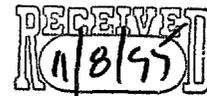


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**MID TERM EVALUATION:  
Adamawa State  
Maternal Health &  
Child Survival Project**

Yola, Nigeria

Aug. 16 - September 8, 1995

**Evaluation Facilitators:**

Dr. Judi Aubel, PhD, MPH, External Evaluator

Stephan Solat, Health Programme Officer, AFRICARE/Washington

Benson Kongyiburi, Adamamawa State MH/CS Project Manager

Roberta Lee, Adamamawa State MH/CS Project Advisor

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Tom Ubuane, MIS Specialist, AFRICARE, Lagos

## EVALUATION REPORT: TABLE OF CONTENTS

Executive Summary

Preface: Evaluation report format

### I. INTRODUCTION:

- A. Background to the Adamawa Project
  - 1. Rationale for the project
  - 2. Relevance to child survival and maternal health problems
- B. Project Objectives
- C. Modifications in the project design
- D. Constraints to project implementation
- E. Goal and objectives of the evaluation

### II. THE PARTICIPATORY EVALUATION METHODOLOGY

- A. Rationale for the participatory evaluation methodology
- B. Steps in the evaluation process

### III. EVALUATION FINDINGS ON PROJECT IMPLEMENTATION:

- A. Accomplishments: inputs, outputs, outcomes
- B. Multi-level capacity-building strategy
  - 1. Capacity-building of Local Government Areas staff
  - 2. Reinforcing health facility health workers' skills
  - 3. Capacity-building of community organizations
  - 4. Training and follow-up of community health workers
  - 5. Improving household level knowledge and practices
    - 5.1 Mid-term assessment of mothers' KAP
- C. Strengthening Child Survival & Maternal Health Interventions
  - 1. Immunizations
  - 2. Control of diarrheal disease
  - 3. Control of malaria
  - 4. Improved infant feeding practices and infant nutrition
  - 5. Maternal health
  - 6. Child spacing
  - 7. Water & Sanitation
- D. Integration of onchocerciasis control into child survival & maternal health activities
- E. Institution-building project-supported activities
  - 1. Training
  - 2. Supervision
  - 3. Management Information System (MIS)
- F. Project staff and management
  - 1. Project staff
    - 1.1 Technical staff
    - 1.2 Support staff and services
    - 1.3 Communication??
  - 2. Project Management and coordination
    - 2.1 Planning
    - 2.2 Coordination of project staff
    - 2.3 Collaboration with the LGAs and NGOs
- G. Sustainability of project-supported PHC activities
- H. Use of technical support

### IV. SUMMARY OF LESSONS LEARNED

V. ASSESSMENT OF PARTICIPATORY EVALUATION METHODOLOGY

VI. PIPELINE ANALYSIS

APPENDICES:

- A. Field Team Members
- B. Data collection sites and interviewees
- C. Mid-term Assessment of Mothers' KAP
- D. Evaluation questions, findings and lessons learned

## EXECUTIVE SUMMARY

The Adamawa State Maternal Health and Child Survival Project, sponsored by AFRICARE, began in Dec. 1993. The mid-term evaluation was conducted from Aug. 16 to September 8, 1995. A participatory methodology was employed to carry out the evaluation. The exercise was coordinated by an External Evaluator and the group of Evaluation Facilitators also included one representative from AFRICARE Washington, one representative from AFRICARE Lagos, the Project Manager from another AFRICARE Child Survival Project in Imo-Abia State, the Adamawa Project Manager and Project Advisor. In addition to this core group, 14 other project staff members and collaborators were part of the Evaluation Team which was involved in virtually all steps in the evaluation process.

The information collected in the evaluation was primarily qualitative based on indepth group and individual interviews in the two intervention LGAs at the community with Village Development Committees, mothers, Village Health Workers and Traditional Birth Attendants, at the health facility level with facility staff, and at the two Local Government Authorities (LGAs) with LGA officials and Primary Health Care Dept. staff. In addition, a short KAP survey was carried out with a purposive sample of mothers to roughly compare present KAP with project baseline KAP findings.

Since the project started 19 months ago, it has faced serious constraints beyond the control of project managers, due to the unstable political situation in Nigeria, including a five-month period of USAID sanctions (one quarter of the entire project life) on all project activities. The political situation in Nigeria has significantly contributed to the fact that many of the anticipated project accomplishments are behind schedule. The most important outputs to date are: the baseline survey conducted in the two LGAs; placement of home-based PHC records in one LGA; and a series of training activities in which LGA/PHC staff and health facility workers were trained in PHC management and mobilization & Training of Trainers, and in which 214 community health workers (VHWs and TBAs) were trained to carry out PHC activities related to CDD, Vaccinations, Malaria, Infant Nutrition, Maternal Health, Child Spacing and Water/Sanitation. No data is yet available on project outcome indicators.

Key lessons learned from the evaluation address the need: to operationalize the PHC/MIS system ASAP; to clearly define the roles of all project actors and collaborators from the LGA to community levels; to strengthen supervision of PHC activities at all levels; to strengthen critical three-way collaboration between VHWs/TBAs, Village Development Committees and PHC Health Facility Workers; to strengthen collaboration between project staff and LGA officials/PHC staff; to improve the quality of the planning and facilitation of training activities based on adult education principles; and to improve communication between project staff by scheduling regular staff meetings.

Key recommendations include immediate recruitment of two additional Project Officers, one for the MIS and the other for Training & Health Education.

In light of the serious constraints which the project has encountered, mainly due to factors outside of the project, which have contributed to significant delays in project implementation, it is recommended that a no cost extension of one year be granted to enable the project to complete key intended accomplishments and to reinforce activities already initiated.

**PREFACE: Evaluation report format**

The content of this report addresses all of the chapters and questions outlined in the USAID 1995 BHR/PVC CHILD SURVIVAL MID-TERM EVALUATION GUIDELINES. However, the format in which the various chapters/questions included in the guidelines are addressed differs from the format in which the guidelines are presented. This is due to the fact that in the participatory methodology employed in the evaluation of the Adamawa Child Survival/Maternal Health Project assessment of the facets and components of the project was organized in a different fashion.

For those readers who wish to quickly locate the findings of the evaluation which correspond to the different chapters/questions in the USAID Guidelines, the following table indicates where each of the elements is found in this report.

In the spirit of the expectations of a mid-term evaluation, the participatory methodology allowed the evaluation team "to identify what is working well with the project, to suggest areas which need further attention, and to recommend useful actions to guide the staff through the last half of the project." The format in which this report is presented reflects the structure of the evaluation process which was followed. It is hoped that this document will be useful to project staff members who were actively involved in the evaluation process while at the same time responding to the expectations of the BHR/PVC Office of USAID.

**RELATIONSHIP BETWEEN BHR/PVC GUIDELINES AND EVALUATION REPORT**

Chapter/questions in  
Evaluation Guidelines

Number & title of corresponding  
section in evaluation report

1. Accomplishments	III A. Accomplishments
2. Effectiveness	III B.5.1 Effectiveness
3. Relevance to Development	I.A.2 Background/Relevance to Child Survival Problems
4. Design & Implementation: 4.1 Design	I.C Modifications in the project design
4.2 Management and Use of Data	III E 3 MIS
4.3 Community Education and Social Promotion	IIIB 3 Community organizations III B 5 Health education IV. Community mobilization for PHC
4.4 Human Resources for Child Survival	III F 1 Project Staff III E 1 Training
4.5 Supplies & Materials for local staff	III C 1-6 (Materials/supplies discussed by intervention)
4.6 Quality	III.B 5.1 Effectiveness (Mothers' KAP at mid-term) III.B 2 Health Workers/Quality Assurance III.B 4 VHws/TBAs/CBDs
4.7 Supervision & Monitoring	III.E 2 Supervision
4.8 Regional & Headquarters Support	III.F 1.3 Communication with AFRICARE Lagos and D.C.
4.9 PVO's Use of Technical Support	III.H. Use of technical support
4.10 Counterpart Relationships	III.F 2.3 Collaboration with LGAs and NGOs III.G Sustainability
4.11 Referral Relationships	III.C.5 Maternal Health
4.12 PVO/NGO Networking	III.F 2.3 Collaboration with NGOs
4.13 Budget Management	VI. Pipeline Analysis
5. Sustainability	III.G Sustainability

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**Africare**

Africare House, 440 R Street, N.W., Washington, D.C. 20001  
Telephone: (202) 462-3614 • Fax: (202) 387-1034 • Telex: 64239

8 November, 1995.

Mr. Eric Starbuck, Project Officer  
USAID BHR/PVC/CSH  
Room 741 SA-8  
Washington DC 20523-0804

Dear Eric:

Enclosed find the Midterm Evaluations of the Adamawa State, Nigeria and Ganzourgou, Burkina Faso Child Survival/Maternal Health Projects.

Africare appreciates the hard work put in by its External Evaluator, Judi Aubel, on these Midterm Evaluations, and believes that a number of valuable insights have emerged from this work which will help to improve the projects.

The Adamawa evaluation report contains several inaccuracies, and there are other observations in the evaluation which require clarification. Therefore, Africare Field and Headquarters staff have included a four page commentary, which is attached to the Midterm.

Comments are also attached to the Ganzourgou, Burkina Faso Evaluation.

Please do not hesitate to contact either Stephan Solat or Laura Hoemeke if you have any questions.

Sincerely,

Joseph C. Kennedy, PhD  
Senior Vice-President



# Africare

Africare House  
440 R Street, N.W. • Washington, D.C. 20001

## Mid-Term Evaluation Comments

From R.Lee, CSP Field Advisor, and S.Solat, HQ CSP Manager

### General Observations

1. Eight out of 10 Project objectives, as presented in this mid-term evaluation, were modified from those stated in the previously submitted Adamawa State CSP Annual Report. Hence, it is recommended that the reviewer of this evaluation refer to the objectives that have been used by project staff: i.e. those stated in the Annual Report.

2. The benefit of using the participatory approach is clearly in its team-building effect on project staff. However, we believe that this beneficial impact could have been achieved in 2 or 3 days, rather than using it as a means to evaluate the project. Moreover, only 4 out of 22 evaluation working days were spent in the field collecting evaluation data. Given its cost in terms of substantially higher consultant fees, additional time, and staff resources required, we don't feel that the selection of this method was cost-effective.

### Comments on Specific Sections

#### Page #

4 - Infant/child nutrition: Exclusive breastfeeding for 0-3 months was not directly assessed, as suggested here.

5 - "...virtually all of (the objectives) focus on mothers..." This statement neglects the substantial focus placed by Project Staff on strengthening of Local Government Area (LGA) and District health care staff skills and infrastructure.

9 - Table 1, No. 4: The "Pilot study" referred to was, rather, a field-based training on house numbering and placement of Home-Based Records. Rather than it having been "not done", it actually had never been planned for Guyuk LGA.

11 - Table 2: The correct numbers of Senior TBAs trained are 7 for Guyuk LGA and 7 for Fufore LGA.

14 - In the context of this CSP, "...to carry out small studies" is not a correct definition of Quality Assurance. Rather, the Project aims to assist in the formation of QA Committees composed of LGA, District, and Community-based workers who will conduct periodic audits of records and services, and then use this information in making appropriate program decisions.

Page #

18 - Growth Monitoring: The reason for the "significant increase in the number of children who have growth monitoring cards..." is that these cards were given out for the purpose of recording immunizations.

19 - Immunization: The reason for the increased number of children with immunization cards (and, in fact, immunized children) was due to three **Local Immunization Days (LIDs)** having been promoted by the State MOH -- and assisted by Africare and UNICEF -- in both target LGAs in April, May, and June 1995. At the time of these LIDs, there was still an adequate supply of vaccines.

27 - Project Staff are aware of the advantages of keeping the size of learning groups down to 20-25 persons. However, due to the US Government's temporary decertification of its funding support to Nigeria and due to other delays beyond Africare's control, the training of larger groups was at times needed to regain project momentum. Decentralized follow-up in small groups is planned.

28 - Regarding the need for *collecting qualitative data*, Guyuk LGA Project Staff are actively developing a prototype narrative log as a reporting tool. Components of this narrative log include write-ups of field notes which will include the recording of significant field observations and, in some instances, case histories.

28/29 - Contrary to what is stated, MIS has been treated as a priority since July, 1994. At this time, the Project had one functional computer and one each of a low-volume copier and printer. At present, the Project has access to three computers and a high speed laser printer. Moreover every 2 months, for at least 4 days per Project Office visit, the Africare/Nigeria MIS Specialist has provided technical assistance consisting of the development and implementation of software to record house numbering and placement of home-based records. This software is now being used to track our target population.

29 - Technical Staff: Contrary to what is stated, the Project Manager has a Master of Public Health degree with a major in health education.

To: Stephan Solat, Africare fax (202)387-1034  
From: Roberta Lee  
Subject: Midterm evaluation for the Yola/Adamawa  
CSP/MH Project, Nigeria  
Date: October 20, 1995

Following are my comments regarding the Yola/Adamawa CSP/MH  
Midterm Evaluation and Report (8/16/95 to 9/8/95).

1. Methodology

The evaluation utilized a "participatory methodology". For this, 20 project staff participated nearly full time for 4 weeks. There were two series of workshops of 3 days each and 4 full days of field activities. The project administrative and support staff were intensively involved during the entire period, working with no time off to maintain minimal routine operations and as well, participate directly in the evaluation activities and/or planning and logistics.

Comment: Project staff did not know ahead of time that such intensive time and resource commitments were required. Resources had to be quickly reallocated and as a result, the project, already 12 months behind schedule, suffered further delay. Staff seized upon the opportunity to do team building and orient recently arrived Project Officers and Nurse Midwives. Combining these functions may have saved some time. Doing so at the last minute however, would not seem to optimize results.

Overall, the writeup is thorough and presents many facts. A few areas need clarification such as interpretation of quality assurance as being no more than a series of small studies. Generally additional field interviews may have been advantageous. Finally, adult health education, MIS strengthening, and specific suggestions for LGA action will be helpful.

## 2. Themes

In reviewing the Midterm, two themes emerged.

### Sporadic Implementation

Project implementation is sporadic. Planning has been based upon making contingencies for immediate termination at anytime, while trying to make up for the 12 months of lost implementation time; (and doing so at an increased pace). Consequently, thoroughly mobilized communities withered in their involvement while the project was grounded. When health workers were finally trained, local leaders had changed in the fluid political climate, and collaborative effects became severely disrupted. Consequently, being aware of this sporadic pattern may assist planning for consistency, effectiveness and ultimately, sustainability.

### Ambitious Implementation

Since inception, the project has exhibited ambitious and wide ranging goals and objectives. With feedback on the DIP that additional focus and depth would be necessary, project staff scaled back. Instead of total coverage of 2 local governments, specific health districts were selected as model intervention areas. It will be important to continue to keep this in mind. Defining our limits and prioritizing are increasingly important with ongoing political and economic pressures which reduce local community capabilities to meet the needs of their vulnerable populations. Project staff has exhibited commitment, flexibility and ability to work as a team. Awareness of a possible tendency to over extend may be helpful in future planning of project activities. In retrospect, it may have been enough in the evaluation to do just that without folding in additional team building objectives.

## I. INTRODUCTION:

### A. Background to the Adamawa Project

The health status of women and children in Adamawa State is among the worst in Nigeria. The goal of the AFRICARE/Adamawa Child Survival/Maternal Health Project (CS/MHP) is to reduce maternal and child morbidity and mortality in two of the Local Government Areas (LGAs) in Adamawa State in which health care services are particularly weak. The overall project strategy consists of strengthening the capability of the two intervention LGAs, Guyuk and Fufore, to manage Primary Health Care (PHC) interventions which promote child survival and maternal health.

#### 1. Rationale for the project

The Federal Ministry of Health (FMOH) in Nigeria has made a strong commitment to implementing Primary Health Care programmes in the country. The FMOH has carefully defined the policies and guidelines for the development of PHC programmes. FMOH PHC guidelines prescribe the establishment of Village Development Committees, the training and supervision of community Village Health Workers, the provision of basic services at the primary health facility level and the development of a collaborative relationship between the community organizations and volunteers and health facility staff. The state level ministries of health are expected to provide guidance and technical assistance to the Local Government Authorities (LGAs) who are charged with managing the implementation of PHC programmes.

While responsibility for implementing PHC programmes falls on the LGAs, their ability to carry out PHC programs is impeded by: a lack of funds; lack of understanding and/or acceptance of PHC principles and preference for tertiary health care; and inadequate management systems and skills.

The underlying assumption made in the project design is that the most appropriate and feasible way to assure continuity and sustainability of child survival and maternal health interventions after the AFRICARE project ends is to strengthen the LGAs ability to plan and implement PHC CS/MH activities. The PHC system involves activities at both the community and primary health facility levels.

The capacity-building orientation of the Adamawa project, which aims to strengthen PHC activities at these two levels, builds on the lessons learned in the AFRICARE Imo & Abia child survival projects. The project also builds on the successful community-based River Blindness (onchocerciasis) project which AFRICARE supported from 1991 to date in Adamawa State. The "oncho" project involved the development of a system of community-based health education and mass distribution of the drug, ivermectin.

#### 2. Relevance to child survival and maternal health problems

The relevance of the CS/MHP is substantiated by the significant child and maternal health problems which exist in the Guyuk and Fufore LGAs in Adamawa State. These problems are revealed in data available from pre-existing sources and from the project baseline survey conducted in Dec. 1993 in Guyuk and in Jan. 1995 in Fufore.

Infant Mortality (IMR) in Adamawa State is estimated at 144/1,000. This is considerably more than the estimate of 102 IMR for Nigeria. It has been estimated that the IMR in Guyuk LGA is 202/1,000. Maternal health indicators: Less than 25% of the women consult a trained health worker during pregnancy (pre-natal consultations); and only approximately 22-30% of women are assisted by a trained health worker during delivery.

The scope of maternal and child health problems in the two LGAs are revealed in the results of the baseline surveys on certain indicators of mothers' knowledge, attitudes and practices (KAP).

Immunization:

Complete immunization of children under 24 months (BCG + OPV123 + DPT123 + Measles): Guyuk 3.3% and Fufore 11%

Infant/child nutrition:

Children with growth monitoring card: Guyuk 47.5% and Fufore 27.9%

Exclusive breast-feeding 0-3 months: Guyuk >1%. (This as not assessed in Fufore.)

Management of diarrhea:

Children who were given more liquids than usual during diarrhea:

Guyuk 18.3% and Fufore 15.9%

Children who received drugs during diarrhea: Guyuk 39.5% and Fufore 26.5%

Maternal health:

Women with maternal health card: Guyuk 45% and Fufore 33%

Women who received at least 2 tetanus toxoid shots during pregnancy: Guyuk 62% and Fufore 49.3%

Child spacing:

Women using a modern family planning method: Guyuk 2% and Fufore 4%.

Malaria:

Household members' bouts of malaria treated with anti-malarials: Guyuk 77.9% and Fufore 76.6%.

3. Project objectives:

The project objectives, defining anticipated project outcomes deal with 8 maternal and child health interventions: child immunization; antenatal visits and TT vaccination for pregnant women; growth monitoring; infant and child feeding practices; diarrhea disease management; child spacing; malaria control; and water and sanitation.

Specific project objectives (revised from the DIP) for each of these interventions are as follows:

Immunization:

-to increase from 3.3% to 50% full immunization of children 0-11 months

Management of diarrhea:

-to increase from 31% to 60% the mothers with children 0-23 months who use ORT (SSS or ORS) as treatment for diarrhea

-to increase to 60% the number of mothers who know how to prepare appropriate fluid and solid diets in dietary management of diarrhea

Growth monitoring:

-at least 50% of children 0-3 years are weighed at least six times a year

-to identify seriously malnourished children and provide their mothers with nutrition counselling

-to ensure that seriously malnourished children receive an improved diet and show evidence of growth

Breast-feeding:

-to increase from <1% to 50% the number of women who exclusively breastfeed their children for 6 months

-to increase the number of women using improved weaning practices

Pre-natal consultations:

-to increase to at least 60% the number of pregnant women have at least one prenatal consultation in their first trimester

-to increase to at least 60% the number of pregnant women who have at least 4

prenatal consultations

-to increase to at least 60% the number of pregnant women who receive two injections of tetanus toxoid

Safe deliveries:

-to increase to at least 33% the number of home deliveries which are assisted by a trained traditional birth attendant (TBA)

Family Planning/Child Spacing:

-to increase from 2% to 40% the number of women of reproductive age and their husbands who accept the use of a modern method of child spacing

-to increase use of modern family planning methods from 2% to 5% among women of reproductive age

Malaria:

-to increase to at least 60% the number of cases of fevers in women and children presumed to be malaria that are properly treated

Water and sanitation:

-to promote the provision of potable water, basic sanitation and increased food production in 50% of intervention villages

As regards these revised DIP objectives, it is noted that virtually all of them focus on mothers and imply expected changes in women's knowledge and practices. It is increasingly realized, however, that a mother's ability to ensure appropriate preventive as well as curative practices at the household level depends not only on her own knowledge and priorities for practice, but often also on the opinions of others at the household level, namely husbands and grandmothers, and to the resources available to her.

4. Modifications in the project design: Project staff have not made any significant changes in the project design as delineated in the DIP. However, the number of target beneficiaries, originally estimated at a minimum of 19,360 women of reproductive age (based on 1991 census data) is now estimated to be less than that figure due to inaccuracy in the 1991 census figure. As soon as the PHC household record system is fully functional the exact number of project beneficiaries will be recalculated.

5. Constraints to project implementation:

Project implementation began in mid-December 1993, three months later than anticipated in the project Detailed Implementation Plan (DIP). Since Dec. 1993 the project has encountered major constraints due to the unstable political and economic situation in the country which continues to the present time. Due to the political crisis in the country, in April 1994 USAID imposed sanctions on Nigeria which paralyzed project activities between April and August 1994 and contributed to decreased support for some activities thereafter. The 5 month paralysis represents one quarter of the entire project implementation period to date. In addition to the constraints resulting from the sanctions, frequent changes of government and policy makers at the State and LGA levels, the scarcity of petrol, particularly during the 4-month strike, have contributed to decreased PHC resources and activities in the LGAs.

Inspite of these serious constraints, in the first twenty months of the project tangible progress has been made toward accomplishing some of the project objectives.

C. Goal and objectives of the evaluation

The evaluation facilitating group defined the goal of the evaluation as:  
To assess the implementation strategies and accomplishments of the

Child Survival & Maternal Health Project within the context of Primary Health Care and to develop lessons learned in order to review and revise the project's action plan where necessary

The evaluation objectives were defined as:

1. to assess the appropriateness of the project's PHC assumptions and strategy
2. to identify and assess the accomplishments, strengths and weaknesses in the implementation of the seven components of the project (Immunization, Nutrition, Child Spacing, Control of Diarrhoea Diseases, Malaria Control, Maternal Health, Water and Sanitation)
3. to examine the status of the integration of onchocerciasis treatment with child survival interventions and recommend strategies for improvement
4. to assess the collaboration between the project and the state & local governments, NGOs and the communities
5. to identify the strengths and weaknesses of communication and coordination within the project and with collaborators
6. to identify factors that affect sustainability of the child survival activities at the community level
7. to assess the usefulness of the participatory evaluation methodology for evaluating primary health care projects

## II. THE PARTICIPATORY EVALUATION METHODOLOGY

### A. Rationale for the participatory evaluation methodology

For the purposes of the mid-term evaluation, AFRICARE had decided that a participatory methodology would be used. The choice of a participatory approach was based on the assumption that the involvement of project "stakeholders" in the evaluation process would help ensure that the evaluation addressed the issues and concerns of importance to them, would increase their sense of ownership of the evaluation findings and would also increase the likelihood that project staff and collaborators would be committed to using the results at the culmination of the evaluation exercise.

The methodology adopted was coordinated and facilitated by the External Evaluator. She worked closely with the group of Evaluation Facilitators, composed of the Child Survival Officer from AFRICARE Headquarters, the Adamawa CS/MH Project Manager and Project Advisor, the MIS Specialist from the AFRICARE office in Lagos and the Project Manager of the CS Imo-Abia Project. The full Evaluation Team was composed of the Coordinating Group in addition to 14 other persons, either project staff or project collaborators.

The decision to adopt the participatory methodology and to involve a sizeable group of people in the entire process did require considerable financial and human resources. AFRICARE viewed the evaluation as a staff development exercise, in part, and committed the resources necessary to carry out the 4-week evaluation.

### B. Steps in the evaluation process

The evaluation was carried out following a process composed of six phases, each phase composed of several steps. (See Table I: Steps in the Participatory Evaluation Process)

- Phase I: Pre-planning meetings (Evaluation Facilitators)  
Aug. 17-18
- Phase II. Evaluation planning workshop (Evaluation Team)  
Aug. 21-23
- Phase III. Development of data collection instruments  
(Evaluation Facilitators)

- Aug. 24-25  
Phase IV. Fieldwork: data collection and analysis (Fieldwork Teams)  
Aug. 28-31  
Phase V. Workshop to formulate lessons learned (Evaluation Team)  
Sept. 4-6  
Phase VI. Prepare evaluation report (External Evaluator)  
Sept. 6-8

Table I.  
Steps in the participatory evaluation process

<p>Phase I: Pre-planning meetings Aug. 17-18  (Evaluation Facilitators)</p>	<p>Step 1: Define evaluation goals &amp; objectives Step 2: Identify evaluation team members Step 3: Plan logistical and administrative arrangements Step 4. Develop visual framework of the project</p>
<p>Phase II. Evaluation planning workshop Aug. 21-23  (Evaluation Team)</p>	<p>Step 5: Organize stakeholders into a working group Step 6: Develop evaluation questions Step 7: Identify data collection techniques Step 8: Finalize data collection sites and interviewees</p>
<p>Phase III. Development of data collection instruments Aug.24-25 (Evaluation Facilitators)</p>	<p>Step 9. Develop data collection instruments</p>
<p>Phase IV. Fieldwork: data collection and analysis Aug. 28-31 (Fieldwork Teams)  Sept. 1-2 (Evaluation Facilitators)</p>	<p>Step 10. Orient fieldwork teams Step 11. Conduct interviews and observations Step 12. Analyze information collected  Step 13. Summarize findings from fieldwork</p>
<p>Phase V. Workshop to formulate lessons learned Sept. 4-6  (Evaluation Team)</p>	<p>Step 14. Formulate lessons learned for each evaluation question Step 15. Team assessment of the evaluation process Step 16. Summarize the lessons learned</p>
<p>Phase VI. Prepare evaluation report Sept. 6-8 (External Evaluator)</p>	<p>Step 17. Prepare the evaluation report</p>
<p>Phase VII. Disseminate and apply evaluation results (Project Team)</p>	<p>Step 18: Disseminate and discuss evaluation results with project collaborators Step 19: Revise project action plan based on evaluation results</p>

### III. EVALUATION FINDINGS ON PROJECT IMPLEMENTATION:

The results or findings of the evaluation are based upon: analysis of project reports and other documents; results of Quality Assurance observations and interviews conducted in 1995; results of a survey of 100 mothers' knowledge, attitudes and practices (KAP); and results of indepth interviews conducted in the two LGAs during the mid-term evaluation.

#### 1. ACCOMPLISHMENTS

The Adamawa Child survival project is in its second year of operation. The project implementation is planned for three years, October 1, 1993 to September 30, 1996. The Tables below summarize the major inputs, outputs and outcomes to date.

Table 1 outlines the major input activities accomplished to date.

TABLE 1: PLANNED PROJECT INPUTS AND ACCOMPLISHMENTS TO DATE

PLANNED INPUTS	GUYUK	FUFORE
(1) Baseline Survey	14-18/12/93	16-20/06/95
(2) TOT <sup>1</sup> workshop for staff in- charge of PHC in health facilities (topic covered --)	17-19/10/94	12-17/06/95
(3) Management Workshop and Mobilization for LGA council members, Head of Departments Directors, Coordinators, SMOH, and NGOs.	20-22/10/94	20-23/12/94
(4) Pilot study of House Numbering and placement of HBR in Furo village areas of Fufore	NOT DONE	6-8/02/95
(5) Training workshop on House Numbering & placement of HBR in the two LGAs (LGA and PHC staff of ADSMOH in attendance)	13-18/09/94	Only House numbering done
(6) Training of VHW and TBA (covered topics on Immunization, FP Malaria Control, Health Ed. and referrals)	24/4-4/5/95	22/5-3/6/95
(7) Training of Senior TBAs for Guyuk and Fufore LGAs (1 year programme in the State School of Nursing, Yola).	Started in May 1994	Started in May 1994

1

HBR = Home Based Records  
 TOT = Training of Trainer  
 VHW = Village Health Workers  
 TBA = Traditional Birth Attendant  
 MIS = Management Information System  
 M&E = Monitoring and Evaluation

(8) MIS TOT Workshop on PHC M&E forms for Health Workers and Supervisors.	One day 19/05/95	One day 10/05/95
(9) Training Workshops for MOH/LGA health staff, supervisors and community workers ( <i>record keeping forms, improved assess to portable water, HE visuals and messages</i> )	NOT DONE	NOT DONE
(10) Training Workshops for MOH/LGA health staff, supervisors and community workers ( <i>record keeping forms, nutrition education visuals and messages and food preparation demonstrations Backyard gardening guidance and supplies</i> )	NOT DONE	NOT DONE
(11) Training Workshops for MOH/LGA health staff, supervisors and community workers ( <i>full registration and related record keeping forms. Breast feeding and weaning education and messages</i> )	NOT DONE	NOT DONE
(12) Training Workshops for MOH/LGA health staff, supervisors and community workers ( <i>House numbering, full registration and related record keeping forms, FP outreach, education visuals, and messages</i> )	NOT DONE	NOT DONE

The input activities which have to date been completed in both LGAs include: the baseline survey; and four training activities. Several input activities have been only partially completed: house numbering and placement of home-based records; and the training of senior TBAs. Four other key training activities for LGA staff have not yet been carried out.

Table 2 shows the major project outputs/accomplishments.

TABLE 2: SUMMARY OF MAJOR CSP-III OUTPUTS

OUTPUT/LGA	GUYUK	FUFORE
Home Based Records Distributed <sup>2</sup> (Clinic Master cards being computerized in the project office and will provide data on exact no. of WRA and C<3)	HBR	HBR
Village Health Workers Trained & Equipped <sup>3</sup>	107	107
Antenatal Referrals to date	No Record	No Record
ORT Corners Established with VHWS/TBAs	Not done	Not done
Routine monthly statistics from Health Facilities, VHW, and NGO services.	Not collected	Not collected
Home Visits Conducted	Not recorded	Not recorded
PHC Facility Staff trained	72	
PHC Senior Facility staff trained	44	48
LGA Council members and LGA Directors trained	72	
Management training for Senior PHC staff.	44	45
Senior TBAs trained	14	
Personnel trained on MIS	15	14

<sup>2</sup> HBR = Total Home Based Records Distributed  
WRA = Women of Reproductive Age  
C<3 = Child Under Three Years of Age

<sup>3</sup> Equipped with register books, record forms, EPI schedule chart, pens, etc. Note that LGA provides DRF.

As shown in Table 2, major project outputs include: placement of home-based records; and trained community and LGA level staff. Other major project outputs have either not been carried out or no data on them is yet available.

TABLE 3: SELECTED OUTCOME INDICATORS FOR GUYUK AND FUFURE

OUTCOME/LGA	GUYUK	FUFURE
New Antenatal Home Visits (VHWS)	NYA	NYA
F.P. Method Acceptors (VHWS)	NYA	NYA
Antenatal Referrals (VHWS)	NYA	NYA
Clients Seen for Tracer Diseases (VHWS)	NYA	NYA
Clients Referred by VHWS	NYA	NYA
Children <1 yr. vaccinated for measles	NYA	NYA

(Not yet available = NYA)

Table 3 reveals that no data is yet available on any of the project outcome indicators.

### C. Multi-level capacity-building strategy

The overall strategy of the project is to strengthen the management, technical and outreach capabilities of the LGAs in the two intervention areas to carry out PHC programs. More specifically, the project aims: to increase the LGAs commitment to PHC and their capacity to implement PHC programs; to strengthen the skills of health facility health workers, specifically related to the 7 priority CS/MH interventions; to strengthen community level committees responsible for promoting health; to create a cadre of community volunteers who collaborate with health facility workers in the promotion of PHC; and to promote changes in knowledge and practices related to child survival and maternal health (C/MH) at the household level.

In the course of the evaluation different facets of project-supported activities at each of these levels were investigated. The findings are summarized here but are dealt with in more detail in Appendix D.

#### 1. Building LGA commitment and capacity in PHC

Given the fact that PHC programs in Adamawa State are reported to be less developed than in most other states, the goal of the project requires first, building commitment to PHC within the LGA leadership and secondly, building capacity amongst PHC staff located both at the LGA headquarters and within the LGA districts.

LGA support for project activities has generally been less than anticipated. In the accord signed with the SMOH it is stipulated that the LGAs are to provide counterpart funding for project activities including: accomodating project officers in the LGAs, accomodating other project staff during project activities in the LGAs; providing motorcycles and other vehicles and fuel to LGA/PHC staff to ensure their involvement in CS/MH activities; and printing PHC forms for the household-based records and M&E activities. LGAs have collaborated in providing: accommodation for project officers and accommodation for other project staff during project activities. In Fufore, the LGA contributed an old vehicle for project activities. In Guyuk the LGA repaired the 7 broken District Supervisor's motorcycles. In Fufore, 6 out of 7 of the District Supervisors have motorcycles although some are not

functioning. The PHC coordinator has recently promised to repair all motorcycles and purchase one additional one as well as to provide the supervisors with a monthly fuel allowance. Neither of the LGAs has funded the printing of the M&E forms.

LGA/PHC staff and project staff feel that more pressure should be applied both by VDCs/DDCs and by project managers to comply with LGA counterpart funding. It is suggested that the AFRICARE Country Representative should bring this issue to the attention of the state government.

The effectiveness of the project's support to the LGA, to build both commitment and capacity depends, to a great extent, on the development of a collaborative and ongoing relationship with both LGA officials and with the PHC technical staff. While project staff state that they have made considerable efforts to develop such a relationship, based on observations and discussions with staff in both LGAs, it appears that the relationship with both LGAs is very weak. It is recognized that in this regard, changes in LGA leadership, both at the level of the Chairman and PHC Coordinator, have constituted a constraint.

In spite of the constraints, it appears that the approach used in working with the LGA has not been very effective as illustrated by several examples. Regular coordination meetings between project staff and PHC staff are not scheduled. LGA staff state that project-supported activities are often planned at the last moment sometimes resulting in confusion and inadequate organization.

Given the project's aim of supporting LGA capacity, as difficult as it may be, it is essential that there be a consensus on the part of LGA staff regarding the appropriateness of all project activities and that such activities be carried out through the LGA. One example of a strategy implemented by the project for which the LGAs were not in full agreement was the placement of senior midwives in the intervention districts in the two LGAs. In a strategy intended to bolster the quality of MH services in the intervention districts, the project obtained support from the SMOH to post and pay salaries for 14 senior midwives. 7 are already at their posts and the SMOH has promised that 7 more will be posted in the coming months. These midwives report to the project but not to the LGA authorities. While this strategy appears to be efficient in terms of getting more MH/OBs skills out into the districts, from the perspective of institutional collaboration it is not very appropriate. The project manager stated that the LGA authorities "were not happy with the project's decision to place that midwives in the districts."

A very positive development in the project, in terms of reinforcing collaboration with the LGAs, is the posting, in June 1995, of two AFRICARE Program Officers to the PHC Unit at the LGA level, one in each of the LGAs. This should contribute to increased collaboration and coordination.

The primary mechanism developed to date for strengthening the capacity of LGA staff to plan and implement PHC programs has been training. Because of a number of constraints on the project and the need to carry out a number of training activities in a relatively short period of time, the quality of the training conducted was generally less than desired. It appears that pre-training planning was not sufficient (e.g. not based on task analysis) and that much of the teaching was based on traditional, lecture methods. From the available training documents and discussions with LGA staff, it is unclear whether the training received has been directly applicable to their jobs.

In conclusion, the extent to which the project has increased LGA commitment and capacity to implement PHC programs appears to be quite limited to the present time.

## 2. Reinforcing health facility health workers' skills

Within the two LGAs, the project aims to strengthen the knowledge and skills of health facility health workers to carry out PHC activities both at the health facility level and in the community. The mechanisms for accomplishing this are primarily training and follow-up supervision. In addition, Quality Assurance activities are being undertaken by the project.

Some of the planned training activities for health facility staff have been carried out, including one workshop on "Training of Trainers" and another on "Management and Mobilization." However, the quality of the training carried out, as mentioned above, appears to have suffered from: inadequate workshop planning based on a systematic analysis of the tasks expected of participants following training; failure to define specific learning objectives based on the preceding analysis; and the use of primarily traditional, lecture methods rather than participatory individual and group learning activities.

Following training, there should be follow-up supervision of health workers to ensure that the skills they were taught are correctly being used. The evaluation revealed that supervision of PHC activities is presently done in a sporadic and informal way. In other words, there is not yet a mechanism, either in the project or in the LGA/PHC Dept., for systematically monitoring and reinforcing knowledge and skills addressed in training.

In the context of the project, a Quality Assurance (QA) component has been developed in an attempt to improve the quality of health services being provided. The idea of the QA activities is to carry out small studies on different aspects of service delivery in order to identify weaknesses or problems in order to correct them. To date three QA activities have been carried out, namely, observations of CS and MH activities in clinics, and structured interviews with VHWs and TBAs on the different CS/MH interventions at the conclusion of their first and second training workshops. The results of both the observations and interviews are to be used to reinforce weak points in clinic services and in VHW and TBA knowledge. So far the results of the QA studies have not yet been distributed and discussed with PHC and health facility staff so that they can take the necessary action, where necessary, to improve PHC activities.

The basic training of most of the health workers in health facilities was in curative medicine and their training focused on providing curative and preventive services within health facilities. In the spirit of PHC, it is expected that health facility workers will work closely with community groups, particularly the VDCs, and with community volunteers, VHWs, TBAs and CBDs. In the PHC strategy, health facility workers need to be able to plan and carry on activities outside of the health facility, particularly with community groups. To the present time the project has not substantively addressed this aspect of the health facility workers' role and the necessary training and follow-up which will be required to help health workers assume a greater role in preventive services and in activities outside of the health facility.

## 3. Capacity-building of community organizations

One of the pillars of Primary Health Care and of the CS/MH Project, is the participation of community organizations, with health workers, in promoting community health. In the national PHC guidelines it is specifically the Village Development Committees (VDCs) and the District Development Committees (DDCs) which are identified as the community organizations which are expected to catalyze community involvement in PHC activities.

One of the important strategies in the CS/MHP has been the establishment of VDCs, where they did not already exist, and strengthening existing VDCs and DDCs. In addition to helping establish VDCs, project staff have helped orient

them to their roles. Unfortunately, a number of problems are encountered related to the present level of functioning of the VDCs: 1) in some communities the VDC is either inactive or dead; 2) some VDCs do not have women members as stipulated in the PHC guidelines; 3) in many cases VDC members do not clearly understand their roles and responsibilities; 4) in most cases there is little collaboration between VDCs and health facility workers; 5) it appears that in no case are VDCs yet involved in monitoring the activities of the VHWs/TBAs/CBDs

While there is a consensus on the part of all project and LGA/PHC staff that the VDCs and DDCs must be "mobilized" to assume an important role in PHC, a clear and common concept of "mobilization" does not exist nor are there guidelines or steps regarding how such mobilization should be carried out. The lack of clarity in this regard is believed to contribute to many of the weaknesses observed in the VDCs/DDCs.

The PHC concept is that health workers establish collaborative relationships with the VDCs in order to work together to identify and solve community health problems. This assumes that health workers have strong skills in "facilitating" rather than "directing" community activities in order to strengthen the capacity of community members and organizations to identify and solve problems themselves. In this regard, a constraint related to working with the VDCs/DDCs is that project and LGA/PHC staff, as well as health facility workers, do not appear to have adequate skills in non-directive, problem-solving approaches to working with community groups.

#### 4. Training and follow-up of community health workers

A key component of the project strategy involves the training of Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs). According to the DIP, "Through the VHW, child survival action messages will be brought to the doorsteps of women of reproductive age." While the use of community volunteers may seem quite simple and straightforward to some project staff, in fact, their effectiveness is dependent upon a series of variables at the project, LGA, health facility and community levels related to their selection, training, supervision and support by the community.

According to the DIP, the project is to train a total of 100 TBAs (50 in each LGA) and 150 VHWs (75 in each LGA). In a two-phase program of training, completed only in June, 1995, a total of 128 VHWs and 86 TBAs were trained. These numbers of approximately 20% less than planned.

Almost all of the VHWs are men (122/128) and almost all of the TBAs are women (84/86). Given the fact that the project CS/MH interventions primarily address women, it is unclear how effective male VHWs can be in the role of "advisor" to women in the community. Women interviewed did state that for topics such as family planning and women's health that they would feel more comfortable discussing with another woman and that most husbands would be more comfortable with this arrangement as well.

As regards the selection of VHWs and TBAs, in most cases they appear to have been chosen according to the established criteria. In some cases, however, problems were identified related to the selection process. In a few cases the choice of people to be trained was made by the DDC itself rather than by VDC and community members; in some cases those selected did not meet the defined criteria; and in a few cases, communities did not select individuals to be trained or selected them too late.

Interviews conducted from the community to LGA level suggest that the role of the VHWs and TBAs is not sufficiently clear either to the VHWs/TBAs themselves or to others. Neither the VDCs nor the health facility workers clearly understand the roles and limitations of the VHWs/TBAs. Also, neither VDC

members nor health facility staff understand their own responsibilities for supervising the VHWS/TBAs. In a few cases, VHWS and TBAs express the desire to carry out activities beyond their scope of work, for example, "giving injections to stop bleeding," and "giving chloroquine injections." Although national PHC guidelines on the roles of VHWS/TBAs exist, the trainees do not have copies of them.

Some of the VHWS/TBAs interviewed said that their training was adequate while others said they wish to receive more training. It is impossible to judge the skill levels of the VHWS/TBAs because no skill assessment has been carried out since they were trained. At the conclusion of their training, all VHWS and TBAs were interviewed to assess their knowledge on the different PHC interventions. Unfortunately, the analysis of the interviews has not yet been completed.

It appears that the level of knowledge and skills varies considerably from one VHW/TBA to another and the follow-up on-the-job training which is planned will be of utmost importance in reinforcing the initial training received.

Following their training, all TBAs received scales and kits containing the basic materials prescribed by the SMOH. As for the VHWS, not all have yet received their kits and due to this fact some had not yet started their PHC activities at the time of the evaluation.

The VHW/TBA training was completed only in late June. Very little supervision of their work has been carried out to date. For this reason it is not possible to determine whether they are carrying out their tasks correctly or not.

From discussions with VHWS and TBAs and from an analysis of the reports of their training it is appears that their approach to working at the household and community level is often based on a "directive" approach as opposed to a "problem-solving" one. Several VHWS interviewed talking about visiting homes "to inspect" to determine whether or not families are "keeping their courtyards clean" or "bathing correctly." In the attempt to promote household behaviour change related to CS/MH directive approaches are generally less effective than problem-solving ones.

##### 5. Improving household level knowledge and practices

For each of the 7 CS/MH intervention areas, project objectives involve promoting changes in knowledge and practices at the household level. The main mechanism in the project for bringing about these changes is health and nutrition education with mothers through home visits, educational sessions at the health facility level and educational activities at the community level, through community groups or during community events. Due to the constraints and delays in project implementation, it is too early to definitively assess the impact which health/nutrition education activities have had on mothers.

At the health facility level, no training or other support has yet been provided to health facility staff in terms of health education methods or materials. In adult education it is known that in order to learn clients need to be actively involved in analyzing their own situations and problems and in assessing alternative solutions. The evaluation revealed, however, that most health workers use directive, message-passing approaches to conducting individual and group education sessions. Hence, the impact of such activates is questionable.

At the household level, the effectiveness of home visits during which child and maternal health situations and problems can be discussed and advice given is difficult to determine. At present, health facility workers are minimally involved in home visiting. The VHWS and TBAs, who are supposed to regularly

conduct home visits have barely begun their activities so the impact of their visits cannot yet be determined.

To date, almost all educational activities have been carried out with mothers. At the household level, however, mothers do not autonomously make decisions regarding preventive and curative practices related to either themselves or their children, e.g. the decision to evacuate a woman during labor to a secondary health facility, the choice of treatment in the case of infant diarrhea. Others in the household setting are involved in making such decisions and in providing resources to implement decisions made, namely men and older women. It appears that few educational activities are being oriented at these other household actors.

#### B. Mid-term assessment of mothers' KAP

The mid-term evaluation primarily consisted of qualitative data collection on the implementation of project-supported activities. However, in order to estimate the effectiveness of those activities in bringing about changes in mothers' knowledge and practices, data was collected on a limited number of the indicators included in the baseline KAP survey in the two intervention LGAs.

A questionnaire composed of 16 of the questions from the baseline survey was administered to a sample of 233 mothers, 133 in Guyuk and 100 mothers in Fufore LGA. Due to the fact that the sample was not randomly chosen the reliability of the findings cannot be ensured. However, it is believed that the data do allow us to roughly compare baseline and mid-term results on the same KAP questions/indicators.

On some of the KAP indicators assessed, it appears that positive changes have come about particularly related to breastfeeding and prenatal care. On the other hand, some of the findings suggest that undesirable changes have occurred, particularly related to diarrheal disease management. (Findings on the mid-term survey are in Appendix C.)

Breastfeeding: In both LGAs there appears to be small increases both in the percentage of mothers currently breastfeeding and in mothers' intended length of breastfeeding. On the other hand, only about one-half of the mothers in both LGAs know the benefits of breastfeeding.

Growth monitoring: The findings regarding growth monitoring are unclear. There appears to be a significant increase in the number of children who have growth monitoring cards in both LGAs. However, there has been a significant decrease in the percentage of children weighed in the preceding four months. There is no clear explanation for this apparent discrepancy.

Management of diarrheal disease: The findings regarding home management of diarrhea are not encouraging. Only 20% of the mothers know that they should increase breastfeeding during diarrhea. Only a small minority (13% and 5%) know that fluid intake should be increased during bouts of diarrhea, and very few (4% and 5%) know that mothers should try to increase semi-solid food intake. In both LGAs mothers' understanding of the importance of giving more liquids and more semi-solid foods appears to have slightly decreased. Mothers' knowledge of the preparation and administration of SSS has appreciably increased. This can be explained by the fact that the advice given by both health workers and VHWS/TEAs focuses more on giving SSS than on giving more fluids, semi-solid foods or breast milk.

Immunization: The number of children who have immunization cards has increased according to the mid-term survey data, in Guyuk from 42%- 88% and in Fufore from 34%-65%. This finding is difficult to explain given the fact that with

the vaccine shortage the past months a decreased number of vaccination sessions have been held.

Prenatal consultations: In both LGAs there appears to be a significant increase in the number of women who possess a properly completed maternal health card, and an increase in the number of women who have received the Tetanus Toxoid vaccine during their pregnancy. The reported increase in TT vaccinations is inconsistent with the fact that there has been a general shortage of the TT vaccine the past months.

Child spacing/family planning: The number of women/couples currently using a child spacing method remains very low.

Malaria control: There appears to have been a decrease in the use of anti-malarial drugs in both LGAs. This may be due to the economic crunch as drugs have become more costly. The interviewers postulated that this may be due to the recent increases in the price of drugs. The use of mosquito nets remains very low (7% and 15%) but there appears to be an increase in the use of mosquito coils in both LGAs.

## D. Strengthening Child Survival & Maternal Health Interventions

During the evaluation, each of the seven child survival/maternal health (CS/MH) interventions was examined in terms of the activities carried out and the strengths and weaknesses of each. A summary of the findings on each intervention is included here. The table in Appendix D. includes the detailed findings.

### 1. Immunizations

One of the project objectives is to increase immunization coverage of children (0-11 months) and of pregnant women. The project is not designed to directly deliver immunization services, but rather to support the LGA immunization program through education and mobilization of communities to attend both fixed facility and outreach vaccination sessions. The main project mechanism to support such activities is the training of LGA/PHC staff and of VHWS/TBAs. Refresher training on immunizations was provided to LGA/PHC staff in three training workshops organized by the project, between September 1994 and June 1995, which addressed various PHC topics. In the VHW/TBA training, participants were given basic information on the different vaccines and the vaccination schedule to enable them to advise mothers during home visits and in the community at large. The training provided to both PHC staff and VHWS/TBAs needs to be followed-up with periodic supervision for which a carefully defined system does not yet exist.

There are a number of problems associated with the supply and distribution of vaccines. The main problem is that since the project started, there have been periodic shortages of all vaccines at the LGA level due to the fact that they are not regularly received from the SMOH. The prediction is that in the coming months vaccines may become even scarcer because of a general shortage at the national level.

In addition to this problem other significant problems include: the absence of a reliable and regular means of transport of vaccines from the SMOH/Yola to the LGA; problems with transport of vaccines from the LGA to the health facility level; problems maintaining the cold chain from the LGA to the health facility level due to inadequate generators and cold boxes; lack of prescribed sterilization practices in some cases; limited outreach vaccination services for communities which do not have easy access to health facilities; severe transport problems in the rainy season; and limited supervision of immunization activities at health facility level by the District PHC supervisors.

Another problem is poor attendance at vaccination sessions in some communities. Health workers interviewed suggested that health education on the importance of vaccinations should be done with community members, including men, to increase understanding of immunizations and attendance at vaccination sessions. It appears that due to project-encouraged health education efforts in certain areas, particularly in the Muslim areas in Fufore, both community attitudes toward immunization and attendance at immunization sessions have improved.

Many of the problems associated with immunization services in the two LGAs cannot be solved by the project alone but depend on the commitment and resources from the LGA, SMOH and even FMOH levels. Therefore, the ability of the project to accomplish its objectives related to vaccination coverage is determined to a great extent by factors which it can try to influence but which it cannot directly control.

### 2. Control of diarrheal disease

The project's CDD component consists primarily of outreach activities by VHWS

who are expected to teach mothers about the importance of ORT for children during diarrhea. In addition, health facility staff are to be trained to effectively manage diarrheal disease and educate mothers.

In both VHW/TBA and health worker training CDD was addressed. No data is yet available on the CDD knowledge and skill levels of either of these categories of health workers. Periodic supervision of both levels of health workers will be important to assess and continuously reinforce CDD knowledge and skills.

As regards the educational activities being carried out by the VHWS/TBAs, some but not all of them have started doing home visits and advising families on management of diarrhea. According to both the VHWS/TBAs and mothers interviewed, the main advice being given is to "give SSS." It appears that VHWS are not sufficiently emphasizing the importance of giving more fluids, more feeding and continued breast-feeding.

Health workers interviewed said that they counsel mothers individually and give health talks at the health facility on preparation and use of SSS. It appears that they too give insufficient attention to the importance of giving more fluids, more feeding and continued breast-feeding. Health workers did not mention that they carry out any health education sessions on diarrhea outside of the clinic.

The tendency to focus on SSS and to neglect the importance of giving liquids, food and breast-feeding is reflected in the results of the mid-term survey in which very few mothers in the two LGAs (13% and 5%) stated that it is important to give more liquids during diarrhea whereas half of the mothers (58% and 53%) stated that it is important to give SSS.

The educational activities being carried out both by facility health workers and VHWS/TBAs are conducted almost exclusively with mothers of young children. Fathers are very rarely involved in health education activities related to CDD or other topics.

### 3. Malaria Control:

The project activities intended to promote malaria control are essentially the same as those related to CDD with the VHWS/TBAs and health facility workers, i.e. educational activities in and outside of the clinics.

Both the VHWS and TBAs have received some training on the treatment of malaria and both are expected to distribute chloroquine and paracetamol which is included in their health worker kits. There is no information available on their level of knowledge and skill in diagnosing and prescribing treatment for malaria and it is important that through supervision a mechanism be established to periodically test their knowledge and skills and to reinforce where necessary. The VHWS/TBAs who have received their kits are treating malaria with the drugs during home visits. The VHWS/TBAs are supposed to replenish their drugs themselves at the LGA level. As they are just initiating their activities, it is too early to know whether this system is viable or not but already it appears that transport to the LGA is a problem for the VHWS/TBAs. The drug supply set-up needs to be followed up to determine whether or not the planned system will be satisfactory.

Those health workers who have participated in the project-supported training activities have received refresher training on malaria as well. Health workers report that at the clinic level they conduct educational sessions with women on sanitary measures to control malaria. Men are rarely included in these sessions. It does not appear that the discussions on sanitary measures in the clinic are linked to actions outside of the clinic.

Supervision data is needed on both VHW/TBA and health worker activities related to malaria in order to determine the extent and effectiveness of their activities in promoting preventive and treatment practices related to malaria.

#### 4. Improved infant feeding practices and infant nutrition

Project objectives related to infant nutrition consist of promoting exclusive breastfeeding, good weaning practices and regular growth monitoring. According to the DIP, the main project-supported strategy to address these objectives consists of training VHWS/TBAs to enable them to carry out community outreach activities, e.g. with women's groups and local organizations, and home visits during which they advise mothers on improved nutritional practices. The secondary strategy involves training health facility staff to conduct baby weighing and to educate mothers on optimal breastfeeding and weaning practices.

As stated above, the VHWS/TBAs have just started their outreach activities and hence, it is too early to determine if and how effectively they are promoting infant nutrition. Baby weighing and nutrition education were addressed in the VHW training, however, the training received was relatively short. The anticipated supervision and quarterly in-service training will be very important to ensure that the nutritional advice they are giving is accurate and that they have adequate interpersonal communication skills to dialogue with mothers rather than to merely tell them what to do. As regard this last point, based on the report of the VHW training it does not appear that much attention was given to participatory educational methods or to basic adult education principles which VHWS should have an understanding of.

As regards baby weighing by the VHWS/TBAs, all who have received their kits have received their scales and many report that they are weighing babies during home visits. Regarding their skills in baby weighing, during the evaluation the majority of VHWS/TBAs interviewed were able to correctly weigh and plot. It appears that the VHWS are starting to counsel mothers and to refer underweight babies to health facilities. It is anticipated that the VHWS will work closely with health facility staff to ensure tracking of malnourished children. However, discussions with both VHWS and health facility workers revealed that there is not yet a well-defined system in place in which VHWS and health facility workers work together to follow-up on such children. Such a system should include keeping a register and providing counseling and ongoing house visits to target children.

Regarding the baby weighing in the health centers data from the Quality Assurance (QA) survey conducted in June 1995, the results indicate that in both LGAs the majority of the health workers do not correctly weigh and plot babies' weights. Since June, Project Officers have been working on this issue with health facility workers. All health facilities are reported to have functioning weighing scales.

Health workers state that although they try to teach mothers to read the growth cards, however, few mothers can accurately interpret their child's card. Most mothers want to have their babies weighed in order to know if they are growing properly. During the group interviews very few mothers were able to interpret the growth card.

Health facility workers state that they systematically provide mothers with nutritional advice following baby weighing. It appears that in most cases locally available foods are recommended to mothers when their babies' weight is faltering. Many health workers also state that they teach mothers the importance of choosing foods from the three food groups. Mothers say that often they can put the advice into practice though sometimes they do not have the resources to do so. Some say that their husbands play a role in providing recommended foods. It is difficult to assess the quality of the nutritional

advice being given to mothers and this would appear to be an important topic for the QA team to investigate.

The main nutrition and education activities at the health facility level are health talks and there is also some use of demonstrations and posters. In a few cases, songs are used while stories and small group discussions are not used at all. A constraint identified with such sessions is that the approach used mainly involves "message passing" with little use of "problem-solving" activities. An important observation is that health workers conduct nutrition education activities almost exclusively with women.

Some health workers do provide nutrition and health advice during home visits and others conduct educational sessions in schools but they rarely organize nutrition or health education sessions elsewhere outside of the health facilities with community groups or at community functions.

Topics addressed in nutrition and health education sessions mainly deal with child nutrition. Maternal nutrition and health which are supposed to be given prominence in the project are given much less attention according to mothers and health workers interviewed.

##### 5. Maternal health

The maternal health component of the project aims to support child spacing education, pre and post natal care, the identification of pregnant women at risk and where necessary referral to other facilities, tetanus toxoid vaccinations during pregnancy, malaria prophylaxis, good nutrition during pregnancy and lactation and deliveries assisted by trained persons.

The primary strategy for promoting maternal health is to strengthen the skills of health facility workers, through training and supervision to enable them to provide good quality pre and post natal services. In addition VHVs and TBAs are expected to counsel women on the benefits of ante-natal visits.

The QA study of prenatal services in the two LGAs, conducted earlier this year, revealed serious insufficiencies in the quality of services in many facilities due to: 1) inadequate skills of health workers related to the detection of risk factors; and 2) the lack of equipment essential for proper obstetrical care, e.g. urine testing apparatus, blood pressure apparatus and thermometers. In one of the LGAs, Guyuk, since the QA study some of these materials have been purchased.

Serious constraints related to the use of health centers for prenatals and deliveries are the absence of toilets, water and light at many of the facilities. Substandard hygienic conditions were observed in several facilities including at the maternity referral center in Guyuk where a huge colony of bats are living. This explains the presence of numerous droppings and an unbelievable and omnipresent stench in the clinic.

A critical component of obstetrical/maternal health services is a reliable strategy for evacuating women in emergencies related to pregnancy and childbirth. None of the VDCs or health facilities have developed such a strategy. All of the health workers and community members stated that in such cases the woman's family does its best to find a way to evacuate her. In the case of women from poor families, sometimes they are successfully evacuated and sometimes not. A major constraint related to the transport of women to referral centers is the bad condition of roads particularly during the rainy season.

Suggestions made by mothers, directed to the LGAs, to improve MH services include: road repair to facilitate evacuations; improved equipment in the health facilities; and the availability of drugs. The VDCs do not appear to

be involved in solving these problems in any of the communities.

The available information suggests that in most cases communities appreciate the services which the trained TBAs can provide. However, TBAs are not receiving any regular support from their communities. This may be related to the fact that the VDCs are not fully informed about their role with the TBAs and have not yet discussed their responsibility toward the TBAs.

In Guyuk, some Christian TBAs report that some Muslim families prohibit them from attending to Muslim women in labor. The possibility of training Muslim TBAs has been discussed with community leaders by project staff. This would appear to be a viable solution to this problem.

## 6. Child spacing

The project aims to increase both mothers knowledge of modern family planning methods and the number of women using such methods. Both VHWs/TBAs and health facility workers are to receive training and carry out child spacing education activities at the clinic and community levels. A constraint associated with the promotion of family planning methods is that at the present time, contraceptives are not available anywhere in Fufore and only at one clinic in Guyuk.

It does not appear that child spacing education activities are being carried out very extensively. At some health facilities health talks are sometimes given to mothers on child spacing. Men rarely participate in such health talks as they rarely come to the health facilities. VHWs and TBAs are supposed to be doing child spacing education during home visits. The extent to which they are carrying out these activities can only be determined once the supervision and PHC/MIS monitoring systems are functioning.

It is important that the development of child spacing educational activities or materials be based on an understanding of local socio-cultural factors related to this topic. In both LGAs indepth interviews were conducted on HIV/AIDs and child spacing in order to understand related socio-cultural factors. The information collected will be used to develop child spacing and HIV/AIDs education activities.

Theoretically, all of the VHWs and TBAs, men and women alike, should be advising women on child spacing methods during home visits. This expectation may not be realistic. During the community interviews most women expressed the feeling that for matters related to child spacing and maternal health they would feel more comfortable discussing these topics with another woman rather than with a man. Also they said that many of their husbands would feel more comfortable with them having a female advisor.

## 7. Water & Sanitation

Access to potable water and inadequate sanitation are major problems in the two LGAs. The CS/MH Project includes two objectives related to improving community water and sanitation related to the provision of potable water and to increased food production. To the present time, no project-supported activities have been carried out related to this project component with the exception of the posting in June 1995 of a Water & Sanitation Project Officer to the Fufore LGA.

### D. Integration of onchocerciasis control into child survival & maternal health activities

A special aspect of AFRICARE activities in Adamawa State is the integrated delivery of CS/MH and onchocerciasis control activities through collaborative

efforts between the CS/MH Project and the Oncho Control Project. The integrated activities are being carried out only in the oncho endemic areas.

The main feature of the integration of these activities at the community level is the provision of both CS/MH and oncho services, namely yearly distribution of ivermectin (mectizon), at the household level by the same community volunteers. The success of the integration stems from the enthusiasm of community members about the benefits of ivermectin which increased their interest in CS/MH activities.

In oncho endemic areas, community volunteers were trained to distribute ivermectin at the household level in Fufore starting in 1993 and in Guyuk beginning 1994. In 1995 all of the CBDs were also trained as VHWS.

One advantage of the integration of CS/MH and oncho activities is that planning for ivermectin distribution is facilitated by the common data base through which individuals requiring ivermectin are identified at the household level. Another advantage is that oncho and CS/MH health education is conducted during the same home visits by the same person. Another positive facet of the integration is that CBDs are being supervised by the CS/MH and Water/Sanitation Project Officers.

The available information suggests that the integration of the oncho and CS/MH activities has been beneficial from the community's perspective as well as from a managerial perspective.

#### E. Institution-building project-supported activities

The project is supporting several activities which are intended to strengthen the capacity of both LGA/PHC staff and health facility workers to carry out all of the CS/MH interventions. These are training, supervision and management information system activities.

##### 1. Training

Training of both health facility and community health workers (VHWS and TBAs) constitutes a major component of the project. The relevance and quality of the training provided will be a significant determinant of the extent to which trainees will later carry out the tasks expected of them. It appears that the quality of the training carried out has in some cases been weak.

Project staff were working under a number of constraints which made it difficult to ensure high quality training in all cases. A major constraint was that there was pressure on the project to carry out a series of training activities in a relatively short period of time as a result of USAID sanctions in 1994 on project activities in Nigeria. Another constraint was that frequent changes in leadership at the LGA level sometimes made it difficult to plan and organize training activities well in advance.

In the DIP it specifies that training activities should be based on adult learning principles, i.e. involving the use of primarily participatory learning methods. The main pedagogical methods used in the different training workshops, however, have been traditional lectures with limited use of group discussions, practicals, demonstrations and drama. In addition to the fact that the training carried out has not been based on adult learning principles and methods, several other constraints are identified related to the planning and implementation of training activities.

In some cases the size of learning groups during training was very large (for example, 72 or 107 persons). It is known that adults learn better when they

can actively participate in learning activities and this requires learning groups of 20-25 persons.

Interviewees at the LGA level said that in some cases training events were not planned ahead of time nor well organized. According to project staff problems were often encountered in coordinating the timely planning of training activities with LGA staff.

The planning and facilitation of past training activities has been the responsibility of project staff in collaboration with outside consultants and LGA/PHC staff. Some LGA PHC staff feel that they have not been sufficiently involved in the planning and facilitation of training activities.

Based on the reports of the training activities, in some cases specific training objectives, based on an analysis of the tasks trainees are expected to carry out after training were not defined. It also appears that in some cases the content presented in training sessions was too complicated for some participants, particularly the low-literate or illiterate VHWS and TBAs.

## 2. Supervision

In this project, as in the LGA/PHC program in general, periodic supervision of health facility staff and of community volunteers is of critical importance in order to identify weaknesses in PHC knowledge and skills and to reinforce concepts and skills taught in training.

According to project staff, supervisory/on-the-job training visits to District PHC Supervisors, health facility staff and VHWS/TBAs/CBDs will ensure that skills taught during training sessions are reinforced. While there is agreement both amongst project and LGA staff that such follow-up supervision is necessary, given the limited resources of the LGA they are only able to carry out a very limited number of supervisory visits. The project does not yet have a well-defined plan for systematic and periodic on-the-job training.

While the national PHC guidelines spell out the roles and responsibilities for supervision from the LGA to community level, few of the persons responsible for supervision at the different levels, namely LGA, District and health facility staff, have copies of the guidelines on their respective roles and responsibilities. The result of this is that supervisory roles are not clear to all parties. Neither do the appropriate people have copies of the supervisory checklists prepared by the SMOH for each level of supervision. At the community level, the VDCs do not understand their role in supervising the VHWS/TBAs/CBDs.

At the LGA level, supervision by PHC staff is being conducted on a sporadic basis due in part to various constraints associated with transport including rough roads, inadequate vehicles, insufficient fuel and lack of a maintenance system for the existing vehicles. Due to this and other constraints, in some cases supervision is not being carried out at all, while in others it is being done sporadically. In only a few cases is regular supervision being ensured by facility health workers.

As a supervisory and follow-up tool, qualitative information on program activities can provide insights into how activities are being implemented, their strengths and weaknesses and lessons learned. The only qualitative information presently being collected is that included in monthly reports sent from health facilities to LGAs and in minutes of district PHC meetings. It is unclear if or how this information is being used at the LGA level.

## 3. Management Information System (MIS)

A very important component of the CS/MH Project is the PHC Monitoring and

Evaluation System in which both community and clinic data are to be collected. The project-supported MIS activities are based on the PHC Monitoring and Evaluation (M&E) format defined by the FMOH. Community data collection is based on both PHC records kept at the household level and by VHWS/TBAs/CBDs, and records of PHC activities in the health facilities.

The MIS component of the project is very weak insofar as the system is not yet fully operational, i.e. from data collection to data analysis and use. Unfortunately, both the training and follow-up required to make the monitoring and evaluation system functional have been carried out to a very limited extent. The same constraints that have contributed to delays in other project components have had an impact on the development of the MIS. In addition, it was anticipated that an MIS Project Officer would be recruited. This position has not been filled and hence, no one has full-time and ongoing responsibility for planning and coordinating MIS activities.

In both LGAs, the baseline surveys on mothers' KAP were completed. At the health facility level, the clinic master cards have been placed in the 2 intervention districts only in Guyuk. No MIS training has been conducted in either Guyuk or Fufore at the health facility level.

At the community level, the M & E Record of Work of VHWS has just been distributed to all VHWS and TBAs. The community volunteers were taught how to complete the form during their basic training. The use of household records has not commenced. The VHWS/TBAs/CBDs have just begun to collect the PHC data so it is too early to fully assess how accurately they are collecting it. It appears, however, that they are not yet either sharing it with health facility staff or VDCs, nor using it in any other way.

The information collected in the MIS should be used to both evaluate past activities and plan future activities. Due to the various constraints, the MIS training has not yet been carried out and hence, PHC data is neither being collected nor analyzed. The absence of any MIS information at present constitutes a severe constraint to rational planning and evaluation. There are plans to conduct this important MIS training in the coming months. Given the fact that MIS activities have not been given great importance in the past and that PHC and facility staff tend to find "statistics" difficult, it will be extremely important that the planning and facilitation of the MIS training be well done and that there be regular supervision of LGA staff on an ongoing basis. While the MIS Project Officer, if recruited, will have an important role to play in such supervision, all Project Officers should be qualified to ensure supervision and follow-up of the MIS activities during their routine field visits.

#### F. Project staff and management

##### 1. Project staff

##### 1.1 Technical staff

The technical project staff include the Project Manager, expatriate Project Advisor and five Project Officers, two posted to the LGAs and three responsible for the different CS/MH intervention areas. The experience and skill levels of the project staff vary but all appear to be highly motivated and there appears to be good communication between them.

Two important weaknesses in project staffing are identified. As mentioned above, an MIS Project Officer has not been recruited and this has significantly contributed to the weaknesses in the MIS component. A second weakness related to staffing, is the absence of someone on the project team who has solid training and experience in adult education, community development, and nonformal education approaches to health education. All

project staff have clinical health training and some training in community health/public health. However, given the fact that the majority of the project activities involve training, supervision, working with community volunteers VDCs and health education, the absence of someone on the team with Masters Level training in these areas constitutes a serious weakness and certainly explains many of the weaknesses in project activities carried out to date.

There is an urgent need for the project to recruit both an MIS Project Officer and a Project Officer responsible for Training and Health Education. It is not necessary, and may be advantageous, that the Training/Health Education Officer have a clinical health background.

### 1.2 Support staff and services

According to the project technical staff, the administration-finance and secretarial services provided by project staff in the Yola office are adequate. However, they state that there is urgent need for a photocopier, a FAX modem and additional printer, preferably a laser printer, to make office activities more efficient. The office is currently using a laser printer which belongs to the Project Advisor.

The project currently has only one 4-wheel drive vehicle and it is in good shape. The project also uses 3 vehicles purchased for the Oncho Project. However, none of the 3 is adequate to withstand the rugged terrain in the two LGAs. An additional old vehicle was contributed to the project by Fufore LGA which the project has refurbished. Due to the speedy rhythm of project activities in the two LGAs the Project Manager feels that an additional 4-wheel drive vehicle is necessary.

### 1.3 Communication with AFRICARE Lagos

According to project staff, there is frequent telephone contact and exchange of memos between the offices in Yola and Lagos which allows for a good flow of information and materials between the two offices. Courier services are used to send mail but such mail is not always promptly delivered in Yola.

As regards the transfer of funds between Lagos and Yola the present arrangement is unsatisfactory whereby large amounts of cash must be hand carried or sent as bank transfers which take a long time to clear or are heavily taxed by the bank. In some instances, implementation of project activities have been seriously jeopardized because sufficient funds were not available. A better mechanism for the transfer of funds would help decrease delays in the implementation of project activities.

## 2. Project Management and coordination

### 2.1 Planning

The steps in the project planning process used by AFRICARE involve: 1) initial discussions based upon the project detailed implementation plan (DIP) between the project manger, project advisor and AFRICARE accountant; and 2) discussions with SMOH and LGA level collaborators. According to the Project Manager, serious constraints associated with the political crisis and sanctions on project activities required the use of a more directive planning process than would have ideally been desired. Some LGA staff interviewed stated that they have not been sufficiently involved in the planning process.

The community organization that should be intimately involved in planning PHC activities at that level is the VDC. To the present, most VDCs are not functioning effectively enough to ensure continuous community involvement in planning such activities.

The systematic and timely planning of project activities needs to be strengthened at all levels. Given the institution-building nature of the project, project management needs to ensure that key project collaborators are involved in activity planning as much as possible.

## 2.2 Coordination of project staff

Regular monthly management meetings are held between the CS/MH Project Manager, Project Advisor and Oncho Project Manager to discuss issues related to both the CS/MH and Oncho projects but CS/MH Project Officers are not included in these meetings. Although regular coordination meetings are not scheduled with project officers, meetings are held when specific activities in the DIP are to be carried out.

Some of the project staff interviewed feel that project meetings are not always useful because sometimes the deliberations are not followed up. The project manager feels that this observation is incorrect because it is impossible for any organization to follow up all suggestions.

Project staff stated that they should be involved at the planning stage and at the implementation stage. The project manager feels that they have been involved but they could possibly be more involved.

## 2.3 Communication and collaboration with the LGAs and NGOs

It appears that communication and collaboration between the project and the LGAs is not as strong as it could be. According to some LGA staff, communication between project staff and themselves is weak. Regular coordination meetings are not held, in some cases they are given very short notice for activities to be implemented.

AFRICARE has made considerable efforts to establish strong collaborative relationships with numerous local and international NGOs. NGO collaborators include 31 local NGOs involved in HIV/AIDs education, UNICEF, VSO, The Christian Health Association of Nigeria (CHAN) and the Lutheran Church of Christ Nigeria (LCCN). Considerable assistance has been received from the NGOs to supplement both financial and human resources provided for by the USAID funding.

## G. Sustainability of project-supported PHC activities:

The fundamental goal of the CS/MH Project is to provide assistance to the LGA in order to increase the LGA's capacity to implement PHC programs on its own in the future. The multi-level capacity building strategy reviewed in Section III B. of this report describes the different project-supported activities which all aim to contribute to sustained PHC programs in the LGAs.

The basic project design is sound in terms of the potential for the project-supported activities to contribute to sustained CS/MH programs and practices in the LGAs. However, the evaluation identified major weaknesses at all five levels of the strategy related to: 1) LGA commitment and LGA/PHC staff skills; 2) health facility workers' knowledge and skills related to CS/MH; 3) the capacity of community organizations, namely the DDCs and VDCs to promote PHC at their level in collaboration with health facility workers and community health volunteers; 4) the training and follow-up of the VHWS, TBAs and CBDs; and 5) household level knowledge and practices related to CS/MH,.

Until actions are taken to overcome the major shortcomings at each of these levels, the sustainability of the project-supported CS/MH activities is highly unlikely. In Section IV. the main actions required to strengthen the project strategy at each of the five levels are summarized.

#### H. Use of technical support:

The project has received technical support from both AFRICARE staff and external consultants in a number of areas, particularly related to training, MIS, quality assurance and HIV/AIDS activities.

External consultants were contracted to assist with: the baseline project survey; the various training workshops related to primary health care, management of PHC, community mobilization, training of trainers and HIV/AIDS proposal writing for other NGOs; and with a study of quality assurance at health facilities in the two LGAs. In a few cases international consultants were used. In most cases, however, local consulting firms or individuals were contracted.

Two technical assistance consultancies were provided by AFRICARE/Lagos MIS specialist, Tom Ubuane, for the training of AFRICARE staff in on the project MIS. Technical assistance/backstopping visits have been provided by staff from AFRICARE/Washington related to overall project management.

#### IV. SUMMARY OF LESSONS LEARNED

In the participatory methodology, for each of the evaluation findings the evaluation team developed a lesson learned for application in the future. The complete list of lessons learned are found in Appendix D. A summary of the lessons is included here.

LGA commitment and capacity to implement PHC programs: The extent to which the project has increased LGA commitment and capacity to implement PHC programs appears to be quite limited to the present time. The effectiveness of project support to the LGAs, to build both commitment and capacity depends, to a great extent, on the development of a collaborative and ongoing relationship with both LGA leadership and with the technical PHC staff. It appears that the approach used in working with the LGA has not been very effective and there is serious need to reassess the approach and define a more effective one based on more frequent and open communication.

Reinforcing health workers' knowledge and skills related to CS/MH: It is unclear at present how effective the project has been in reinforcing health workers' knowledge and skills. The main mechanism used to strengthen the capacity of LGA staff to plan and implement PHC programs has been training, however, the quality of the training conducted has been less than desired. Specific recommendations were made by the evaluation team to improve the effectiveness of training. The need to systematize the supervision scheme is also critical to increasing the effectiveness of the activities of facility health workers.

Village Development Committees (VDCs) and District Development Committees (DDCs): Given the key role which the VDCs and DDCs are expected to play in the PHC activities which the project is supporting, increased and continuous efforts need to be made to strengthen their capacity to assume their intended role.

In order to strengthen the effectiveness of the VDCs/DDCs a number of actions should be taken: the LGA/PHC Dept should develop and maintain a roster on all VDCs and DDCs; the LGA/PHC Dept. should ensure that all DDCs and VDCs have women members as stipulated in PHC guidelines; the LGA/PHC Dept must ensure that all DDCs and VDCs have copies of the written guidelines on their roles in PHC and that they are thoroughly discussed with them to ensure their understanding; there needs to be continuous health education sessions and discussions on CS/MH topics with each of the VDCs/DDCs; through the manual on community mobilization (discussed below) and training the skills of LGA/PHC

staff in participatory, adult education methods need to be strengthened to enable them to work in a facilitative fashion with the committees; there needs to be increased commitment on the part of PHC staff to ensure that the DDCs and VDCs meet regularly and that they are properly supervised; and LGA/PHC staff should educate the VDCs on the necessity to generate funds and discuss with them possible uses of such funds to promote PHC.

All of the above actions are necessary in order for the DDCs and VDCs to assume the role and responsibilities expected of them in promoting PHC in collaboration with health facility workers and community health workers.

Village Health Workers (VHWs, TBAs and oncho CBDs): The VHWs are to play a critical role in strengthening PHC activities at the community level, however, they are not yet fully playing the role expected of them. This is partly due to the fact that their training was completed only two months ago. To increase their effectiveness a number of actions need to be taken: the project should ensure that all VHWs, DDCs, DDCs and health workers clearly understand the roles and limitations of the VHWs/TBAs; all VDCs and DDCs should have women members as stipulated in national PHC guidelines; regular supervision needs to be ensured by health facility workers based on the National PHC guidelines; the VDCs should ensure that adequate and regular support, either in kind or cash, is given to the VHWs and TBAs to encourage them to perform their duties effectively; facility staff should be oriented on how to supervise and reinforce the VHWs' work; anticipated quarterly training of VHWs/TBAs should be carefully planned in order to overcome some of the shortcomings identified in past training events; regular meetings should be held between TBAs, VHWs, health facility staff and VDCs to develop a closer working relationship for the benefit of their communities; LGAs must ensure that drugs are made available at the LGA level; the DDC, VDCs and health facility staff should develop a system for replenishing drugs from the LGA level to the VHWs/TBAs; the LGAs, DDCs, VDCs, VHWs, TBAs and project staff should meet regularly to discuss and solve the problems of the VHWs/TBAs. If all of these actions are not taken, the effectiveness and longevity of the VHWs and TBAs will be jeopardized.

Community Mobilization for PHC: One element which is necessary for the success of PHC in both the short and long term is community mobilization and participation in promoting PHC. The evaluation revealed that the PHC staff responsible for community mobilization do not have a clear and common understanding of how to "mobilize" communities so that they can effectively assume the multi-faceted role that they are expected to play in PHC.

The project should develop a detailed manual on the steps in the community mobilization process based upon, but not limited to, the National PHC guidelines. The manual will be useful to LGA/PHC staff, District Health Supervisors, health workers at the facility level and project staff in establishing and strengthening the VDCs/DDCs, in working with the VHWs/TBAs/CBDs and in working with the community at large in developing community level PHC activities.

Immunizations: The immunization program in the LGAs depends on regular availability of vaccines at the health facility level. At present vaccines available on only an irregular basis. The following measures need to be taken by the LGAs to remediate this situation: work out modalities for regular supply of vaccines to avoid future shortages from the SMOH; provide additional cold chain equipment at the LGA and during transport; reinforce health workers' knowledge and skills on cold chain system procedures; improve sterilization of equipment at the health facility level; and reinforce logistics support to enable health facility staff to conduct outreach immunization sessions.

Given the uncertainties regarding the LGAs ability to ensure continuous

availability of vaccines, the project should also explore the possibilities of purchasing vaccines from a reliable private sector source and of putting in place a reliable cost recovering system.

Control of diarrheal disease: All health workers should counsel mothers individually and in groups not only on the use of SSS but they should put more emphasis on fluids intake, food and breastfeeding. They should also organize educational sessions on management of diarrhea outside the clinic and with fathers.

During supervision, District PHC Supervisors and health facility workers should emphasize to the VHWS the importance of encouraging mothers to give more fluids, to continue feeding and breastfeeding when their children have diarrhea. At present the health workers do not put enough emphasis on these three essential behaviors during diarrheal episodes.

Control of Malaria: Health facility workers should supervise the VHWS/TBAs on an ongoing basis to determine whether they are treating malaria correctly or not. They should effect corrections in VHWS/TBAs knowledge and skills where necessary.

Health workers should include men in educational sessions outside the clinic on sanitary measures to control malaria. Health workers should ensure that such discussions on prevention/control of malaria are followed up with actions at the household and community level.

Improved infant feeding practices and infant nutrition: To increase the effectiveness of baby weighing and nutrition education activities a number of actions need to be taken. Facility health workers should be retrained in correct baby weighing and plotting. Both health workers and VHWS/TBAs should draw up regular schedules for conducting baby weighing. VHWS and TBAs should counsel mothers on nutrition and refer underweight babies to health facilities for further management. The baby weighing skills of VHWS and TBAs need to be continuously reinforced to ensure that their work is accurate. Health workers should continue to explain to mothers how to interpret the existing growth monitoring cards but at the same time, alternative, simpler forms of recording baby weights appropriate to the needs of illiterate/low-literate mothers should be discussed and developed by the project with the LGAs. Health facility workers and VHWS/TBAs should advise parents whose children's weight is faltering on the use of locally-produced foods which families can afford. Nutrition education sessions should be organized for men. A system of tracking malnourished children at the health facility level should be developed by the health facility workers in collaboration with VHWS/TBAs. Project and LGA staff should encourage collaboration between Agricultural Extension Workers, VDCs and social workers to strengthen family nutrition/food security at the community level.

Health and nutrition education: Certain aspects of the health and nutrition education activities being carried out by VHWS/TBAs and health facility workers, related to the educational content and to the teaching methods used, were identified which should be reinforced to increase the impact of these activities. Health workers should be encouraged to use a variety of participatory learning methods in addition to traditional health talks, e.g. songs, stories, dramas. Methods used should primarily be based on "problem-solving" activities rather than on "message passing" activities. Problem-solving activities encourage community members to actively participate in finding solutions to their own problems. Nutrition /health activities should be carried out in a variety of settings with men and children as well as with women, e.g. in schools, at community festivals, in homes. Health workers need to give more attention to maternal nutrition and health in their educational sessions. The project should provide Health Workers with simple techniques to collect qualitative information from mothers on their practices and beliefs

relating to breast-feeding and to other CS/MH problems.

Maternal health: At the LGA level, greater support needs to be provided to promote improved maternal health services. The LGAs should provide essential equipment and supplies for proper obstetrical care and improved worker morale. The LGAs should increase the number of facilities where family planning services are provided. The quality of maternal care being provided by facility staff should continue to be monitored through regular supervision. Together the VDCs and Health Facility staff should develop a clearly defined strategy for evacuating mothers during pregnancy/childbirth. VDCs should be involved in monitoring the sanitary conditions in their health facilities to ensure that they are adequate e.g. toilets, extermination of bats.

All the VDCs/DDCs should have women members because "only women understand and can express the maternal health problems and needs of women." During DDC and VDC meetings health workers should discuss MH/OBs problems and needs so as to increase committee members understanding of the problems and commitment to solving them.

Traditional Birth Attendants: The LGAs should provide the VDCs with the PHC guidelines on the TBAs' activities and the need to support their work in the community. It is the responsibility of the VDCs to educate or enlighten the community on the activities of the TBAs.

Child spacing: Child spacing activities have not been given as much attention as expected and in the coming months more focus needs to be given to this component.

Health facility staff should be encouraged to carry out more child spacing education sessions with women but also with men through the VDCs/DDCs outside of the health facilities. Activities with men are extremely important to increase their understanding and support for child spacing. There is need to train LGA staff on both child spacing education and service provision. There is need for more family planning centres in the LGAs to increase the availability of FP services and commodities. In discussing topics related to child spacing it is more appropriate for women VHWs/TBAs to counsel other women and for male VHWs to counsel men. This is particularly true in Muslim communities.

The project should identify ways to increase child spacing activities with the funds and resources available.

Control of onchocerciasis: In oncho endemic areas, the integrated delivery of child survival and onchocerciasis control activities has been very advantageous because it has allowed for better planning and use of resources at both project and community levels. Communities' willingness to participate in CS/MH activities is enhanced by their satisfaction with ivermectin distribution.

Training: For future training activities, initial planning needs to be more carefully done to ensure greater participation of LGA/PHC collaborators and to ensure that the training content directly relates to trainees' tasks once they are trained. The development of the content for all workshops should be based on the identification of the knowledge and skills to be taught and specific learning objectives based on a "task analysis" of the tasks expected of trainees. In order to strengthen the quality of training workshops the project should also ensure that: the size of learning groups be limited to 25; and that training methods be based on adult education principles of participatory learning rather than on lecture methods.

Supervision: Actions should be taken at several levels to strengthen the system for monitoring and supervision of PHC activities: supervisory roles and tasks, according to national PHC guidelines, should be clarified for all

levels of health workers, community health workers and VDCs/DDCs; those responsible for supervision should receive copies of the existing checklists for supervision and if checklists do not exist guidelines should be drawn up; the LGAs should increase logistics support for the District Supervisors to enable them to carry out their supervisory functions; a simple mechanism for collecting qualitative information on the strengths and weaknesses of PHC program implementation should be developed and this information used in planning.

Management Information System (MIS): Given the fact that the MIS component of the project activities is not yet fully functional, several urgent actions should be taken: an MIS Project Officer should be recruited; project and LGA/PHC staff must be trained on the use of the PHC/MIS forms, analysis of data and use of data for activity planning; the revised M&E booklets should be made available to both LGAs; guidelines for monitoring/supervising use of the MIS should be developed and all Project Officers trained to ensure such monitoring.

Technical project staff: There is an urgent need for the project to recruit both an MIS Project Officer and a Project Officer responsible for Training and Health Education. The Training/Health Education Officer need not have a clinical health background.

Communication with AFRICARE Lagos: Delays in the transfer of funds between Lagos and Yola have in some cases contributed to delays in the implementation of project activities. A better mechanism for the transfer of funds should be identified possibly using Highland Bank.

Project Planning: The systematic and timely planning of project activities needs to be strengthened at all levels. Given the institution-building nature of the project, project management needs to ensure that key project collaborators at the LGA level are involved in the planning of all project-supported activities as much as possible.

Coordination of project staff: Regular meetings should be scheduled with Project Officers and with all project staff in order to strengthen communication and coordination of all project activities.

Communication and collaboration with the LGAs: One of the keys to the success of the project and the sustainability of project inputs to the LGA is close collaboration between project staff and the LGA, specifically but not only with LGA/PHC staff. In order to strengthen communication and collaboration between the project and the LGAs regular coordination meetings should be held with the LGA PHC Dept. and periodic meetings should be held with the LGA Chairman and Councilor for Health. In Fufore, the prospects for improving collaboration appear to have improved with the arrival of the new PHC Coordinator.

Collaboration with NGOs: Project collaboration with numerous NGOs should continue and be increased if possible.

Sustainability of project-supported CS/MH activities: The evaluation identified major weaknesses at all five levels of the project capacity-building strategy related to: 1) LGA commitment and LGA/PHC staff skills; 2) health facility workers' knowledge and skills related to CS/MH; 3) the capacity of community organizations, namely the DDCs and VDCs to promote PHC at their level in collaboration with health facility workers and community health volunteers; 4) the training and follow-up of the VHWs, TBAs and CBDs; and 5) household level knowledge and practices related to CS/MH,.

Until actions are taken to overcome the major shortcomings at each of these levels, the sustainability of the project-supported CS/MH activities is highly

unlikely.

#### Recommendation for non-cost extension of CS/MH Project

In order to increase the chances of sustainability of the project-supported activities, and given the delays in the full implementation of many of those activities, in many cases due to factors beyond the control of the project, it is recommended that a no-cost extension be granted to the project to enable it to implement all of the activities envisioned in the DIP. Such a no-cost extension would probably be required for a period of one year, i.e. through September 1996.

#### **V. ASSESSMENT OF PARTICIPATORY EVALUATION METHODOLOGY**

The last objective for the CS/MH Project evaluation was "to assess the usefulness of the participatory evaluation methodology for evaluating PHC projects." In order to accomplish this objective, two short exercises were carried out on the last day of the meetings with the full Evaluation Team: 1) a small group exercise in which team members identified the advantages and disadvantages of the participatory evaluation methodology; and 2) individual indepth interviews with each evaluation team member to elicit their individual feedback on the evaluation process in which each of them was involved. The results of the two exercises are summarized here.

Many of the team members compared this experience with past evaluations with which they had been involved in which they felt "nervous," "anxious" and "uncertain about exactly what as going on." In contrast, participants stated that they felt very much a part of the evaluation process and they felt "comfortable and relaxed even though we worked very hard."

There was also agreement amongst the evaluation team members that their participation in the evaluation was beneficial both in terms of contributing to the validity of the evaluation results and in terms of increasing their sense of ownership over the evaluation findings and lessons learned.

Several other key ideas were frequently expressed by evaluation team members in the feedback exercises.

**Benefits of stakeholder participation in the evaluation:** All participants said they felt their involvement in the evaluation was beneficial insofar as: the experience helped them to better understand the different components and functioning of the project; the experience demystified evaluation for them and gave them confidence to carry out their own evaluations in the future.

**Ownership of the evaluation results:** All of the evaluation team members insisted that the evaluation findings are accurate and the lessons feasible because they participated in producing them. Many participants stated, "The lessons from the evaluation are in our heads. Even if we don't get copies of the report we already know what we need to do next."

**Team-building:** Many team members stated that the team approach used in the evaluation was valuable insofar as it involved people with different backgrounds and responsibilities in exchanging ideas in an "open environment" in which "everyone's ideas were listened to by the other team members."

**Understanding the community perspective:** Most of the participants stated that the evaluation methodology which was based primarily on conducting indepth, qualitative interviews helped them to understand that the community's perspective is often different than their's and that it is very important to try to understand the community's perspectives in planning program activities.

**Skills in community data collection:** Many of the team members stated that the skills they acquired through their involvement in planning and carrying out the entire evaluation, as well as specifically in indepth interviewing, will be very useful to them in their ongoing work in PHC.

There was a final consensus amongst all evaluation team members that the participatory approach is preferable to traditional approaches to evaluation in which program staff and collaborators are not fully involved in the process. They also concluded that for future PHC evaluations the participatory methodology should be used if the financial and human resources are available to do.

Adamawa Child Survival/Maternal Health Project

EVALUATION PLANNING WORKSHOP  
Aug. 21-23, 1995

Goal of the workshop:

-to develop the methodology for the mid-term evaluation with the participation of different project actors and partners

Objectives of the workshop:

1. to identify three key questions to be answered in planning any evaluation
2. to define the purpose of an evaluation
3. to know the characteristics of a Learning Process Approach to project implementation and evaluation
4. to identify the advantages and disadvantages of the "traditional" and "participatory" approaches to project evaluation
5. to know the steps to be followed in this participatory evaluation
6. to define the role of each member of the evaluation team in the evaluation process
7. to know the goals and objectives of the CS/MH Project evaluation
8. to develop the questions to be answered in the evaluation
9. to identify the sources of information to be used to answer the evaluation questions
10. to know the differences between quantitative and qualitative information
11. to know 5 different data collection techniques which can be used in community health projects

## Discussion of the comparative findings

1. There has been an increase in the practice of breastfeeding among mothers in both LGAs. In Guyuk LGA 90% - 95%. Fufore LGA 88% - 94%.
2. There has been a tremendous attitudinal change in the duration (1½-2 yrs) of breastfeeding among the mothers. Guyuk LGA (no baseline figures available) to 100%, Fufore 91% to 100%.
3. Weaning practice of mothers at 6 months or later have also increased from 31% - 40.0% in Guyuk, and 30% - 49% in Fufore ...
4. Mothers knowledge on the importance of breastfeeding is still low. Guyuk 52%, Fufore 48%.
5. a. There is a tremendous increase in the number of children that have a growth monitoring card. 41% - 88% in Guyuk, 28% - 63% in Fufore.  
b. There has been a great drop in the percentage of children that had their weights recorded in the last four months in both LGAs. This is due to a decline in the attitude of health workers to growth monitoring. Guyuk 48%- 30%, Fufore 78%- 7%.
6. Mothers in both LGAs have little knowledge on the importance of increased breastfeeding in the control of diarrhoeal diseases. Guyuk 14% - 20%, Fufore 16 - 20%.
7. In Guyuk and Fufore, the practice of providing fluids more than usual in the control of diarrhoeal diseases is low. Guyuk 18% -13%, Fufore 10%-5%.
8. Importance of providing semi-solid foods more than usual in the control of diarrheal diseases is also low in both LGAs. Guyuk 13%-4%, Fufore 7%- 5%.
9. The knowledge of mothers in both LGAs in the preparation and administration of SSS in the control of diarrheal diseases has risen. Guyuk 28%-58%, Fufore 1%-53%.
10. The number of children who have immunization cards has increased in both LGAs. Guyuk 42%- 88%, Fufore 34%-65%.
11. Mothers have now changed their attitude to ante-natal care because there is an increase of women with properly completed maternal health cards. Guyuk 45%-62%, Fufore 33%-56%.
12. More women have received Tetanus Toxoid vaccine during pregnancy in both LGAs. Guyuk 62%-80%, Fufore 52%-64%.
13. Almost all mothers interviewed in both LGAs are not currently using any type of family planning method. Guyuk 2%-9%, Fufore 8.2%-9%.
14. It was observed that most women interviewed in both LGAs are aware that malaria is caused by mosquitoes. Guyuk 34%-73%, Fufore 66%- 72%.
15. There has been a decrease in the use of anti-malarial drugs in both LGAs. This may be due to the economic crunch as drugs have become more costly. Guyuk 78%-65%, Fufore 77%-60%.
16. While there is a decrease in the use of mosquito nets in both LGAs (Guyuk 11%-7%, Fufore 19%-15%), there is an increase in the use of mosquito coils (Guyuk 34%-55%, Fufore 53%-79%). This may be because the coils are cheaper and so are more accessible to many households.

Appendix A.



FIELD TEAM MEMBERS

TEAM I - FUFURE LGA

1.	Dr. Judi Aubel	- Ext. Evaluator
2.	Mr Benson B. Kongyiburi	- Project Manager CS/MH
3.	Mal. Moh'd Mahmood Nyako	- Coord. Disease Control SMOH
4.	Mal. Gidado Moh'd Yolde	- Program Officer
5.	Glory Yalatu	- Midwifery Sister, Guirn
6.	Esther Ayuba	- District Senior Mid/Nurse

TEAM II - GUYUK LGA

1.	Roberta Lee	- Project Adviser, Africare Yola
2.	Tom Ubanne	- MIS Specialist, Africare Lagos
3.	Andori Geofrey K.	- Program Officer, Guyuk LGA
4.	Maxwell Kekene	- Chief Health Educator SMOH
5.	Helen Anjili	- Prin. Mid. Sister, Guyuk Maternity
6.	Christy Zinass	- District Sen. Mid/Nurse, Bobini Dist.

TEAM III

1.	Sola Ogunturoti	- Africare FHS Consultant
2.	Glory Suleiman	- MH/FP
3.	Rhoda Bello	- Program Officer, ORT Sch. Health Services
4.	Alh. Ibrahim Babale	- Program Officer, Immunization

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Appendix B.

DATA COLLECTION SITES AND INTERVIEWEES - FUFURE LGA

TEAM I

S/NO	COMMUNITY	INTERVIEWEES	DATE
1.	GURIN	26 Community Leaders 10 Mothers 4 VHW's 2 TBA's 5 Health Workers	28/8/95
2.	PARIYA	5 Health Workers 4 VHW's 1 TBA	30/8/95
3.	FURO	11 Mothers 8 Community Leaders	30/8/95
4.	LGA PHC DEPT.	Alh. Kabiru Mohammad Bamanga Mohammad Naphthali Irmiya Usman Bello Dudu Umar Aisha Tukur Usman Ahmad Mohammed Danladi Kwali Aliyu J. Bayo Alh. Musa Dawre - PHC Director Mr Benjamin Bagale - Councillor for Health	31/8/95

DATA COLLECTION SITES AND INTERVIEWEES - GUYUK LGA

TEAM II

S/NO	COMMUNITY	INTERVIEWEES	DATE
1.	PURAKAYO	12 Mothers 4 Community 4 VHW/TBA's	28/8/95
2.	GUYUK	6 District Heads 7 VHW's/TBA's 12 Health Workers	28/8/95
3.	ARAH-TEH	10 Mothers 7 VHW/TBA's 5 Community Leaders 2 Health Workers	29/8/95
4.	KWADADAI	7 Mothers 8 VHW/TBA's 6 Community Leaders	30/8/95
5.	LGA OFFICIALS	1) Mr Joseph Kalakala - Chairman ii) Mr V.V. Zira - Treasurer iii) Alh. I. Sanda - DPM	31/8/95
6.	LGA PHC OFFICIALS	i) Mrs Alice Danbaki - Councillor for Health ii) Mrs Emily Samuel - Director PHC iii) Mrs Cecilia Janba - Asst Coord M&E iv) Grace I. Danbaki - Asst Coord H/E v) Mohammed D. Hong - Asst Coord Drugs, Equip Supplies vi) Nimfas Mafindi - Asst Coord Social Welfare	31/8/95
7.	LGA DISTRICT HEALTH SUPERVISORS	<b>DISTRICT</b> 1) Mr Danton Janba - Guyuk 2) Mr Irmiya Abalis - Bobini 3) Mrs Rebecca Galadima - Banjiram 4) Mr Johnson Lasuwa - Kola 5) Mr Alfred M. Alaparu - Kurnyi 6) Mr Pwalas Bwidal - Chikila	

Appendix C: Mid-term assessment of mothers' KAP  
Results of interviews with mothers with children 0-2 years of age

KAP INDICATOR	Base.	Mid.	Base.	Mid.
	GUYUK	GUYUK	FUFORE	FUFORE
1. Presently breastfeeding	90.7%	95.4%	88.2%	94%
2. Duration of intended breast-feeding between 1.6 & yds	Not asked	100 %	91.1%	100%
3. Weaning should start at 6 months or later	31.2%	40%	30%	49%
4. Importance of breastfeeding	Not asked	52.2%	Not asked	48%
5. a. Growth monitoring card available	41%	88%	28%	63%
b. Child weighed in the last 4 months	48%	30%	78.3%	7%
6. CDD: importance of breast-feeding more than usual	14.2%	20%	16%	20%
7. CDD: importance of providing fluids more than usual	18.3%	13%	10%	5.2%
8. CDD: importance of providing semi-solid foods more than usual	13%	4.1%	7.3%	5.1%
9. CDD: administration of sugar-salt solution (SSS)	28%	58%	1%	53%
10. Immunization card available	42%	88%	34%	65%
11. Maternal health card available	45%	62%	33%	56%
12. Tetanus vaccination received	62%	80%	52%	64%
13. Currently using family planning method	2%	9%	8.2%	9%
14. Knowledge on the cause of malaria.	34%	73%	66%	72%
15. Use of anti-malarial for treatment of malaria.	78%	65.4%	77%	59.4%
16. Use of household sprays or coils as protective measure against malaria.	34%	55%	53%	79%

# Appendix D.

## AFRICARE/ADAMAWA CS/MH MID-TERM EVALUATION REPORT

Evaluation Questions	Findings	Lessons Learned
<p><b>IMMUNIZATION:</b></p> <p>1. Are all vaccines being provided at all levels?</p>	<p>1. In both LGAs there are periodic shortages of all vaccines at the LGA level due to the fact that they are not regularly received from the SMOH. Neither LGA has a reliable means of transport to bring the vaccines from Yola to the LGA.</p> <p>Shortages in vaccines also occur at the clinic level due to: 1) shortages at the LGA level; 2) problems with transport of vaccines from LGA to health facility level. At present the health facility's only means of transport are motorcycles which cannot carry cold boxes.</p> <p>To solve this problem, health facility staff sometimes: 1) carry small quantities of vaccine in vaccine carriers by motorcycle; 2) contribute from their own pockets to pay for transport; 3) send vaccines with a known traveler. It seems that to date the VDCs have not been involved in solving this problem.</p>	<p>1. The LGAs should work out the modalities for regular supply of vaccines to avoid future shortages from the SMOH. In extreme shortages, the project should continue to back-up vaccine supplies as is currently done.</p> <p>Given the uncertainty of the effectiveness of the above suggestion, also explore the possibilities of purchasing vaccines from a reliable private sector service putting in place a reliable cost recovering system.</p> <p>The LGA should provide additional Deep Freezers and cold boxes for the storage of vaccines to ensure continuous availability. VDCs should be involved in transporting vaccines from LGA Headquarters to health facilities to ensure continuous supply.</p> <p>The project in collaboration with VDCs, SMOH, LGAs should identify strategies to apply pressure to ensure continuous supply of adequate stock of vaccines.</p>

47

Evaluation Questions	Findings	Lessons Learned
<p>2. Are the cold chain system maintained from LGA to the village level?</p>	<p>2. There are problems maintaining the cold chain system at all levels. At the LGA level electricity is not always available. In Fufore the LGA has a functioning generator. In Guyuk, LGA commitment to solving the cold chain problem has been demonstrated by the purchase of a generator which should soon be operational.</p> <p>Between the LGA, district and facility level infrequent means of transport of ice packs limits the availability of potent vaccines. VDCs have not been involved in solving the cold chain problem.</p>	<p>2. The LGAs with the involvement of the VDCs should ensure that stand-by generators are in good working condition to maintain the cold chain at all times to avoid spoilage of vaccines.</p> <p>The LGAs should provide adequate thermometers and ice packs to maintain the cold chain system at all health facilities</p> <p>The LGAs need to verify that temperature sensitive monitors are available for all cold chain and are being used. Staff should be also be made aware that they are available in all cold boxes.</p>
<p>3. Are properly sterilized syringes and needles used in immunization?</p>	<p>3. In most cases syringes and needles are steam sterilized which is preferable to the boiling system. In some cases, sterilization is not done due to the shortage of kerosene (fuel).</p>	<p>3. The LGAs with the involvement of the VDCs, should provide all health facilities with necessary resources to assure proper sterilization of equipment. All LGAs and Project staff should ensure that in cases where proper sterilization is not possible, no immunization is carried out.</p>
<p>4. Is there a maintained sterilization log book in each stationary vaccination centre?</p>	<p>4. In a majority of cases the uses of the sterilization log book is not part of the standard procedure. In many cases facilities do not have log books and in other cases the log books are present but not used.</p>	<p>4. The LGAs should ensure that sterilization log books are available at all health facilities.</p> <p>District supervisors should ensure that health facilities staff regularly and correctly maintain the sterilization log books to ensure that health facilities maintain adequate sterilization.</p>

Evaluation Questions	Findings	Lessons Learned
<p>5. What other problems are encountered in providing outreach and health facilities immunization services?</p>	<p>5. Outreach vaccination services are being provided on a very limited basis. This is due to inadequate vaccines and transport. In addition, when outreach sessions are carried out the turn out is often poor.</p> <p>During the rainy season the turn out of mothers is generally low both at the facility and outreach sessions.</p>	<p>5. That health facility staff should work closely with the VDCs, they should enlighten the men about the importance of immunization and mobilize the women to attend the immunization sessions to ensure very high turn out.</p> <p>During the raining season, the health facility workers/VDCs should fix Sunday/Market days for the immunization sessions in order to get high turn-up.</p>
<p>6. How often are refresher or vaccination training conducted with health workers?</p>	<p>6. Some LGA staff stated that they have not recieved any refresher training on immunization for the past two years. In fact, in both LGAs between September 1994 and June 1995, 3 training activities supported by the project attended by PHC health facility staff participated were carried out in which vaccination was one of the topics addressed.</p> <p>When district supervisors make contact with health facility staff they should be reviewing immunization procedures, however, this is not being done.</p>	<p>6. LGA health facility staff and the project should continue to keep proper records of their training in order to ensure adequate documentation of this information.</p>
<p>7. Are the three prescribed stages of health talks being followed in an immunization session?</p>	<p>7. Although the SMOH has defined the three stages of health talk which should be followed during an immunization session, many health workers are not following them.</p>	<p>7. District supervisors should enforce the use of the three stage of health education talk during immunization session in all the health facilities to ensure proper dissemination of information to mothers.</p>

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Evaluation Questions	Findings	Lessons Learned
<p>8. What is the communities' view of the immunization services being carried out in their area?</p>	<p>8. It appears that most mothers want to have their children vaccinated. However, they are often disappointed when they turn up for immunization sessions and find that there are no vaccines or that the health workers arrive late, often due to logistics problems.</p> <p>It appears that in certain areas, particularly in the Muslim areas in Fufore, community attitudes toward immunization have improved due to project-encouraged health education efforts.</p>	<p>8. LGAs and VDCs should ensure that adequate logistics arrangement are made to enable health facility staff to arrive at the immunization centres before the mothers.</p> <p>The Project should continue with various health education program in the LGAs to encourage more mothers to come for immunization.</p>
<p>9. What suggestions do health workers have to improve immunization services?</p>	<p>9. Health workers made suggestions to improve the mobilization of mothers and transport of vaccines. They said that more health education should done with community members to increase understanding of immunizations and attendance at vaccination sessions.</p> <p>Regarding vaccine transport they said that they need functioning motorcycles. All district supervisors received motorcycles however most are broken. No maintenance arrangements were made before the motorcyces were distributed. Some health workers have bicycles, however, many are broken. For example, in Guyuk only 2 out of 20 bicycles are still functioning. LGA staff stated that when the motorcyces and bicycles were distributed recipients were not expected to sign a contract regarding use and maintenance.</p>	<p>9. Health facility staff allocated with project machines/bicycles should sign a written agreement on the maintenance of such machine/bicycles to ensure that they last for a long time.</p> <p>Broken down machines and bicycles should be repaired by the LGAs/VDCs and put back into use to improve the logistics of the LGA.</p>

Evaluation Questions	Findings	Lessons Learned
<p><b>VILLAGE HEALTH WORKERS:</b></p> <p>10. To what extent were the criteria for choosing VHWS and TBAs adequate?</p>	<p>10. In some cases, there were problems associated with the application of the criteria for choosing VHWS and TBAs. The plan was for the VDCs to select both VHWS and TBAs to be trained. The criteria and process to be followed was communicated to the District Supervisor who, in turn, was expected to communicate with the DDC. The DDC was to communicate with each VDC. Several problems were identified related to the selection process. In a few cases the choice of people to be trained was made by the DDC itself; in a few cases those selected did not meet the defined criteria; and in a few cases, communities did not select individuals to be trained or selected them too late.</p>	<p>10. Project staff/LGA PHC staff and the VDCs should ensure that the prescribed criteria for the selection of VHWS and TBAs are followed so that the right person is selected for the right job.</p>

46

Evaluation Questions	Findings	Lessons Learned
<p>11. Is the role of the VHWS and TBAs clear to all concerned from the community to the LGA level?</p>	<p>11. Interviews conducted from the community to LGA level suggest that the role of the VHWS and TBAs is not very clear either to the VHWS/TBAs themselves or to others. Neither the VDCs nor the health facility workers clearly understand the roles and limitations of the VHWS/TBAs. Also, they do not understand their own responsibilities for supervising them. Although the roles of the VHWS/ TBAs were sent to the LGAs in order from them to pass them on to the VDCs and DDCs, some of the VDCs and health workers do not have written guidelines on their roles.</p> <p>In some cases, VHWS and TBAs express the desire to carry out activities beyond their scope of work, for example, "giving injections to stop bleeding," and "giving chloroquine injections." Although national PHC guidelines on the roles of VHWS/TBAs exist, the trainees do not have copies of them.</p>	<p>11. The Project should ensure that all VHWS, VDCs, DDCs and health workers have copies of the guidelines regarding the roles and limitations of the VHWS/TBAs.</p>
<p>12. Is the work of the VHWS supervised and how often?</p>	<p>12. Some supervision of the VHWS/TBAs is being carried out by health workers but none by the VDCs. In the cases where health workers are supervising them, it is sporadic and informal. No supervision guidelines are available or followed. Health workers agree that VHWS/TBAs should be supervised once a week to ensure that they are working correctly.</p>	<p>12. Health facility staff, District supervisors, VDCs should all have copies of the National PHC guidelines on supervision to ensure that supervisory activities are properly carried out.</p>

Evaluation Questions	Findings	Lessons Learned
<p>13. Are village health workers given regular support or incentives?</p>	<p>13. For the drugs that the VHWS/TBAs sell there is a small profit margin which they retain for themselves. In Fufore, where distances are greater, communities provided support for the transport of the trainees to the training session. However, since the training it appears that in no case are VHWS/TBAs being provided with regular support by their communities. In a few cases, community members have given them soap to show their appreciation. Many communities have been discussing the possibility of providing support to VHWS/TBAs.</p>	<p>13. The DDCs and VDCs should ensure that adequate and regular support either in kind or cash is given to the VHWS and TBAs to encourage them to perform their duties more effectively. The Project and PHC staff should monitor the motivation and activities of VHWS/TBAs to assess success or problems in this regard.</p>
<p>14. Was the training provided for the for VHWS adequate for the tasks they are expected to carry out?</p>	<p>14. Some of the VHWS/TBAs interviewed said that their training was adequate while others said they wish to receive more training. It is impossible to make any judgement regarding the knowledge and skills of the VHWS/TBAs at the end of their basic training because no assessment of their skills was carried out. At the end the basic training, all VHWS/TBAs were interviewed to assess their knowledge on the different PHC interventions however, their responses have not yet been analyzed.</p> <p>It appears that the level of knowledge and skills varies considerably from one individual to another. It is planned that additional in-service training will be provided to them by project staff in their communities.</p>	<p>14. On the job training should be provided by the Project and LGAs Department for VHWS/TBAs to make them perform more adequately in the future. The Project should orient HF staff on how to conduct on the job training of VHWS/TBAs. The result of the QA interviews with all VHWS/TBAs at the end of their training on their knowledge of CS/MH activities should be communicated to the health facilities workers to assist them in carry out on the job training of their VHWS/TBAs.</p>

96

Evaluation Questions	Findings	Lessons Learned
<p>15. Are the Village health workers provided with adequate working materials?</p>	<p>15. The provision of materials was assured in part by AFRICARE and in part by the LGAs. According to the VHWS some received their VHW kits while others only have received their scales. Some VHWS complain that the materials in the kits are incomplete or inadequate. They request cotton wool &amp; bandages, iodine and more drugs.</p> <p>All TBAs received scales and kits containing the basic materials prescribed by the SMOH. It was recognized in the project that the TBAs should have some simple reference materials on pregnancy and deliveries. All TBAs were given a booklet written in Hausa on delivery practices. The TBAs interviewed did not mention whether the booklet has been useful to them or not. Another pictorial booklet on deliveries is being produced also in Hausa for the TBAs. Some of the TBAs complained that they did not receive aprons to protect themselves during delivery.</p> <p>For the VHWS, the The Voluntary Village Health Workers Manual is being translated into Hausa by the project into Hausa by the project. The manual provides guidelines on their roles and responsibilities.</p>	<p>15. The project and LGAs should ensure that kits promised to the VHWS are supplied to all of them so as to make them more functional. The Project is currently developing a manual for the VHWS regarding their work. These materials should be reviewed by PHC facilitators and pre-test with VHWS in order to make necessary modification before printing.</p>

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Evaluation Questions	Findings	Lessons Learned
<p>16. What activities do Village Health Worker provide?</p>	<p>16. Some VHWs in Fufore say they have not started their activities yet because they have not yet received their kits and drugs. Many have started doing home visits including health education and treating people with their drugs. Some are also referring cases to the clinics. The CBDs in Fufore have been distributing ivermectin at the household level since early 1993 while in Guyuk some initiated this activity in Sept. 1994 and others in July 1995.</p>	<p>16. LGA/DDCs/VDCs should monitor the activities of VHWs/TBAs and make sure that they have their kits and other resources to enable them to carry out their prescribed duties.</p>
<p>17. Are Village Health Workers correctly carrying out each of their tasks?</p>	<p>17. Due to the fact that the VHW/TBA training was completed only in late June and that in most cases their activities have not been supervised it is not possible to determine whether they are carrying out their tasks correctly or not.</p>	<p>17. Supervision guidelines should be followed by DS and HF staff to ensure that VHWs/TBAs activities are correctly monitored and reinforced.</p>
		<p>18. District Supervisors, VDCs and the Project staff should motivate the VHWs/TBAs to sustain the current level of interest and enthusiasm which they have for their work.</p>
<p>19. What is the relationship between the VHW and Facility Health Workers?</p>	<p>19. In most cases the VHWs/TBAs say they have cordial a relationship with the health workers. However, their relationship with the health workers regarding their role is not yet clearly understood either by the health workers or VHWs/TBAs.</p>	<p>19. There should be regular meetings between the TBAs, VHWs and HF staff and the VDCs in order to develop closer working relationships for the benefit of the communities.</p>

50

Evaluation Questions	Findings	Lessons Learned
<p>20. Who replenishes the drug stock of the VHWS and how is it replenished?</p>	<p>20. The system planned was for the VHWS to go to the LGA to replenish their drug supplies. Most of them have not yet needed to replenish their drugs but are informed that they should go directly to the LGA. In some cases, the planned arrangement is not convenient for the VHWS because of the cost of transport to the LGA. At the PHC Dept. in Fufore it was agreed that the district supervisors should ensure that VHW drugs are replenished.</p>	<p>20. The LGAs should ensure that drugs are available at LGA level. The DDC, VDCs and health facility staff should develop a system for replenishing drugs from the LGAs to the VHWS/TBAs.</p>
<p>21. What problems do the VHWS encounter in the course of providing their services and what suggestions are there for solving them?</p>	<p>21. VHWS identify several types of problems in carrying out their tasks. In some cases it appears that their role is not sufficiently clear to community members as they have been denied entry to certain houses or charged with being fakes because they have no kits. Other VHWS said that community members do not follow their advice either because they are unwilling or because they do not have the resources to do so. During the rainy season it is difficult for them to move around and community members are very busy.</p> <p>It was suggested that VHWS, VDCs, AFRICARE and health workers should periodically meet to discuss and solve the VHWS problems.</p>	<p>21. LGAs/DDCs/VDCs/VHWS/TBAs and Project staff should meet regularly to discuss and solve the problems of the VHWS/TBAs.</p>

Evaluation Questions	Findings	Lessons Learned
<p><b>GROWTH MONITORING</b></p> <p>22. Are weighing of babies being conducted in the village and how often?</p>	<p>22. In most but not all health facilities baby weighing is being carried out at various intervals. Many VHWS are weighing babies during home visits. VHWS are supposed to counsel or refer underweight babies to health facilities. It appears that the VHWS are starting to carry out these tasks.</p>	<p>22. Health workers should draw up a regular schedule for baby weighing at all health facilities.</p> <p>VHWS and TBAs should draw up regular schedule for baby weighing during home visits.</p> <p>The VHWS and TBAs should counsel mothers on nutrition and refer all underweight babies to health facilities for follow-up management.</p>
<p>23. Are the weights and ages being plotted correctly in the babies health cards?</p>	<p>23. Regarding the baby weighing in the health centers data from the QA survey conducted in June 1995 indicate that in both LGAs the majority of the health workers do not correctly weigh and plot babies weights. Since June the Project Officers have been working on this issue with health facility workers. The report of the survey has not been communicated to the health facility level and could assist facility workers by pointing out weaknesses to them.</p> <p>Regarding the VHWS' skills in baby weighing the majority of those tested during the interviews were able to correctly weigh and plot.</p>	<p>23. Health workers should be retrained in correct baby weighing and plotting of weights by project staff.</p> <p>The VHWS/TBAs who accurately weigh and plot baby weights need to be encouraged to continue to do so by midwives or project staff. Those TBAs or VHWS who don't accurately weigh plot baby weighs and need retraining by District midwives and project staff, District Supervisors.</p>
<p>24. Can the mothers read the growth monitoring card?</p>	<p>24. Health workers report that they have been teaching mothers to read the growth cards. According to the health workers, few of the mothers can read the growth card. Most mothers want to have their babies weighed in order to know if they are growing properly. Unfortunately, most of them cannot read the growth card which tells them if their baby is growing or not. During the interviews only a few mothers were able to interpret the growth card.</p>	<p>24. Health workers should explain to mothers how to read and interpret the GMCs so that mothers can know whether their babies are losing or gaining weight. At the same time, alternative, simpler forms of recording baby weights appropriate to the needs of illiterate/low-literate mothers should be discussed and developed by the project with the LGAs.</p>

Evaluation Questions	Findings	Lessons Learned
25. Does each Health facility have a functioning and well maintained weighing scale?	25. All health facilities have functioning weighing scales. It appears that in most cases they are being well kept.	25. Health workers should be encouraged by district supervisors to maintain their weighing scales in good condition so that the scales will last longer.
26. When growth faltering is detected, do mother have the resources to put the nutritional advice into practice?	26. It appears that in most cases locally available foods are recommended to mothers when their babies' weight is faltering. Mothers say that often they can put the advice into practice though sometimes they do not have the resources to do so. Some say that their husbands play a role in providing recommended foods.	26. HF workers and the VHWs/TBAs should advise parents whose children's weight is faltering on the use of locally-produced foods which families can afford. Advice should be given not only to mothers but also to fathers so they can help provide the support necessary to obtain recommended foods.
27. Do MOH and Village Health Workers have a way of tracking the treatment of malnourished children in the villages?	27. At present there does not appear to be an adequate system for tracking malnourished children at the health facility level. Such a system should include keeping a register and providing counseling and ongoing house visits to target children. It is anticipated that the VHWs will work closely with health facility staff to ensure better tracking of malnourished children.	27. The LGA and Project should develop a system of tracking malnourished children at the health facility level by keeping a register of children at risk, counselling the mothers of these children and organizing home visits to these families. The tracking should be done by the HF workers in collaboration with VHWs/TBAs. The project/LGAs need to develop simple tools for the tracking system.
28. Is there a nutrition and household food security program in each LGA?	28. Collaboration between the health, agricultural and social welfare sectors provides for management of identified severely malnourished children in both urban and village settings. At the community level such services are not yet adequate. The activities of VHWs and TBAs in close collaboration with VDCs and facility health staff will hopefully strengthen those services at the community level.	28. The project staff/LGA officials should encourage collaboration between Agricultural Extension Workers, VDCs and social workers to strengthen family nutritional/food security at the community level. Examples of such collaboration could include community provision of seedlings, farming tools and establishing community farms.

43

Evaluation Questions	Findings	Lessons Learned
<p><b>NUTRITION AND HEALTH EDUCATION.</b></p> <p>30. What nutrition and health education activities are being carried out?</p>	<p>30. The main nutrition and education activities at the health facility level are health talks. Also some demonstrations are carried out and poster are used. In a few cases, songs are used although there are not songs on all of the CS/MH topics. None of the mothers or health workers said that stories are being used. These activities are carried out almost exclusively with women.</p> <p>Some health workers provide nutrition and health advice during home visits and others in schools. Health workers rarely organize nutrition or health education sessions outside of the health facilities.</p>	<p>30. Health Workers should be encouraged to continue nutrition/ health education activities but they should use a variety of teaching methods in addition to health talks, e.g. songs, stories, dramas. The project in and the LGAs should organize workshops to develop songs, stories and dramas on CS/MH topics. Once developed these materials should be disseminated to the health facility level.</p> <p>Nutrition/health activities should be carried out in a variety of settings with men and children as well as with women, e.g. in schools, at community festivals, in homes.</p>
<p>31. What nutrition and health education topics are covered?</p>	<p>31. Topics addressed in nutrition and health education sessions mainly deal with child nutrition and health including locally available foods, balanced diet related to the food groups and food hygiene. Also personal and environmental hygiene are addressed. Topics related to maternal nutrition and health which are supposed to be given prominence in the project are given much less attention according to mothers and health workers interviewed.</p>	<p>31. Health workers need to give more attention to nutrition/health talks to balance child/maternal nutrition and health education to ensure complete health of mothers and their children.</p>

54

Evaluation Questions	Findings	Lessons Learned
<p>32. During the health and nutrition education sessions are problem solving or passing messages approaches used?.</p>	<p>32. The approach being used in nutrition and health education is mainly message passing with little use of problem-solving activities such as stories.</p>	<p>32. To ensure effectiveness of nutrition and health education health workers should base their sessions on problem-solving activities, e.g. open-ended stories, rather than on merely passing health messages. Problem-solving activities encourage community members to actively participate in finding solutions to their own problems.</p>
<p>33. What problems do mothers encounter during breast feeding?</p>	<p>33. Mothers identified some problems related to breast-feeding such as insufficient milk, spoiled milk, mastitis, mothers' fatigue from breast-feeding and constipation. During the evaluation interviews there was not time to fully explore the beliefs and problems related to breast-feeding.</p>	<p>33. Health workers should educate mothers regarding breastfeeding techniques and possible problems and solutions from the prenatal to the post-natal period. Health workers need to have more information on mothers' KAP related to breast feeding.</p> <p>The project should provide Health Workers with simple techniques to collect information from mothers on their practices and beliefs relating to breast-feeding and to other CS/MH problems.</p>
<p><b>TRAINING</b> 34. What type of training that were carried out and how many people were trained?</p>	<p>34.</p> <p>In some cases the size of learning groups during the training were very large (for example, 72 or 107). It is known that adults learn better when they can actively participate in learning activities. Groups of 20-25 allow trainees to be actively involved.</p>	<p>34. PHC training activities should be jointly planned by Africare and LGA/PHC staff. The planning of any training should involve first, analyzing the tasks that the trainees are expected to carry out once they are trained, second, developing the training content based on the knowledge and skills required to carry out those tasks. This approach will ensure that the training content provided for each category of trainees is appropriate to their future tasks.</p> <p>In training sessions, the size of trainee learning groups should be limited to a maximum of 25 people to encourage full trainee participation and effective learning.</p>

Evaluation Questions	Findings	Lessons Learned
<p>35. To what extent has the planning and organization of training activities been adequate?</p>	<p>35. Interviewees at the LGA level said that in some cases training events were not well planned ahead of time nor well organized. According to project staff problems were often encountered in coordinating the timely planning of training activities with LGA staff. Frequent changes in leadership at the LGA level also affected this situation. There was pressure on project staff to carry out a series of training activities in a relatively short period of time as a result of USAID sanctions in 1994 on project activities in Nigeria.</p>	<p>35. To increase the effectiveness of future training sessions, all training activities should be carefully planned and planning should be done ahead of time. The planning should be done in collaboration with LGA/PHC staff to ensure more successful training events.</p>
<p>36. Who have responsibility for planning and facilitating of the training activities?</p>	<p>36. The planning and facilitation of past training activities has been the responsibility of project staff in collaboration with outside consultants and LGA/PHC staff. Some LGA PHC staff said that they were not sufficiently involved in the planning and facilitation of training activities.</p>	<p>36. Decisions on the planning of training should never be made without consulting the LGA/PHC staff. To the extent that they have the required skills, they could be involved as facilitators.</p>
<p>37. For each category of training, was the content of the training adequate for the task they are expected to carry out?</p>	<p>37. Based on the reports of the training activities in some cases specific training objectives were not defined. Specific training objectives should be based on an analysis of the tasks trainees are expected to carry out after training.</p>	<p>37. For all training activities the training team should meet to develop the training content and topics. For each topic specific learning objectives should be developed so that both facilitators and trainees know what they should learn by the end of the session. The project office should continue to maintain complete files on the contents of all training workshops to include: specific workshop objectives; workshop time table; all handouts; and the report of the training.</p>

Evaluation Questions	Findings	Lessons Learned
38. Were there adequate instructional materials for each training?	38. Training materials consisted mainly of handouts and charts. Some of the relevant PHC information and guidelines included in the national PHC manual were distributed during the LGA training sessions. In many cases, it appears that information distributed is not being used.	38. Project staff should encourage LGA/PHC staff to use the PHC guidelines and other PHC materials distributed during the training sessions for better productivity.
39. Was the methodology mainly traditional/lecture or the participatory method?	39. The main pedagogical method used during training was traditional lectures. In addition, there was use of group discussions, practicals, demonstrations and drama. It is known that adults learn more when learning activities require them to actively participate.	39. In future training sessions the project should ensure that there is more use of participatory teaching methods as opposed to lectures. Participatory methods are known to be more effective in helping trainees learn.
40. What suggestions do trainees have to improve training workshops?	40. In some cases, VHWS and health workers said that the level of the content presented in training sessions by some facilitators was too high for all to understand.	40. All training facilitators should plan workshop sessions in which the materials used are appropriate for the educational and skills level of the trainees, e.g. for low-literate trainees, complex language and materials should not be used.
41. What plans are being made for follow-up training for the trainees?	41. To ensure follow-up of training activities, at the district level, District PHC Supervisors will receive on the job training from project officers and LGA staff. At the health facility level, health workers will receive on the job training from District Supervisors and AFRICARE project officers. VHWS/TBAs/ CBDs will receive on the job training from health facility staff and senior midwives.	41. The project should ensure that the quarterly in-service training specified in the D.I.P is carried out for PHC staff and VHWS/TBAs.

Evaluation Questions	Findings	Lessons Learned
<p><b>COMMUNITY BASED DISTRIBUTORS</b></p> <p>42. What are the features of integration of household-based oncho surveillance into the CSP activities?</p>	<p>42. The main feature of the integration of oncho and CS/MH activities at the community level is the provision of both oncho and CS/MH services at the household level by the same community volunteer. The success of the integration stems from the enthusiasm of community members about the benefits of ivermectin which increased their interest in CS/MH activities.</p>	<p>42. The integrated provision of Oncho and CS activities should continue. It enhances the community's willingness to participate in health-related activities in the future because of the success that has been experienced with ivermectin distribution.</p>
<p>43. What are the advantages and disadvantages of ivermectin distribution within CSP activities?</p>	<p>43. An advantage of the integration of CS/MH and oncho activities is that planning for ivermectin distribution is facilitated by the common data base through which individuals requiring ivermectin are identified at the household level. Another advantage is that oncho and CS/MH health education is conducted during the same home visits by the same person. For now, no disadvantages have been identified in this integration of services.</p>	<p>43. CSP/Oncho integration is over-whelmingly advantageous because it allows for better programme planning at both project and community levels.</p>
<p>44. Who are the CBDs and what are their roles?</p>	<p>44. In oncho endemic areas, community volunteers were trained to distribute ivermectin (mectizon) at the household level in Fufore starting in 1993 and in Guyuk beginning 1994. In 1995 all of the CBDs were also trained as VHWs. At present the same volunteers are responsible for the community-based oncho and CS/MH activities.</p>	<p>43. The integration of CSP/Oncho fosters the principles of PHC which aims to deliver a complete health care package at the community level.</p>
<p>45. Who supervises the CBDs?</p>	<p>45. As a result of the integration of oncho and CS/MH activities at the community level, CBDs are being supervised by the CS/MH Water/Sanitation Project Officers.</p>	

Evaluation Questions	Findings	Lessons Learned
<p><b>MANAGEMENT OF DIARRHEA DISEASE</b></p> <p>46. Are group educational activities or individual counselling on proper home management of diarrhea being carried out by VHWS and health workers at the community level?</p>	<p>46. Some but not all VHWS have started doing home visits and advising families on management of diarrhea. According to the VHWS/TBAs interviewed and mothers the main advice being given is to prepare SSS. It appears that VHWS are not emphasizing on the importance of giving more fluids, more feeding and continued breast-feeding. As for group educational sessions, they are not yet conducting them and may be able to do so in the future.</p>	<p>46. During supervision, DS and HF workers should emphasize to the VHWS the importance of encouraging mothers to give more fluids, to continue feeding and breastfeeding when their children have diarrhea. VHWS do not put enough emphasis on these three essential behaviors during diarrheal episodes.</p>
<p>47. Are group educational activities or individual counselling on proper home management of diarrhea being carried out at the clinic level?</p>	<p>47. Health workers say that they counsel mothers individually and give health talks at the health facility on preparation and use of SSS. They appear to give insufficient attention to the importance of giving more fluids, more feeding and continued breast-feeding. Health workers did not mention that they carry out any health education sessions on diarrhea outside of the clinic or with fathers.</p>	<p>47. All Health workers should counsel mothers individually and in groups at the health facilities not only on the use of SSS but should give more emphasis on fluids intake, food and breastfeeding. They should also organize educational sessions on management of diarrhea outside the clinic and with fathers.</p>
<p><b>MALARIA CONTROL</b></p> <p>48. Are group educational activities or individual counselling for prevention and treatment of malaria being carried out at the community level by VHWS and TBAs?</p>	<p>48. The VHWS who have received their kits are treating malaria with chloroquine and paracetamol during home visits. No information is available yet on whether the treatment being prescribed by VHWS is correct or not.</p>	<p>48. The HF workers should supervise VHWS/TBAs to determine whether they are treating malaria correctly or not. They should effect corrections in VHWS/TBAs knowledge and skills where necessary.</p>

Evaluation Questions	Findings	Lessons Learned
<p>49. Are group educational activities or individual counselling for prevention and treatment of malaria being carried out at the clinic level by health workers?</p>	<p>49. Health workers say that at the clinic level they conduct educational sessions with women on sanitary measures to control malaria. Men are rarely included in these sessions. It does not appear that the discussions on sanitary measures in the clinic are linked to actions outside of the clinic.</p>	<p>49. Health workers should include men in educational sessions outside the clinic on sanitary measures to control malaria. The Health workers should also follow-up to ensure that such discussions on prevention/control of malaria are followed up with action at the household and community level.</p>
<p><b>MH/OBs SERVICES</b></p> <p>50. What is the distance in km to the village from the clinic?</p>	<p>50. During the evaluation it was not possible to collect information on the distance from each of the villages to the nearest health facility.</p>	<p>50. The LGAs should maintain up-to-date records and information on the distance from each of the villages to the nearest health facility.</p>
<p>51. What MH/OBs services are provided in the clinics.</p>	<p>51. Some health facilities provide prenatal consultations including TT immunizations, deliveries and referrals in the case of complications. In Fofore none of the clinics provide family planning services while in Guyuk only one clinic provides these services. The QA observations reveal serious insufficiencies in the skills of health facility workers conducting prenatal consultations related to the detection of risk factors and to regular physical examinations. The evaluation team found that many health facilities lack equipment which is essential for proper obstetrical care, e.g. urine testing apparatus, blood pressure apparatus and thermometers. In Guyuk, since the QA study some of these materials have been purchased.</p>	<p>51. The LGAs should provide essential equipment for proper obstetrical care. They should also provide more family planning services and providers in all the health facilities.</p>

Evaluation Questions	Findings	Lessons Learned
<p>52. How do mothers feel about MH/OBs services?</p>	<p>52. As some health facilities do not provide MH/OBS services, some mothers interviewed complained about the absence of these services. A few mothers stated that health facility workers providing these services are not sufficiently competent.</p> <p>Other serious constraints to the use of health centers for prenatal and deliveries which were identified by women interviewees are the absence of toilets, water and light at many of the facilities. Substandard hygienic conditions were observed in several facilities including the presence of a huge colony of bats causing an unbelievable stench from their droppings in the maternity referral center in Guyuk.</p>	<p>52. The LGAs and VDCs should provide more MH/OBs services and health workers. The VDCs should be involved in monitoring the sanitary conditions in their health facilities to ensure that they are adequate e.g. toilets, extermination of bats. They should monitor to ensure continuous maintenance and cleanliness of the facilities. In cases where serious problems are identified in the sanitary conditions in a health facility, in collaboration with the DDCs/LDs the Project should encourage the PHC Coordinator to advocate for timely improvements e.g. provision of water, toilets.</p>
<p>53. How do staff feel about the positive and negative aspects of their job?</p>	<p>53. Some health workers stated that they derive satisfaction from serving their communities, for example by treating illnesses and by successfully delivering babies. Health workers identify a number of problems which discourage them in their jobs: lack of drugs, lack of equipment, lack of promotion opportunities, lack of staff.</p>	<p>53. The LGAs should provide the essential drugs and equipment to all health facilities to increase the morale and productivity of health facility staff. They should also give incentives to health workers.</p>

Evaluation Questions	Findings	Lessons Learned
<p>54. What strategies and transport are used during pregnancy and births to refer women?</p>	<p>54. The information collected shows that neither VDCs nor health facilities have a clearly defined strategy for evacuating women in emergencies related to pregnancy and childbirth. All of the health workers and community members stated that in such cases the woman's family does its best to find a way to evacuate her. In the case of women from poor families sometimes they are successfully evacuated and sometimes not. A major constraint related to transportation of women to referral centers is the bad condition of roads particularly during the rainy season.</p>	<p>54. The VDCs and Health Facility staff should together develop a clearly defined strategy for evacuating mothers during pregnancy/childbirth. The LGAs/VDCs should discuss how to improve on the conditions of bad roads especially during raining season.</p>
<p>55. Do mothers have suggestions on how to improve MH services in the clinics and communities?</p>	<p>55. Suggestions made by mothers to improve MH services include: the need for the LGAs to repair roads to facilitate evacuations and to improve the equipment and drugs at the facility level. No one mentioned the possibility of involving the VDC in helping to solve some of these problems.</p>	<p>55. All the VDCs/DDCs should have women members because "only women understand and can express the MH problems and needs of women." During DDC and VDC meetings health workers should discuss MH/OBs problems and needs so as to increase committee members understanding of the problems and commitment to solving them.</p>

62

Evaluation Questions	Findings	Lessons Learned
<p><b>TBAs.</b></p> <p>56. Are the TBAs appreciated and supported by their communities?</p>	<p>56. The available information suggests that in most cases communities appreciate the services which the trained TBAs can provide. However, TBAs are not receiving any regular support from their communities. This may be related to the fact that the VDCs are not fully informed about their role with the TBAs and have not yet discussed their responsibility toward the TBAs. Some Christian TBAs in Guyuk report that sometimes they are prohibited from attending to muslim mothers because of the family's non-acceptance of a non-Muslim. At meeting with all district heads in Guyuk, it was decided that the Chief of Longuda should discuss with Muslim communities the possibility of training Muslim TBAs.</p>	<p>56. The LGAs should provide the VDCs with the PHC guidelines on the TBAs' activities and the need to support their work in the community. It is the responsibility of the VDCs to educate or enlighten the community on the activities of the TBAs.</p>
<p><b>HOME VISITS/FAMILY CONTACTS:</b></p> <p>57. Do TBAs/VHWS/CBDs have a strategy for scheduling, planning and prioritising home visits.</p>	<p>57. VHWS and TBAs do not have a way of organizing and prioritizing home visits.</p>	<p>57. Standardized guidelines on how to organize and prioritise home visits should be written, distributed and discussed with VHWS/TBAs and HF staff by LGA PHC staff to ensure that home visiting is more organized. When VHWS/TBAs in the PHC Record of Work sheet, they should include all health-related "contacts" made with family members whether they occur at the household level or elsewhere in the community, e.g. at the market, at church etc.</p>
<p><b>HIV/AIDS</b></p> <p>58. Are HIV/AIDS activities being carried out in the LGAs? By whom? With whom?</p>	<p>58. It appears that as of yet no HIV/AIDS education activities are being carried out in either of the LGAs.</p>	<p>58. While the project can not be intensively involved in HIV/AIDS education activities, project staff should encourage the LGAs to develop and implement HIV/AIDS Prevention/Education activities since such activities are not presently being carried out in either LGA.</p>

Evaluation Questions	Findings	Lessons Learned
59. What was the aim and outcome of the AIDs proposal writing workshop?	59. The aim of the workshop was to provide guidelines to NGOs on the development of proposals for HIV/AIDs education activities which can be submitted for funding. 30 NGOs attended the workshop and each developed a proposal. Follow-up contacts are being made with all of the NGOs to finalize the proposals and to assist them to plan their own action plans for HIV/AIDs education.	59. The HIV/AIDs prevention/education workshop which the project organized for other NGOs was very relevant insofar as it served as a catalyst to other NGOs to get involved in HIV/AIDs prevention activities.
<b>REFERRALS</b> 60. Is there a functioning referral system from the community to the tertiary level?	60. While cases are being referred to higher levels of the health system, referrals are not being made in a structured and organized way. Health centers do not systematically document referred cases using the prescribed forms. Often the referral is only verbal in nature.	60. During supervisory visits District Supervisors should ensure strict compliance by HF staff to the established, standardized referral system to ensure continuity of care for all patients. The PHC department should ensure continuous supply of referral forms in all health facilities.
61. To what extent do clinics and VHWS receive feedback on referred cases?	61. Feedback on referred cases is not systematic.	61. When patients are referred to a higher level of health facility, there should be systematic feedback to the lower levels of the health system to keep the relevant parties informed about the patient's state of health.

64

Evaluation Questions	Findings	Lessons Learned
<p><b>PLANNING</b></p> <p>62. How is planning carried out within the project?</p>	<p>62. The steps in the project planning process used by AFRICARE involve: 1) initial discussions based upon the project detailed implementation plan (DIP) between the project manger, project advisor and AFRICARE accountant; and 2) discussions with SMOH and LGA level collaborators. Serious constraints associated with the political crisis and sanctions on project activities required the use of a more directive planning process than would have ideally been desired. Some LGA staff interviewed stated that they are not sufficiently involved in the planning process.</p>	<p>62. The planning and implementation of project activities takes place at different levels. Depending upon the level of discussion on planning and implementation of project activities, SMOH, LGA staff and communities need to be involved as much as possible to ensure greater acceptance, cooperation and sustainability between all project partners.</p>
<p>63. To what extent are the communities involved in planning PHC activities at that level?</p>	<p>63. The community organization that should be intimately involved in planning PHC activities at that level is the VDC. To the present, most VDCs are not functioning effectively enough to ensure continuous community involvement in planning such activities.</p>	<p>63. VDCs should be trained by Project staff and LGAs to know how to plan, and implement and evaluate PHC activities in their communities. In order to do this, project and LGA staff will need carefully developed training materials.</p>
<p><b>COORDINATION</b></p> <p>64. Are there periodic meeting between staff to coordinate project activities?</p>	<p>64. Regular monthly management meetings are held between the CS/MH Project Manager, Project Advisor and Oncho Project Manager to discuss issues related to both CS/MH and Oncho Project. Minutes are taken at each of these meetings.</p> <p>Regular coordination meetings are not scheduled with project officers, however, meetings are held when specific activities in the DIP are to be carried out. Minutes are not taken at each of these meetings.</p>	<p>64. Two types of regular staff meetings should be held at the project level: 1) regular management meetings should be held in which all project officers participate 2) Periodic coordination meetings involving all key project collaborators should be held to discuss the implementation of project activities, to continuously reassess and readjust strategies. Minutes of all meeting should be taken to record all points of views and suggestions so as to ensure appropriate follow up.</p>

Evaluation Questions	Findings	Lessons Learned
<p>65. To what extent do project staff feel that these meetings are useful? What suggestions do they have to improve the meetings?</p>	<p>65. Some of the project staff interviewed feel that project meetings are not always useful because some of the deliberations are not followed up. The project manager feels that this observation is incorrect because it is impossible for any organization to follow up all suggestions. Project staff stated that they should be involved at the planning stage and at the implementation stage. The project manager feels that they have been involved but they could possibly be more involved.</p>	<p>65. Project management should be more supportive of suggestions made by field staff about how to carry out their work effectively in the LGAs.</p>
<p><b>COMMUNICATION:</b></p> <p>66. What are the strengths and weaknesses of communication between the Project office and the LGAs? Suggestions?</p>	<p>66. According to some LGA staff, communication between project staff and themselves is weak. Regular coordination meetings are not held, in some cases they are given very short notice for activities to be implemented and in some instances project staff have stated that project supported activities will be cut off if LGA staff do not comply with project staff demands. Project staff deny having threatened LGA staff in this way.</p>	<p>66. There should be regular coordination meeting meetings between the LGA/PHC department and the Project, in order to ensure adequate communication between all parties including advance notice and timely planning and coordination of all activities.</p>

49

Evaluation Questions	Findings	Lessons Learned
<p>67. What are the strengths and weaknesses of communication between the Project office and Africare Lagos? Suggestions?</p>	<p>67. There is frequent telephone communication and exchange of memos between the offices in Yola and Lagos which allows for a good flow of information and materials between the two offices. Courier services are used to send mail but such mail is not always promptly delivered in Yola.</p> <p>As regards the transfer of funds between Lagos and Yola the present arrangement is unsatisfactory whereby large amounts of cash must be hand carried or sent as bank transfers which take a long time to clear or are heavily taxed by the bank. In some instances implementation of project activities have been seriously jeopardized because sufficient funds were not available. The Yola office suggests that funds be transferred on a quarterly basis. The Yola office has suggested that transfers be made through the Highland Bank in Lagos but this mechanism has not yet been used.</p>	<p>67. Good communication between Africare Yola and Lagos should continue by telephone. Given the problems with postal/courrier services, installing a fax in the Africare Yola office could improve Lagos-Yola communication. Transfer of funds between Lagos and Yola should be on a quarterly basis using the Highland Bank Lagos/Yola.</p>
<p>68. What are the strengths and weaknesses of communication between the Project office and Africare Washington?</p>	<p>68. All communications between the project and Washington is routed via Africare Country Office, Lagos.</p>	<p>68. (There is no lesson for question 68 because insufficient information was available due to the unanticipated absence of the Project Advisor during the latter portion of the evaluation.)</p>

Evaluation Questions	Findings	Lessons Learned
<p><b>SUPPORT SERVICES</b></p> <p>69. How adequate are (admin., Fin, Tran. Sec.) support services? What suggestions are there to strengthen the services?</p>	<p>69. The administration-finance and secretarial services provided by project staff in the Yola office are adequate. However, there is urgent need for a photocopier, a FAX modem and additional printer, preferably a laser printer, to make office activities more efficient. The office is currently using a laser printer which belongs to the Project Advisor for which she is not being compensated. The Project Manager feels that she should be compensated for same.</p> <p>The project currently has only one 4-wheel drive vehicle which is in good shape. The project also uses 3 vehicles purchased for the Oncho Project. However, none of the 3 is adequate to withstand the rugged terrain in the two LGAs. An additional old vehicle was contributed to the project by Fufore LGA which the project has refurbished. Due to the speedy rhythm of project activities in the two LGAs the Project Manager feels that an additional 4-wheel drive vehicle is necessary.</p>	<p>69. There is need for the project to recruit a Supply &amp; Logistics Officer to work with both the CS/MH and Oncho Projects.</p> <p>The Project Manager and Advisor should submit a memo to the Country Representative explaining why it is necessary to acquire the following: 1) Large Rank Xerox photocopier; 2) Fax/modem; 3) HP 4L laser printer. This memo should be accompanied by 3 price quotations for each item.</p> <p>There is also need for a 4 wheel drive vehicle for the CS/MH project. The Project should seek donor support to finance the purchase of a vehicle.</p>

89

Evaluation Questions	Findings	Lessons Learned
<p><b>COLLABORATION</b></p> <p>70. What type of collaboration exists with SMOH?</p>	<p>70. In the accord signed with the SMOH prior to the political crisis, the SMOH agreed to assign ministry staff to the project. Subsequently, 5 Project Officers (Community Health Nurses and Community Health Officers/Public Health Nurses) and 7 Senior Cadre Nurse Midwives were posted to the projet and stationed at the LGA level. The salaries of all of these staff are paid by the SMOH. 7 more Senior Cadre Nurse Midwives have been promised by the SMOH to be posted to the district level of the LGAs. Prior to the political crisis and USAID sanctions SMOH/PHC staff participated in training activities along with LGA and project staff.</p> <p>The CS/MH PHC strategy adopted in the project is in line with SMOH and Federal Ministry of Health guidelines. There is ongoing dialogue and communication with the SMOH to ensure that project activities are in keeping with SMOH guidelines and priorities.</p>	<p>70. The level of collaboration with the SMOH has been satisfactory so far and the collaborative momentum should be continued.</p>

69

Evaluation Questions	Findings	Lessons Learned
<p>71. What type of collaboration exists with LGAs?</p>	<p>71. In the accord signed with the SMOH it is stipulated that LGAs should provide counterpart funding for project activities including: to accommodate project officers in the LGAs, to accommodate other project staff during project activities in the LGAs; to provide motorcycles and other vehicles and fuel to LGA/PHC staff to ensure their involvement in CS/MH activities; to print PHC forms for the household-based records and M&amp;E activities. LGAs have collaborated in providing: accommodation for project officers and accommodation for other project staff during project activities. In Fufore, the LGA contributed an old vehicle for project activities. In Guyuk the LGA repaired the 7 broken District Supervisor's motorcycles. In Fufore, 6 out of 7 of the District Supervisors have motorcycles although some are not functioning. The PHC coordinator has recently promised to repair all motorcycles and purchase one additional one as well as to provide the supervisors with a monthly fuel allowance. Neither of the LGAs has funded the printing of the M&amp;E forms.</p> <p>LGA support for project activities has been less than anticipated. LGA/PHC staff and project staff feel that more pressure should be applied both by VDCs/DDCs and by project managers to comply with LGA counterpart funding. It is suggested that the AFRICARE Country Representative should bring this issue to the attention of the state government.</p>	<p>71. The lack of commitment on the part of LGA/PHC staff to project-supported activities could be reversed through a more participatory approach on the part of the project. Also, greater and continuous pressure should be applied on the LGAs by VDCs, DDCs and State government to encourage them to comply with their commitment to PHC activities.</p>

Evaluation Questions	Findings	Lessons Learned
<p>72. What type of collaboration exists with NGOs?</p>	<p>72. AFRICARE has made considerable efforts to establish strong collaborative relationships with numerous local and international NGOs. AFRICARE is currently collaborating with 31 local NGOs in the area of HIV/AIDS education to assist them in developing and implementing community HIV/AIDS activities. UNICEF has been an important supporter of the CS/MH Project and have provided substantial funds and motorcycles for project activities and has promised one lap-top computer and two additional motorcycles. The Project Manager and Advisor participate in quarterly zonal CS review meetings. UNICEF has also provided consultants for training activities. VSO has provided 2 volunteer midwives who are posted in each of the LGAs. VSO also invited one project officer to participate in a workshop on advocacy for women in Kaduna. The Christian Health Association of Nigeria (CHAN) subsidized the purchase of PHC books and scales for the project. The Lutheran Church of Christ Nigeria (LCCN) provided vaccines which were distributed to the two LGAs.</p>	<p>73. The various categories of PHC staff responsible for community mobilization do not have a clear and common understanding of how to "mobilize" communities so that they can effectively assume the critical and multi-faceted role that they are expected to play in PHC. The success of all PHC activities depends to a great extent on the strength of the VDCs and DDCs and the effectiveness of their collaboration with both community and facility health workers. The project should, therefore, develop a detailed manual on the steps in the community mobilization process based upon, but not limited to, the National PHC guidelines. The manual should be useful to LGA/PHC staff, District Health Supervisors, health workers at the facility level and project staff in establishing and strengthening the VDCs/DDCs and in encouraging their collaboration with health workers.</p>

Evaluation Questions	Findings	Lessons Learned
<p><b>COMMUNITY MOBILIZATION/HEALTH EDUCATION</b></p> <p>73. Is there a defined approach to community mobilization for CS activities?</p>	<p>73. The project has been involved mobilizing DDCs and VDCs however these activities were not fully implemented due to constraints on project implementation. Clear guidelines have not yet been developed and communicated to all project collaborators regarding the steps in the community mobilizing process with DDCs and VDCs which should be followed in all project-supported communities.</p>	<p>73. The various categories of PHC staff responsible for community mobilization do not have a clear and common understanding of how to "mobilize" communities so that they can effectively assume the critical and multi-faceted role that they are expected to play in PHC. The success of all PHC activities depends to a great extent on the strength of the VDCs and DDCs and the effectiveness of their collaboration with both community and facility health workers. The project should, therefore, develop a detailed manual on the steps in the community mobilization process based upon, but not limited to, the National PHC guidelines. The manual should be useful to LGA/PHC staff, District Health Supervisors, health workers at the facility level and project staff in establishing and strengthening the VDCs/DDCs and in encouraging their collaboration with health workers.</p>
<p>74. What are the obstacles encountered in mobilising the community to identify their problems and finding solutions?</p>	<p>74. A constraint to mobilizing communities is that many community members are illiterate and it takes time to help them to understand new ideas and approaches. Another constraint seems to be the lack of sufficient skills on the part of all LGA/PHC and project staff in participatory techniques for working with community groups. Another constraint is the lack of commitment on the part of some PHC staff to ensure the necessary follow-up support to the VDCs once they were formed.</p>	<p>74. In order for VDCs and community members, who are mostly illiterate, to acquire new ideas and practices related to CS/MH, there needs to be continuous teaching and discussions on these topics with them. This work requires special skills on the part of LGA/PHC staff in participatory, adult education methods. In addition to the manual on community mobilizing, the project should organize training activities on the use of participatory, adult education methods in PHC. PHC should be committed to their work to ensure that the DDCs and VDCs are regularly and properly supervised. It is also suggested that the VDC's should organize adult literacy programs for community to enlighten them on new ideas and approaches.</p>

Evaluation Questions	Findings	Lessons Learned
<p><b>VILLAGE AND DISTRICT DEVELOPMENT COMMITTEES</b></p> <p>75. How many Districts and villages in the project areas have functioning VDCs and how many Districts have DDC?</p>	<p>75. DDCs were created in all of the districts in the two LGAs but it is not known whether they are all functioning or not. A roster does not exist of the functioning VDCs. It would be useful to have such a roster to enable PHC and project staff to follow-up with each VDC. During the field visits a number of communities were visited where the VDC is either not functioning or not functioning well.</p>	<p>75. The LGA/PHC Dept. with the help of project staff should reactivate the DDCs and the VDCs to strengthen their functioning. The LGA/PHC Dept should develop and maintain a roster on all VDCs and DDCs (to include the names and functions of all DDC/VDC members.)</p>
<p>76. Are women represented in all VDCs and DDCs?</p>	<p>76. When the DDCs were formed all of them had at least one women as a member. At the present, it is not known how many women sit on the DDCs. Some VDCs do not have any women members. Given that this is a CS and MH project it is important that women be well represented in all of the DDCs and VDCs.</p>	<p>76. The LGA/PHC Dept. should enlighten and insist on the presence of women on all DDC's and VDC's. Proper record-keeping (see Lesson no. 75) and monitoring should be kept and maintained to ensure compliance in this regard.</p>
<p>77. Do the VDCs and DDCs clearly understand thier roles?</p>	<p>77. The roles of the DDC and of the VDCs are clearly spelled out in the national PHC guidelines. Project actors distributed the guidelines to DDCs in order to enlighten them on their role in PHC. When the VDCs were created the guidelines on their role in PHC were supposed to be communicated to them by the District Supervisors. However, during the interviews it was obvious that some of the VDCs do not understand their roles.</p>	<p>77. The LGA/PHC dept must ensure that the District Supervisors provide all DDCs and VDCs with copies of the written guidelines on their roles in PHC and that they be thoroughly discussed with them to ensure their understanding.</p>

Evaluation Questions	Findings	Lessons Learned
78. Were the national PHC guidelines for creating VDCs followed in all cases?	78. It is not clear whether or not the PHC guidelines for creating VDCs were followed in all communities or not. Communities visited where VDC memberships exceeds 40 or 50 people, and where there are no women members show that in some cases the guidelines were not followed.	78. The PHC guidelines for creating VDCs/DDCs should be clearly presented in writing, discussed and followed by the committees. There should be representation on all VDCs and DDCs.
79. How frequently do they meet?	79. There are no records to show how frequently the DDCs or VDCs meet.	79. The LGA/PHC Dept. should ensure that minutes of all VDC/DDC meetings are taken and copies sent to the dept. for proper record keeping and follow-up (monitoring) to ensure that monthly meetings are carried out.
80. Have the VDCs been involved in promoting CS/PHC?	80. It appears that in Guyuk the VDCs are more involved in health activities than in Fufore given the fact that most of the clinics in the LGA were constructed by the communities. The level of involvement of VDCs with CS and MH problems and solutions varies greatly from one VDC to another in terms of: 1) their knowledge of the CS/MH problems; 2) their involvement with PHC staff in discussing problems and finding solutions; and 3) their support and supervision of VHWS, TBAs and CBDs.	80. At present, the level of effectiveness and involvement of the VDCs with PHC activities varies greatly from one to another. The LGA/PHC Dept. should identify and address the problems/weaknesses of each VDCs on an individual basis.

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Evaluation Questions	Findings	Lessons Learned
<p>81. Why and how do the VDCs generate funds for CS/PHC?</p>	<p>81. In the national PHC guidelines it is stipulated that each VDC should generate funds to constitute an ongoing treasury. From the community interviews it appears that all VDCs do not clearly understand the purpose of collecting such funds and how they should be used. Not all VDCs have treasuries. In some communities where the VDC has collected funds and where pressing PHC needs exist they are hesitant to spend the existing funds "until AFRICARE tells them to do so."</p>	<p>81. The LGA/PHC staff should educate the VDCs on the necessity to generate funds to constitute and ongoing treasury. PHC staff should clearly explain to the VDCs the purpose of such fund and how the money could be used.</p>
<p><b>CHILD SPACING EDUCATION</b></p> <p>82. Is there a way to assess socio-cultural factors affecting child spacing in the communities and to use this information to develop the educational activities?</p>	<p>82. In both of the LGAs indepth interviews were conducted on HIV/AIDS and child spacing in order to understand socio-cultural factors related to these two topics. The information collected will be used to develop child spacing and HIV/AIDS education activities.</p>	<p>82. It is valuable to collect information from the communities about socio-cultural practices and attitudes on any given CS/MH topic before developing health education activities or materials for the community on this topic.</p>

75

Evaluation Questions	Findings	Lessons Learned
<p>83. Are child spacing activities being carried out at the Health facility level?</p>	<p>83. At some health facilities health talks are sometimes given to mothers on child spacing. Men rarely participate in health facility health talks. However, of all of the facilities in the two LGAs only one clinic in Guyuk (Guyuk Maternity) has family planning commodities.</p>	<p>83. Health Facility staff should be encouraged to carry out child spacing activities with mothers. They should also be encouraged to conduct more health-related and child spacing activities with men through the VDCs and DDCs outside of the health facilities. Activities with men are important to increase their understanding and acceptance of child spacing.</p> <p>There is need to train LGA staff on child spacing education and services.</p> <p>There is need for more FP centres in the LGAs to increase the availability of FP services and commodities.</p>
<p>84. Are child spacing activities being carried out at the community level?</p>	<p>84. VHWs and TBAs are supposed to be doing child spacing education during home visits. It is not clear the extent to which they are carrying out these activities.</p>	<p>84. District Supervisors should inform and ensure that health facility staff carry out Child Spacing education activities at the community level in collaboration with VHWs/TBAs.</p>
<p>85. Can topics such as child spacing and other maternal health issues be effectively discussed by both male and female VHWs?</p>	<p>85. During the community interviews some women expressed the feeling that for matters related to child spacing and maternal health they would feel more comfortable discussing these topics with another woman rather than with a man. Also they said that many of their husbands would feel more comfortable with a female advisor.</p>	<p>85. In discussing topics related to child spacing it is more appropriate for women VHWs/TBAs to counsel other women and for male VHWs to counsel men. This is particularly true in Muslim communities.</p>

76

Evaluation Questions	Findings	Lessons Learned
<p><b>HOUSE NUMBERING AND PLACEMENT OF HOME-BASED RECORDS</b></p> <p>86. Was house numbering completed in the two LGAs in the target districts?</p>	<p>86. According to national PHC guidelines all houses should be numbered in order to: 1) delimit the households for which each VHW is responsible; 2) ensure that facilities have complete records on all household members; 3) facilitate monitoring of PHC activities; 4) facilitate the use of home-based records; and 5) facilitate referrals to the next level of care.</p> <p>In Guyuk, house numbering and placement of home-based records was almost completed in the two intervention districts. In Fufore, house numbering has been completed in all the project areas however home-based records have not been distributed to all areas.</p>	<p>86. The Africare project should identify ways to increase child spacing activities with the funds and resources available.</p>
<p>87. Do communities in CSP project areas know why houses were numbered?</p>	<p>87. Based upon the interviews, few communities know why houses were numbered.</p>	<p>87. House numbering needs to be completed in Guyuk and placement of home-based records needs to be completed in both LGAs.</p>
<p>88. What are the problems associated with house numbering?</p>	<p>88. In Guyuk problems with house numbering were encountered in some places due to the shortage of paint and brushes and lack of resources for transport to the communities to be numbered.</p>	<p>88. Proper planning and supervision should be done by the LGAs to ensure that enough materials (paints and brushes) are purchased for the house numbering exercise and make sure that all houses are numbered in the intervention areas of the two LGAs.</p>
<p>89. What are the constraints to the use of the home-based records?</p>	<p>89. Due to the delay in placement of the home-based records (completed in some places only 2 weeks ago) the use of the records cannot yet be determined. However, LGA/PHC staff stated that the growth monitoring cards are being used. In Fufore, cards have been placed in most homes.</p>	<p>89. The Project and LGA PHC staff should follow-up to determine whether or not the home-based records are being used and where necessary teach the health facility staff, VHWs and TBAs and LGA on the proper use of the cards.</p>

77

Evaluation Questions	Findings	Lessons Learned
<p><b>MIS</b></p> <p>90. To what extent has the MIS system been put in place at all levels (Project, LGAs, District, Health Facility and community)?</p>	<p>90. In both LGAs the baseline surveys were completed. At the project level, routine monitoring and evaluation data is not yet being collected from the two LGAs. The computerization of the clinic master cards has been received from Guyuk LGA completed up to 90%. From Fufore, the only MIS activity completed so far is the baseline survey.</p> <p>At the District and LGA levels, the M &amp; E record-keeping system has not been put in place and training of health workers and PHC staff has not been done.</p> <p>At the health facility level, the clinic master cards have been placed only in Guyuk in the 2 intervention districts. No MIS training has been conducted in either Guyuk or Fufore at the health facility level.</p> <p>At the community level, the M &amp; E Record of Work of VHWs has just been distributed to all VHWs and TBAs. The community volunteers were taught how to complete the form during their basic training. The use of household records has not commenced.</p>	<p>90. The project should organize a training and review workshop on the MIS forms for project staff, LGA PHC staff and district supervisors to commence data collection for the Project in the two LGAs at all levels.</p>
<p>91. Are the forms regularly available at the different levels?</p>	<p>91. At the LGA level in Guyuk the old M &amp; E booklets are in short supply. The revised/new booklets are not yet available because the LGA has not yet printed them.</p>	<p>91. The project should make available the first set of the revised M &amp; E booklets to both LGAs to last at least six months.</p>

Evaluation Questions	Findings	Lessons Learned
92. How is the information collected used at all levels.	92. The information collected in the MIS should be used to both evaluate past activities and plan future ones. Due to a number of constraints on the project, the MIS training has not yet been carried out and hence data is neither being collected nor analyzed. The absence of any MIS information at present constitutes a severe constraint to rational planning and evaluation. There are plans to conduct this important MIS training in the coming months.	92. The project should have in place an MIS officer as stipulated in the DIP to ensure accurate data organization at all levels of the project.
93. Is the PHC data collected by VHWs, TBAs and CBD being used at the community level.	93. The VHWs/TBAs/CBDs have just begun to collect the PHC data so it is too early to fully assess how accurately they are collecting it. It appears, however, that they are not yet either sharing it with health facility staff or VDCs, nor using it in any other way.	93. Supervision of the VHWs, TBAs and CBDs by the district supervisor and health facility staff on MIS should be done as soon as possible to ensure proper data collection.

Evaluation Questions	Findings	Lessons Learned
<p><b>SUPERVISION</b></p> <p>94. What are the roles of the supervisors from LGA to Community for PHC activities.</p>	<p>94. In the national PHC guidelines, the roles and responsibilities for supervision from the LGA to community level are spelled out. However, the interviews revealed that the supervisory roles of LGA, District and health facility staff, as well as of VDC members and VHWS/TBAs/ CBDs are not clear to all parties. It appears that few of the persons expected to ensure the supervision at the different levels have copies of the guidelines on their respective supervisory roles and responsibilities.</p> <p>While health facility workers interviewed agreed that it is important that they supervise the VHWS, they do not have a clear idea of how to go about it. The VDCs interviewed were not aware that they have a role in supervising the VHWS/TBAs/CBDs.</p>	<p>94. Given the fact that supervisory roles and tasks are not sufficiently clear, all grades of health staff should receive PHC guidelines on supervision of VHWS/TBAs/CBDs from the LGA and Project staff so that all people whatever their rank will know their role. There should be opportunity for discussions at all levels by the LGA project staff so there is greater understanding of the supervisory role and tasks where appropriate. The LGA and Project staff should have regular meetings with the VDCs in order to support and monitor their activities. The district supervisors should work closely with the VDCs and DDCs.</p>
<p>95. Are supervisory checklists used at each level in accordance with PHC guidelines?</p>	<p>95. In the national PHC guidelines, supervisory checklists for each level are provided. While some LGA/PHC staff said they know that such guidelines exist, none reported using them. At the district and community levels it appears that the checklists are not available and hence not used.</p>	<p>95. The PHC director should provide the existing national supervisory checklists to all Assistant Coordinators and District Supervisors and health facility staff to ensure that they are regularly used.</p>

88

Evaluation Questions	Findings	Lessons Learned
<p>96. How frequently are supervisory visits being carried out at each level?</p>	<p>96. LGA staff interviewed stated that according to the national PHC guidelines the District PHC Supervisors should supervise all the PHC activities in their area on a monthly basis. It appears that supervision is being conducted on sporadic basis due in part to the constraints associated with transport: 1) in both LGAs the terrain is rough especially during the rainy season; 2) the LGAs do not have sufficiently sturdy vehicles at their disposal; 3) resources are not always available for fuel; and 4) there is no system in place to ensure preventive and curative maintenance of vehicles.</p> <p>The PHC guidelines prescribe monthly supervision of the VHWS/TBAs/CBDs by health facility staff. It appears that in some cases supervision is not being carried out, in others it is being done sporadically. In only a few cases is regular supervision being ensured by facility health workers.</p>	<p>96. To ensure that monthly supervisory visits are carried out by district PHC supervisors the LGA needs to improve transport, ensure maintenance, and provide fuel in order to mobilize PHC staff for this task.</p> <p>A schedule should be developed for on-the-job training/supervision by CHEWS and project staff for TBAs and VHWS to ensure continuous updating of their knowledge and skills.</p>
<p>97. Is both qualitative and quantitative data collected in the monitoring and evaluation information?</p>	<p>97. Qualitative information on program activities can provide insights into how activities are being implemented, their strengths and weaknesses and lessons learned. The only qualitative information being collected is that included in monthly reports sent from health facilities to LGAs and in minutes of district PHC meetings. It is unclear if or how this information is being used at the LGA level.</p>	<p>97. In addition to the conventional quantitative information, the LGA/PHC Dept. should be collecting qualitative information on ongoing PHC activities to ensure effective/accurate monitoring and evaluation. The results need to be analyzed at the LGA level in order to develop lessons so as to ensure appropriate future assessment, planning and implementation.</p>

Evaluation Questions	Findings	Lessons Learned
<p>98. Is there a mechanism for developing lessons learned from supervision and are they utilised to strengthen CS/MH activities?</p>	<p>98. At the LGA level, PHC staff report that during their meetings with district supervisors findings from supervision reports are discussed and lessons developed.</p>	<p>98. It is important for the LGA PHC staff to continue to periodically discuss findings of supervisors reports and develop lessons learned.</p>

23

1995 PIPELINE ANALYSIS: PART A -- HEADQUARTERS BUDGET

Check one: ORIGINAL BUDGET  REVISED BUDGET

PVO/COUNTRY: NIGERIA  
 COOPERATIVE AGREEMENT NO.: FAO-0500-A-00-3024-00  
 DATE BUDGET PREPARED: October, 1995  
 DATE SUBMITTED TO USAID: 31 October, 1995

		Total Agreement Budget 10/93 - 09/95		Actual Expenditures 10/93 - 06/95		Projected Expenditures 07/95 - 09/95		Projected Expenditures 10/95 - 9/97		Revised Budget Total 10/93 - 9/97		REVISED TOTAL YEARS 1-4
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	
<b>I. DIRECT COSTS</b>												
<b>A. PERSONNEL (salaries, wages, fringes)</b>												
1. Headquarters - salaries/wages		\$108,890	\$4,471	\$22,477	\$0	\$46,427	\$2,384	\$37,986	\$1,900	\$106,890	\$4,284	\$111,154
2. Field, Technical Personnel - salaries/wages		\$0	\$0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Field, Other Personnel - salaries/wages		\$0	\$0	\$0	\$208	\$0	\$0	\$0	\$0	\$0	\$208	\$208
4. Fringes - Headquarters		\$32,067	\$0	\$6,743	\$0	\$0	\$0	\$0	\$0	\$6,743	\$0	\$6,743
<b>SUBTOTAL - PERSONNEL</b>		<b>\$138,957</b>	<b>\$4,471</b>	<b>\$29,220</b>	<b>\$208</b>	<b>\$46,427</b>	<b>\$2,384</b>	<b>\$37,986</b>	<b>\$1,900</b>	<b>\$113,633</b>	<b>\$4,472</b>	<b>\$118,105</b>
<b>B. TRAVEL/PER DIEM</b>												
1. Headquarters - Domestic (USA)		\$7,450	\$0	\$0	\$0	\$4,098	\$0	\$3,352	\$0	\$7,450	\$0	\$7,450
2. Headquarters - International		\$26,100	\$0	\$10,889	\$0	\$8,366	\$0	\$6,845	\$0	\$26,100	\$0	\$26,100
3. Field - In country		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
4. Field - International		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>SUBTOTAL - TRAVEL / PER DIEM</b>		<b>\$33,550</b>	<b>\$0</b>	<b>\$10,889</b>	<b>\$0</b>	<b>\$12,464</b>	<b>\$0</b>	<b>\$10,197</b>	<b>\$0</b>	<b>\$33,550</b>	<b>\$0</b>	<b>\$33,550</b>
<b>C. CONSULTANCIES</b>												
1. Evaluation Consultants - Fees		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Other Consultants - Fees		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Consultant travel / per diem		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>SUBTOTAL - CONSULTANCIES</b>		<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
<b>D. PROCUREMENT (provide justification/ explanation in narrative)</b>												
1. Supplies												
a. Headquarters		\$2,880	\$590	\$0	\$0	\$1,584	\$590	\$1,298	\$0	\$2,880	\$590	\$3,470
b. Field - Pharmaceuticals (ORS, Vit A, drugs, etc.)		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
c. Field - Other		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Equipment												
a. Headquarters		\$1,435	\$2,500	\$0	\$0	\$789	\$1,375	\$648	\$1,125	\$1,435	\$2,500	\$3,935
b. Field		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Training												
a. Headquarters		\$1,260	\$360	\$0	\$0	\$693	\$360	\$567	\$0	\$1,260	\$360	\$1,620
b. Field		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>SUBTOTAL - PROCUREMENT</b>		<b>\$5,575</b>	<b>\$3,450</b>	<b>\$0</b>	<b>\$0</b>	<b>\$3,066</b>	<b>\$2,325</b>	<b>\$2,509</b>	<b>\$1,125</b>	<b>\$5,575</b>	<b>\$3,450</b>	<b>\$9,025</b>
<b>E. OTHER DIRECT COSTS (provide justification/ explanation in narrative)</b>												
1. Communications												
a. Headquarters		\$6,000	\$1,200	\$0	\$0	\$3,300	\$660	\$2,700	\$540	\$6,000	\$1,200	\$7,200
b. Field		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Facilities												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Other												
a. Headquarters		\$1,300	\$0	\$76	\$0	\$673	\$0	\$551	\$0	\$1,300	\$0	\$1,300
b. Field		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>SUBTOTAL - OTHER DIRECT</b>		<b>\$7,300</b>	<b>\$1,200</b>	<b>\$76</b>	<b>\$0</b>	<b>\$3,973</b>	<b>\$660</b>	<b>\$3,251</b>	<b>\$540</b>	<b>\$7,300</b>	<b>\$1,200</b>	<b>\$8,500</b>
<b>TOTAL - DIRECT COSTS</b>		<b>\$185,382</b>	<b>\$9,121</b>	<b>\$40,185</b>	<b>\$208</b>	<b>\$65,930</b>	<b>\$5,349</b>	<b>\$53,943</b>	<b>\$3,565</b>	<b>\$160,058</b>	<b>\$9,122</b>	<b>\$169,180</b>
<b>II. INDIRECT COSTS</b>												
<b>A. INDIRECT COSTS</b>												
1. Headquarters		\$35,870	\$2,149	\$11,895	\$56	\$13,186	\$1,256	\$10,789	\$837	\$35,870	\$2,149	\$38,019
2. Field (if applicable)		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>TOTAL - INDIRECT COSTS</b>		<b>\$35,870</b>	<b>\$2,149</b>	<b>\$11,895</b>	<b>\$56</b>	<b>\$13,186</b>	<b>\$1,256</b>	<b>\$10,789</b>	<b>\$837</b>	<b>\$35,870</b>	<b>\$2,149</b>	<b>\$38,019</b>
<b>GRAND TOTAL (DIRECT AND INDIRECT COSTS)</b>		<b>\$221,252</b>	<b>\$11,270</b>	<b>\$52,080</b>	<b>\$264</b>	<b>\$79,116</b>	<b>\$6,605</b>	<b>\$64,732</b>	<b>\$4,402</b>	<b>\$195,928</b>	<b>\$11,271</b>	<b>\$207,199</b>
												<b>TOTAL PROJECT</b>

\$207,199  
TOTAL PROJECT

1995 PIPELINE ANALYSIS: PART B - COUNTRY BUDGET

Check one: ORIGINAL BUDGET  REVISED BUDGET

PVO/COUNTRY: NIGERIA  
 COOPFRATIVE AGREEMENT NO.: FAO-0500-A-00-3024-00  
 DATE BUDGET PREPARED: October, 1995  
 DATE SUBMITTED TO USAID: 31 October, 1995

		Total Agreement Budget 10/93 - 09/96		Actual Expenditures 10/93 - 09/95		Projected Expenditures 07/95 - 09/96		Projected Expenditures 10/96 - 9/97		Revised Budget 10/93 - 9/97		REVISED TOTAL YEARS 1-4
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	
<b>I. DIRECT COSTS</b>												
<b>A. PERSONNEL</b>												
(salaries, wages, fringes)												
1. Headquarters-salaries/wages		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Field, Technical Personnel-salaries/wages		\$173,352	\$0	\$75,985	\$0	\$53,552	\$0	\$43,815	\$0	\$173,352	\$0	\$173,352
3. Field, Other Personnel-salaries/wages		\$43,810	\$0	\$3,153	\$0	\$22,361	\$0	\$18,296	\$0	\$43,810	\$0	\$43,810
4. Fringes - Field		\$110,178	\$0	\$30,092	\$0	\$44,046	\$0	\$36,040	\$0	\$110,178	\$0	\$110,178
SUBTOTAL - PERSONNEL		\$327,338	\$0	\$109,230	\$0	\$119,959	\$0	\$98,151	\$0	\$327,340	\$0	\$327,340
<b>B. TRAVEL/PER DIEM</b>												
1. Headquarters-Domestic (USA)		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Headquarters-International		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
3. Field - In country		\$172,110	\$40,643	\$41,848	\$0	\$59,276	\$22,354	\$47,621	\$18,289	\$148,743	\$40,643	\$189,386
4. Field- International		\$34,450	\$0	\$3,116	\$0	\$19,700	\$0	\$14,000	\$0	\$36,816	\$0	\$36,816
SUBTOTAL - TRAVEL / PER DIEM		\$206,560	\$40,643	\$44,962	\$0	\$78,976	\$22,354	\$61,621	\$18,289	\$185,559	\$40,643	\$226,202
<b>C. CONSULTANCIES</b>												
1. Evaluation Consultants- Fees		\$20,800	\$0	\$599	\$0	\$11,110	\$0	\$8,090	\$0	\$20,799	\$0	\$20,799
2. Other Consultants- Fees		\$23,250	\$3,600	\$0	\$0	\$12,788	\$1,980	\$10,462	\$1,620	\$23,250	\$3,600	\$26,850
3. Consultant travel / per diem		\$23,000	\$5,500	\$4,000	\$0	\$10,450	\$3,025	\$8,550	\$2,475	\$23,000	\$5,500	\$28,500
SUBTOTAL - CONSULTANCIES		\$67,050	\$9,100	\$4,599	\$0	\$34,348	\$5,005	\$26,102	\$4,095	\$67,049	\$9,100	\$76,149
<b>D. PROCUREMENT</b>												
(provide justification/ explanation in narrative)												
1. Supplies												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field - Pharmaceuticals (ORS, VR A, drugs, etc.)		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
c. Field- Other		\$32,240	\$99,640	\$21,929	\$0	\$15,555	\$54,802	\$12,636	\$44,838	\$50,120	\$99,640	\$149,760
2. Equipment												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field		\$8,060	\$128,140	\$8,156	\$13,118	\$1,090	\$63,262	\$0	\$51,760	\$9,246	\$128,140	\$137,386
3. Training												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field		\$12,180	\$5,620	\$8,727	\$0	\$8,250	\$3,091	\$6,750	\$2,529	\$23,727	\$5,620	\$29,347
SUBTOTAL - PROCUREMENT		\$52,480	\$233,400	\$38,812	\$13,118	\$24,895	\$121,155	\$19,386	\$99,127	\$83,093	\$233,400	\$316,493
<b>E. OTHER DIRECT COSTS</b>												
(provide justification/ explanation in narrative)												
1. Communications												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field		\$13,857	\$3,600	\$4,988	\$0	\$5,506	\$1,980	\$4,505	\$1,620	\$14,999	\$3,600	\$18,599
2. Facilities												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field		\$21,300	\$8,916	\$30,616	\$0	\$2,179	\$4,904	\$1,700	\$4,012	\$34,495	\$8,916	\$43,411
3. Other												
a. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
b. Field		\$23,900	\$900	\$12,156	\$727	\$7,214	\$173	\$5,903	\$0	\$25,273	\$900	\$26,173
SUBTOTAL - OTHER DIRECT		\$59,057	\$13,416	\$47,760	\$727	\$14,899	\$7,057	\$12,108	\$5,632	\$74,767	\$13,416	\$88,183
<b>TOTAL - DIRECT COSTS</b>		<b>\$712,485</b>	<b>\$296,559</b>	<b>\$245,363</b>	<b>\$13,845</b>	<b>\$273,077</b>	<b>\$155,571</b>	<b>\$219,368</b>	<b>\$127,143</b>	<b>\$737,808</b>	<b>\$296,559</b>	<b>\$1,034,367</b>
<b>II. INDIRECT COSTS</b>												
<b>A. INDIRECT COSTS</b>												
1. Headquarters		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
2. Field (if applicable)		\$169,977	\$70,586	\$71,488	\$4,205	\$54,615	\$36,528	\$43,874	\$29,853	\$169,977	\$70,586	\$240,563
<b>TOTAL - INDIRECT COSTS</b>		<b>\$169,977</b>	<b>\$70,586</b>	<b>\$71,488</b>	<b>\$4,205</b>	<b>\$54,615</b>	<b>\$36,528</b>	<b>\$43,874</b>	<b>\$29,853</b>	<b>\$169,977</b>	<b>\$70,586</b>	<b>\$240,563</b>
<b>GRAND TOTAL (DIRECT AND INDIRECT COSTS)</b>		<b>\$882,462</b>	<b>\$367,145</b>	<b>\$316,851</b>	<b>\$18,050</b>	<b>\$327,692</b>	<b>\$192,099</b>	<b>\$263,242</b>	<b>\$156,996</b>	<b>\$907,785</b>	<b>\$367,145</b>	<b>\$1,274,930</b>
												<b>TOTAL PROJECT</b>

68

1995 PIPELINE ANALYSIS: PART C -- HEADQUARTERS/FIELD BUDGET

Check one: ORIGINAL BUDGET  REVISED BUDGET

PVO/COUNTRY: NIGERIA  
 COOPERATIVE AGREEMENT NO.: FAO-0050-A-00-3024-00  
 DATE BUDGET PREPARED: October, 1995  
 DATE SUBMITTED TO USAID: 31 October, 1995

		Total Agreement Budget 10/93 - 09/96		Actual Expenditures 10/93 - 06/95		Projected Expenditures 07/95 - 09/96		Projected Expenditures 10/96 - 9/97		Revised Budget 10/93 - 9/97		REVISED TOTAL YEARS 1-4
		USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	USAID	PVO	
<b>I. DIRECT COSTS</b>												
<b>A. PERSONNEL</b> (salaries, wages, fringes)												
	1. Headquarters - salaries/wages	\$106,890	\$4,471	\$22,477	\$0	\$46,427	\$2,364	\$37,988	\$1,900	\$106,890	\$4,284	\$111,154
	2. Field, Technical Personnel - salaries/wages	\$173,352	\$0	\$75,985	\$0	\$53,552	\$0	\$43,815	\$0	\$173,352	\$0	\$173,352
	3. Field, Other Personnel - salaries/wages	\$43,810	\$0	\$3,153	\$208	\$22,361	\$0	\$18,296	\$0	\$43,810	\$208	\$44,018
	4. Fringes - Headquarters + Field	\$142,243	\$0	\$36,835	\$0	\$44,046	\$0	\$36,040	\$0	\$116,921	\$0	\$116,921
	<b>SUBTOTAL - PERSONNEL</b>	<b>\$466,295</b>	<b>\$4,471</b>	<b>\$138,450</b>	<b>\$208</b>	<b>\$166,386</b>	<b>\$2,364</b>	<b>\$136,137</b>	<b>\$1,900</b>	<b>\$440,973</b>	<b>\$4,472</b>	<b>\$445,445</b>
<b>B. TRAVEL/PER DIEM</b>												
	1. Headquarters - Domestic (USA)	\$7,450	\$0	\$0	\$0	\$4,098	\$0	\$3,352	\$0	\$7,450	\$0	\$7,450
	2. Headquarters - International	\$26,100	\$0	\$10,869	\$0	\$8,366	\$0	\$6,845	\$0	\$26,100	\$0	\$26,100
	3. Field - In country	\$172,110	\$40,643	\$41,846	\$0	\$59,276	\$22,354	\$47,621	\$18,289	\$148,743	\$40,643	\$189,386
	4. Field - International	\$34,450	\$0	\$3,116	\$0	\$19,700	\$0	\$14,000	\$0	\$36,816	\$0	\$36,816
	<b>SUBTOTAL - TRAVEL / PER DIEM</b>	<b>\$240,110</b>	<b>\$40,643</b>	<b>\$55,851</b>	<b>\$0</b>	<b>\$91,440</b>	<b>\$22,354</b>	<b>\$71,818</b>	<b>\$18,289</b>	<b>\$219,109</b>	<b>\$40,643</b>	<b>\$259,752</b>
<b>C. CONSULTANCIES</b>												
	1. Evaluation Consultants - Fees	\$20,800	\$0	\$599	\$0	\$11,110	\$0	\$9,090	\$0	\$20,799	\$0	\$20,799
	2. Other Consultants - Fees	\$23,250	\$3,600	\$0	\$0	\$12,788	\$1,980	\$10,482	\$1,620	\$23,250	\$3,600	\$26,850
	3. Consultant travel / per diem	\$23,000	\$5,500	\$4,000	\$0	\$10,450	\$3,025	\$8,550	\$2,475	\$23,000	\$5,500	\$28,500
	<b>SUBTOTAL - CONSULTANCIES</b>	<b>\$67,050</b>	<b>\$9,100</b>	<b>\$4,599</b>	<b>\$0</b>	<b>\$34,348</b>	<b>\$5,005</b>	<b>\$28,102</b>	<b>\$4,095</b>	<b>\$67,049</b>	<b>\$9,100</b>	<b>\$76,149</b>
<b>D. PROCUREMENT</b> (provide justification/ explanation in narrative)												
	1. Supplies											
	a. Headquarters	\$2,880	\$590	\$0	\$0	\$1,584	\$590	\$1,296	\$0	\$2,880	\$590	\$3,470
	b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	c. Field - Other	\$32,240	\$99,640	\$21,029	\$0	\$15,555	\$54,802	\$12,636	\$44,838	\$50,120	\$99,640	\$149,760
	2. Equipment											
	a. Headquarters	\$1,435	\$2,500	\$0	\$0	\$789	\$1,375	\$646	\$1,125	\$1,435	\$2,500	\$3,935
	b. Field	\$8,060	\$128,140	\$8,156	\$13,118	\$1,090	\$63,262	\$0	\$51,760	\$9,246	\$128,140	\$137,386
	3. Training											
	a. Headquarters	\$1,260	\$360	\$0	\$0	\$693	\$360	\$567	\$0	\$1,260	\$360	\$1,620
	b. Field	\$12,180	\$5,620	\$8,727	\$0	\$8,250	\$3,091	\$6,750	\$2,529	\$23,727	\$5,620	\$29,347
	<b>SUBTOTAL - PROCUREMENT</b>	<b>\$58,055</b>	<b>\$236,850</b>	<b>\$38,812</b>	<b>\$13,118</b>	<b>\$27,961</b>	<b>\$123,480</b>	<b>\$21,895</b>	<b>\$100,252</b>	<b>\$88,668</b>	<b>\$236,850</b>	<b>\$325,518</b>
<b>E. OTHER DIRECT COSTS</b> (provide justification/ explanation in narrative)												
	1. Communications											
	a. Headquarters	\$6,000	\$1,200	\$0	\$0	\$3,300	\$660	\$2,700	\$540	\$6,000	\$1,200	\$7,200
	b. Field	\$13,857	\$3,600	\$4,988	\$0	\$5,506	\$1,980	\$4,505	\$1,620	\$14,999	\$3,600	\$18,599
	2. Facilities											
	a. Headquarters	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
	b. Field	\$21,300	\$8,916	\$30,616	\$0	\$2,179	\$4,904	\$1,700	\$4,012	\$34,495	\$8,916	\$43,411
	3. Other											
	a. Headquarters	\$1,300	\$0	\$76	\$0	\$673	\$0	\$551	\$0	\$1,300	\$0	\$1,300
	b. Field	\$23,900	\$900	\$12,156	\$727	\$7,214	\$173	\$5,903	\$0	\$25,273	\$900	\$26,173
	<b>SUBTOTAL - OTHER DIRECT</b>	<b>\$66,357</b>	<b>\$14,616</b>	<b>\$47,836</b>	<b>\$727</b>	<b>\$18,872</b>	<b>\$7,717</b>	<b>\$15,359</b>	<b>\$6,172</b>	<b>\$82,067</b>	<b>\$14,616</b>	<b>\$96,683</b>
<b>TOTAL - DIRECT COSTS</b>		<b>\$897,867</b>	<b>\$305,680</b>	<b>\$285,546</b>	<b>\$14,053</b>	<b>\$339,007</b>	<b>\$160,920</b>	<b>\$273,311</b>	<b>\$130,708</b>	<b>\$897,866</b>	<b>\$305,681</b>	<b>\$1,203,547</b>
<b>II. INDIRECT COSTS</b>												
<b>A. INDIRECT COSTS</b>												
	1. Headquarters	\$35,870	\$2,149	\$11,895	\$56	\$13,186	\$1,256	\$10,789	\$837	\$35,870	\$2,149	\$38,019
	2. Field (if applicable)	\$189,977	\$70,586	\$71,488	\$4,205	\$54,615	\$36,528	\$43,874	\$29,853	\$189,977	\$70,586	\$240,563
<b>TOTAL - INDIRECT COSTS</b>		<b>\$205,847</b>	<b>\$72,735</b>	<b>\$83,383</b>	<b>\$4,261</b>	<b>\$67,801</b>	<b>\$37,784</b>	<b>\$54,663</b>	<b>\$30,690</b>	<b>\$205,847</b>	<b>\$72,735</b>	<b>\$278,582</b>
<b>GRAND TOTAL (DIRECT AND INDIRECT COSTS)</b>		<b>\$1,103,714</b>	<b>\$378,415</b>	<b>\$368,931</b>	<b>\$18,314</b>	<b>\$406,808</b>	<b>\$198,704</b>	<b>\$327,974</b>	<b>\$161,398</b>	<b>\$1,103,713</b>	<b>\$378,416</b>	<b>\$1,482,129</b>
												<b>TOTAL PROJECT</b>

8