants.
- The Interviewer is prone to make errors in asking questions. These are errors of "encoding" information. Worse, the interviewer often leads the respondent in such a way as to "tell" the respondent which is the preferred answer to give. The interviewer also makes errors in recording data.

I say all of this only to underline that sound training, even in the use of a one-page questionnaire, is essential.

In developing a training curriculum, you and your staff should take turns "playing" interviewer and respondent roles, trying to imagine every possible mistake that could be made. If you can think of it, then be assured it will happen in the field.

At the clinic, be sure the sister or charge nurse has advance warning that you will require some time for staff training. In these sessions, in addition to the mechanics of completing the forms and the explanations of question-meaning, stress the importance of the staff not "suggesting" answers to clients. (Certainly, tact is the order of the day.) With the staff, do the same kind of "role-playing" as above, to get them into the spirit of the enterprise and to educate them, too.

The kinds of things you should tell them are, for example, that data on media sources and time of first learning are very unreliable, and they should explore such answers according to guidelines you give them. Also, tell them to write down any answer that does not fit the categories.

8. Recording Historical Events:

Finally, you and I have discussed a different kind of monitoring: the trends of the number of acceptors during the life of the project. This could be done for all clinics (since PPFN has those data) or only for the project clinics. I would plot both trend lines on a wall graph, if only to see the deviations of our small sample from the overall picture for the State.

By time periods, you may wish to plot something else on the graph: the activities of your own project as well as occurrences of other significant FP events, programs, media campaigns, new budgets, government decree, new projects, etc. That is, if possible, keep track of changes in the FP system of which this project is a part. While it has been said above that we cannot directly measure the cause-and-effect impact of the project on acceptors, we can measure our own efficiency in the production and distribution of materials; and we can chart our dissemination in relation to all else that is happening.

Why do this? Suppose, for example, that the entire system except this project, remains at relatively the same level of present activity over the next 18 months or so, but adoption rates climb. We will not be able to say the increase is due solely to us (it may be simply a cumulative effect of past activities), but for the purposes of accountability, it would suggest that our interaction with the system has, indeed, had something of the synergistic impact we planned.

Again, there is nothing conclusive about such data, but they are a useful reconstruction of project history. Moreover, collecting such information, systematically keeps the project in touch with the main FP agencies, and may offer you advance information on opportunities to share resources or otherwise benefit from other's activities.

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However, you are short of staff and time. This may not be one of your top priorities.

Let me conclude with two final points. First, it is recognized that because of your need to economize on staff time, petrol vehicle upkeep, etc., you may have to choose mostly accessible clinics for monitoring.

Second, one last word on re-interviewing at the end of the project a sample of FP acceptors who come to the MCH clinic within the first six months after the project becomes active. Because we are covering the entire State, there is no "control" group of villages which is not potentially exposed to project IEC materials. Such a control group (that is, villages not potentially exposed to project materials) would have to be found in other States. Lacking a control group, we cannot compare Plateau State villages (or the clinics that represent them) which are exposed to project output versus those which are not.

As a result, we have to sample the same type of potentially exposed villages. The best way to infer project impact on the total population of villages is to sample at different points in time.

Thus, we compare acceptor rates for the same villages "before" and "after" the project's life.

Regardless of how weak, in present circumstances, this will be our most useful evidence that the project has benefited the people of Plateau State.

III. QUALITATIVE VILLAGE RESEARCH

The foregoing addresses the problem of monitoring. But monitoring is only the quantitative part of the data needed for the project. For the purposes of IEC

material development, we need qualitative (meaning fairly unstructured, informal, and impressionistic) data gathering on why people come or do not come to FP clinics; what obstacles in the villages do we and they have to overcome; what is the credibility or believability of the FP message; and so on.

Unfortunately, because of our conflicting schedules, this topic has been mentioned only in passing, as we focused on monitoring and other problems. I very much regret now presenting it to you in a memo, but as you know there is no alternative. As said before, the purpose of this low-cost qualitative study is to guide the advertising agency and yourselves in developing materials that will be culturally appropriate for our audiences in Plateau State. That is, our messages have to be understood, believed, and trusted as well as compatible with the traditions and way of life of Christian, Moslem, and other members of urban and rural societies here. In our present project, not enough is yet known on these problems to permit us to be confident in committing large sums of money to material production. We need, in short, to pause to talk with our audience before dashing ahead with expensive media materials.

While visiting the clinics, we raised the question with MCH staff about holding group discussions in rural villages on sensitive FP issues. The responses were enthusiastically encouraging:

- Clinic staff are known and welcomed to the villages.
- Staff could, if desired, help form groups in the villages.
- Highly literate assistants (e.g. school headmaster) could be found for recording the discussion. (This is a written record, as no tape recorders will be used.)
- People, even traditional leaders, will talk willingly for and against FP.

- Traditional leaders will consent to participate. (Advance written notice is required.)
- Other local bodies that will usually help are the Village Health Committee, Christian and Moslem clergy, Women's Associations, and Dispensaries.

Although perhaps not an ideal pre-campaign research undertaking (ideally, we would have more villages), the following recommendations are what we might be able to do rather quickly in a situation of scarce resources.

- Villages and Respondents: To economize, interview small groups of people in dispensary villages near the clinics that you select for monitoring. If the fact of your presence in these villages serves to impel some clients to the clinic who might not otherwise have come, we could probably say that:
 - a. Their willingness to join FP is very close to the surface if mere discussion brings them to the clinic; and/or
 - b. If acceptor rates among these monitoring-and-research clinics are artificially higher than for other clinics in the State, we will detect that in monitoring.

If either of the above were the case, it would be a very strong argument for more "research." I do not think you have much to worry about.

Of your monitoring sites, you may be able to select four villages in which you and Mrs. Musa would spend a day discussing FP with two different groups--one in the morning and one in the afternoon. Unless you think otherwise, it makes most sense to me to meet with groups of women, village leaders, and men, with a slight emphasis on women (the most likely acceptors) and leaders (forceful obstacles in the village). Your discussion groups might look like this:

	<u>Morning</u>	<u>Afternoon</u>
Village 1	Women	Leaders
Village 2	Leaders	Men
Village 3	Men	Women
Village 4	Women	Leaders

An alternate plan would be to go to eight (8) villages, interviewing only one group per village. Please consider this because it has special advantages:

- a. You will achieve a greater diversity of villages, and, in all likelihood, of views as well; and
- b. Logistically you will probably spend less time in the field and find the work less demanding.

The reasoning here is as follows: To economize, you would combine the village interviewing with training MCH staff in monitoring. If you conduct training sessions and two group discussions, you will often stay overnight in the area. If, instead, you train at the MCH in the morning, and interview one group in the afternoon, you will usually be back in Jos in early evening. You will, of course, decide which works best.

Regardless of whether one or two groups per village, each group would be about 8 to 12 discussants. It is usually too much to handle when you go over 10 people. In villages, it is often more difficult to exclude people than include them in interviews.

True, discontinued contraceptive use may be a problem, but it has not been described as a major problem in Plateau State. At any rate, discontinued users are non-users. But if you get some discontinued users, be prepared for special antagonisms about male responsibility, safety of FP practice, and quality of FP services.

Questions: Like monitoring, only a few essential questions need be asked. Some suggestions are:

AWARENESS PERCEPTION

1. What is "family planning," what do you understand family planning to be?
2. Why has the government started family planning? What is the government trying to do? Is this good or bad? Why?
3. Have you ever seen FP messages on posters, in newspapers or television, or heard about FP over the radio? What do you think when you see these FP messages, do you trust them? Do you think they are meant for you or for other people? Do they make you think FP may be good for your family or the village?
4. Do you know where any FP services (like clinics, hospitals) are located? What kinds of services do they have? What good things have you ever heard about these services? What bad things have you heard? Have you/your spouse ever gone there for any FP services?

ATTITUDES

1. Regardless of whether you are for or against FP, what reasons do some of the people in the village give for being in favor of FP? What other reasons are there? Do you agree or disagree with them? Why?

2. What reasons do people here have for being against FP? What other reasons do you know? Do you agree or disagree with them? Why?
3. (To those of child-bearing age) Do you think you would ever try FP? Why/why not? Would you ask your wife/husband to try FP?
4. Just suppose that the people in favor of FP are right, that FP is good for this village and good for the country. What would it take to convince you they are right? Could anything else convince you?
5. If your Priest/Minister/Mullah told you to go for FP, would you/your spouse go? If your village chief told you to go, would you go?
6. Let us review all that we have said with one question: What is the most important reason people have here for being against FP?

PRACTICES

1. Do you ever talk with others about their reasons for being against FP? Who do you talk to? What do you talk about?
2. Do you ever talk with others about their reasons for being in favor of FP? Who do you talk to? What do you talk about?
3. Have you ever recommended to someone to try FP? If yes, who? Why did you recommend FP for him/her?

You will probably improve on these questions. Note that they are all aspects of communication: understanding, trust, believability, stereotypes, reasoning, beliefs, exposures, leadership, interpersonal contact. The questions appear lengthy because I have written in the kinds of follow-up questions you might naturally use in drawing out group responses.

IMPLEMENTATION

1. Question Form: Let's not call it a questionnaire. It is a single page of questions that helps guide you through the discussion. While it may be preferable to ask the questions in order, there is no strict rule. These are fairly unstructured situations in which you guide the "natural" flow of conversation, inserting the appropriate question where it best fits. Just be sure all questions are asked. Here, again, in making up the questions, Chris Nwosu should be greatly helpful.

2. Contact: At the same time you notify the clinics in advance of your visit for training in the monitoring the questionnaire, you could ask the head nurse to arrange the appropriate group meeting(s) for you. With the uncertainty of mail to the villages and of village locations, this is very helpful to you.

Be cautious of two things:
 - a. You are there to gather information; to learn what people believe without unnaturally influencing their responses. You are not there representing the Government's FP program. Being introduced by MCH staff could produce an undesired effect on the group's discussion.

 - b. Do not let the MCH staff choose "their" people. You want a range of respondents, all different kinds of people who have one special quality in common: they are non-acceptors.

3. Interviewing: You, not the MCH staff, are conducting the interview. It would be best if no MCH staff remained during the discussion. If they do stay, politely but firmly keep them out of the conversation. Another individual to guard against is the one (or two) who tries to

dominate the discussion. This is particularly sensitive with village elders, but you have to keep the conversation open to all. We do not want someone's views smothered by the views of another.

Speaking of smothering someone's views: you absolutely must not take sides in the discussion. When the group appeals to you for their arbitration, turn the conversation immediately back to them, saying something like:

"My views are not important, it's your opinion that counts."

"I can't answer that for you. You are the ones who live here, only you can answer that."

"What I think is not important, because we are here to learn what you think. We can discuss my views after this meeting."

These seem innocuous enough, but these kinds of tactics work surprisingly well. Above all, you are trying to show the group that there are no "right" or "wrong" answers. Different people think different things, and no view is "better" than another.

Just as you cannot take sides in the discussion, you cannot propagandize for FP. We are not trying to change people's views with this research, we are only trying to learn what those views are.

As for interviewers, I would suspect that you and Mrs. Musa would want to work as a team. Given the male-female division of your groups and the possible sensitivity of the topic, you may sometimes take the lead (with leaders) and sometimes she should (with women).

4. Probing Questions: Just because the discussion stops doesn't mean it's finished; and just because one person keeps trying to have the last

word doesn't mean it is the prevailing view of the group. You have to keep "digging" for more information. One way is to ask follow-up (probe) questions designed to elicit more information. For example:

"Why do you think like that?"

"Do you have any other reasons for saying that?"

"Have you always believed that, or is this a new view?"

"How strongly do you feel about that?"

"How do you think other men in the village feel about that?"

"Who else in the group feels the same? Why?"

"Who thinks differently?"

"Can anyone else give other reasons for that belief?"

"How do other people here feel about what has just been said?"

These are only suggestions. There are many such questions that are intended either to keep one person talking in greater depth or to shift the conversation away from one person to others.

5. Recording Data: You will not have portable tape recorders. It's just as well because in some remote villages they provoke curiosity. Worse yet, trying back in the office to understand what is being said by four people talking on tape at the same time is a frustrating chore.

You will have to record your information by hand, on the spot. For these four to eight villages you go to for interviewing, it would be a

real advantage if you could take Mr. Malo, in addition to Mrs. Musa. You need some one who is highly literate and knows the objectives of your research. MCH clinic staff assured me that you can obtain the services of a school teacher or other skilled-literate to write notes, if Mr. Malo cannot be used. Such persons would be available for little or no pay.

If it were my choice, and Mr. Malo could be spared, I would use two people to record notes (he and a school teacher), because one person can never keep up with the full discussion.

6. Summarizing Data: Now comes the different part: making sense of the data. Because this is a relatively new experience for you and because you have to rely on written notes (which are never fully complete) and your own recall, it is essential that you summarize the group's discussion immediately. If you wait until returning to Jos you will lose the aid of any local person you used and your own memory will not be as fresh. Here are some suggestions:
 - a. Divide your questions into logical sections. For example, by FP knowledge, attitudes, and practices, at the end of each section in the discussion, stop and summarize the main points of that section for the benefit of the person taking notes.
 - b. Prepare and take with you a special form (a "debriefing" form). The first could be divided into two parts: first, the major sections (e.g., K-A-P); and, second, each individual question. On each page allow space for writing lengthy notes. (In fact, you may want to give one full page to each of the K-A-P sections, and one-half page to each individual question.
 - c. Immediately after the interview (with "STAR" or "FANTA" in hand) or as soon as you can find privacy (perhaps back at the clinic),

meet with your team of interviewers and recorder(s) and go over the notes, transcribing them onto the debriefing form where appropriate for each question.

First, summarize the most important points for each of the major K-A-P sections.

Then, go through the notes carefully for the more detailed responses to each question. In the process of each team member contributing his or her recollections, you will be able to decide the most important points made; you will be able to correct discrepancies in responses, and you will be able to fill in the gaps of missing information in the notes.

Although this seems arduous, you will never regret it. If you "debrief" the interview on the spot in the field, you will avoid countless hours and undue frustration back in your office when sometime later you try to reconstruct the interviews in order to write a report.

As you can see, the necessity of capturing the information while it is freshest in your mind is a strong argument for doing only one village group interview in a day. Two group interviews plus training clinic staff in monitoring in one day would be a killing workload. It would probably result in your staying one day and one-half in the field.

Finally, you will have to write a report of your findings to guide the advertising agency as well as your own material production. It does not have to be long and scholarly. It is only your summary and interpretation of the most important findings for the major K-A-P sections and individual questions. You will find that your debriefing forms will write much of the report for you. Attach copies of your debriefing form as an appendix.

IV. TIME SCHEDULE

Detailing the work involved in the village interviews (including up to eight days in the field) brings us back to the basic problem: You have only ₦4,000.00 to work with. You have to decide with Chris Nwosu how much research you can do without jeopardizing the activities begun to date.

Your decisions will not be easy, but permit me to stress again the importance, the necessity, and urgency of getting these two research activities underway as quickly as possible. I have talked with members of the Advisory Committee. They put great importance on this project and eagerly await the materials. But good materials need good research. I advised them to be patient for about three months while the research gets done. So research now becomes a critical activity. And it cannot be a minimal effort. What we do must be believable and useful. My point to you is that the research and monitoring activities must for two to three months become more important than some of your communication activities--if only because you do not have the staff, budget, or vehicles to do all jobs well at the same time.

Now, let me propose something to you that may at first seem unreasonable: with a modest shifting of staff resources and activities and at no great extra cost in money, staff, time, and calendar time, you could complete the village interviews on or before October 15 and submit a report on or before November 1. Consider these points:

A. Preparation Time

There is almost no serious preparation time needed to select the villages, write letters to MCH clinic staff to arrange village visits, and develop question or debriefing forms. All of the work involved in selecting villages (e.g., by location, access, ethnic groups) is being done as part of the monitoring activity. You simply look at the results, and pick a diverse group for interviewing.

Further, although I may or may not have given you exactly the questions you will use, you certainly can agree that the assignment is not difficult: a few basic questions on communication aspects of K-A-P. You and Chris can agree on the list of questions in one sitting. Once the questions are written, they only have to be transferred to one type of stencil for the question form and to another type of stencil for the debriefing form.

Finally, with the same letter that you notify MCH staff of your visit to brief them on monitoring, you can request that they arrange a group (non-acceptors: women, leaders, or men) discussion for that same day.

B. Field Time

Just as preparation for monitoring aids village research, so do your site visits for monitoring aid your village interviewing. Suppose you select eight (8) villages, and group per village. (Again, this is less strenuous and, in the end, less time-consuming than two groups per village). In your first week of going to 10 to 12 clinics to train staff in monitoring, you could complete one-half of the village interviews. Your real costs in staff, time, and money is the cost reaching the field. Once there is an additional half day, the cost is much reduced.

In light of what is said above, below is a tentative time schedule for the two data-gathering activities:

TIME SCHEDULE

MONTH	CLINIC MONITORING	VILLAGE INTERVIEWING
AUGUST		
Week 1	Get sample data Start questionnaire	

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Week 2	Draw sample Complete question- aire	Do question form Do debrief form
Week 3	Inform sites Train PPFN staff	Choose villages
Week 4	2 Clinics training	1 Village interviewing
SEPT		
Week 1	3 Clinics training	2 Villages interviewing
Week 2	2 Clinics training	2 Villages interviewing
Week 3	3 Clinics training	2 Villages interviewing
Week 4	2 Clinics training	1 Village interviewing
OCT		
Week 1	3 Clinics training	2 Villages end interviewing
Week 2	3 Clinics training	Data analysis Report writing
Week 3	3 Clinics training	Report writing
Week 4	3 Clinics training End verification	Report completed
NOV 1		Report Submitted

NOTES:

1. During September-October, I have made alternate weeks fairly light in terms of field workload. This would give you time to catch up with other project activities.

2. During mid-August, in her normal visits to clinics, Mrs. Musa could inform sample clinics of their selection for participation and request village group discussions be arranged where appropriate. This is important because of the time required for mail to reach other clinics.
3. Jos clinics can be visited any time.
4. At the end of Week 1 in October (village interviewing completed), you drop out of the fieldwork in order to start writing the report.
5. Of course you may find many ways to improve on this schedule.

Finally, I have been told repeatedly that the materials are the "bottleneck" of this project. May I add, to stress its importance, that research is the "cap" on the bottle.

ADDITIONS TO DRAFT EVALUATION PLAN:

I omitted discussion of pre-coded (numbered) response categories for Question 1 of Awareness and Qs. 1,4,5,7 of Attitudes. The few categories that you would print on the form for each of these questions have to be broad enough to catch all types of answers and specific enough to be clearly different from each other. To develop categories for each question:

1. On the basis of your own knowledge, that of Chris Nwosu, available research reports, etc., develop a set of response categories.
2. Try them out on people in the FP field to see what answers do not fit.
3. Have Mrs. Musa try them at her clinics.
4. Consult research people in FP -- for example, the University of Jos Center for Fertility Studies.

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5. Once you have learned "all" responses that could be given to a question, revise your categories accordingly. Be sure the categories capture all responses and are clearly different from each other -- e.g. "It's God's will," "FP is unsafe," etc.
6. Re-check the categories with FP professionals.
7. Leave space in the questionnaire for clinic staff to write-in any answers that don't fit.

Page 11 - Monitoring

New acceptors are given the questionnaire only once on their repeat visits to the clinic. The monitoring questions are not asked again. Instead, the nurse only records the person's status as in Q.3 of Practices: Contraceptives, first visit or repeat visit; and other FP services, first visit or repeat visit.



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