

PD-ABN-614

World Vision Relief & Development, Inc.

**WVRD/Nigeria FY92
THIRD ANNUAL REPORT
OGBOMOSO SOUTH CHILD SURVIVAL PROJECT
October 31, 1995**

Grant No.:FAO-0500-A-00-2042-0

Beginning Date: October 1, 1992
Ending Date: September 30, 1996

Submitted to:

**PVO Child Survival Grant Program
Office of Private and Voluntary Cooperation
Bureau for Humanitarian Response
Room 103C, SA-8
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Project Organogram

Project FY95 Pipeline

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I. Overview of Third Year :

A. Actual Accomplishments with the Goals and Objectives for FY95.

The table below shows the actual accomplishments with the objectives set for the period under review (FY95):

Table 1 FY95 Accomplishments

OBJECTIVES FOR FY 95	ACCOMPLISHMENTS
Immunization:	
1. 80% full immunization coverage with six EPI vaccines of children 12-23 months of age by their first birthday	66.6 percent*
2. 80% of women aged 15-45 years immunized with TT2	86.4 percent*
3. Establish a tracer disease (neonatal tetanus, measles, and poliomyelitis) surveillance	Village Health Workers (VHWs) Traditional Midwives (TMWs) and Community Development Committee (CDC) members report cases of tracer diseases to project technical staff during monthly supervisory visits to the village health posts. Cases of any of the tracer diseases coming from the project area and reporting to the Baptist Medical Center, Ogbomoso are being monitored.
Control of diarrheal disease	
1. 60% of eligible infants/children treated with ORT.	42.4 percent*
2. 70% of eligible mothers competent in ORT usage.	60.6 percent*
3. Line 7 hand dug wells with concrete rings	100.0 percent
Growth Monitoring and Nutrition	
1. Train 100 nutrition promoters.	112 were trained
2. Train 10 VHWs.	18 VHWs were trained
3. 70% of children aged 0 - 23 months and all malnourished children weighed monthly.	61.2 percent**
4. 85% of children aged 0-23 attained appropriate weight for age.	74.9 percent**
5. 400 farmers supplied with soybean seeds for planting.	1325 farmers were supplied
Care of Mothers	
1. 208 pregnant women in their third trimester receive malaria prophylaxis.	398 received pyrimethamine#
2. 417 pregnant women receive curative treatment of malaria with chloroquine at their first visit to a community-level health facility	428 received chloroquine#
3. 2454 couples with children less than 2 years practice modern contraception.	198 new acceptors with 1901 repeat visits#
Control of Malaria	
1. 90% of children with malaria receiving chloroquine.	81.5 percent*

* Status as of 30 September, 1995 based on project's monitoring system.

** Based on monthly report for September, 1995

Based on cumulative total for FY95

B. Training Activities for Project Staff

The following training activities were undertaken by project staff during FY95:

1. One nutritionist attended a three-day workshop on Vitamin A deficiency organized by UNICEF.
2. One public health nurse attended a four-day international conference on onchocerciasis operation research.
3. The health information coordinator attended a one-day seminar on child survival, protection and development organized by UNICEF and Oyo State MOH.
4. The project manager, health information coordinator, and data analyst received four-days of training on computer programming.
5. Seventeen technical staff were trained on Ivermectin Distribution Program (IDP).
6. Sixteen technical staff were trained on Vitamin A supplementation.
7. One public health nurse participated in a two-day review meeting on IDP health education materials.
8. The project manager participated in a two-week Area Development Program workshop which focused on integration of child survival with other developmental activities.
9. Ten project technical staff had one-day training on health information system on IDP.

C. Technical Support Received for Child Survival Activities

1. Dr.'s Stan Foster of Rollins School of Public Health at Emory University, Susan Saba and Hezekiah Adesina of NCCCD, Daniel Gbadero of Baptist Medical Center, and Tom Ventimiglia of WVRD provided technical assistance during the mid-term evaluation conducted in December, 1994.
2. Terry Robinson, a health information specialist from USAID/NCCCD, Lagos, Nigeria reviewed and improved project's monitoring system.
3. Professor O. Walker, a malariologist, from University College Hospital, Ibadan, Nigeria, provided some technical input into the study of the sensitivity of *P.falciparum* to chloroquine. However, the study has been postponed due to logistic problems. Attempts

are being made to overcome these problems at the time of this annual report.

4. Dr Bode Kayode and Patrick Idah of Africare, Kwara State office provided technical support in the training of the project's technical staff in Onchocerciasis Control Program (OCP).

5. The project also received technical papers from WVRD sub-regional office and headquarters and the PVO Child Survival Support Program at the Johns Hopkins University School of Hygiene and Public Health.

D. Report on the Work of Active Community Development Committees

The number of Community Development Committees (CDCs) established, in the project area, since inception to date is 89. The CDC members selected those who were trained as volunteer health workers to participate in community mobilization for health activities. These activities included encouragement of mothers to embrace child survival activities, patronage of the health posts by the community members and fixing of selling prices for drugs at these posts. One committee led its community to raise funds which were spent in upgrading their village health post to a dispensary. Seven committees mobilized community resources to dig wells. Some CDCs gave some incentives in cash and/or kind to the volunteer health workers. They provided administrative support to the Village Health Workers (VHWs), Traditional Midwives (TMWs) and Nutrition Promoters (NPs).

A total of 153 meetings were held by these CDCs during the last 90 days (July to September, 1995). The table below shows the analysis:

Table 2 Meetings Held by CDCs (July - September, 1995)

No. of CDCs	Frequency of meeting in the last 90 days	Total number of meetings held	Cumulative Total	Percentage	Cumulative Percentage
22	0	0	0	0	0.0
13	1	13	13	8.5	8.5
22	2	44	57	28.8	37.3
32	3	96	153	62.7	100.0

E. Linkages Made Between the Project, MOH, and Other Health and Development Activities in Country

The project maintained its strong link with Oyo State MOH, the Oyo

State Agricultural Development Program and the National Primary Health Care Development Agency through its zonal office in Ibadan and the Nigerian Association of Non-Governmental Organizations on Health (NANGO) - an umbrella organization of many national and international NGOs/PVOs with interest in health programs in the country. Through its involvement in IDP, linkages have been established with the River Blindness Foundation, and the International Eye Foundation. During the year under review, the project also strengthened its relationship with UNICEF through a joint campaign to eradicate guinea-worm from some endemic communities. During discussions with project staff, the Catholic Diocese of Oyo Rural Health Services, showed interest in primary health care delivery in some of the project communities. As a result of these fruitful discussions, some communities have been handed over to this group while a joint supervision of these communities and the community based health workers has started.

F. Professional Staff Changes

Mrs. Cecilia Monisola Adebambo, a public health nurse, joined the staff in April, 1994. She replaced Mrs. Bola Ogunjumo who resigned her position a few months earlier. Mrs Adebambo has 24 years of nursing to her credit, with 17 of these spent practicing community nursing. She holds a diploma in Public Health Nursing and certificates in Community and Family Planning and Administration. She had served as a programmer for family planning and child survival in Osun State of Nigeria. (Please see organogram attached below.)

II. Follow-up of Mid-Term Evaluation (MTE)

The MTE of the project was conducted in December, 1994. Following the acceptance of one of the recommendations that a request for a one year no-cost extension of the current project to September 30, 1996 be made, and the approval of this request, this aspect of the annual report will deal with issues raised in the MTE report rather than the DIP. The first annual report prepared in October, 1993 has already dealt with the issues raised in the DIP review. All of the MTE recommendations, except two, were accepted and have been implemented or are in the process of being implemented. While the project staff agreed that community level monitoring should be strengthened, they did not agree that central monitoring of immunization and nutrition data be limited to quarterly reviews. If these recommendations were accepted, the project would not be in a position to meet headquarters and donor reporting requirements, some of which need to be submitted on monthly basis. The delay in implementing some recommendations can be attributed to circumstances beyond our control. For example, delay in completion of in-vivo tests of chloroquine sensitivity in parasitemic pre-school children is due to the inability to find a substitute for the consultant initially contacted for the study

after the consultant got involved in similar studies outside the country. The implementation of the recommendations has no negative budgetary impact.

III. Changes Made in Project Design

There has been no significant change in project design from the approved DIP. However, some steps were taken to further improve the health status of the target population. As a means of improving their nutritional status, children aged 12 - 59 months were given free anti-helminthic drugs to help reduce possible worm load. During the period under review, the Federal Government of Nigeria and UNICEF directed that children between the ages of 6 and 24 months and women who delivered within the past one month, be given Vitamin A supplementation. This followed a survey which found that Vitamin A deficiency had become an issue of public health concern. The project participated in two campaigns held during the year. The cost of extending the supplementation to older children was considerable because of the large population. The age cohort of 6 - 24 months, which was judged to be at greatest risk, was chosen to receive the supplementation by the government. The project chose to abide by the government's position.

In addition, following the acceptance of the recommendation of the MTE team, VHWS have been trained to identify and use co-trimoxazole in the treatment of childhood pneumonia.

Another intervention which, though not directly related to child survival, can have serious implications for the survival of the child's health, is the control of river blindness. A national survey identified some of the project communities as endemic for onchocerciasis (river blindness). The project has, therefore, added the distribution of Ivermectin to eligible population. A sub-set of this group is women of child bearing age, a significant portion of project beneficiaries. The location or number of project beneficiaries has not changed from that proposed in the DIP. The cost of these additional activities to the project is minimal.

IV. Constraints, Unexpected Benefits, and Lessons Learned.

A. Constraints

1. Vaccine Shortage

There was a widespread shortage of vaccine nationally especially during the last four months of the year under review. The vaccines most affected were BCG and oral polio. There was been a slight improvement over the few weeks prior to the preparation of this report, but the supply is still erratic.

2. Economic Downturn

Due to the harsh economic situation in the country, it is now more difficult for a mothers to attend health education sessions or to bring their children for project interventions. These women are having to spend longer hours trying to eke out a living.

3. Non-functional Community Development Committees(CDCs)

Some of the CDCs, especially in the larger communities, have not been as active as expected. Tasks for which the CDCs had responsibility were left undone. This has dampened the morale of the volunteer community-based health workers. About 20% of project beneficiaries live in the communities with non-functional CDCs.

4. Non-functional Village Health Workers/Traditional Midwives

For a number of reasons, including economic pressures, some volunteer VHWs and TMWs moved away from their original places of abode. Some communities could not find replacements for them. A few other VHWs and TMWs have stopped providing services though they still reside in their communities.

5. Non-performance by Local Government Staff

Due to the dearth of adequate personnel and logistic support, the local government staff, especially in Ogo Oluwa Local Government Area, did not perform as anticipated. However, the situation improved during the last few weeks of the year under review.

6. Fuel Scarcity

Fuel shortages occurred periodically during the year. Consequently, movement of people and goods became difficult. There were instances when mothers who travelled to distant markets or towns to sell their goods were stranded and missed opportunities to participate in child survival activities during outreach visits to their communities.

7. Dispute Among Communities

For political, social, or other reasons, some communities could not agree to continue to work together on health related activities. Such conflicts, when they occurred, often disrupted implementation of child survival activities.

8. Bad Weather

The rains were unusually heavy and prolonged this year. There were instances when activities could not be held due to bad weather. Many of the unpaved roads have been washed away.

9. Annual Urban Migration

During the months of December and January, many people often migrate from the rural area to the city for the Christmas and New Year celebrations. As this also coincides with the time when there is not much to do on the farms, many of them choose to stay longer in the towns and therefore miss opportunities for child survival activities.

B. Strategies Used to Overcome Constraints

1. To combat vaccine shortage, the project contacted adjacent reliable EPI cold stores for assistance. This effort paid off to some degree as the Baptist Medical Center (BMC) was able to supply some vaccines for a period. The project also provided transport assistance to the zonal EPI storekeeper as he travelled to other stores, including the State store, in search of vaccines on a number of occasions.

2. On some occasions project staff had to leave the village health posts, the usual place for health interventions, to meet the mothers at locations where they were carrying out income-generating activities in order to immunize them and their children. The project introduced an award for any child who completes the full immunization between age 9 and 10 months as a further incentive.

3. Non-functional CDCs were reconstituted with membership drawn from some of the beneficiaries. Advocacy meetings were held constantly with opinion leaders.

4. A committee comprised of representatives from the project office, the local governments, BMC, and the VHWS/TMWS was set up to recover debts owed on the income generating activities and manage these. This effort paid off as 82 VHWS/TMWS received cash incentives totalling US \$250. The money was paid from recovered debts. A token fee for service was introduced. The mothers responded well to this. The money realized was managed by the mothers and spent in part as incentives to the community based VHWS/TMWS. This increased their morale and decreased attrition. In six months, a sum of US \$560 was realized on fee for service. Project staff provided services that otherwise would have been provided by VHWS were they (VHWS) active pending the identification and training of replacement for those VHWS, who dropped out.

5. The project staff continued their efforts to encourage dialogue with the local government leadership and staff. Pragmatic suggestions were made as to how available resources could be best utilized. These efforts began to yield good results towards the end of the year under review.

6. Any time the project sensed that there was going to be a fuel scarcity, the commodity was purchased and stored for use throughout the period of scarcity. The mothers who have temporarily moved to Ogbomoso are often encouraged to come to the project office for their immunization and that of their children. The project on occasions helped to take the beneficiaries from Ogbomoso back to their communities when visits were made to those communities.

7. Project staff often tried to arrange dialogue to resolve disputes. When it was felt necessary, persons from outside the communities in which there was a dispute were invited by the project to intervene. If all attempts at reconciliation failed and there was realignment in relationships, that is, one community decided to align with a different one, the project staff never hesitated to transfer the records of the beneficiaries to their new areas and provide the necessary services.

8. Meetings for health activities were re-scheduled whenever they were disrupted by bad weather.

C. Circumstances which Facilitate Implementation and Produce Unexpected Benefits

1. Soybean seeds had been given to farmers in the past so that this grain could be made readily available to enrich the children's diet. Being a leguminous plant, it enriched the soil fertility enabling the farmers reap bounty harvests of those crops subsequently planted on the land.

2. Mectizan® (ivermectin) was distributed to the eligible population primarily to control onchocerciasis. The drug also expelled other worms and increased the general well-being and productivity of the recipients.

3. Free anti-helminthic drugs were given free of charge, to children aged 12 - 59 months. Many mothers like the drug and for this reason many of them brought their children for health services during the months when the drug was distributed.

4. During the period of fuel scarcity one of the beneficiaries delivered a baby in the project area. When she developed post-partum haemorrhage, her husband trekked to the project office to ask for assistance. The project promptly sent two senior nurses who brought the woman to the hospital for care. She survived. Thereafter, community members paid greater attention to project activities. There were other calls for transportation assistance to which the project responded favourably. On one occasion someone was stung by bees and needed hospitalization. At another time a child who was severely anaemic had to be rushed to the hospital by the project staff. Both of them lived. The child's father has

since become a strong advocate of the project in his community. All of these acts further endeared the project to the communities.

5. The project paid one-third of the cost of rehabilitation of malnourished children admitted to BMC's Kersey Children's Home. The subsidy encouraged acceptance of children's transfer to the home for nutrition rehabilitation and mother's training in child nutrition. The cost of treatment for the few cases of an injection abscess following vaccination was borne by the project. Instead of being discouraged as a result of the possibility of injection abscess, the assurance that if an abscess occurred, the project would assist in the care of the child facilitated vaccination compliance.

6. The project staff had always taught exclusive breastfeeding for the first four months of a child's life and recommended that in the unfortunate incident of a mother dying at childbirth, then other nursing mothers could assist in breastfeeding the orphan. The latter position was not fully endorsed until one project staff member, who was nursing her own baby, had an opportunity to publicly breastfeed a child whose mother died at childbirth. This practical demonstration changed the attitude of the women to breastfeeding other people's children whenever necessary.

7. One of the project's nutritionists and other project staff, spent several days and nights in a community, training some women as nutrition promoters. One night during the visit, a woman went into labor and had difficulty delivering her baby. The nutritionist attended to her and she delivered safely. This was an additional benefit the project brought to the community.

8. Project beneficiaries who happen to be in Ogbomoso metropolis, which is outside the project area, could receive their immunization in the project office located in the town. This helped to increase immunization coverage.

D. Lessons Learned and Institutionalization of These Lessons

Previous reports have documented many rich lessons learned. However, the following additional lessons have been learned in the implementation of the project.

1. Not all mothers whose children are doing well like attention to be drawn to them. During a visit to one community, the nutritionist showed a well-nourished child to all who were present and commended the child's mother for a job well done. The mother did not show up during the following month's growth monitoring and nutrition support clinic. When she was visited by the project staff she said she chose to stay away so that people with malevolent spirits would not harm her child. Project staff must be sensitive to mothers who may have such thoughts.

2. Project staff must be watchful and recognise the powers that be in their area of operation. One female VHW who was nominated by the community was found deficient in her performance. The project staff drew her attention to this. Her community, through the CDC, relieved her of her duty. Some mothers stopped coming to the village health post. During enquiries, it was discovered that the sacked VHW was nominated by an influential member in the community. He felt he had been humiliated by his colleagues. Both this leader and the VHW had maligned the project, hence the mothers stayed away. Dialogue ensued. The VHW was patiently re-trained in her areas of weakness. She returned to her job, her performance is satisfactory now, and the mothers have returned to the health post.

3. Health workers must always be flexible to accommodate changes in roles and responsibilities of volunteer health workers. A woman was nominated by her community to be trained as a TMW, but after she was trained, no pregnant woman ever invited her to provide assistance during delivery. This caused some concern for the project staff. Before long, the TMW learned how to use soybeans to prepare many meals, some of which she sold to members of the community. She was further trained to function as a nutrition promoter. She was well accepted in her new role. Another person had been selected and trained to play the role of TMW in that community. Meanwhile, the original worker leads the nutrition promoters in her community and no longer practices as a TMW.

4. Closely related to number 3 above is the fact that project staff must exercise patience with the community and allow them to learn from their mistakes. While project staff may give guidelines to the community on choosing volunteers who would probably serve the community's interest, the final choice must be made by the community. Otherwise, if anything goes wrong, the project staff will be held responsible.

5. Optimism should be the watchword of project staff even in the face of seemingly intractable difficulties. One community is made up of people who belong to a different faith from the project staff. For this reason, the community often viewed all activities with suspicion. The project staff never wavered from meeting the health needs of the community. The community eventually realized that the project meant well for its members. They have fully embraced and are actively supporting child survival activities in their community now.

6. Though painful sometimes, people may have to be penalized in order for them to become sensitive and responsible. Maternal cards were issued freely to all women in the child bearing age group. Some women carelessly lost their cards and others left them at home when they attended sessions at the village health posts. When a fee was charged for replacing lost card, the incidence of missing cards or cards being left behind at home reduced drastically.

These lessons are shared with collaborators and other PVOs during meetings. When opportunities arise, such as a worldwide conference sponsored by USAID in Bangalore, India in October, 1994, where the project manager presented a paper on the project's experiences, the project staff are willing to share their experiences.

V. Progress in Health Information System (HIS) Data Collection

A. The Characteristics and Effectiveness of the Project HIS

The project HIS prepared immunization calendars for the children and the mothers thereby improving the quality and the accuracy of field data collected from the field by the technical crew with minimum supervision. The use and updating of the community register was discontinued to allow the VHWS to concentrate on some other things they could do better. An HIS expert from USAID/NCCCD Lagos gave the project HIS a new lease on life by helping to restructure its program files, drastically reducing in the number of files held by the computer memory and consequently saving time gained in data processing and analysis. The project staff further improved on the restructuring. It is now easier and quicker to access the record of any child or woman of child-bearing age or any community or individual beneficiary of an intervention from the HIS system.

Data collection forms previously used were modified to eliminate collection of information not relevant to the users and the project. The new forms have been found very helpful and effective in the project's monitoring activities. These include VHW summary of activities and monitoring of activities. The data analyzed has enabled the project to identify areas of weakness in its planned implementation strategies and take the necessary steps to correct the weaknesses. The forms used for data collection are attached as Appendix I.

B. Collection and Utilization of HIS Data

The HIS data are being collected by two main groups, viz, the project technical crew and the VHWS/TMWs. The technical crew collect data on the immunization status of eligible children and women, weight of children, and the women who attended training sessions. They also report on the activities of the CDCs at the various communities, the number of cases of diarrhea occurring during the two weeks preceding a visit to a particular community, and how such cases were managed.

The VHWS report on their daily activities, particularly the number of cases of malaria, diarrhea and other illnesses they managed, how much money they realized or expended. These records are cross-checked by the technical staff. The TMWs have a pictorial form for reporting their activities vis-a-vis the number of pregnant women who received pre-natal care and the number of deliveries they

attended to in the month. During immunization and growth monitoring sessions, the VHWS sort immunization and growth monitoring charts into two groups. One group shows children who have completed their immunizations and the other those who have yet to complete their immunizations.

A similar exercise for nutritional status is done by sorting cards into children who gain weight and have attained appropriate weight for age and those who are malnourished or losing weight. The mothers and others who are present are thereby able to judge the performance of the community by these indicators. Appropriate decisions as deemed fit are then made by the CDC members on behalf of the community.

The data, having been analyzed by the HIS unit, are being utilized at various levels. At the project level, achievements are compared with goals and results enable project management to make decisions to direct project staff efforts. Data on immunization are also sent to the zonal State EPI store and local government headquarters for processing and transmission to the next higher level.

The data are being used to prepare monthly and quarterly reports to regional and headquarters offices. These data are also used in preparing annual and other reports to U.S.A.I.D., WVRD Headquarters and other partners.

C. Further Refinement of the System

The area that needs immediate attention is pictorial data presentation at the community level because those who were not there during sessions and miss the demonstration involving piles of cards as explained above can still know the community's achievement. A permanent simple record system which will be kept at the community level is also needed so that trends can be compared over time.

VI. Budget and Expenditures

A. Changes in Budget

No major change was made to the budget since the DIP was prepared. However, as a result of underspending (explanation of the reason see section D below) a no-cost extension for one year has been approved on request.

B. Pipeline Analysis

The pipeline analysis is attached below.

C. Quantitative Data for Project Outputs

Please see the following table for quantifiable project outputs.

Table 3 Analysis of Costs

Analysis of Costs into Unit Costs					
Intervention	% of total cost allocated	Allocated Cost (\$)	Cost bases	Output	Cost/Unit (\$)*
Immunization	20	58265	No. of antigens administered	49773	1.2
Control of diarrhea diseases	30	87397	No. of training contacts	7140	12.2
Growth Monitoring	10	29132	No. of weighing contacts	25072	1.2
Nutrition Education	15	43698	No. of training contacts	12188	5.6
Maternal Care	5	14566	No. of women who have received TT2	5019	2.9
Family Planning	10	29132	No. of people trained	6385	4.6
Malaria Control	10	29132	No. of recipients of malaria prophylaxis	4317	6.7

* Total field costs less equipment and Income Generating Activities

D. Additional Pertinent Information

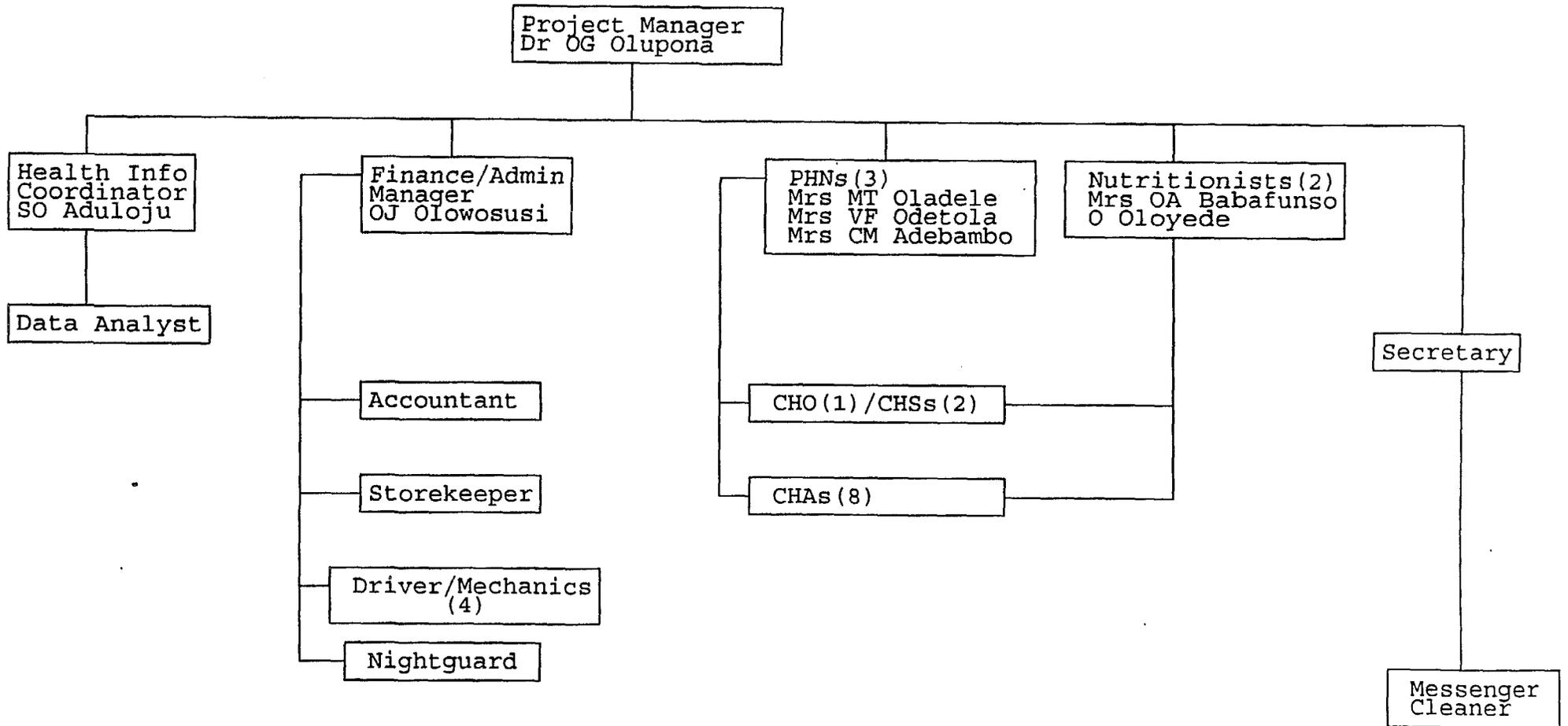
There was a slight overrun in the supplies budget due to hyper inflationary trends in the country. The exchange rate of the local currency to the dollar changed significantly. From a rate of 20 Naira (₦20) to the US dollar at the onset of the project, the closing rate was ₦80 to the dollar - an increase of 300 percent in favour of the dollar!

The MTE also cost less than was budgeted. It was not necessary to conduct a field survey as was originally envisaged. The net result of this was a budget surplus which could be expended during the one year no-cost extension. A substantial amount of money was spent in assisting the communities to line hand dug wells with concrete rings for the control of diarrhea diseases. This activity was not included in the cost per unit calculation though the expenditure is part of the allocated cost for control of diarrhea diseases. This explains why there is a higher unit cost for this intervention when compared with other interventions.

VII. Other

The project has a maternal care/family planning component. The curriculum for training health workers and health messages used to teach mothers are attached to this report as separate documents (Appendices II and III).

WORLD VISION INTERNATIONAL
OGBOMOSO CHILD SURVIVAL PROJECT
ORGANOGRAM



WORLD VISION RELIEF & DEVELOPMENT, INC.

AGREEMENT NAME: NIGERIA

AGREEMENT NUMBER: FAO-0500-A-00-2042-00

AGREEMENT PERIOD AUGUST 31, 1992 - SEPTEMBER 30, 1996

Financial Report Through SEPTEMBER 30, 1995

	USAID GRANT BUDGET	TO-DATE ACTUAL COSTS	REMAINING FUNDS
USAID GRANT COSTS			
SALARIES, BENEFITS & HOUSING	242,777	179,648	63,129
TRAINING	0	6,037	(6,037)
TRAVEL	32,450	7,172	25,278
SUPPLIES AND MATERIALS	31,706	15,232	16,474
OTHER DIRECT COSTS	35,810	22,462	13,348
PROFESSIONAL SERVICES	24,499	3,432	21,067
CAPITAL EXPENDITURES	0	4,760	(4,760)
OFFICE RENTAL	1,020	9,423	(8,403)
COMMUNICATIONS	7,532	5,024	2,508
I G A ACTIVITIES	0	2,350	(2,350)
M S C	0	0	0
TOTAL DIRECT COSTS	<u>375,794</u>	<u>255,540</u>	<u>120,254</u>
INDIRECT COSTS	74,206	51,410	22,796
TOTAL COSTS	<u><u>450,000</u></u>	<u><u>306,950</u></u>	<u><u>143,050</u></u>

MATCHING COSTS

SALARIES, BENEFITS & HOUSING	42,433	20,717	21,716
TRAINING	0	4,335	(4,335)
TRAVEL	10,226	5,196	5,030
SUPPLIES AND MATERIALS	65,454	8,593	56,861
OTHER DIRECT COSTS	12,823	2,588	10,235
PROFESSIONAL SERVICES	4,323	391	3,932
CAPITAL EXPENDITURES	0	43,668	(43,668)
OFFICE RENTAL	180	723	(543)
COMMUNICATIONS	1,329	350	979
I G A ACTIVITIES	0	6,946	(6,946)
M S C	0	0	0
TOTAL DIRECT COSTS	<u>136,768</u>	<u>93,507</u>	<u>43,261</u>
INDIRECT COSTS	18,024	10,217	7,807
TOTAL COSTS	<u><u>154,792</u></u>	<u><u>103,724</u></u>	<u><u>51,068</u></u>

A P P E N D I X I
REPORT ON MONITORING VISIT

Community _____

Date: _____

A Activities:

Were these activities held between last month and now? Tick as appropriate

	Yes	No
1. Growth Monitoring		
2. Food Demonstration		
3. Immunization		
4. CDC meeting		
5. Community members buying drugs from post		

B Supplies:

	Available	Not available
1. Adequate drugs		
2. Family planning supplies		
3. Daraprim for chemoprophylaxis		
4. Sugar and salt for SSS		

C Morbidity:

Are there new cases of	Yes	No
1. Neonatal tetanus?		
2. Measles?		
3. Poliomyelitis?		

Obtain details for each yes answer. Please collect Disease Surveillance form.

E Deaths:

	Name	Age	Sex	Date of death	Symptom
1					
2					

F List important people you met

G Any other comment:

Name of supervisor _____ Signature _____

COMMUNITY DEVELOPMENT COMMITTEE MEETING REPORT FORM

VILLAGE _____ DATE _____ TIME _____

A. MEMBERS PRESENT (NAME AND POSITION)

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

B. WHAT WERE THE REASONS GIVEN FOR OTHER MEMBERS NOT PRESENT?

C. HOW OFTEN DO MEMBERS OF CDC VISIT THE HEALTH POST?

D HOW MANY MEMBERS VISITED THE HEALTH POST THIS MONTH?

E HOW IS THE TREASURER DOING HIS WORK?

(State how much was received and spent between last visit and now
₦ _____ / ₦ _____)

F. WHAT ARE THE PROBLEMS OF THE HEALTH POST AS SEEN BY THE CDC?

G. IN YOUR OPINION, WHAT ARE THE MAIN PROBLEMS OF THE VHws/TMws ?

H. WHAT RECOMMENDATIONS DID YOU MAKE TO THE CDC TO HELP IMPROVE THE PROGRAM? GENERALLY? THE TEACHING? THE GENERAL WORK OF THE VHws?

S U P E R V I S O R

DISEASE SURVEILLANCE

Diagnosis _____

Name _____ Sex _____

Date of birth _____

Date of onset of illness _____

For cases of Neo-natal Tetanus

Place of delivery _____

Person who cut the cord _____

Method of cord dressing _____

Tetanus toxoid immunization status of mother

Date

Place

For cases of Poliomyelitis and Measles

Immunization status of the child

Vaccine

Date

Place

Outcome _____

Any other comment

Name of reporting officer _____ Signature _____

Date _____

TECHNICAL REPORT FORM

DATE _____ COMMUNITY _____

A. Control of Diarrhoeal Diseases (0 - 23 months old)

1.	Diarrhoea within the last 2 weeks	0000	0000	0000	0000
2.	Used SSS or home based fluid to treat diarrhoea	0000	0000	0000	0000
3.	Mothers who correctly followed CDD protocol	0000	0000	0000	0000

B. Maternal Care

1.	Mothers' delivery within past 1 month attended to by trained personnel (trained TBA, midwife, nurse, doctor).	0000	0000	0000	0000
2.	Pregnant women receiving chloroquine	0000	0000	0000	0000
3.	Pregnant women in third trimester receiving Daraprim	0000	0000	0000	0000
4.	Pregnant women receiving Iron tablets/folate	0000	0000	0000	0000

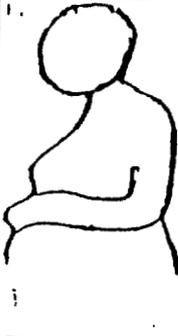
C. Malaria fever

1.	Number of children 0 - 23 months sick with fever (within past 2 weeks)	0000	0000	0000	0000
2.	Number receiving chloroquine	0000	0000	0000	0000

D. Child Spacing

1.	New acceptor of modern contraception	0000	0000	0000	0000
2.	Commodities supplied:				
	Condoms /foaming tab _____				
	Oral Pills _____				
	Referrals _____				

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A P P E N D I X II

Curriculum for Training Health Workers in Maternal Care and Family Planning

I. Traditional Midwives (TMWs)

Traditional midwife in the context of this project is similar to what many others refer to as Traditional Birth Attendants (TBAs). The term traditional midwife is preferred to underscore the fact that a volunteer health worker so called is not expected to attend to a woman only when she is in labor as the term TBA may suggest. A TMW provides care during pregnancy, child birth and post-partum.

Requirements:

- resident in the community
- preferably married women
- willingness to learn and practice new ideas
- respectable members of the community

Job Description:

- conducts prenatal care at the community level
- screen pregnant women and refers high risk pregnancies
- attends to women in labor
- mobilizes mothers for immunization
- provides initial care and follow-up for mothers and new born babies
- prepares graphic report of activities and submits it during continuing education sessions.
- functions as a member of health care providers at the community level
- pays home visit to pregnant women

Learning Objective:

The overall learning objective is to produce a community based volunteer who is able to provide maternal care and care of the newborn with a view to reducing morbidity and mortality related to pregnancy and child birth. Specific learning objectives are highlighted under each topic.

Teaching Methodology:

A mix of various techniques and methods is employed. The method used is determined by its appropriateness to achieve learning objective. The techniques include group discussion, story telling, role play, practical demonstration, lecture, songs, poems and video show.

At the end of training, each trainee is assessed and those who have been adjudged successful are provided with a delivery kit and allowed to practice. The initial training which is conducted at the community level lasts for two weeks. Continuous monitoring and evaluation of activities are carried out by project's technical staff.

Course Content:

1. Local beliefs and customs about pregnancy: Time: 2 hours.

Learning Objective:

At the end of the discussion, participants are able to identify beliefs and cultural practices about pregnancy in the community with a view to identifying those that are beneficial, neutral or harmful.

Teaching Methodology: Group discussion

Action to take: Beneficial practices should be encouraged while harmful practices must be discouraged.

2. Infection and hygiene: Time: 2 hours

Learning Objective:

At the end of the session, participants will know that diseases can follow the introduction of harmful organisms into the body. They will also know that simple measures like hand washing with soap and water, delivery in a clean environment will greatly eliminate chances of infection.

Teaching Methodology: Story telling at the end of which participant will draw important lessons, role play and songs.

Action to take: TMWs will use clean instruments while taking delivery in a clean environment. They will be examples of good personal hygiene to the community.

3. Reproductive Organs: Time: 1 hour.

Learning Objective:

At the end of the class, participants will have an idea about the anatomy of female and male reproductive organs.

Teaching Methodology: Lecture with appropriate visual aids

Action to take: Community education

4. Menstrual Cycle and Fertilization: Time: 1 hour

Learning Objective:

At the end of the class, participants will have an idea about the physiological changes that take place in the woman between menarché and menopause.

Teaching Methodology: Lecture

Action to take: Community education

5. Signs of pregnancy: Time: 2 hours

Learning Objective:

At the end of the discussion, participants will be able to name physiological and anatomical changes that characterize pregnancy. These are: amenorrhoea, nausea, vomiting, quickening, and increased frequency in micturition. Others include breast and skin changes and enlargement of the abdomen.

6. Management of minor problems in pregnancy: Time: 2 hours

Learning Objective:

At the end of the session, participants will be able to name minor health problems in pregnancy, their management by simple measures, and discourage the indiscriminate use of drugs during pregnancy.

Teaching Method: Lecture/group discussion

Action to take: Community education

7. Prenatal Care: Time: 10 hours

Learning Objective:

By the end of training, participants will know how to identify high risk pregnancies including grand multiparity, pregnancy in women younger than 18 years or older than 35 years, previous surgical delivery, short stature or deformed pelvis, bad obstetric history, history of medical illness, and last confinement under 2 years. In

addition, participants will be able to estimate fetal growth, lie and presentation by palpation and listening for fetal heart sounds and prepare the women for labor and lactation.

Teaching Methodology: A mix of lecture, story and practical demonstration.

Action to take: TMWs will hold many sessions of prenatal care under the supervision of project staff before being allowed to conduct such care on their own.

8. Danger Signs in Pregnancy and Referrals: Time: 4 hours

Learning Objective:

By the end of the session, participants should be able to name and identify the following danger signs:

bleeding per vaginam with or without pain, swollen feet and face, severe headache, blurring of vision, excessive tiredness, severe pallor, passing of fluid other than urine, and convulsions. Others include labour lasting more than 12 hours, medically ill patients, abnormal presentation and retained placenta.

They would be able to name and refer patients in this category to referral centers that can adequately manage such cases.

Action to take: Work with other community members to arrange for immediate evacuation of pregnant women with danger sign to referral center.

9. Management of Labor: Time 6 hours

Learning Objective:

At the end of the session, participants should be able to identify when labor is established, support the woman during the first stage of labor, manage second stage of labor properly by ensuring that the woman pushes only during contractions and guiding the baby's head to prevent it from falling to the floor and ensuring there is no perineal tear. Others include how to suck baby's nostrils and mouth with mucus extractor and ensure that baby is breathing, ligation of the cord to prevent bleeding, proper management of the third stage of labor, including keeping baby dry and warm and ensuring mother breastfeeds baby within the first hour of delivery if there is no contra-indication.

Teaching Methodology: A mix of lecture, story, demonstration.

Action to take: TMW to ensure her delivery kit is prepared as soon as labor is established. Her hands are washed with soap and water, uses new razor blade which is discarded after use, wears plastic hand gloves and ensures good environmental hygiene in the area of delivery.

10. Care of the baby and mother: Time: 2 hours

Learning Objective:

At the end of the session, participants should be able to teach mothers how to care for the baby's cord, examine newborn and identify congenital abnormalities such as cleft lip, club foot, meningocele and other gross abnormalities. Participants should be able to name referral center for a baby who may need to be referred.

Teaching Methodology: Lecture with visual aids to show various abnormalities.

Action to take: Bathe and examine baby for abnormalities. Demonstrate to mother how cord should be cared for.

11. Child Spacing: Time: 6 hours

Learning Objective:

By the end of the session, participants should be able to mention all of the methods of modern contraception, know how to counsel couples to adopt modern contraception. The TMWs should be able to teach couples how to use condoms and foaming tablets. They will know where to refer clients for other methods.

Teaching Methodology: Group discussion, story telling, role play, video show.

Action to take: Community education and distribution of condoms and foaming tablets to interested couples.

12. Nutrition of mothers in pregnancy: Time: 4 hours

Learning Objective:

At the end of the discussion, participants will be able to name food items rich in iron, Vitamin A and other nutrients which the pregnant woman must eat. They will know that a pregnant woman needs to eat more to meet her requirement and that of the baby in her womb. They will be able to identify malnourished woman and those with flat or retracted nipples for care before delivery.

Teaching Methodology: Group discussion and demonstration

Action to take: Check weight trends with supervisors. Dispense chloroquine, pyrimethamine, iron and folate tablets.

13. Immunization: Time: 2 hours

Learning Objective:

At the end of the lecture, participants will know that a pregnant woman needs at least two doses of tetanus toxoid taken either prior to or during pregnancy to protect herself and the baby from tetanus. In addition, they will know the immunization schedule for the unborn baby and locations where the vaccines are available.

Teaching Methodology: Lecture and video film

Action to take: Community health education.

II. Village Health Worker (VHW)

Although the VHW does not have the primary role for providing maternal care, nonetheless, as a member of the health team at the community level, (s)he is given some orientation in maternal care and family planning.

Requirements:

- resident within the community
- patient and long suffering
- gainfully employed
- honest in her/his dealing
- literate in Yoruba Language
- preferably married
- willing to learn and apply new teachings
- good story teller

Job Description (as it relates to maternal care and family planning)

- pays home visit to pregnant woman and those who have just been delivered of babies
- dispense condoms and vaginal tablets while referring couples for other methods of family planning

Curriculum:

The course is incorporated in the initial three-week training for VHWS. The following topics, similar in content to those of TMWs, are taught:

- local beliefs about pregnancy, management of minor problems in pregnancy, danger signs in pregnancy, child spacing, nutrition of mother in pregnancy, immunization, and care of the newborn.

III. Project Personnel

The project's technical personnel have the responsibility to train, evaluate, supervise and provide technical backstopping to the TMWs and VHWS. Their training, therefore, ensures that they are capable of dealing with all of the topics under maternal care and family planning as planned for the community based workers. In addition, they are trained to fulfil the responsibility earlier on mentioned and monitor the weight and blood pressure of the pregnant women.

Curriculum

One day refresher course.

Maternal Care and Family Planning

Learning Objective:

By the end of the refresher course, participants would have been reminded of the contents of the training curriculum for TMWs and VHWS vis-a-vis maternal care and family planning. In addition, they would have been reminded of their roles as technical backstoppers, accurate weight and blood pressure measurement and other related issues in maternal care and family planning.

Teaching Methodology: Group discussions, video and other materials review.

A P P E N D I X III

Health messages to teach mothers about maternal care/family planning.

General issues about pregnancy

- It is not a disease
- You can go through it successfully If you do what trained health workers tell you
- Teenagers should avoid getting pregnant, pregnancy is an adult's affairs

Prenatal Care

- As soon as you miss your period, confide in your traditional midwife
- Do not use any drug except the one given to you by trained health worker
- Malaria can kill your baby and harm you, take your Sunday - Sunday medicine (pyrimethamine)
- You are eating for two people. Remember to eat your baby's portion, take extra food!
- Nutrients will reach your baby through your blood. You need more, so take your iron tablets and folate. Eat more of dark green leafy vegetables, palmoil, pawpaw, carrot, spinach, liver, beans, and oranges to give your body blood and Vitamin A.
- If you are not gaining weight, chances are that your baby is not growing well. Seek the advice of a health worker.
- As soon as labor is established, inform the health worker.
- You need special care if you have any of the following: medical problem, short stature, previous surgical delivery, bad obstetric history, deformed pelvis, your last baby is less than 2 years, more than 5 previous pregnancies, past history of bleeding, and you are younger than 18 years or older than 35 years.
- You must see a health worker if you notice any of the following signs:
bleeding per vaginam with or without pain, passing of any fluid other than urine, swollen feet or face, excessive tiredness, blurred vision, severe headache, fever, cessation of fetal movement, prolonged labor, pre-term labor.
- You need at least two doses of tetanus toxoid taken before or during pregnancy to protect yourself and your baby from tetanus.
- Make sure you deliver your baby in a clean environment.
- Insist on attendant using clean instruments.
- If your attendant feels you need to be transferred to more experienced health worker, agree. To disagree may cost your life and that of your baby!
- Do not push out your baby until the trained attendant asks you to do so.
- If you labor for more than 12 hours, you need help.

Care of the Newborn

Breastfeed your baby as soon as you deliver, preferably within one hour of delivery. Do not give glucose water, concoction, artificial milk to your baby during his/her first four months of life. Your breast milk is enough for her/him. Breastfeeding helps your womb to return to normal faster. You and your baby have many benefits to derive from breastfeeding. Failure or refusal to breastfeed your baby is costly!

- Keep your baby dry and warm.
- Avoid rubbing cow dung, powder and other things on your baby's cord. Cover it with clean dressing which you need to change daily.
- Ensure your baby is vaccinated with BCG and first dose of oral polio

Postnatal Care

- Continue to breastfeed for at least one year while you introduce other food from between 4 and 6 months.
- If lochia becomes offensive, seek medical attention.
- If you develop fever with or without rigors, seek medical attention
- You need plenty of rest to regain your health.
- Continue to eat more of the foods you ate during pregnancy. Take a lot of fluids.
- You need to see a trained health worker for check-up 6 weeks after delivery.
- Your baby is due for further vaccination (polio and DPT) at 6, 10 and 14 weeks. As soon as he is nine months old, he needs measles vaccine for full protection against killer diseases.

Family Planning

- Space your children to have a happy family.
- There is a family planning method suitable for you.
- Too many children is an invitation to poverty.
- A birth interval of at least 2 years ensures that you do not burn yourself out prematurely
- Ask for family planning services wherever you see this sign
(Please see logo - Appendix IV)

Songs on maternal care/family planning

1. Plan your family/3x
So as to enjoy good life,
So as to enjoy old age,
So as to enjoy your child,
I have already planned my own,
Your had better plan your own,
Plan your family so as to enjoy good health
2. Family planning/2x
Family planning is a good program
To have children you can look after,
Family planning is a good program
3. All: Plan your family/2x
Each one must know his limitation,
Plan your family

Solo: I have vaginal tablet for you
All: Plan your family

Solo: I have condoms to offer you
All: Plan your family

Solo: IUCD is available in the hospital
All: Plan your family

Solo: Do not forget surgical contraception too.
All: Plan your family

Solo: It is available in the hospital
All: Plan your family

All: Plan your family/2x
Each one must know his limitation,
Plan your family
4. Soyabeans makes us grow well
Can't you see I am looking good?
It is good for me and my baby
Soyabeans makes us grow well

5. Pregnancy is no disease
It's God's grace
May you have safe delivery
6. Hygiene will destroy many germs
Personal hygiene
Environmental hygiene
Food hygiene
Hygiene will destroy many germs



Child-Spacing Services Available Here