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ANNUAL REPORT - SAWSO MATCHING GRANT

Grant No. FAO-0158-A-00-4066-00

OCTOBER 1995 - SEPTEMBER 1996

Submitted to USAID

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I. Background to Grant and Project Context

The Salvation Army has provided health services to developing countries since 1892. It has a broad network of hospitals, clinics, and training programs throughout the world, and it has recently expanded its activities in support of the Child Survival Initiative and HIV/AIDS.

In addition to these recently expanded health activities, there are other pressures that are causing a reexamination of how the Army approaches its health programs. These are:

- 1) the realization that more people, especially the most needy - those traditionally served by the Army, can be reached through community-based health programming;
- 2) the high cost of maintaining a hospital-based system; and
- 3) community-based health programs are more effective in promoting community involvement in health care issues and are more sustainable programs.

At present, the goal of The International Salvation Army is to move toward the provision of genuinely community-based health services by decentralizing its health systems and making them more self sufficient.

This matching grant program builds on both SAWSO and Salvation Army experience in health care and local capacity building. Programs in four countries are targeted: Bangladesh, Indonesia, Ghana, and Zambia. Each of these programs is in a different stage of development and faces unique challenges, from those strictly clinic-based programs to those which have already evolved to a more community-based system. Whatever the case, this grant program will develop and strengthen these programs and develop models to fit different contexts - cultural, medical, and economic. Lessons will be shared between Salvation Army projects and lessons will be learned from the experiences of other PVOs.

The strategies implemented include:

- 1) training health staff and community members in basic health principles and practices;
- 2) developing and applying community-based approaches to existing programs;
- 3) providing local and international technical assistance in management systems, monitoring and evaluation, health information systems, community mobilization, and program and financial sustainability strategies; and
- 4) documenting community-based approaches and sharing those with other programs.

A Knowledge, Practice, and Coverage baseline survey for each of the programs was completed in February-April, 1995. This was a very positive experience for SAWSO and field staff. Action plans were modified to meet newly discovered needs in the communities as a result of the survey, and new strategies were proposed where necessary.

The efforts of this last year have been focused on bringing the basic infrastructures of the programs up to optimal operation including:

- developing monitoring and evaluation systems;
- making the connection between the KPC survey and the field program activities;
- developing community participation efforts.

During the next year, the programs will focus on:

- community involvement/ownership;
- improvement in capacity of field staff to communicate health messages and share these with communities;
- objectives not yet achieved.

II. Project Methodology

1. The project **goal** is to improve the health status of reproductive-age women and children under-five in targeted communities in Bangladesh, Ghana, Indonesia, and Zambia. The purpose of the project is to increase the capacity of the local Salvation Army NGOs in the four countries so that they can develop, implement, monitor, and evaluate sustainable community-based health programs.

Objectives include: providing outreach health services to communities and involving communities in managing their health problems (as opposed to providing clinical services only); developing health information and monitoring and evaluation systems to meet the needs of community-based health projects; and improving the knowledge, skills, and attitudes of project personnel and community members regarding health services and issues.

Participatory **methodologies** are applied and promoted in most areas of the project, from training field staff in participatory training methods for use with field staff and community members, involving community members in baseline survey activities, creating or improving community health committees for participation in the project and public health issues, community health insurance programs, to encouraging community involvement in project planning.

The **strategy** being followed can be examined at two levels: capacity building at SAWSO and capacity building for field health staff. SAWSO's capacity is being increased to enable transfer of knowledge to the local Salvation Army staff managing the projects in specific areas. These areas include baseline health assessments, monitoring and evaluation, and health information systems.

Field capacity is being increased by training and technical assistance received from SAWSO staff, in-country training sessions provided by local consultants, and sharing lessons learned with other NGOs and other Salvation Army programs. Capacity will be built in baseline surveys, monitoring and evaluation, community mobilization, health information systems, and project planning and management.

This strategy includes women at all levels: SAWSO staff has an equal distribution of women and men; women are well represented at the field level -three out of four project directors are women and the majority of community health workers are women; at the community level the project targets women of reproductive age and communities are strongly encouraged to include women on community health committees.

Key inputs for achieving this strategy include: conducting a baseline assessment of current health status and approaches to community health in the project catchment areas; technical assistance; training; and information sharing/networking.

General expected **outputs** for the project are:

- 1) personnel trained and capacity built in the above mentioned areas both at SAWSO and in the field;
- 2) health information, monitoring and evaluation, and assessment systems developed;
- 3) improved health service delivery and coverage;
- 4) techniques and methods developed and documented for involving communities in public health issues.

2. The general project accomplishments originally proposed for the second year include the following:

- Develop and strengthen monitoring and evaluation skills of SAWSO and field staff; work with evaluation consultant.
- Review of quantitative and qualitative grant indicators assuring their use in the field.
- Design of monitoring and evaluation system for building NGO capacity in health service delivery and for community mobilization.
- On-going work on developing and refining health information systems for each country project.
- Mid-grant evaluation.
- Field staff submit status and financial reports to SAWSO.

The following accomplishments have been achieved:

- Monitoring and evaluation skills were improved in the first year by participating in training in a knowledge, practice, and coverage baseline survey at both SAWSO and the field level. The impact of this training is still be felt. An evaluation consultant was contracted to work with SAWSO staff on the refinement of evaluation components not specifically targeted by the KPC survey. SAWSO staff and field staff participated in the mid-term evaluation with the external consultant. A similar model will be used to complete an internal evaluation in the two remaining countries - Ghana and Bangladesh.
- Quantitative and qualitative indicators have been developed for general training assessment, community mobilization, and health. They were reviewed and refined with the help of the evaluation consultant. Indicators are discussed further in the

next section.

- A monitoring and evaluation system has been developed and was reviewed by the evaluation consultant. Included in the monitoring and evaluation system are:
 - supervision at all levels
 - field visits
 - in-service training
 - periodic program assessments by SAWSO and field staff.
- Health information systems for each country were developed or refined. Three out of the four projects have systems in various stages of completion.
- The mid-grant evaluation took place in August, 1996 and included Zambia and Indonesia.
- Field staff have submitted status and financial reports to SAWSO.

III. Monitoring and Evaluation

1. SAWSO has put into place or is in the process of putting into place all of the monitoring and evaluation activities originally proposed. As capacity has grown at SAWSO in monitoring and evaluation, critical indicators have changed to reflect this new knowledge.

- a. **Baseline Data**

Baseline data was collected through a knowledge, practice, and coverage (KPC) survey developed by Johns Hopkins University. SAWSO staff participated in a two week training course in December, 1994 in KPC survey methodology and techniques.

During the subsequent technical assistance visits to the field, SAWSO staff trained core health team staff in conducting the KPC survey. Surveys were conducted between February-April, 1995. At all project sites, conducting the survey served to educate, motivate, and inspire core team health staff.

Action plans were developed out of survey data and are discussed in the Detailed Implementation Plans submitted in late April, 1995 along with extensive survey reports which outline the baseline data collected.

- b. **Targets**

Targets were set and defined in the action plans developed following the survey for each of the country projects. They are included in the Detailed Implementation Plans which were then reviewed by USAID and recommendations were made for modification as needed.

- c. **Critical Indicators of Effectiveness**

Critical indicators of effectiveness in terms of health service delivery are outlined in the Detailed Implementation Plans for each country project. They have also been reviewed by USAID and modifications made as necessary.

Indicators for other project-wide activities (community involvement, capacity-building, monitoring and evaluation, etc.) have been developed and were reviewed by the evaluation consultant in September, 1995. See attachments. These indicators were then taken back out to the field to be reviewed again with field staff and put into place with modifications made to reflect the individuals circumstances of each project site.

d. Monitoring Plan

SAWSO technical staff reviewed and modified indicators developed for on-going monitoring to the field on their technical assistance visits. Prior to those trips, the evaluation consultant reviewed those indicators to assure appropriate coverage and validity. During the visits, SAWSO staff also reviewed monitoring systems already operating in-country.

Zambia's health information system reviewed and revamped by an in-country consultant. Bangladesh has an existing system and this system was reviewed and refined by in-country staff and SAWSO program staff. Ghana and Indonesia have comprehensive HIS systems dictated by their respective governments. However, components were added to these HIS systems which will make it possible to monitor project interventions.

e. Evaluation Plan

Periodic evaluations take place in country programs already: Indonesia reviews project activities annually and sets annual activity schedules; Zambia reviews program progress and makes necessary adjustments every six months; Ghana and Bangladesh review program progress and assesses change needed on a quarterly basis. In 1995 Ghana reviewed activities for the long term (5 years) for inclusion in the Salvation Army country strategic plan.

2. The formal mid-term evaluation for the overall grant took place in August, 1996. The KPC survey will be conducted in late 1997 as part of the final evaluation. Specific arrangements for monitoring and evaluating gender issues, specifically including women as participants and beneficiaries have not been made because the majority of participants and beneficiaries are women.

IV. Review and Analysis of Project Results by Country

ANNUAL REPORT - SAWSO MATCHING GRANT

GHANA

OCTOBER 1995 - SEPTEMBER 1996

ANNUAL REPORT

GHANA: Matching Grant Health Project October 1, 1995 through September 30, 1996

BACKGROUND

GOALS:

The primary goals of the Matching Grant in the Ghana project are:

1. To expand and improve outreach and clinic-based health services.
2. To involve communities in planning, implementing and evaluating health activities and issues.

OBJECTIVES:

The general objectives of the Ghana project are to ensure that:

1. All seven Salvation Army clinics collaborate with communities in their catchment areas to set up community health committees and work together to prevent and control community health problems.
2. Each of the seven clinics put their energies into improving their achievements in one or two interventions (of the many activities that the clinics are committed to) for the purposes of this grant.
3. Health information systems will be assessed and redesigned as necessary to facilitate monitoring and evaluation of grant activities.

STRATEGIES:

Strategies for achieving these objectives were discussed during the visit of SAWSO Consultant Faye Hannah on her October 1995 visit. Evaluation of year one, and objectives, strategies and implementation activities for year two were examined during the visit. It was decided that:

1. Each clinic would continue with the particular health intervention they used in their first year for continuity, although another intervention can be added if the need is apparent.
2. Collaboration with communities to strengthen capacity and encourage participation in the solving of community health problems will continue.

3. In addition to the HIS system currently in place, the SAWSO designed forms "Output Indicators for Formative Evaluation, Community Participation Indicators" will be completed each month as the primary method for interim monitoring and evaluation of the project.

OUTPUTS/ACHIEVEMENTS: YEAR TWO

TEAM BUILDING AND TRAINING:

- **In-service Training:** In-service training of professional and ancillary staff has taken place at all implementation points. Project interventions appropriate to each clinic site were covered during the training.

Discussion groups for staff have been set up at one clinic on the importance of immunization.

A seminar on STD's and treatment for all clinic administrators and clinic staff was facilitated by THQ, in Accra.

A workshop on eye care and prevention of blindness was held with clinic and community rehabilitation centre staff.

Several workshops were conducted for clinic staff by Community Rehabilitation Centre on hearing screening.

Representatives from all 7 clinics attended 2 day Cold Chain seminar sponsored by CHAG (Christian Health Association of Ghana).

4 VHWs were trained in immunization mobilization. 20 mobilization sessions were held.

A Workshop on family planning was conducted by District Health Director for midwives.

A two day Family Planning workshop took place using local Public Health Nurse from the community hospital. 22 volunteer participants completed the course with representation from different religious denominations, women's groups and health workers. Family planning and health education workshops were carried out with community health workers,

- **Village Health Worker Training:** Training of Village Health Workers continues. Topics include the prevention and appropriate treatment of: Diarrhea and Dehydration, Malaria, Malnutrition, Acute Respiratory Infection, and HIV/AIDS; promotion of Antenatal care, Immunization and Breastfeeding.

- **Volunteer Training:** Health education seminars for Salvation Army officers and women's groups has been provided. 40 trained volunteers work with community members to enable them to take more ownership of their own health and the health of their community. Topics included prevention and treatment of: Diarrhoea and Dehydration, Malnutrition, Immunization, Breastfeeding, basic eye care and prevention of blindness and HIV/AIDS.
- **TBA Training:** Training of TBA's is ongoing, supported by the 4 (project-hired) nurse midwives: each TBA is presented with a TBA supply box to keep their supplies for home deliveries at the end of their training.

TEACHING MATERIALS

- Flip charts and Family Life Series booklets have been made available to 10 Salvation Army Divisions throughout Ghana. Information covered is breast feeding, weaning, growth monitoring, immunization and family planning.

INSTITUTIONAL DEVELOPMENT

- Clinic staff have been upgraded by in-service in areas such as nutrition, eye care, family planning as well as a host of health related issues such as HIV/AIDS and ORT.
- Clinic teams meet on site to evaluate and plan activities.
- Medical/Social Services Department facilitate and organize workshops/seminars at THQ, Accra for clinic administrators and clinic staff.
- Continuation of collaboration and training of community based health teams (village health workers) has strengthened clinics.
- Bi-monthly, 1/2 day meetings are held at THQ, with all clinic administrators and counterparts.
- THQ, Medical/Social Service, administration (support staff) has been strengthened through the purchase of a computer increase efficiency of the department.
- The Extension Training Centre has benefitted through occupancy funds to upgrade kitchen and dining area. The use of the training center for project seminars has saved a significant amount of money over the cost of renting outside training facilities.
- Women's organizations have purchased a word processor which has greatly helped them with the producing of Home League programme booklets to assist the rural women with ideas for health education.
- Clinic administrators met with staff to discuss the health component of the Salvation Army 5 year plan to evaluate and revise before submitting it to THQ.

REPORTING

- Two reporting forms are filled by clinic administrators and sent to THQ, Health Project Coordinators monthly. One includes an "Output Indicators for Formative Evaluation" from. These forms are used to gather information for a quarterly report which is submitted to SAWSO by the Projects Coordinator. The actual monthly forms submitted to THQ by the clinics are sent in along with the quarterly report.
- Several statistical forms are filled in by clinic administrators and sent to the Ministry of Health on a monthly basis as well.
- Clinics submit financial report with receipts to Medical/Social Secretary monthly. Monthly financial statements with receipts are submitted to SAWSO Consultant monthly by Medical/Social Secretary.

SUPERVISION

- Clinic staff meet with community health teams/workers on site.
- The Health Project Coordinator and the Medical/Social Services Department head meet with the clinic and occasionally with the health teams on their quarterly visits to the clinics.
- Project coordinators maintain an open door policy for discussion of problems or technical assistance whenever necessary.

TECHNICAL ASSISTANCE:

- The SAWSO Program Consultant made 2 technical assistance visits to Ghana in year two, October 1995 and January 1996.
- On each SAWSO Consultant visit a workshop was conducted at THQ for all administrators and selected clinic staff. Such topics as finance, budgeting, reporting, and program planning has strengthened administration skills of clinic administrators.
- In addition to workshop facilitation, the SAWSO consultant visited 5 clinic sites to observe project interventions and to talk to village health committee members.
- Internal consultants have been used for training in management and technical skills building, for community participation techniques, and for HIV/AIDS counselling processes.

EFFECT ON TARGET GROUPS

- The health project in Ghana focuses primarily on mothers and their under five year old children, with a special emphasis on under twos. Child care-givers other than the mother are also targeted, as are children in elementary school.
- In Family Planning awareness the target groups include both men and women
- In HIV/AIDS awareness and community counselling, all community members, male and female, as well as Salvation Army officers and adolescents are targeted.

PROBLEMS ENCOUNTERED

- One issue is not receiving funds in a timely way. At times it has been 2-3 months after requesting funds that they have received them in Ghana Territorial account in New York. Headquarters in Ghana cannot operate on deficit financing as they do not have the funds. Therefore, at times some project activities have been curtailed because funds have not been available. This has in some cases been difficult for program continuity.

Solutions: SAWSO records indicate that a faxes are sent on the same day that the project money was put in the bank. There seems to be a communication gap somewhere at THQ in Ghana and this is being resolved. SAWSO has instituted a tracking system to be sure that funds are sent very quickly after the expense report is received and processed as soon as possible .

- Involvement of communities and community health committees at all levels of project implementation has been a slow process. It has worked best in the three clinics where Ghanaian clinic heads are involved and/or in communities which required community involvement as a condition of setting up a health center initially. (See UNINTENDED RESULTS for a possible solution to this problem).

IMPACT ON LOCAL INSTITUTIONS

NETWORKING AND COLLABORATION

- Collaboration with District Ministry of Health and NGOs who have provided facilitators, has built capacity and strengthened relationships with both government and other NGOs.
- Many other contacts have been made for technical assistance, resource materials, sharing ideas, and sharing lessons learned. Networking and collaboration has taken place with Planned Parenthood Association of Ghana, UrbanAID, National AIDS Programme, Ministry of Health both district and national, several hospitals

in different districts, Cape Coast University, Legon University, CAS (Catholic Action for Street Youth), several community based churches, UNICEF, Save the Children, Who in-country, UNAIDS in-country and USAID in-country.

UNINTENDED EFFECTS

The integration of the HIV/AIDS work with the other health interventions has resulted in a process of rethinking how the clinics work with communities. The unique approach to HIV/AIDS in The Salvation Army, which employs community counselling and community decision making in a very participatory way, has helped the clinic teams to change slowly from the more traditional approaches to how project activities are implemented.

CONCLUSION

Ghana appreciates the funding we receive from USAID and acknowledge the fact that it is through this funding that they have been able to improve their existing clinic services and begin to shape their outreach services in a more community based fashion.

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ZAMBIA

OCTOBER 1995 - SEPTEMBER 1996

**Annual Report for Zambia Matching Grant
October 1995 - September 1996**

I. Intensified Community Involvement - Decentralization Process

In an effort to transfer responsibility for health care into the hands of the community, five communities connected to rural health centers have been targeted for concentrated focus in the three year program. At this point the program is working with three and the goal is to reach the other two communities in year three of the grant. This intensive focus involves an integrated team going out to these communities to work with them for seven days and then periodic follow-ups, with a two intensive follow-up in July and August.

The three communities where the intensive work has been started are Nameembo, Chaanga, and Moonga. Each of the three communities has had a seven day visit and follow-up visits. Reproductive and child health services (ANC, FP and UCI) except school health services were decentralized to Nameembo RHC and Chaanga RHC, with extensions to Sianyoolo. The hospital has been working at improving the infrastructure (water, electricity, communication, transport) at these two rural health clinics (RHCs) and the two RHCs are working closely with the communities on the roads. A dam is being constructed in Chaanga where drought is a big problem.

Church service group members, from within the community are beginning a program of visiting those who are sick. Members of one community, Handulwe, have actually constructed a house for a member of their community who has AIDS. Community based nutrition demonstration clubs have started in Nameembo and the surrounding communities of Ngangula and Malala. More than 100 orphans have been offered places in two schools in exchange for renovations done at the two schools. In the Nameembo and Ngangula communities income generating projects are also being started.

II Organizational Restructuring

In the past each outreach program (HIV/AIDS, LEP/TB, PHC, etc.) would go out on its own. This meant that there were vehicles going out every day in several different directions. Not only was this costly but often confusing to the community. With the reorganization (see new organizational chart), the various outreach teams sit down once a quarter and work out an integrated approach of going out to the community. In the past the emphasis was on providing service, now the emphasis is on supporting the community health and development teams and the volunteers trained to work in the community.

The reorganization, although begun in early 1995, was not completed until mid-1996. It has taken a great deal of discussion and cooperation to accomplish, and adjustments are still having to be made.

II Outreach Programs

Mother Child Health (MCH) coverage and basic primary health care is provided at 17 of the Village Health Clinics (VHC) and Rural Health Centers. Each site is visited 9 times during the year. In 1994-95 the outreach team made visits to 25 locations. The reason for the reduction in visits in 1996 is that services have been decentralized in 8 locations. Chaange Rural Health Center is working with Siakalinda, Sianyoolo and Kabuyu; and Nameembo Rural Health Center is working with Hapwaya, Hakantu and Sichula. They are providing basic primary, mother and child care including immunizations and providing health education - all the services that the mobile clinic generally provides.

The baseline survey identified a portion of the catchment area that has no community volunteers and where there are no outreach services. Two village health clinics have been opened in this previously uncovered area, they are Masangu and Chisoba.

Immunization, health education and enviromental inspections were conducted at 23 schools, three times a year.

III Drought Relief/Recovery and disaster/epidemic

Although more maize was needed to provide adequate nutrition, no deaths due to starvation were recorded in this past year (as compared to many in previous years).

Nine epidemic task force teams were formed in the following communities: Nameembo, Malala, Sianyoolo, Moonga, Hapiku, Dundu, Hampande, Nadezwe, Siakalinda

CCBP formed a water and sanitation core team which mapped out an enviromental protection strategy for the catchment area. The team is working with the United Nations International Conservation of Nature, Lusaka Regional office.

IV. Human Resources Development

A. Community Volunteers

The following volunteers were trained or received refresher training this past year. There were a total of 18 workshops.

Volunteers	Initial Training
Comm Health Workers	60 Indv.
Comm Sanitation Workers	40 Indv.
Trad. Birth Attendants	26 Indv.
Teachers	9 Indv.
Nutrition Demonstrs	10 Indv.
Comm Counsellor	13 Indv.
Comm-Based Rehab. Demonstrs	40 Indv.
Comm Health & Dev. teams	30 (teams of 3)
Agro-forestry workers	45 Indv.
Water & Sanitation Workers	45 Indv.
Church Service groups	30 (teams of 3)

Each volunteer trained was also followed up at least once. One refresher course for each cadre of volunteers, who were trained in previous years, also received one two day refresher course during this year.

B. Staff

- * In December of 1995, 16 of the Outreach Staff took part in a four day workshop on training for transformation a follow-up workshop was held in September of 1996.
- * In July of 1996, 20 members of the outreach staff also took part in a week-long counselling course conducted by staff of the Ministry of Health, counselling unit.
- * Two nurses took a two week course on reproductive health and safe motherhood.
- * One clinical officer attended a six weeks course in social development.
- * Two members of the office staff received a two week computer training course in Windows 6.1.
- * One nurse training community members on how to care for individuals with HIV/AIDS took a 2 week course in clinical management of HIV/AIDS.
- * The staff member dealing with the Health Information Management System took a three week course on the Health Research Process and Project Management.

- * PHC Coordinator responsible for school health and training of CHWs and other volunteers took a three week course on teaching methodology.

V. HIMS System

The new Health Information System (HIMS) computer program has been completed and the process of coding all the information that will be inputted is underway. Currently, statistics are being collected and stored in Lotus. The goal is to have the new HIMS system fully operational by the end of 1996, earlier if at all possible. There have been some problems in developing the system, it has been more complex than initially thought. The researcher, therefore, has taken longer to develop the program. The computer to run the system had to be imported and that took six months longer than initially anticipated.

VI. Evaluation System

During the mid-term evaluation with Dr. Leonard Dawson, the need for a more structured monitoring and evaluation system was identified. The HIMS system will tell you "what" and "when", but not "why" and "how." For the "why" and "how" you need an evaluation system.

A consultant was contacted (July, 1996) to help develop a system that will help effective training, follow up and the program as a whole in integrating and decentralizing services. It will also help the program determine if it is having an effect on health in the catchment area and it will provide information to be used at every level to make decisions, from the community, to the program implementers, to administration. The setting up and implementing of this evaluation system is a priority and it is hoped to be in place by January of 1997.

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BANGLADESH

OCTOBER 1995 - SEPTEMBER 1996

ANNUAL REPORT

BANGLADESH: RURAL HEALTH PROJECT (RHP), Jessore October 1, 1995 through September 30, 1996

BACKGROUND

The Salvation Army, Rural Health Project (RHP), Jessore commenced in 1980. In 1990, the Deputy Director of Family Planning Jessore allocated specific areas to this organization covering 15 villages in 6 Unions in Jessore Sadar Than. Since then through our services in all components of Primary Health Care, RHP has continued to develop in all areas of the programme, expanding its clinical services to include leprosy treatment, commencing a leprosy control program, integrating HIV/AIDS awareness and developing a Training Center.

BASIC INFORMATION

1. INFORMATION ON THE CATCHMENT AREA, June 1996:

Name of Thana	Kotwali (Sadar Thana) Jessore
No. of Union	06
No. of village	15
No. of households	8,383
No. of population	35,765
No. of Male	18,463
No. of Female	17,302
0-1 yr. children	890
1-2 yr. children	883
Under five	3,934
15-45yr. women	8,395
Fertile Couple	7,589
Pregnant Women	821

2. CLINIC INFORMATION

Main Clinic Two (2): Kholadanga & Ne Satellite Town (NST), are full time out-patient facilities.

Village Clinics Five (5): Fatepur, Ramnagar, Sitarampur, Ghurulia & Kanejpur operate three hours a day, in Salvation Army village primary schools, run by nurses and paramedicas. Each clinic receives a monthly visit by a doctor and conducts an ante-natal and post-natal clinic.

3. STAFFING

The project has increased its staff levels by one person in this year with the appointment of a new leprosy worker. A new position of senior nurse will be created in September 1996 in response to the need for care of surgery patients.

Management staff	05
Main Clinics' staff	38
Nutrition Unit staff	10
Field and Village Clinics' staff	35
Total:	88

GOALS:

The primary goals of the Matching Grant project are:

1. To improve infant nutrition practices.
2. To decrease the incidence of diarrhea, and improve diarrhea management.
3. To improve the treatment of Acute Respiratory Infection.
4. To increase the number of family planning acceptors.
5. To improve the immunization coverage of children under two years of age.
6. To increase the understanding of the means of infection and how to provide care for HIV/AIDS, Leprosy and TB.
7. To involve communities in planning, implementing and evaluating health activities and issues.
8. To continue the Child Survival Initiative in order to reduce infant mortality to less than 60 per 1,000 live births and to improve the quality of community life.
9. To develop the community health training facilities in order to become a Training Resource Center for The Salvation Army and other organizations.
10. To strengthen the project's ability to become fully nationalized (staffing) and more self-reliant through human resource development.

CHILD SURVIVAL OBJECTIVES:**TARGETS**

A.	Appropriate treatment given for Diarrhoea episodes and reduction of the incidence of Diarrhoea	100%
B.	Full vaccination coverage for all children under one year of age.	100%
C.	Increase the percentage of children under 5 years gaining weight & reduce the rate of malnourishment	75%
D.	Increase case identification, referral and follow-up of Tuberculosis sufferers.	80%
E.	Increase the proportion of women receiving Ante-natal care and Tetanus Toxoid vaccination.	85%
F.	Increase contraceptive prevalence among married women 15-45 years of age.	75%
G.	Prevention of Vitamin "A" Deficiency among children through promoting the importance of Kitchen Gardens for Family use and distribution of Vitamin "A" supplementation accordingly to National Protocol.	90%

OTHER PROGRAM OBJECTIVES

- A. Develop a leprosy Control Program within the project and in Jessore District for the control and eventual eradication of the disease.
- B. Develop an integrated approach to AIDS awareness within the community, establishing a relationship to increase the community's capacity to respond positively to the AIDS epidemic, through information dissemination, identifying and mobilising "Key" volunteer resource persons from the community and prevention towards individuals and families "At Risk" in the community.
- C. Further develop education/information sharing between the project and the community, encouraging greater community participation in the Health Development Plan.
- D. Encourage and mobilise the community members to develop vegetable and fruit production in the Homesteads as well as other tree plantation, production providing training and resources as needed.

(See the Detailed Implementation Plan for expansion of these objectives)

ACHIEVEMENTS/OUTPUTS, Year 2:

ACHIEVEMENTS:EPIDEMIOLOGICAL STATISTICS

SL. NO.	PARTICULARS	IMPACT
1.	Infant Mortality Rate (IMR)	50/1000
2.	Neonatal Mortality Rate (NMR)	26/1000
3.	Post-neonatal Mortality Rate (PNMR)	24/1000
4.	Maternal mortality Rate (MMR)	3.4/1000
5.	Crude Birth Rate (CBR)	16.33/1000
6.	Crude Death Rate (CDR)	4.14/1000
7.	Average Family Size	4.3
8.	0 - 1 year children	2.5%
9.	Total under 5 year children	11%
10.	Pregnant women	2.3%
11.	Growth Rate	1.2%

ACHIEVEMENTS: MATERNAL AND CHILD SURVIVAL INTERVENTIONS

1.	Diarrhoea treatment with ORS	99.9%
2.	Expanded Programme of Immunization (EPI)	100%
3.	Under 5 children gaining weight regularly	77.96%
4.	TB Treatment	84.21%
5.	Leprosy Treatment	77.7%
6.	Ante-natal Care (T.T.)	86.48%
7.	Contraceptive Acceptance Rate (CAR)	73.2%
8.	Vitamin "A" distribution	99.6%

OUTPUTS:

CLINICAL SERVICES (MAIN & VILLAGE CLINICS)

These services were provided:

- Ante-natal & Post-natal care.
- EPI (Expanded Programme of Immunization) Vaccination Clinics.
- Family Planning IUD insertion, servicing clients for injection, counselling of clients.
- Minor surgery has been increased, resulting in additional self-income into the project.
- Tuberculosis diagnosis & treatment - has resulted in all patients on treatment, completing treatment through DOTS (Directly Observed Treatment by Short term treatment) method.
- Leprosy diagnosis & treatment - continues to grow with new patients under treatment, many who are now self-reporting as a result of community awareness.
- Laboratory facilities for routine tests and some special tests in both main clinics plus -- with introduction of new tests, more income is coming from laboratory tests. Split skin smears for Leprosy diagnosis are carried out in Kholadanga Clinic.

PATIENTS ATTENDING CLINICS OF THE PROJECT

CLINIC	NEW	REPEAT	TOTAL
NST	9,023	15,133	24,156
KHOLADANGA	6,766	10,174	16,940
GHURULIA	487	901	1,388
KANEJPUR	746	1,523	2,269
FATEPUR	604	1,077	1,618
RAMNAGAR	1,830	34,662	6,492
SITARAMPUR	1,020	2,227	3,247
TOTAL	20,476	35,697	56,173

LEPROSY CONTROL

This Programme has become further established in the current year with a continued number of new in patients self reporting for diagnosis and treatment. Leprosy awareness in the community has been valuable in making people aware of where they can come for treatment.

- The Leprosy Control Assistant (LCA) received upgrading training in November 1995 and was promoted to Leprosy Control Supervisor. A motorcycle was purchased for the LCS.
- A new position was created for the LCA in April 1996, and initial training was given by the project. He will receive 3 months LCA training at Nilphamari, North Bangladesh from October 1996.

LEPROSY	MULTI-BACILLARY	PAUCI-BACILLARY	TOTAL
New Patients	29	23	52
Completed Treatment	27	22	49
Under Treatment	48	14	62

NUTRITION REHABILITATION SERVICES

- Provided care and nutritious food to severely malnourished children.
- Helped the attending mothers and guardians of the children to learn through Health Education about cheap but nutritious food for their children and teach its hygienic preparation and mothercraft practices.
- Demonstrated kitchen gardening to mothers

Nutrition Unit	Admitted	Discharged	Dropout	Daily Average
NST	112	62	26	19
Kholadanga	47	14	30	10

FIELD SERVICES

- Monthly home visits were made by the Village Health Workers (VHW) with regular supervision by Health Educators.
- Weighing of children under 5 years for growth monitoring and education in balanced diet.
- EPI motivation and assistance to the Government. Satellite Clinics in project area as well as in project clinics.
- Ante-natal care given, Tetanus Toxoid given and Post-natal check-up and advice.
- Family planning motivation and distribution of contraceptives.
- 6 monthly Vit "A" round and regular Vit "A" capsule distribution to cases of Measles, Diarrhoea and Night Blindness and encouraging use of kitchen gardens for family use.
- Leprosy & tuberculosis health education to individuals & groups, with follow up of the diagnosed cases under treatment.
- HIV/AIDS awareness to individuals and groups.

TRAINING

- Sharing, feedback and staff development training is on-going twice a month for Village Health Workers (VHWs) and Supervisors, based on records and findings on the Field.
- One day training in clinical management and professional etiquette was held for all Clinic Staff.
- One day training seminar for guards, cleaners and helpers in professional etiquette was held.
- Three days Clinical Management and Development Training from 16th - 19th October 1995 with 10 participants including staff from other Salvation Army programs.
- Basic Health Care Seminars for three days was held in January 1996, for 13 Salvation Army Cadets.
- Refresher Training for Traditional Birth Attendants (TBAs) was held in October 1995 and April/May 1996. Thirty TBAs attended in two groups in April and May, the largest number who have attended for several years.

- Basic Health Care training for 25 Village Health and LCAs for three days was conducted in June and July. This included staff from other Salvation Army programs. Included in this training was improving skills of giving health education which would impact for changes in attitudes and practice. Use of prime messages which everyone needs to know was taught and used in practical role plays.
- A two day Workshop on "Planning Monitoring and Evaluation" was conducted for Salvation Army Project Managers and Field Supervisors, facilitated by the Project Manager and Director of Projects in August 1996. Follow-up Workshop is planned later, to review lessons learned and allow time for practical learning experiences. It is planned that the lessons learned from these Workshops will be used to form a curriculum which can be used in training local organizations, some of whom are requesting such training.
- The Office Assistant took a local computer course to improve her computer skills.
- The LCA attended 6 weeks training for Leprosy Control Assistants at Nilphamari, North Bangladesh in November 1995.
- The Training Coordinator attended a three week training course on training of Trainers at COMMUNICA, a training centre in Dhaka, during August 1996.
- The Leprosy nurse visited The Salvation Army leprosy control programme in Dhaka for refresher training for two weeks in July 1996.
- Due to the unstable political situation in the country over 6 months of the current year, some planned training could not be accomplished. This included postponed training for the Project Manager and Director of Health Services. The Project Manager will do Advanced Training in November 1996.

TEACHING MATERIALS

- The Project Training Coordinator translated the 10 PRIME MESSAGES from the WHO book 'Facts for Life' for use by educators in reinforcing health messages which people need to know. These have been used in training, checked and corrected for accuracy and are ready for producing in laminated booklet form in September 1996. An eleventh Prime Message on Leprosy has been prepared by the Director of Health Services for inclusion in the booklet.
- New log books for VHWs have been printed, which include newly included information for monitoring and deleting some which are no longer relevant to the project monitoring systems. An effort was made to monitor only what is needed for the program.

- Ante-natal and Family Planning Cards were revised and reprinted. These cards are retained by the mother.

TECHNICAL ASSISTANCE

Ms. Faye Hannah, SAWSO Program Health Consultant, visited the project in June 1996 and gave advice and assistance in finalizing the Detailed Plan of Action (DIP) for submission to USAID. Although two trips had been planned for the second year it was possible to get into the country only once due to the political unrest in the country.

EFFECT ON TARGET GROUPS

- The health project in Bangladesh focuses primarily on mothers and their under-five year old children, with a special emphasis on under twos.
- Family Planning focuses on both men and women
- HIV/AIDS Awareness, Leprosy and TB control efforts targets all community members

PROBLEMS ENCOUNTERED

- As an outcome of a Knowledge, Practice and Coverage baseline survey (KPC) conducted in January, 1995, a review and revision of the survey and of the Detailed Implementation Plan (DIP) was necessary.

The SAWSO health consultant, Faye Hannah, in consultation with field project staff made preliminary revisions in both documents. The final review and approval by field staff was delayed twice due to adverse political activities in the country. That review and the start of formal implementation of the DIP did not occur until June of 1996, during the visit of the SAWSO consultant to Bangladesh. As a result of the survey the project health interventions will focus on three areas for improvement- health knowledge, health practice, and immunization and family planning coverage.

Solution: Although formal approval of the revised KPC survey and the DIP were significantly delayed, activities based on preliminary discussions and agreements, were begun.

- **Community Participation and Ownership of Health Outcomes**
A major weakness of the project implementation so far has been the difficulty in transferring ownership of health outcomes to communities themselves. Although communities obviously value the health services provided, as seen by the very high health status indicators, they resist the opportunity to be more directly involved. Several strategies have been tried without success over the last two years.

Solution: This problem will be a major focus of the upcoming internal evaluation facilitated by the SAWSO consultant.

- The Project received re-registration with the Family Planning Directorate in this year. However, condoms are no longer supplied free to the project by the government. They must be purchased for sale to clients at a reduced price. The question of sustainability of high family planning acceptance under these conditions need to be addressed.

Solution: Contraceptives are currently purchased for distribution to clients. Further discussions will be held with regard to what to do in the long term during the upcoming planning for year three of this project.

IMPACT ON LOCAL INSTITUTIONS

- The RHP has been a member of The District Family Planning Performance Surveillance Team, District Committee of Family Planning and also of MCH & EPI. Regular attendance of Coordinators meetings have occurred and participation in planning strategies for the District.

In cooperation & coordination with the government of Bangladesh, project implementors:

- Jointly sponsored World AIDS Day rallies, information booth and Discussion with other Salvation Army programme staff and the District Health Department over one week prior to the day. This included a joint visit to one of the local brothels to give HIV/AIDS awareness which was well received and has resulted in a new outreach commencing into the Brothel community by The Salvation Army.
- Actively participated in the following with the concerned department of GOB:
 - World Population Day
 - National Population Day
 - World Health Day
 - World Leprosy Day
 - National Immunization Day
 - Mother and Child Survival Fortnight
 - First National Anti-Drug Day Observation in which two cups were presented for best rally representation and second best cycle rally.
- Participated in two National Polio Eradication Days, when each child under 5 years was given a dose of OPV. A Vitamin "A" dose was also given with the OPV.
- Were able to obtain smooth and quick delivery of Family Planning materials, EPI logistics, High potency Vit "A" capsules from the government.
- Received vaccines for EPI programmes and Vitamin A capsules and ORS packets from the local government on a regular basis.

ANNUAL REPORT - SAWSO MATCHING GRANT

INDONESIA

OCTOBER 1995 - SEPTEMBER 1996

ANNUAL REPORT

INDONESIA: PRIMARY HEALTH CARE PROJECT
OCTOBER 1, 1995 through SEPTEMBER 30, 1996

BACKGROUND

During the second year of the grant, The Salvation Army primary health care project in Central Sulawesi has progressed in most of the areas begun with the Matching Grant. The activities reviewed below include not only health specific goals and objectives, but also those support activities which enhance the achievement of those goals and objectives.

GOALS

The primary goals of the Matching Grant project in Indonesia are:

1. To improve infant nutrition practices.
2. To decrease the incidence of diarrhea, and improve diarrhea management.
3. To improve the treatment of Acute Respiratory Infection.
4. To improve the number of family planning acceptors.
5. To improve the immunization coverage of children under two years of age.
6. To increase the understanding of the means of infection and how to provide care for HIV/AIDS.
7. To involve communities in planning, implementing, and evaluating health activities and issues.

OBJECTIVES and STRATEGIES

Child Survival and Maternal Health Interventions

The child survival and maternal health intervention objectives are listed in the Detailed Implementation Plan (DIP) and will be measured at the end of the grant by a second Knowledge, Practice, and Coverage Survey. The process through which the project implementors hope to achieve these objectives include:

- health education messages presented at monthly village weighing sessions;

- follow-up home visits to mothers of children who are malnourished and/or ill and counselling after the weighing sessions by a local or project team nurse;
- referral to nearby clinics for assessment and treatment if needed; and
- participation of community leaders and community members in preventing illness, and providing appropriate nutrition and treating simple illnesses themselves.

Number of weighing sessions held in Year 2:

- Children were weighed at 48 posts every month except December and January.

HIV/AIDS Intervention

Awareness and prevention of HIV/AIDS is another important objective of this project. Because it is targeted at all community members, it is implemented differently from the child survival and maternal care interventions (See below).

SUPPORT ACTIVITIES

Public Health Committees

The health team has continued to work with communities to establish public health committees (PHCs). In year one, the project team was instrumental in setting up health committees in 3 villages (the target is 10 committees in place at the end of the project). The team reports that the only one of the original three committees is operational. In 10 other communities where the project team has tried to establish health committees they have met with mixed success.

A formal leadership structure exists in every community and functions as the primary support group for all health activities. When the team attempts to add to that structure certain other components, such as representatives for training, health, education, and fund raising, they have been met with passive resistance. It isn't clear why this is so.

The team has made the assumption that the reason is that low educational levels and difficult economic circumstances are the strongest obstacles to establishing the health committees as well as other kinds of community participation. They recognize that that isn't the case in establishing insurance systems or in making kitchen gardens, which have been very successful. The project team will try to find out why this is happening and what needs to be done about in in year three of the grant.

Discussions with communities about the importance of public health committees as a tool for taking control of their own health needs will continue. Training community leaders is ongoing and other, more creative ways of encouraging participation in, and ownership of, community health status will be pursued. One option is to review what

health committees , or village leaders who substitute for committees,are expected to do at the present time.

Currently committees are meant to have weekly meetings where community health status is reviewed and community health activities, such as kitchen garden contests or environmental clean-up campaigns are approved. In addition,the health team shares information with the committees about special health concerns noted in the most recent child weighing sessions. Committees are not being asked to prioritize the health problems found at weighing sessions and determine what to do about them as a community, but rather to approve what the health team has decided to do. Perhaps there is another approach which might work better.

If a way can be found to involve community members in a more active way, a diversified health committee will evolve. Already in place to facilitate community ownership in health problems is involving religious leaders in the process, emphasizing the importance of addressing health as part of holistic spiritual development.

Year 2 activities related to public health committees included:

- Meetings with community leaders in Winatu, Lempelero, Watabula, Petimbelagi,Lonebasa, Onu and Katewu in November, 1995
- Discussions between project senior staff, community leaders and the SAWSO consultant about how community health committees work, their uses and how to encourage participation in them, November, 1996
- Meeting with Petimbelagi leaders in January, 1996
- Training of community leaders in July, 1996

Agricultural Extension

Over the past year the agriculturalist has become part of the core team. He has been very successful at establishing model gardens in 5 of the project communities. The model gardens demonstrate effective land use and agricultural techniques. In addition to growing nutritious foods for family consumption, some of the gardens grow medicinal plants and beautiful flowers. The field workers emphasise the importance of balanced nutrition for good health. The agriculturalist demonstrates the suitable nutritious crops, how to raise disease-resistant breeds of poultry and how to keep animals penned so that they do not destroy crops or dirty the environment. The agriculturalist also works closely with villagers on other environmental issues, such as use of latrines, clean water and clean villages.

Year 2 activities related to Agricultural Extension and Environment included:

- 8 latrines built and in use 'some of the time' during the year.
- 5 villages have model demonstration gardens in place.

- 60% of villages have some kitchen gardens in place.
- Environmental assessment of eight villages took place in March, 1996.
- Kitchen garden and clean environment contests took place in April and August, 1996.
- Clean water systems in place in Banasu and Masewo villages as of March, 1996.

Community Health Insurance

Community health insurance participation has become more and more popular and acceptable in the last year. Using knowledge gained from participating in workshops and observing projects of the Indonesian Association of Christian Hospitals in North Sulawesi, the health team has begun their work in this area with the mothers of children under 5 who participate in activities at each clinic. Subsequently promotion of the scheme was done through the Salvation Army corps. (NB in many of the villages, 65-95 % of the villagers belong to the Salvation Army church).

Currently, the health team is establishing community-wide health insurance funds in 10 communities. The message being promoted is that community health insurance is a concrete expression of cooperative responsibility for health and a way of addressing the needs of the indigent.

During the SAWSO technical assistance visit there will be a review of the progress made in this area and training in appropriate management methods if required.

Year 2 activities related to Community Health Insurance included:

- Information sharing in eight villages in October, 1995.
- Information and counselling about the program in Palolo area-Banpres village in November, 1995.
- Establishment of a health insurance scheme in Petimbelagi Maranatha village.
- Reports received about health insurance programs in progress in Winatu, Palu and Kalawi in August, 1996.

HIV/AIDS Activities

During the second year a great deal of emphasis has been placed on HIV/AIDS awareness and the beginning of open discussion of the pandemic in the project area. After an initial period of staff training and discussion, work has begun in the form of a generalized, initial informational campaign. This involves group discussion during

meetings of women's groups, training for Salvation Army officers, young people (7 - 16 years) and the public health committees. The nature of the infection, the forms of transmission and the effects have been explained.

People are concerned about how to prevent transmission and the health team has encouraged people to avoid sexual contact with people outside of their communities. The other focus of prevention education has been to discuss the importance of strong family and couple relationships.

Year 2 activities related to HIV/AIDS included:

- Information sharing in Palu, 160 people attended, February , 1996
- Information session in Palolo district and at the Woodward post, 170 people attended, February, 1996
- Information sharing in Kalawi, 130 people attended, March, 1996
- Information sharing on HIV/AIDS and other health issues, in Palu, March, 1996
- Information sharing with a women's group from the PLN (State electricity enterprise), March, 1996
- Core team meeting with the Salvation Army HIV/AIDS team from the Phillipines, March, 1996

The strategies for incorporating HIV/AIDS education in the primary health care agenda of the project will also be reviewed during the next SAWSO technical assistance visit.

Training

In addition to the work at the community level with the public health committees and the community health insurance funds, capacity building in this period has involved specialized training for project participants at each level. Training objectives are listed below for each kind of project participant as well as the training which took place during the second year of the project.

Village Health Workers/Cadres:

Each year of the project, 349 village workers will receive formal training and/or refresher courses in growth monitoring and health education topics. Training for each focus takes place in a one week session led by the primary health project core team. As a follow-up to the training VHW skills and activities are assessed during visits by the Field Workers and Core Team.

Training activities for year 2 included:

- Training for prospective Cadres, April, 1996

- Refresher courses for senior Cadres, May, 1996

Traditional Birth Attendants

No training activities were held for TBAs in the second year because the government no longer provides instructors for training and support of TBAs. The government intends to replace them with trained professional midwives.

- **Result:** The project staff will shift its focus from training TBAs to facilitating cooperation and collaboration between existing village TBAs and the new Midwives assigned to the villages. In villages where there is no government assigned midwife, TBAs will be trained by the project.
- **Possibilities:** Some of the senior TBAs who currently also function as village health cadres may be encouraged to become supervisors/field workers.

Field Workers/Supervisors

In year one 6 Field Worker/Supervisors for 349 village health workers were in place. For various reasons 3 have dropped out and have not yet been replaced. The FWs are the liaison between the village cadres and the core health team and have enormous responsibility for supervising and encouraging the village health cadres, so the dropout rate of 50 % in one year is a crisis of sorts.

One solution is to ask TBAs to become FWs (see above). In addition, consideration will be given to greatly increase the number of field supervisors on staff to enable them to cope with the very large number of village health workers.

Training for Field Worker/Supervisors in Year 2 included:

- One refresher course, June, 1996

Village Headmen

The FWs and VHWs are expected to share the health data which they collect on a monthly basis with the headmen, using a form elaborated for that purpose. During all visits of the Core Team and the FWs the headmen will be visited and they will be included and consulted at all appropriate meetings. In those communities where community health committees are formed, the headmen will play key roles.

Training for Village Headmen in Year 2 included:

- One training session for village headmen was held in August, 1996

Salvation Army Officers

Salvation Army officers at community level participate in these project interventions: general health education, promotion of community participation and ownership of health status, promotion of health insurance schemes and HIV/AIDS awareness and prevention.

Training and participation in health programs by Salvation Army Officers in year 2 completed or planned:

- Meetings with project staff in January 1996
- Information session at the Woodward Salvation Army Post in Palu about the important role children can play in caring for their own health, February, 1996
- Training in health education topics planned for October, 1996

Nurses, Teachers, Children

Although training courses are not specifically focused on these groups, they are encouraged to attend workshops as appropriate to their age, work assignments and

PROBLEMS, ISSUES, SOLUTIONS

All the infrastructure is in place to implement this project, and all health staff, both professionals and volunteers have been trained for various levels of implementation. However, there are some significant issues that need to be addressed in order to have an impact on health status at the end of the grant.

Problems

- An assumption is made that if health program implementors talk about various health interventions, mothers will know how and when to use the information. For example, VHWs talk about nutrition at every weighing session, but do not question the reality that in some cases, malnutrition remains the same for long periods of time.
- Information about health status is collected, but not used as a tool for improving or changing implementation strategies. Also, only the information the government requires is collected. For example, the percentages of children who have gained or lost weight is reported as required, but analysis is rarely done to determine why. On the growth monitoring cards there is space to note whether a child has been ill or having other problems which might offer an explanation. Usually, the VHW simply writes "sick" in the space. In the absence of information, children who are malnourished are referred to the clinic where the same questions will be asked.
- Health staff and volunteers do not demonstrate an understanding of

relationships between various health problems. Possible illnesses that might account for a child losing weight are not usually recorded on the growth monitoring card. Even when they are, no connections are made which could help the child recover.

NB. the examples above were based on activities seen at weighing sessions.

Solutions

- Project implementors at all levels need to be helped to analyze data and put it to use in practical ways.
- VHWs need to gain skills in how to involve mothers more directly in responding to their children's health problems.
- All health staff need help to approach health behavior change in a more participatory, integrated, and comprehensive manner.

V. Management: Review and Analysis of Headquarters/Support Functions

1. a. **Project planning and management activities.** On-going project planning and management activities occurred during the year. On each of the technical assistance visits to the field, planning activities take place; these are outlined in the individual country sections.

Formal planning and management activities at SAWSO covered:

- Review of project status and outline of "next steps" during August, 1996 to assure that SAWSO is meeting activities and plans set forth in the proposal and logframe.
- Planning and conduct of the mid-term evaluation during August, 1996.
- Development of output indicators for use in on-going monitoring including indicators for community involvement, training, and health (see attached). A consultant was hired to review these indicators. Development of a report form based on objectives.
- Financial review.

- b. **Staff Resources.** Management staff resources are adequate to meet program needs. Last year, SAWSO made a shift in program staff for the Bangladesh program to assure technical needs were met. This met with good results.

With the mid-term evaluation it has become clear that Indonesia needs a more concentrated application of technical assistance by a health professional. SAWSO will approach this in one of two ways: a health professional will be hired at SAWSO who speaks Indonesian or a health professional will be hired at SAWSO and this person will provide in-depth oversight to an in-country consultant (who speaks Indonesian). This will be completed by mid-October, 1996.

- c. **Training.** In addition to training taking place in the field which is discussed in individual country sections, the following has taken place at SAWSO:
 - On-going informal training by SAWSO health technical specialist.
 - Discussion with consultant concerning issues in monitoring and evaluation.

- d. **Logistical Support.** Logistical support was provided by SAWSO to field programs and the consultant for the mid-term evaluation. Support was also provided in locating in-country consultants when they were necessary.

- e. **Technical Assistance.** Two technical assistance visits per year was the planned number of visits for the reporting period. However, in one of the four projects more visits were made to provide technical assistance (Zambia). More visits were planned for Bangladesh but the general strikes that occurred during the year in that country resulted in last-minute cancellations. The political situation seems to have calmed down and we do not foresee any future problems. The program consultant for Indonesia was injured riding a horse to a community served in this project - a member of the international Salvation Army health team who formerly worked on this project filled in on two trips.

The following technical assistance was provided (unless otherwise noted, these items refer to all projects):

- Review of KPC survey results including implementation of activities necessary to reach revised project objectives; review of community reaction to the survey results especially community response relative to the causes of health problems noted in the KPC.
- Review and revision of 2nd and 3rd year budgets.
- Review program progress and problems encountered; planned for next quarterly or semi-annual period with core teams.
- Revision of DIP document in Bangladesh.
- Worked with administration and core team to develop and put into place new integrated organizational structure for the CCBP program in Zambia.
- Worked with core team on techniques and methods of involving communities in health efforts and monitoring this process.
- Worked on organizing training opportunities for field staff members or provided workshops on methods of participatory education or "Training for Transformation."
- Review with health teams the available health education materials.
- Visits to USAID with project staff; discussion and modeling of networking with other NGOs, government, etc.; locating possible in-country consultants available to assist with program areas needing support.
- Worked with core team and in some cases a consultant on developing and refining HIMS systems.
- Worked with core team on reviewing curriculum for training of

community volunteers.

- Worked with core team on developing monitoring system to work in conjunction with the HIMS system.

2. There is one major variance in the category of technical assistance. SAWSO will be providing much more concentrated technical assistance to Indonesia over the next year. This assistance will be provided by a health professional who will be hired this month. If the new person hired does not have KPC survey experience, he/she will attend this training. Due to language and cultural issues and the illness of the SAWSO program consultant, the Indonesia project is lagging in some areas.

SAWSO does not anticipate any problems in meeting final project objectives.

VI. Financial Report

1. Attached is a pipeline analysis with actual expenditures through July 31, 1996 and projected expenditures through September 30, 1997.
2. We are close to budget both in amount and timing.
3. Letter of credit drawdowns have sometimes been slow because SAWSO utilizes its own funds first and is then reimbursed by federal funds. There will be no change in the rate of drawdowns; the rate will be approximately once a month.
4. No fundraising plans and activities.
5. There have been no problems in meeting our agreed cost-share. SAWSO is currently matching USAID funds equally.

PROJECT FINANCIAL OVERVIEW

	(1) * Adjusted Budget Per Cooperative Agreement 10-1-94 to 9-30-97			(2) Actual Expenditures 10-1-94 to 7-31-96			(3) Projected Expenditures 8-1-96 to 9-30-97		
	AID	SAWSO	TOTAL	AID	SAWSO	TOTAL	AID	SAWSO	TOTAL

COST ELEMENTS:									
a) Salaries	313,450	313,450	626,900	183,961	183,961	367,922	129,489	129,489	258,978
b) Fringe Benefits	46,100	46,100	92,200	27,798	27,798	55,596	18,302	18,302	36,604
c) Travel & Per Diem	226,500	226,500	453,000	136,425	136,425	272,850	90,075	90,075	180,150
d) Subcontracts	0	0	0	0	0	0	0	0	0
e) Procurement	95,100	95,100	190,200	65,807	65,807	131,614	29,293	29,293	58,586
f) Other Direct Costs	39,299	39,299	78,598	24,204	24,204	48,408	15,095	15,095	30,190
g) Indirect Cost	139,551	139,551	279,102	86,367	86,367	172,734	53,184	53,184	106,368

TOTAL	860,000	860,000	1,720,000	524,562	524,562	1,049,124	335,438	335,438	670,876
=====									

* Original budget was decreased by \$80,000 (\$40,000 AID & \$40,000 SAWSO)

VII. Lessons Learned and Long-Term Project Implications

Over the course of the two years since the project started, the following lessons have been learned with corresponding project implications:

- Conducting the baseline surveys was a very useful exercise for both SAWSO and field project staff - it provides a very clear basis from which to proceed.
- Begin planning KPC survey logistics early because these surveys are a very large undertaking.
- Manually tabulating the survey data is a very exhausting but a more useful task than using EPI-Info. The health team feels more familiar with the data and becomes more involved in the planning that follows.
- There is great value in a survey which empowers the people involved at all levels of the project - staff, community, and local government - the survey becomes a very potent team builder. Make use of the momentum generated by the survey even if it means delaying some other project activities such as training.
- Building local participation and community mobilization is a long process and there is a need to begin working on these issues immediately. Take advantage of the enthusiasm generated by the baseline survey. Also, field staff benefit from having processes and examples to follow and learn from: steps commonly used when entering communities, tasks performed by community health committees, etc.
- The projects have benefitted more from collaboration and contact with other local agencies than expected. In some cases there have been more lessons learned regarding community participation strategies from other local NGOs than from external sources. Project personnel need to be encouraged to seek out these other agencies because sometimes they get mired down in the day-to-day management of the project, or if other agency personnel are expatriates, local Salvation Army staff are less likely to approach them. However, this is changing with explicit encouragement and information from SAWSO staff.
- It is very easy for a health management information system to become too complex and then one runs the risk of it not being used at all. Questions to ask: What information is essential to keep? What will be done with the information? If data is collected but not used as a tool for assessing and improving programs, it has

little practical value beyond satisfying local government or oversight agencies.

- Training without a structured follow-up system can be problematic. A structured follow-up system helps to ensure the quality of the work of the volunteers trained, demonstrates the commitment of the project to the community, and helps to reduce attrition.
- Curriculum need to be reviewed periodically to see if what is being taught is up-to-date and still relevant to the context. The content must connect to the needs and issues being faced in the local community. The process of how to facilitate and work with community groups must be a significant part of the curriculum.
- In an area where HIV/AIDS has a high prevalence, one must assume attrition and train more volunteers than one thinks will be needed.
- Integrating outreach teams which have existed as individual units requires patience and time. It is important that there is agreement at every level, and all must be involved in determining how the process will occur. Change is not easy.
- In decentralizing basic care and prevention activities, it is important to remember that it is a partnership, not an abdication of responsibility. The outreach team, as it moves from being the only provider of health services to being the facilitator of those community members who are providing for themselves, must remember that both the quality and quantity of their support will be essential to the success of the decentralizing process. "Partnership" in this setting means continuing essential health services while providing information and training and encouragement to communities who are proactively assuming responsibility for their own good health.
- Village health committees which replace or profoundly change the existing village authority structure may be met with passive resistance that is difficult to overcome. Alternatively, if they evolve over time as communities take more responsibility for their own health, diversification of the committee structure will become self-evident and will be more acceptable.
- For outreach programs that have been set up as a way to provide health services to remote areas and which have acted primarily as a referral system for clinics, the transformation to a more community-based system can be problematic. Much more direct oversight is needed from someone not involved in the development and implementation of the original project.
- Information gathered in-country cannot be assessed and decisions made with regard to program content or program assessment in the absence of in-depth consultations with program implementors.

- Communities are very interested in some kind of activity which provides a financial cushion in the event of family illness, such as a community health insurance scheme. Where this is implemented there is very high participation.
- Indigenous staff have a better sense of how to work with local communities and are more easily able to facilitate change in many cases. Most of these programs are staffed with indigenous staff, but in the cases where this is not so, the difference is clear.
- There has been some success with the practice of providing some health services, such as family planning and growth maintenance, in the homes of community members instead of requiring that clients come to a clinic or central location.

VIII. Recommendations

- KPC survey results and the DIP documents need to be used by project staff as frequent reference point when measuring project activities against the achievement of health status objectives. SAWSO needs to facilitate the use of the documents in this fashion on an ongoing basis and in very practical ways. Considerable facilitation and follow-up may be needed if this is a new idea to project implementors.
- Project staff should assess their community participation and community mobilization efforts in depth. That assessment, and the resulting actions taken should include, but not be limited to:
 - A clear definition of terms, and how the idea of participation differs from acceptance of the provision of health services
 - Understanding the value of community participation as it relates to behavior change, sustainability of program activities, and long term effect on health status in their particular project
 - Deciding, in consultation with representatives from all levels of project staff and, most particularly, from community members themselves, what kind of community participation is most useful and how it should be applied
 - Accepting the necessity to go slowly, to be non-directive, to ensure that community members' values and priorities are the most important part of the process.

SAWSO staff should expect to spend a lot of time facilitating this process and must be prepared to be patient, to be a facilitator only and to be able to offer practical, not just theoretical suggestion.

- Training curriculum need to be closely reviewed in relation to the results of the KPC surveys to assure content is relevant to the local context. In addition, training needs to have a structured follow-up system.
- SAWSO needs to assure formal periodic review of outcomes and trace these outcomes back to the baseline to assure relevance (outcomes-targets-messages-activities-workplan-DIP-baseline) and how program activities are related to these outcomes.

IX. Attachments to Annual Report

Attachments include:

1. Output indicators for formative evaluation: health.
2. Output indicators for formative evaluation: training and community organization.

MATCHING GRANT:
Output Indicators for Formative Evaluation, 1996
(Non-KPC)

Breastfeeding and Nutrition

1. Number of mothers counselled on these topics:
breastfeeding during the first 8 hours after birth-----;
exclusive breastfeeding for the first 4 - 6 months-----;
continued breastfeeding to 24 months-----.
2. ----- # of brochures, pamphlets, or other educational materials distributed on this topic.
3. ----- # of health education sessions held on appropriate feeding for children under two years.
- 3a. ----- # of mothers/school children/community members attending health education sessions on this topic.
4. ----- # of Mothers (with growth-faltering children) counselled on appropriate feeding.
5. ----- # of community members/volunteers/health workers trained or certified in this topic.

Maternal Care & Family Planning

Maternal Care:

1. ----- # mothers seen for antenatal care for the first time.
2. ----- # mothers counselled about nutrition during pregnancy.
3. ----- # of births attended by trained persons (clinic staff, trained TBAs).
4. ----- # of high risk mothers seen by a health worker.
5. ----- # mothers and/or family members counselled on the danger signs of pregnancy, (i.e malaria, diabetes, hypertension, liver disease, and others) and the need to be seen at clinic for these danger signs.
6. ----- # of obstetrical complication cases treated.

Family Planning:

1. ----- # of mothers (or couples) counselled about family planning.
2. ----- # of new FP acceptors.
- 2a. By FP method:
Pills----- Condoms----- Injections----- Norplant-----
Foam----- Loops ----- Natural FP----- Breastfeeding-----
3. Number of contraceptives distributed, by kind:
Pills----- Condoms----- Foam Tablets-----
Number of FP injections given ----- Number of Loops inserted-----
Number of Norplant units inserted-----
4. ----- # of Health Workers trained in family planning (counselling and family planning promotion).
5. ----- # of referrals from family planning unit to clinic for FP services.
6. ----- # of health education sessions/mass campaigns held on this topic.
7. ----- # of community health committees/volunteers/Village Health Workers trained in family planning promotion.

Immunization

1. ----- Total number of children 0 - 11 months, who were immunized.
- 1A. By antigen - total number of children 0 - 11 months who were immunized:
BCG----- DPT1----- DPT3----- OPV3----- Measles-----
2. ----- Total number of children 12 - 23 months, who were immunized.
- 2a. By antigen - total number of children 12 - 23 months, who were immunized:
BCG----- DPT1----- DPT3----- OPV3----- Measles-----
3. ----- # immunized against Yellow Fever (12 - 23 months only).
4. Number of Pregnant Mothers immunized against tetanus:
#1----- #2----- #3-----
5. ----- # of community health committees/volunteers/Village Health Workers trained in immunization, by training topic: promotion, mobilization, counselling re: side effects, immunization schedule.

Diarrhoea

1. ----- # ORS packets distributed.
2. ----- # of mothers trained/certified/counselled on preparation and administration of ORS/SSS solution.
3. Number of health education sessions held on diarrhoea prevention and treatment by topic:
hygiene----- importance of fluids----- foods----- breastfeeding-----
recognition of dehydration----- preparation of ORS-----
preparation of SSS-----.
4. ----- # of attendees at each session.
5. ----- # of wells, water barrels, or other water sources constructed.
- 6 ----- # of pit latrines (new) built.
7. ----- # of community health committees/volunteers/Village Health Workers trained in this topic.

Malaria

1. ----- # of mothers trained and/or certified in malaria.
2. ----- # of outreach visits made by health workers to deal with malaria issues.
3. Number of community strategies for malaria control implemented:
cleanup campaigns----- community meetings----- other-----.
4. ----- # of health workers trained to treat malaria.

Acute Respiratory Infection

1. Number of mothers trained and/or certified in ARI issues: signs/symptoms-----
referral process for treatment -----.
2. ----- # of health education sessions held on this topic.
2. ----- # of children treated for pneumonia;
----- # referred to appropriate health service for treatment.
3. ----- # health workers trained in ARI case management.

HIV/AIDS

- 1a. _____ # of community counselling sessions held.
- 1b. _____ # of HIV/AIDS awareness sessions held (# of group HIV/STD prevention activities held during the last 1-3 months; meetings, presentations, TV/radio broadcasts, media events, etc.).
- 1c. _____ # of IEC materials distributed to target populations.
2. _____ # of women who know what AIDS is.
- 3a. _____ # of HIV/AIDS care and prevention strategies in place and documented.
- 3b. _____ # or percentage of target groups screened last 3 months (or shorter period if necessary) for HIV/STDs.
- 3e. _____ # number or percentage of clients referred by health workers for diagnosis, treatment, or testing.
- 3g. _____ # of condoms distributed to the target population.
- 4a. _____ # of HIV/AIDS patients who are being cared for by family and community volunteers.

TB/Leprosy

1. _____ # mothers trained in topic area.
- 2a. _____ # health workers trained in prevention, treatment and referral for these diseases.

MATCHING GRANT
Output Indicators for Formative Evaluation, 1996

I. Community Organization

These five indicators are the minimal indicators of progress in capacity building at the community level in the area of public health. If possible these indicators should be measured two ways: 1) total figures for the period beginning immediately after the KPC survey through October 1st. and then 2) quarterly for the period from October 1st through the date of the mid-term evaluation. Together these figures would provide a fair approximation of project impact in this area for the first half of the project.

The information may be gathered in a variety of ways: the preferred method is to go through these questions with the committee as a whole at the end of each meeting, as a tool for self-evaluation and monitoring. Alternatively, the information may be gathered through observation of meetings by a staff member and interviews. Although methods may vary between countries, it is important that within a project country the information gathering methods be consistent for the period covered.

It may be appropriate to incorporate some or all of these indicators into the health information system on a permanent basis.

1. Did your health committee meet at least once a month during the last three months? (Yes) (No)
Total number of participants: _____
Number of women participating: _____
Number of young people (under 18) participating: _____
Do women participate as much as men in meeting? (Yes) (No)
Do young people participate as much as older people in meeting? (Yes) (No)
This question addresses the regularity of meetings, representativity and inclusiveness of participants.

2. Do you feel that your participation in this committee is important to the wellbeing of the community? (Yes) (No) Why: *(Anecdotal description)* _____

This question addresses ownership of health work, commitment, relative importance of health work versus other community efforts, perceived prestige of participation, etc.

3. Did the community committee do the following:
Establish priorities of most important problems? (Yes) (No)
Examine past experiences to determine best actions? (Yes) (No)
Evaluate alternative actions before deciding on plan? (Yes) (No)
Follow-up on decisions made? (Yes) (No)
Manage conflict and differences of opinion between participants well? (Yes) (No)
Get the community involved in working towards health goals? (Yes) (No)

Depend on the health worker for direction? (Yes) (No)

This question addresses the quality of group process and planning.

4. What resources did the community contribute directly to public health services during the last three months?

Labor? (Yes) (No)

Buildings? (Yes) (No)

Money? (Yes) (No)

Equipment? (Yes) (No)

Political commitment? (Yes) (No)

Mass activities? (Yes) (No)

This question addresses the level of impact of the health committees' activities.

5. Which of the following activities has the committee been involved in organizing?
(create a list of 3 or 4 which reflect the project's local priorities; the following is an example)

Family planning? (Yes) (No)

Description: _____

Potable water? (Yes) (No)

Description: _____

Child-to-child? (Yes) (No)

Description: _____

Immunization? (Yes) (No)

Description: _____

II. Indicators of the effectiveness of training

For each quarter report the following:

1. For each training related to project objectives and done by project staff (not activities of village health workers), require filling out a SAWSO-provided form which records the following:
 - # of participants and program position or other defining characteristics.
 - Training objectives.
 - Curriculum design.
 - Description of trainers' qualifications.
 - Information indicating pre and post capacity; do these reflect knowledge only or knowledge plus practice (in which case how are skills demonstrated?)
2. For different types of staff training there will be distinct ways of measuring value:
 - 2.a For discrete, clinical skills (ie. Norplant implanting) there will probably be pre and post testing of capacity and the indicator can be the % of participants who achieved capacity.
 - 2.b For community extension skills (ie. beekeeping, teaching skills) there will probably not have been pre and post testing and you can best measure the # of occasions or # of people whom this new information was shared with.
 - 2.c For refresher courses (which may or may not be clinical) where there is no certification of competency it should be possible to count heads of participants who received the training.
 - 2.d For management skills there should be certification of competency.
3. Also report the percentage of achievement of target goals for training activities.

III. Monitoring and Evaluation of Staff

Explore the possible processes which can be implemented to monitor the quality of staff efforts. The Program Consultant and Project Director should agree on a minimum set of requirements for both internal and SAWSO evaluations

- * Meetings (Require agendas, minutes, etc.)
- * Performance reviews (Require copies, signed off on by the Project Director and Staff person)
- * Job descriptions for each position (Use in performance reviews).
- * Contact logs.
- * Evaluation of SAWSO technical assistance etc.