



# COMPASS

Community Participation for Action in the Social Sector

May 2004 – August 2009

An integrated approach for maximizing results in the social sector

## End-of-Project Report

Submitted to the

United States Agency for International Development (USAID)

September 30, 2009



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## EXECUTIVE SUMMARY

This End-of-COMPASS Project Report offers the United States Agency for International Development (USAID)/Nigeria Mission, the Government of Nigeria, national, international developmental stakeholders and NGO partners a composite roadmap on the implementation stages and milestones of the Project. It highlights implementation context, core components and strategic approaches, key achievements, challenges, lessons learned and recommendations for future programs.

The report is divided into ten sections – Establishing the Context, The COMPASS Project, Overview, Program Achievements and Results, Collaboration and Partnerships for Results, Management and Administrative Structure, Financial Summaries, Project Close-out Activities, Lessons Learned, Challenges, Changes, Opportunities, Sustainability, and Recommendations for Future Programs.

The Community Participation for Action in the Social Sector (COMPASS) Project was implemented under Cooperative Agreement No. 620-A-00-04-00125-00 between Pathfinder International and USAID. The Project was launched in 2004 to expand participation, ownership and use of healthcare and education sector services to the community level in four states (Bauchi, Lagos, Kano and Nasarawa) and the Federal Capital Territory (FCT) of Nigeria over a period of five years.

COMPASS represented a new exciting scale of investment by USAID in Nigeria, with programming that stimulated and promoted the integration of education and health development across all project activities at all levels. While the undertaking was challenging, the Project recorded major accomplishments. The impacts at the community levels were especially unique and expanded the Mission's on-going attempts towards integration that was not present before.

From its inception, the COMPASS Project made extensive investments in manpower and organizational development through hiring and establishing operational field offices in the project states. Equally, rigorous attempts were made to nurture various partnerships and relationships especially between national ministries and state and local government leaders, major parastatals in the education and health, Nigerian NGOs and community-based organizations, religious leaders and school officials, communities and their Local Government Authorities, and among the four Nigerian partner organizations on the project and the five US-based implementing partners.

With nine partner organizations collaborating and US-based leadership under Pathfinder International, COMPASS was the first major development project in Nigeria to integrate health with education, engaging the knowledge, effort, and commitment of leaders at the national, state, local and grassroots levels in a common quest for sustainable progress. The project envisioned an environment in which every Nigerian was involved in learning, planning, and action to improve health and education in his or her community.

This vision was actualized through the development and implementation of annual work plans and targets over the five-year project period. Headquartered in Abuja and working out of state offices in Lagos, Kano, Bauchi, and Nasarawa, and the FCT, COMPASS reached a total population of over 18 million Nigerians over the course of five years serving as the major source of behavior change communication materials support on reproductive health and family planning (RH/FP), basic education and child survival for project beneficiaries and stakeholders. The undertaking was staggering in its scope and vision. This report captures some of the extensive work of the project particularly in making expandable and sustainable inroads into the problems of healthcare and education in Nigeria. It also focuses on the Nigerian people, in particular those who pioneered change initiatives in the communities where COMPASS worked.

To achieve substantial gains in education and health, COMPASS specifically targeted basic education, RH/FP and child survival as core areas where major interventions yielded significant results. A set of key cross-cutting activities permeated programming in all areas which included: community mobilization, institutional capacity building, public-private partnerships, policy and advocacy, and monitoring and evaluation. Project activities focused on four USAID-defined intermediate results with a set of indicators and targets for each technical area and were phased to allow the project to implement, measure, and learn at each stage. The lessons learned were used in succeeding phases of the project to increase community ownership and effectiveness.

Pursuant to USAID Strategic Objective (SO) 13: *Increased Use of Social Sector Services*, COMPASS contributed to the achievement of the four SO13 Intermediate Results (IRs), namely:

- IR 13.1: Improved Quality of Social Sector Services;
- IR 13.2: Strengthened Enabling Environment;
- IR 13.3: Expanded Demand for Social Sector Services;
- IR 13.4: Increased Access to Services, Commodities, and Materials.

The Project developed an organizational structure that ensured the active participation of all stakeholders in the process of change. The central management team at the Abuja Central Office, comprised of senior managers and technical advisors for each core and cross-cutting technical area, provided technical and management support to the state teams. They in turn guided and implemented programmatic activities within their respective states. The degree of integration between COMPASS staff, local experts, and government stakeholders was carefully maintained throughout the Project, increasing community representation at every level.

The Project fostered collaboration including those with other USAID-funded projects: GHAIN for specific HIV/AIDS activities (primarily in prevention of mother-to-child transmission (PMTCT) and for activities targeting the uniformed services), and ENHANSE to cover policy-related activities contributing to an enabling environment at state and local levels.

To achieve significant and sustainable results across all four states and FCT, COMPASS harnessed the cooperation and commitment of thousands of individuals, from the Ministries of Health and Education down to village elders, local Imams, and traditional birth attendants (TBAs). To achieve the necessary bottom-up participation, with genuine local ownership and demand for quality in education and healthcare, major obstacles, including customary hierarchies, were overcome.

Interventions at all levels employed reliable, pragmatic, results-oriented input of resources, including equipment and materials, to achieve tangible improvements in schools and health facilities. To organize and mobilize at the local level, COMPASS introduced community coalitions, local-level volunteer task forces that advocated on behalf of community members with different perspectives on social issues, such as religious and educational leaders, members of community- and faith-based organizations, business and government leaders, and leaders of special interest groups like women's associations.

Apart from core COMPASS integrated health and education interventions, the Project also implemented specific add-on programs for USAID through the polio eradication initiatives that targeted eight additional states labeled high-risk states in 2005. Specific interventions on the polio project included the provision of technical assistance to improve data quality and reliability, intense capacity building for several cadres of government officials and community members, active utilization of COMPASS Nigerian partners, and high-scale community mobilization and strategic communication for reducing the spread of wild polio virus. The polio eradication portfolio also included focused initiatives with the Kano Polio Victims Trust Association (KPVTA). In the final year of the project, through additional funding from USAID-PEPFAR, COMPASS implemented the Orphans and Vulnerable Children Wraparound Initiative.

# INTRODUCTION

This report describes the basis for the United States Agency for International Development's (USAID) investment in the Community Participation for Action in the Social Sector (COMPASS) Project, the different phases of the Project over the five years of implementation, and highlights critical program successes and results.

Section I gives an overview of the Nigerian context focusing on both health and education sectors prior to COMPASS intervention in 2005.

Section II describes the purpose, rationale and design of the Project, its goal, vision, objectives, expected outcomes, and geographic coverage.

Section III focuses on the members of the consortium and their responsibilities on the Project, COMPASS technical components and key strategies, process and methodology for interventions, monitoring, evaluating and reporting systems, and highlights key project baseline data.

Section IV key program achievements and results are highlighted in this section with comparisons between baseline and midline data for impact level indicators, as well as year 1 through year 4 for output level indicators. The section also includes information on the final end of project evaluation.

Section V highlights key results of partnerships and collaboration at the national, zonal, state, local government, and community levels.

Section VI describes the management and administrative structure adopted by the Project.

Section VII provides a breakdown of expenditure by funding source and total obligation received from USAID during the lifespan of the Project.

Section VIII describes key programmatic and administrative activities implemented as part of the Project close out procedure.

Section IX describes key lessons learnt, challenges, changes, opportunities, as well as sustainability initiatives implemented by COMPASS.

Section X lists some key recommendations for designing and implementing future programs

The report concludes with an annex which includes key documents referred to in the report

Further details can be gleaned from the strategy documents, state profiles, compilation of COMPASS success stories "Our Change Story" and CD that accompany this report.

## SECTION I: ESTABLISHING THE CONTEXT

Nigeria has witnessed more years of military than democratic rule since its independence in 1960. Despite the country's immense natural and human resources, it remains one of the poorest nations in the world with about half of the population living on less than \$1 per day. This poor economic situation contributes significantly to low learning outcomes and high maternal and infant mortality. Despite government efforts to implement sustainable development projects, especially for health and education services, development indices remain low. In most cases health and education sectors receive low budgetary allocations, largely because they do not contribute directly to short-term income in the country.

As a result, it is not uncommon to find inadequate and unqualified teachers and service providers in Nigerian public schools and health facilities. The environments in which health and education services are provided do not meet the national standards and lack basic equipment and instructional materials to enhance quality service provision. School lessons are conducted in overcrowded classrooms. Although several agencies are implementing health and education projects in Nigeria, these sectors require more funding and technical assistance to improve quality, increase access and demand, and create an enabling environment for policy and advocacy to achieve better health and education for sustainable development.

### **Social Sector Indicators – Basic Education**

Nigeria's education sector declined due to decades of social conflict and neglect, with adult literacy declining from 44 to 41 percent for women and from 68 to 58 percent for men between 1991 and 1999. Only 60 percent of Nigeria's children aged 6-11 attended school, and these numbers fell by almost half in the northern states. Only 28 percent of children aged 4-12 were able to read part or all of a sentence, and 45 percent were able to add numbers correctly. Although a new Universal Basic Education law took effect in January 2005, few states and local governments had the resources to provide all children with the mandated six years of primary and three years of junior secondary education. Net enrollment in primary school hovered between 50-60 percent, and approximately one-third of children who entered primary school did not complete it.

### **Social Sector Indicators - Reproductive Health/Family Planning**

As Africa's largest nation with 140 million people (20% of sub-Saharan Africa), Nigeria plays a key leadership role in the African Union and New Partnership for Africa's Development (NEPAD). Nevertheless, its human development indicators are among the worst in the world. Primary health care systems have been in decline for over a decade largely due to poor role harmonization among different levels of government, inefficient management, lack of resources, dilapidated infrastructures, unclear professional standards, poorly trained health providers, and lack of community participation in health care provision.

Maternal mortality is still unacceptably high in Nigeria and remains the leading cause of death among women of reproductive age (15 -49 years). The Nigerian maternal mortality ratio (MMR) is 800/100,000 live births and the neonatal mortality rate is 35/1,000 live births. A recent needs assessment on safe motherhood based on hospital figures and conducted by SOGON in all the six geopolitical zones of the country, showed alarmingly high MMRs at 3300 and 3900/100000 live births in Lagos and Kano States respectively. The most common cause of death is hemorrhage (bleeding in pregnancy), hypertensive disorders in pregnancy leading to eclampsia, followed by sepsis, and anemia (lack of blood). It is estimated that 11% of maternal deaths are from abortion and its complications, most of which are unsafe. While the desire for large families in Nigeria remains high, there is also significant unmet need

for family planning (FP). At present, 12% of all currently married women want to space their next birth and an additional 5% would like to stop child-bearing altogether.

According to the 2003 Nigeria Demographic Health Survey, (NDHS), a total of just 13% of currently married women are using a method of FP, including 8% who are using a modern method. Acquiring knowledge about methods of FP is a key factor in gaining access to and using a suitable method.

According to the survey, 77% of all women age 15-49, and 89.5% of all men knew at least one modern method of FP. Of these, 37% of the women had knowledge of female sterilization, 10.6% of vasectomy, 60% of pills, 57% of injectables, 27% of IUDs, 10% of implants and 59% of male condoms. Men had similar knowledge of female sterilization, pills and IUDs. Male knowledge of male sterilization and implants was higher at 21% and 19% respectively. Only 0.2% of all women and men had been sterilized, 1.6% of women had used IUDs, and 0.1% had used implants. In relation to adolescent reproductive health (ARH), nationwide 20% of girls were married by age 15, and 40% were married by age 18. Early marriage is very common in some regions (NDHS 2003). In the Northwest region, 48% and 78% of girls were married by age 15 and 18 respectively. Early marriage is accompanied by early childbearing, where almost 50% of women nationwide and 70% of those in the northern regions give birth before their 20<sup>th</sup> birthday.

### **Social Sector Indicators - Child Survival**

At 217 deaths per 1,000 births, Nigeria's under-five mortality rate is one of the highest in the world. Malaria alone is responsible for an estimated one-third of under-five deaths in Nigeria, accounting for more than 200,000 deaths per year. To reduce this rate, Nigeria must aggressively reduce preventable deaths both from malaria and vaccine-preventable diseases.

### **The Education Sector in Nigeria**

Crisis with the education sector was compounded by the isolation of Nigerian schools within the education system. Channels of decision-making and communication exist, but were often weak and under-resourced. The relationship between parents and schools was also weak. Even if communities know about communication channels, they often lacked the capacity or the authority to utilize them effectively. The absence of systems that would enable schools and communities to communicate, collaborate, and resolve problems is troubling and merits much attention. The mechanisms that could assist in addressing the most pressing health and education problems are not in place, which creates critical obstacles.

The consequences of low enrolment and retention are seen in children who are not in school and who are at risk of becoming social miscreants, victims of child trafficking and/or abuse, and entrenched in a lifetime of poverty. In most Northern states, low enrolment and retention of girls leads to the inadequate number of female teachers in the primary school system who can act as role models for the girl children. Major stakeholders have lost confidence in the educational system that could not bring about the desired impact on national development. Various studies attest to these extremely poor conditions, and encourage the government, in partnership with public and private organizations, to intervene and halt this dangerous trend in the education sector.

Since government resources cannot meet all the needs of the present primary education system in Nigeria, the aphorism "Education For All is the responsibility of ALL" speaks to the strategy of involving a wide range of stakeholders.

## **The Health Sector in Nigeria**

The Nigerian health system and healthcare services were in a deplorable state, as a result of myriad issues, ranging from inadequately trained personnel with poor interpersonal communication skills, dilapidated facilities lacking such essentials as potable water, electricity, toilet facilities, and seating facilities, and minimal equipment and job aids. Standards of practice and service protocols were unheard of at health facilities. The National Reproductive Health and Family Planning Policy Guidelines, Standards of Practice and the service protocols were unavailable in health facilities at both state and local government levels.

Service providers in primary healthcare centers (PHCs) are the lowest cadre of healthcare providers in Nigeria, and with little or no training, they are challenged with making far-reaching decisions about the lives of unformed mothers and children. At the local government headquarters and the state ministries of health, officials lack resources, vehicles, and tools for effective supervision and monitoring to ensure quality standards. Essential drugs and RH commodities like contraceptives were rarely available at the average PHC.

Poor immunization coverage in Nigeria is associated with the declining performance of the primary health care system in the country. The most frequent reasons provided by mothers/caretakers whose children were found not to be immunized during the 2003 national immunization coverage survey were lack of vaccines at the health facility (17.9%), followed by “vaccination site too far” (10.5%) and “unaware of need for vaccination” (9.2%).

Dramatically reducing the number childhood deaths due to malaria and vaccine-preventable diseases is critical to improving child survival and achievement of the Millennium Development Goals (MDGs). The challenges of routine immunization reflect the country's weak primary health care system. Many health facilities are nonfunctional. They do not provide immunizations and many do not have the required personnel. The majority of health facilities provide routine immunizations only on an ad hoc basis, depending on availability of vaccines and personnel.

These problems are compounded by poor supervision and support, lack of transport, and inadequate supplies and funding. The personnel are poorly motivated, and many lack appropriate provider-client communication skills. High vaccine wastage and cold chain logistics put further constraints on the system. The COMPASS baseline survey found that only 15% of health facilities provide immunization and 14% conduct outreach sessions. The survey found diphtheria, pertussis, and tetanus (DPT) 3 coverage at only 13%. The inability of the system to perform at a minimum level leads to dissatisfaction, high dropout rates, and loss of confidence by clients. Ignorance about immunization and cultural factors such as women's lack of decision-making power contributes to low uptake of immunization at the household level.

The challenges for reducing deaths from malaria are multifaceted, as no vaccine is available. The National Malaria Control Program (NMCP) recommends intermittent preventive therapy (IPT) during pregnancy, prevention of mosquito bites by regular use of insecticide treated nets (ITNs), and vector control through indoor residual spraying (IRS).

## SECTION II: THE COMPASS PROJECT

### **Purpose, Rationale, and Design**

In response to the aforementioned unfavorable health and education indicators in Nigeria, in 2003 USAID, in collaboration with the Federal Government of Nigeria (FGoN), designed as part of its overall support to the FGoN its 2004 – 2009 Country Strategy Plan (CSP). The overall objective of the CSP was to “support Nigeria achieving a more transparent and participatory democracy with a healthier and better educated population in a growing and diversified economy”.

The COMPASS Project contributed to achieving the USAID Strategic Objective (SO) 13 “Increased use of Social Sector Services”. The rationale for SO13 was based on Nigeria’s ineffectiveness in providing quality social sector services to the people largely owing to over 15 years of undemocratic rule. The unavailability or inaccessibility to these services therefore resulted in extremely high child and maternal morbidity and mortality, prevented people from planning their families, and contributed to reduced literacy or academic performance especially in most rural communities. Additionally, the 2004 – 2009 USAID CSP demonstrated the possible linkages and integration between health and education, based on data from the NDHS and other studies which show strong reciprocal relationships among health and education variables. For instance, increasing levels of maternal education was directly linked to smaller family size and increased use of preventive measures such as immunization, oral rehydration therapy, and ITNs. It also asserts that the number of young children in the household was a significant predictor of school enrolment and attendance among those children. As a result, these linkages justified the strategic integration of programs in RH and FP, child survival and basic education, where feasible and practical.

COMPASS was therefore the first and largest integrated health and education initiative funded by USAID in Africa implemented under Cooperative Agreement 620-A-00-04-00125-00. The Project was formally launched in May 2004 under a bilateral agreement between the US and the Federal Republic of Nigeria. The project was implemented in Lagos, Kano, Bauchi, and Nasarawa States as well as the Federal Capital Territory (FCT). Full program support and integrated programs were implemented in three states<sup>1</sup> while only RH/FP interventions were implemented in the other two states.<sup>2</sup> It is interesting to note that despite the lack of integrated activities in the other two states, positive results were achieved by the project in both education and child survival program areas as well. Detailed illustrations are provided in Section II of this report.

COMPASS built extensively on existing investments and structures by previous USAID-funded projects<sup>3</sup> by integrating them into its established community coalitions (CCs) and quality improvement teams (QITs) which were the primary interface between the project and grassroots. Typically, a CC draws membership from all interested members of the participating community including members of Parent-Teacher Associations, (PTAs), women’s groups, youth groups, religious and traditional leaders, men, community based organizations and QITs.

In its implementation, the Project used two conceptual frameworks based on participatory problem solving approaches – the Community Action Cycle (CAC) and Partnership Defined Quality (PDQ) to encourage community members to work together to identify and prioritize problems in their community, define and identify solutions to those problems, and take action to improve or remedy the situation.

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<sup>1</sup> Lagos, Kano, Nasarawa

<sup>2</sup> Bauchi and FCT

<sup>3</sup> LEAP, VISION, BASICS

## **Goal, Vision, Objectives, Outcomes**

The COMPASS Project's goal was to create an environment in which every Nigerian – parents, patent medicine vendors (PMVs), market women, factory owners, and religious leaders – can be involved in learning, planning, and action to improve health and education in their community. By the end of program intervention in August 2009, the Project had reached and developed the capacities of several thousands of Nigerians at the local level as powerful advocates who had pioneered health and education initiatives and significantly influenced development outcomes in their local communities.

Through the establishment and mentoring of 215 CCs and 731 QITs throughout the 51 project supported local government areas (LGAs) in the five project states, COMPASS formalized and scaled up platforms for communal troubleshooting and problem solving with specific emphasis on priority health and education issues. The Project also engaged state and LGA officials in both sectors for the strategic improvement of service delivery. These levels of collaboration significantly led to the achievement of the COMPASS overall purpose.

## **Geographic Coverage**

COMPASS reached over 18 million men, women, adolescents, and children in the 51 LGAs of Kano, Nasarawa, Bauchi, and Lagos States as well as in the FCT. The key features of the COMPASS-supported states are briefly described below:

### ***Bauchi State***

Situated in the northeast region of Nigeria, Bauchi State has an estimated population of 4.7 million and is divided into three senatorial districts and 20 LGAs. The state fairs poor in key RH issues including high maternal mortality (1,549 maternal deaths per 100,000 live births), low acceptance of and use of FP services (4% contraceptive prevalence rate), poor quality of and access to RH services, early marriage and high fertility rates, harmful traditional practices, and high rates of teenage pregnancy and unsafe abortion - the highest in Nigeria. COMPASS worked in eight LGAs in the state. They were: Bauchi, Alkalari, Kirfi, Tafawa Balewa, Giade, Ningi, Misau and Zaki.

### ***FCT***

FCT has six area councils and a population of approximately 800,000 people. Like Lagos, FCT is challenged by rapid population growth, high cost of living, hard-to-reach migrant communities, and broad ethnic diversity. The difficulty of reaching a large transient population is compounded by the lack of traditional institutions with the authority to reach and motivate communities to action. COMPASS worked with all six area councils in FCT.

### ***Lagos State***

Lagos State is a sprawling urban centre in which its unique endowments and strategic location have created an attraction for domestic and international immigration, producing a mega city of immense dynamism, complexity and opportunities. In 1963, the population of metropolitan Lagos was about 1.44 million; by the 1991 National Census, Lagos State had a population of 5.7 million. A UN study from 2000 estimated the projected population of Lagos State to be around 15 million in 2003. With rapid population growth, public and private resources have been stretched thin as Lagos citizens struggle to get by.

Key health indicators in Lagos State are relatively better than national averages. Nonetheless, life expectancy stands at 55 years; the infant mortality rate is 85 deaths per 1,000 live births; the MMR is 650 deaths per 100,000 live births (the worldwide average is 400); and the measles immunization coverage rate stands at 60%, though the DPT 3 rate was 38.2% as at May 2004. The Project worked in 14 LGAs. They were Ajeromi Ifelodun, Badagry, Ibeju Lekki, Kosofe, Lagos Island, Lagos Mainland, Mushin, Somolu, Surulere, Alimosho, Eti Osa, Ikorodu, Ojo, and Oshodi Isolo.

**Kano State**

The health and educational status of citizens of Kano State has been challenged by institutional resistance and lack of access to modern FP methods and vaccinations, poor health infrastructure, a significant nomadic population that is difficult to reach, and low enrollment rates in public primary schools. In Kano State, fewer girls attend public primary schools because parents favor enrolling them in Islamiyya schools due to lower costs, a focus on Islamic values, and shorter amount of time required to complete the basic curriculum. The Project worked in 16 LGAs: Dala, Kano municipal, Gwale, Nassarawa, Warawa, Ajingi, Gaya, Garko, Bichi, Tsanyawa, Kura, Kibiya, Bebeji, Kano, Gabasawa, and Gwarzo.

**Nasarawa State**

Nasarawa State is largely agrarian with the majority of people engaged in farming and petty trading. The State is structured into 13 LGAs. According to the 1991 Nigerian census, the population of Nasarawa State was 1.2 million. However, with a nationally accepted growth rate of 2.83% coupled with the influx of people into the southern part of the State due to its proximity to Abuja, Nigeria's capital, Nasarawa now has an estimated population of 670,000 people. The Project worked in 7 LGAs: Keffi, Doma, Akwanga, Kokona, Keana, Wamba, and Karu.

**Polio Intervention States**

The COMPASS Polio Program was implemented in eight states in northern Nigeria labeled high-risk states for wild polio virus transmission in 2005. They were Kano, Bauchi, Jigawa, Katsina, Zamfara, Kebbi, Sokoto, and Kaduna.

## SECTION III: OVERVIEW

### The Consortium

The COMPASS Project was implemented by a dynamic 9-member Team led by Pathfinder International. The Nigerian members of the consortium included the Nigerian Medical Association (NMA), Civil Society Action Coalition on Education For All (CSACEFA), the Federation of Muslim Women’s Associations of Nigeria (FOMWAN), and the Adolescent Health and Information Project (AHIP). The US-based International Partners included Creative Associates International Inc. (CAII), Johns Hopkins University Center for Communication Programs (JHU/CCP), Management Sciences for Health (MSH), and Futures Group (FG). All members of the consortium provided technical oversight and expertise according to their comparative advantage. The chart below highlights areas of responsibilities by each partner.

COMPASS Team Partner	Responsibilities on the Project	
<b>Pathfinder International</b>	<ul style="list-style-type: none"> <li>• Project and grants management</li> <li>• Public-Private Partnerships (PPP)</li> <li>• FP, RH, Safe Motherhood</li> <li>• Male Involvement in RH</li> <li>• Institutional Capacity Building (ICB)</li> </ul>	<ul style="list-style-type: none"> <li>• Workplace programs</li> <li>• Management Information Systems</li> <li>• LGA strategic planning</li> <li>• Logistics</li> </ul>
<b>AHIP</b>	<ul style="list-style-type: none"> <li>• Youth</li> <li>• Sexuality Education Policies</li> </ul>	<ul style="list-style-type: none"> <li>• HIV prevention</li> <li>• Youth Friendly Services (YFS)</li> </ul>
<b>CAII</b>	<ul style="list-style-type: none"> <li>• Basic Education</li> <li>• School Health and Nutrition</li> </ul>	<ul style="list-style-type: none"> <li>• Mobilization of PTAs</li> <li>• National Union of Teachers</li> </ul>
<b>CSACEFA</b>	<ul style="list-style-type: none"> <li>• Local educator organizations</li> </ul>	
<b>FOMWAN</b>	<ul style="list-style-type: none"> <li>• Education and health</li> <li>• Islamiyya schools</li> </ul>	<ul style="list-style-type: none"> <li>• Advocacy for women’s and girls’ education</li> </ul>
<b>JHU/CCP</b>	<ul style="list-style-type: none"> <li>• Community Mobilization</li> <li>• Social Mobilization</li> <li>• Demand Creation</li> <li>• Partnership-defined quality</li> </ul>	<ul style="list-style-type: none"> <li>• Behavior Change Communications for community support and project core and cross cutting technical intervention area</li> </ul>
<b>MSH</b>	<ul style="list-style-type: none"> <li>• Child Health/Child Survival</li> <li>• Immunization (including polio)</li> </ul>	<ul style="list-style-type: none"> <li>• Malaria</li> </ul>
<b>NMA</b>	<ul style="list-style-type: none"> <li>• Performance Improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Continuing Medical Education</li> </ul>
<b>FG</b>	<ul style="list-style-type: none"> <li>• Policy and Advocacy/Enabling Environment at State and LGA Levels</li> <li>• Local level advocacy</li> </ul>	<ul style="list-style-type: none"> <li>• Generation of reliable data</li> <li>• Monitoring and evaluation (M&amp;E)</li> </ul>

In addition to the partners listed above, COMPASS identified and strengthened nongovernmental organizations (NGOs) at the state level to increase their involvement in the social sector. These NGOs were both sub-recipients and key collaborators at the state level (see annex for contact sheet of sub-grantees).

From inception, Pathfinder International was committed to the participation of the four Nigerian organizations as full partners in the consortium, in the areas of staffing and programmatic responsibilities. Though staffing responsibilities were fulfilled at the launch of the Project, the level of participation for full programmatic responsibilities was dependent on the respective organization’s

management capacity and as a result, most Nigerian partner organizations did not fully participate in programmatic responsibilities until the last two years of the project.

As part of its annual work plan development process, each member organization provided short-term technical assistance (STTA) plans for specific activities. This provided a platform for on-the-job training and capacity building for specific COMPASS staff and helped to realize specific project goals which required such technical resources. Though each technical component was initially managed by expatriates, by year 4, the project was entirely managed by Nigerians.

<b>Nigerian Partner Staff at the Launch of the Project</b>
FOMWAN: Advocacy Advisor
NMA: Senior Clinical Services Advisor
AHIP: Adolescent Advisor
CSACEFA: Education Network Coordinator

It is noteworthy that following intensive capacity building and mentoring of staff from the Nigerian partner organizations, they evolved into higher positions within the COMPASS Project by the end of year 5.

## **Technical Components and Key Strategies**

### ***A. Basic Education***

The ability to read, write, and compute ensures that a boy or girl will be able to participate in the economy and make healthy choices in adult life. Research confirms that girls who complete primary school are three times more likely to avoid pregnancy, and their children equally more likely to attend school. COMPASS addressed the many social and environmental issues affecting the quality and use of education in Nigerian primary schools through the introduction of a number of interventions aimed at improving student’s skills in math and literacy and increasing primary school retention and girls’ enrolment. Activities also targeted teacher performance, community support, and the integration of health and education.

The needs of the educational system are immense, as indicated earlier. Unfortunately, the resources made available to COMPASS were limited. As a result, tough choices had to be made on what the key focus should be. Because teacher competency is clearly an important determinant of the system's performance, COMPASS felt it was essential to prioritize the quality and content of pre-service and in-service training programs. In order for COMPASS to make an impact on the situation and concentrate on other underlying challenges, selective interventions were implemented to address the seven most critical problems of the primary education system:

- *Interactive Radio Instruction (IRI)*: The IRI lessons were developed to be interactive and activity-based. Though their focus was on teaching literacy and numeracy, they included health messages as well. The broadcasts allowed time for pupils' responses, singing songs, playing games and listening to stories. The IRI was designed to allow for interaction between the classroom audience (teacher and pupils) and radio characters, who were usually a teacher and pupils in a radio class or culturally-relevant setting. The radio pupils learned along with the classroom audience. The IRI programs were developed to have separate characters for each grade level, each with a unique theme song that the pupils could identify with. It was a participatory, holistic approach that encouraged the pupils, teachers, and community members to interact with each other as the radio set the scene. Because the programs were culturally relevant, pupils loved the songs, games, stories, and activities. The programs also improved teachers’ self-esteem and self-respect because it contributed to their professional development. COMPASS aired 90 episodes for each grade from 1- 6 for a total of 540 programs each year.

- *In-service teacher training:* The quality of a teacher is dependent on various factors, of which the most important is the teacher's professional development. This factor tends to translate most strongly to students' learning and achievement. The COMPASS in-service teacher training intervention was created to improve teachers' skills through a series of professional development activities with the objective of building capacity for teachers in student-centered teaching (SCT) to meet national standards and improve students' achievement levels, particularly in literacy and numeracy.
- *Pre-service teacher training:* Pre-service teacher training lays emphasis on providing quality training services to Primary Education Studies (PES) trainees and trainers with a view to improving quality education at the primary school level. COMPASS worked with three Colleges of Education (Sa'adatu Rimi College of Education, Kano State, Adeniran Ogunsanya College of Education, Lagos State, and Akwanga College of Education, Nasarawa State) and supported the review of the PES curriculum to improve teaching of literacy and numeracy, the provision of scholarships to boost the interest of student teachers to join PES, the training of PES lecturers, and the provision of equipment and material to teacher resource centers. A Proficiency in the English Language Intervention (PELI) curriculum was also developed to improve the English skills of PES students
- *Community mobilization and PTAs:* PTA training and grants were key strategies in improving community participation and school infrastructures. COMPASS built on the success of the former LEAP Project by involving parents as primary stakeholders in conducting needs assessments of the schools. Baseline assessments showed that many schools lacked basic infrastructure, instructional materials, and the school environments were not conducive to teaching and learning. Pupils sat on the floors of their classrooms, teachers sat on planks as makeshift chairs. Most schools lacked functional toilets. The overall effect of these problems was ineffective teaching and learning, poor motivation of teachers and pupils, and low enrolment in public primary schools. To ensure ownership and sustainability, each PTA was engaged and new PTA's were established where they were not in existence especially in Islamiyya schools. Three members of each PTA were trained in project identification, community mobilization, record keeping, financial management, and conflict management. PTA executive members were given orientation on USAID compliance to grants.
- *NGO subgrants:* COMPASS awarded small grants to the PTAs and local NGOs to transform selected public primary schools to quality sites. The strategy helped to create and support a mechanism to ensure community ownership of the program, focused on establishing public-private partnerships, promoting ICB at all levels with the focus on empowering local communities and institutions, and ensuring that previous best practices were identified and replicated.
- *School Health and Nutrition (SHN):* There is growing evidence that the health and nutrition of young children has a long-term effect on their cognitive development. For example, *Giardia lamblia* infection in the first 2 years of life is associated with a lower IQ at 9 years of age. Children undernourished in the first 2 years of life have lower IQs, lower educational achievement, and higher levels of conduct disorders in adolescence than well-nourished children. The scope of the COMPASS SHN interventions included de-worming, physical examination, and establishment of health promotion programs in schools. Health topics included malaria, diarrhea, HIV/AIDS, micronutrient deficiencies, and drug administration and storage. Community participation and action plan development were essential in establishing an effective referral system between schools and public health facilities.

## ***B. Child Survival***

Throughout Nigeria, high rates of illness and death in children under the age of five are mainly caused by treatable and preventable diseases such as malaria, measles, diarrhea and acute respiratory infections. At the same time, more than half of Nigerian children are malnourished, attributable to

low rates of exclusive breastfeeding, poor quality of food, and simply not enough to eat. This is in addition to parents' lack of basic knowledge and management of childhood illness.

By working with community-based and facility-based health providers and advocating for child health policies at national and state levels, COMPASS supported a focused and coherent child health program that contributed to a significant reduction in child deaths. The child survival activities were based in 37 LGAs in Kano, Lagos and Nasarawa States.

COMPASS aimed to strengthen child survival services in Nigeria by improving quality, increasing demand, and expanding access to health services in communities. COMPASS' child survival interventions address the following components:

- **Malaria:** Overseeing distribution of approved anti-malarial drugs; improving quality of advice and drug choices by training local PMVs; advocating for the use of ITNs; and organizing outreach events to educate communities about malaria prevention and treatment.
- **Nutrition:** Promoting exclusive breastfeeding, appropriate complementary feeding, and Vitamin A supplementation during National Immunization Days Plus (IPDs), organized by the Federal Ministry of Health (FMOH).
- **Immunization:** Providing program assistance with routine and supplementary immunization in national training and social mobilization working groups and monitoring and supporting National Immunization Day activities.
- **Diarrhea Diseases, Acute Respiratory Infections, Newborn Care:** Strengthening the home-based skills of community health promoters through refresher trainings and promoting messages on healthy household practices.

### *C. Family Planning/Reproductive Health*

Seeking to reverse this decline in health care delivery, COMPASS worked with local governments, health-care providers, and communities to improve the RH of millions of Nigerians. COMPASS strengthened RH services by improving quality, increasing demand, and expanding access to hard-to-reach communities. COMPASS' RH interventions addressed the following components:

- **Safe Motherhood:** Strengthening antenatal care (ANC), labor and delivery, and postpartum care;
- **Family Planning:** Addressing the unmet need for FP through optimal birth spacing and use of permanent and long-term methods of contraception and encouraging child spacing through the healthy timing and spacing of pregnancies approach;
- **Postabortion Care (PAC):** Providing emergency treatment of complications from unsafe abortion, offering counseling and postabortion FP, and referring for other RH services;
- **Youth-Friendly Services:** Using culturally sensitive approaches to respond to the reproductive and sexual health needs of youth;
- **HIV/AIDS:** Preventing Mother-to-Child Transmission of HIV (PMTCT) by creating referral systems for ANC and delivery at PMTCT facilities, providing FP to HIV positive women and integrating reproductive services with HIV/AIDS programming;
- **Men's Roles in Reproductive Health:** Including men in RH discussions and encouraging their participation in decisions involving their partner's RH; and
- **Gender-Based Violence:** Emphasizing community commitment to address gender-based violence and working with health facility staff to recognize it as a health problem affecting women's RH outcomes.

#### ***D. Polio Eradication***

Despite several rounds of nationwide immunizations, Nigeria remains the epicenter of transmission of the Wild Polio Virus. According to the World Health Organization, nearly 800 cases of Wild Polio were diagnosed in Nigeria in 2004.

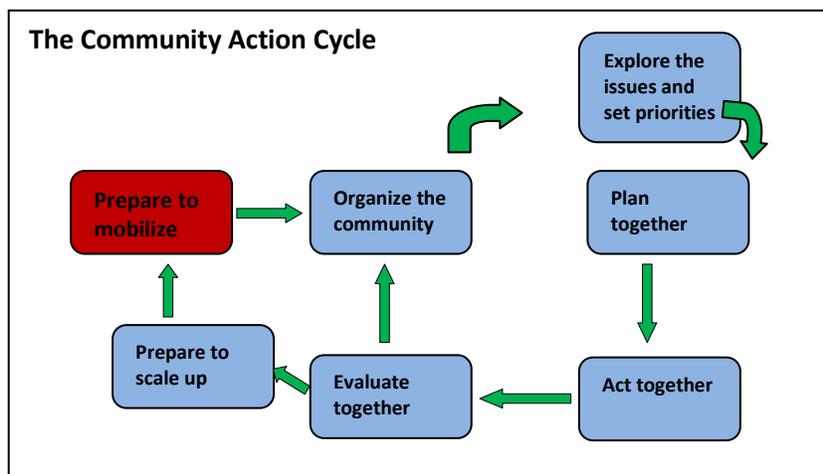
COMPASS worked to eradicate this debilitating disease by deploying strategic technical assistance to the polio eradication campaign through its collaboration with the Nigerian National Polio Eradication Initiative. COMPASS strengthened polio immunization activities by mobilizing communities, improving vaccination coverage and management, and overseeing the monitoring and evaluation of all immunization efforts. COMPASS' polio eradication work took place in Bauchi, Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto and Zamfara States.

COMPASS' polio interventions addressed the following components:

- **Micro-planning and operational preparedness:** Improving planning and implementation of supplementary polio immunization activities and participating in advocacy meetings at the federal, state, and local levels to ensure resource allocation.
- **Supervision and monitoring systems:** Assisting with selecting vaccination teams and supervisors; supervising trainings according to national guidelines; identifying and planning for high-risk areas; developing community maps and providing critical supplies and transportation.
- **Community and social mobilization:** Reviewing and analyzing data from each immunization round and applying results to subsequent activities; exploring with communities and providers ways to recognize and build upon achievements; and identifying emerging priorities and focusing resources where they are most needed.
- **Training:** Advising on planning and implementation of training programs for supervisors, vaccinators and recorders; sharing best practices; and training trainers and field staff how to influence content and quality of training.
- **Information collection and use:** Using data to identify unvaccinated children; sharing information to identify aspects of unsuccessful campaigns and make improvements; and supporting the acute flaccid paralysis surveillance system
- **Rehabilitation of polio victims:** Assisting adult polio victims with developing appropriate skills and knowledge for self-sufficiency and independence.

#### ***F. Community Mobilization***

COMPASS' community mobilization strategy contributed to promoting a sense of participation and ownership whereby community members take responsibility for their own community's development. To ensure active community participation, COMPASS used two conceptual frameworks based on participatory problem solving approaches: the CAC and PDQ. The CAC encourages community members to work together to identify priority problems in their communities, define and identify solutions, and take action to improve the situation. The process also includes reviewing progress made in order to adjust strategies and/or address new problems. PDQ is a similar methodology that involves service providers and community members working on specific quality issues at the health facility or school level.



The CAC approach resulted in the formation of CCs with the membership of all interested community groups within a specific community. Representatives included members of the local PTA, women groups, youth groups, and community-based organizations. Through the CAC process, CCs developed action plans to address health and education problems in their communities and promote the use of health and education services. COMPASS provided technical assistance and mentored the CCs in identifying strategies for implementing their action plans.

Additionally, QITs were established at the facility level (hospital, clinic, or school) and consisted of both service providers or teachers and community representatives working together to improve quality of services. The QITs, which essentially acted as a sub-committee within the CCs, worked with the other CC members to address quality improvement issues.

### ***G. Policy & Advocacy***

COMPASS worked at state, local government, and community levels to strengthen capacity for legislative action, increase awareness of policies that have been enacted to address social issues, advocate for leadership action in response to challenges, and promote community participation in using and providing services. Through its interventions, the Project contributed to increased political and popular support for primary health care and basic education services. Specifically, COMPASS' policy and advocacy activities included

- Supporting dissemination and promoting understanding of national policies, guidelines and procedures for social sector services;
- Building the capacity of state governments, local government authorities, civil society organizations and CCs to collect and use reliable data for decision-making and action;
- Increasing the capacity of partner organizations, civil society organizations, and networks to plan and advocate for improved health and education policies;
- Increasing the resources allocated by state and local governments for basic education and primary health care services, as well leveraging private sector support for these services;
- Building the capacity of local media outlets to support dissemination of policies and advocate for improved services in their area of coverage.

### ***H. Public Private Partnerships***

The Project involved NGOs, community groups, school and health facility quality improvement teams, and private businesses and individuals in leveraging resources for improved health and

education services in Nigeria. Once challenges were identified, groups were encouraged to support COMPASS initiatives through cost-sharing efforts such as donating needed goods and services.

Through public-private partnerships, COMPASS established durable mechanisms for sustaining interventions. The key indicator for the public private partnership component of the project was the leveraging of resources through public and private sector alliances at state and LGA levels.

COMPASS was expected to leverage \$14.4 million internally through financial and in-kind contributions from the private sector, giving it an obligation to enter into partnership with this sector. Too often, developmental agencies fail to harness the broad range of community resources and assets that can be brought into play through participatory planning and action-oriented mechanisms. Relationships with religious and traditional leaders, faith-based organizations (FBOs), community-based organizations (CBOs), women's and youth organizations, and key community gatekeepers were not developed enough to sustain services beyond the life of a project. In response, the COMPASS Nigeria project developed a community-level initiative to harness the power on local public-private partnerships.

Over the five years of the COMPASS project, CCs learned to draw on their own human and material resources and to engage local governments to provide necessary health and education services. Local challenges hampered effective monitoring and reporting of these resources, and, in reality, the project has captured less than half of the actual contributions.

### ***I. Institutional Capacity Building***

COMPASS built the capacity of Nigerian NGOs, equipping them with the tools and resources necessary to contribute to Nigeria's development and successfully oversee community-based interventions in education, child health, and RH, well beyond the COMPASS Project timeline.

Through the ICB interventions, the COMPASS-supported NGOs are stronger, more effective, and more responsive to the needs of the communities they serve. This was accomplished by providing the NGOs with the tools and technical assistance they need to successfully develop work plans, raise funds, manage resources, and implement activities.

**ICB support to Nigerian Partners:** The objective of the support provided to FOMWAN, CSACEFA, NMA, and AHIP was to enhance their sustainability and to strengthen management/organizational systems, policies, and procedures to make them eligible for direct funding from USAID by the end of the project period. Intensive and tailored ICB support was provided to each of these partners in the second year of the project based on organization-specific ICB intervention plans developed as a result of organizational self-assessments using the Management and Organizational Sustainability Tool (MOST) developed by COMPASS partner, MSH. Because MOST is a self-assessment tool designed primarily to generate internal motivation to strengthen the organization, another more evidence-based tool - the Organizational Capacity Assessment Tool (OCAT) - was developed by Pathfinder International to assess the partners in year 3 of the project. The Nigerian partners also received equipment support to cover technical assistance in capacity-building and sponsorship of organizational representatives ("catalysts") on the COMPASS staff.

**ICB support to COMPASS sub-grantees:** To achieve the desired results under COMPASS, the project awarded sub-grants to local organizations to implement activities in the areas of RH/FP, child survival, and basic education. To strengthen their organizational effectiveness, the COMPASS ICB support focused on providing the sub-grantees with technical assistance. The efficacy of the ICB support to the sub-grantees was measured as, "NGOs that demonstrate improved organizational management capacity." COMPASS' ICB approach was guided by a framework (initially developed by Pact Inc., and since modified by Pathfinder International) that identified seven elements of organizational effectiveness:

- **Governance**: The provision of leadership and direction to an organization;
- **Management practices**: The mechanisms intended to coordinate the activities and facilitate processes within an organization;
- **Human resources**: Management, staff, communities, donors, and board members who have the skills, motivation, and opportunity to contribute to an organization;
- **Financial resources**: The resources to purchase goods and services needed to conduct an organization's affairs, track financial transactions, report on financial status, and ensure transparency and accountability;
- **Service delivery**: The programs and services carried out by NGOs that are appropriate, cost-effective, and of high quality;
- **External relations**: Interaction between an organization and other development partners; and
- **Sustainability**: The long-term continuation of an organization, program, or project.

The COMPASS ICB component recognized that organizational development is a long-term, interactive, and iterative process that includes several distinct stages through which an organization can pass:

- **Start-up or nascent stage**: The NGO is in the earliest stages of development.
- **Development or emerging stage**: Structures for governance, management practices, human resources, financial resources, and service delivery are in place and function.
- **Expanding growth or consolidation stage**: The NGO has a track record of achievement and is recognized by its constituency, the government, and other agencies.
- **Sustainability or mature stage**: The NGO is fully functioning and sustainable, with a diversified resource base and partnership relations with national and international networks.

A total of 22 sub-grantees (including the Kano Polio Victims Trust Association (KPVTA), a grassroots organization providing advocacy and vocational support to polio survivors) benefited from COMPASS' ICB support. In the third year of the project, five sub-grantee organizations were dropped based on under performance. Of the 16 sub-grantee organizations that benefited most from the ICB interventions, five each were in Kano and Lagos States and two each in FCT and Bauchi and Nasarawa States.

### ***J. Sub-Grants***

COMPASS developed partnerships through sub-awards to PTAs, and local NGOs. These sub-awards served 1) to support implementation of community-level activities responsive to community priorities and COMPASS goals; and 2) to strengthen the capacity of local organizations to provide quality social sector programming through community mobilization activities, training, and technical assistance. Pathfinder International produced a COMPASS Subgrant Manual in year one, and all relevant staff were trained in sub-award procedures in early June.

Through sub-grants, COMPASS mobilized the best of what existed – successful CBOs and programs, existing community structures - and introduced best practices, community transformation and values of accountability and transparency.

### ***E. OVC***

The COMPASS Orphan and Vulnerable Children (OVC) Wraparound Initiative provided access to comprehensive nutrition, education and referral to basic health care for OVC. A total of 12 US government OVC implementing partners (IPs) were offered various technical assistance, support and services including capacity building for caregivers, service providers and volunteers. Trainings were conducted on Positive Deviance (PD) Hearth for rehabilitating malnourished children and Child Status Index (CSI) tool for the assessment of OVC wellbeing. COMPASS, in collaboration with Catholic Secretariat of Nigeria (CSN), also engaged COMPASS CCs in Lagos State to carry out the identification and verification of OVC for educational support.

## **Process and Methodology**

All relevant stakeholders were included at the each stage of the design and implementation of the project, which helped to garner their full participation and laid a basis for sustainability. Before the project launch, advocacy visits were made by state teams to the state ministries of health, environment, education, as well as the local government authorities and State Universal Basic Education Board (SUBEB), LGA executive members, and opinion leaders in the communities.

Broad based consultation with government and nongovernment stakeholders preceded the design of the COMPASS annual workplans which ensured ownership, buy in and sustainability by key ministries, agencies and civil society.

Prior to the official launch of the project in September 2004, COMPASS implemented advocacy meetings at the federal, state, LGA and community levels to inform stakeholders of the Project's intended interventions and their expected roles. The meetings facilitated open dialogue on how project interventions could be tailored to meet the specific health and education needs. In most cases, these meetings resulted in signed memorandum of understanding (MOUs) with the various government institutions. Specific highlights of the processes included:

- High level advocacy visits to state governors, traditional rulers and other top government functionaries to improve political commitment for RH, child survival, and basic education program initiatives across the five states, and to share the COMPASS vision and expected results of the project.
- Stock-taking of existing structures, mechanisms and policies that regulate health and education service delivery at the state and LGA levels, and the extent to which policies were disseminated and understood at the state and community levels.
- Opportunities for better coordination and integration within existing frameworks.
- Establishment of a regular government and stakeholder forum at the LGA that served as platform for joint planning, review, consensus building and feedback.
- Identification of key stakeholders to participate in the implementation of the jointly developed workplan, and agreement on partners roles.
- Identification of institutional capacity gaps and design of system strengthening workshops in collaboration with the ICB component to address gaps. This included an assessment of the capacities of existing NGO and civil society organizations (CSO) networks to undertake advocacy activities focusing on basic education and primary health care
- Following these interventions, CCs were supported to develop advocacy work plans addressing health and education concerns. The CCs utilized problem-solving skills to advocate for improved quality and demand for basic education and primary health care services, and addressed other emerging issues of public concern.

Detailed implementation processes and methodologies are included in the Project technical strategy documents submitted with this report.

## **Monitoring, Evaluation and Reporting**

COMPASS used a comprehensive M&E system to monitor progress in reaching results in terms of project outputs, results and outcomes. Approved by USAID, the system included a well- documented Performance Monitoring Plan (PMP) with 77 indicators developed to track progress by IRs. Of these, 20 were required USAID indicators. Throughout project implementation, the PMP was streamlined to reflect the M&E requirements of COMPASS. The final USAID-approved PMP is included in the annex section of this report.

Among the USAID IPs in Nigeria, the COMPASS Project made a major contribution to the achievement of Strategic Objective (SO) 13 “Increased Use of Social Sector Services” and its associated IRs.

The COMPASS M&E plan measured performance at three levels:

- i. USAID Mission Strategic Objective Level: COMPASS measured progress in achieving the Mission’s SO-level indicators which are - DPT3 immunization coverage, contraceptive prevalence rate (CPR), birth interval, and pupil retention.
- ii. Mission IR Level: The IRs measured results that were attributable to COMPASS’ efforts and for which the project implementation team were held accountable. COMPASS however shared responsibility with the USAID-funded ENHANSE Project for achieving IR13.2.
- iii. Activity Level: These indicators provided data for ongoing management of project activities, and as such, were both operational as well as results-oriented.

***Intermediate Result 13.1: Improved quality of social sector services:*** Because of several concerns, many families prefer using private schools or clinics if they can afford them. Even when schools or health facilities are run by well-intentioned staff, performance is often constrained by lack of supplies, inadequate infrastructure, insufficient training, lack of funds for outreach or supervision, little influence with policymakers, and uninformed and poorly-motivated clients or parents. As a result, COMPASS interventions addressed the concerns of most Nigerian families about the quality of schools and health services, including poor teaching skills and lack of student-centered teaching methods; absent or lack of interpersonal communication and counseling between clients and health providers; health services that disregard client needs and preferences; and dilapidated and poorly-equipped schools and health facilities.

***Intermediate Result 13.2: Strengthened enabling environment for social sector services:*** Largely due to more than 15 years of military rule, most Nigerians feel powerless to affect social change for their families or communities. They are simply not familiar with holding elected officials or civil servants accountable. Through its interventions, COMPASS promoted a community environment where citizens increasingly learned to voice their needs, demands, and standards, to make choices, realize the benefits of participation, and finally maintain responsibility for social sector service improvements. Advocacy strategies used under this project engaged public and private sector partners and community members in the process of promoting policies in support of positive education and health outcomes. Working with ENHANSE, COMPASS collaborated in harmonizing targeted national policies and guidelines with local and state needs. The project also improved community capacity to plan, budget for, and mobilize public and private sector alliances for improving social sector services.

***Intermediate Result 13.3: Expanded demand for social sector services:*** Constraints that inhibit the demand for quality services include the lack of information on self-care or service accessibility, distrust of public sector service providers, lack of supplies, and conflicting community norms around behaviors such as seeking skilled-assisted delivery. Several communities have little capacity to effectively express their needs and mobilize for action and change in an integrated, sustained manner. Building on successful community mobilization models, COMPASS built the capacity of local governments and NGOs and CCs. The project involved stakeholders as leaders, models, and action-agents to foster additional community support and ensure a participatory process.

***Intermediate Result 4: Increased access to social sector services:*** Several barriers prevent Nigerians from accessing and using quality education or health services especially at the grassroots level. These include poor infrastructure, cultural or religious beliefs, provider skills and attitudes, medical procedures and restrictions, cost and lack of service integration especially for maternal and child health. The COMPASS approach to increasing access to basic education and skilled health services included mobilizing communities and government to upgrade schools or health facilities, expanding the logistics

supply system, working with peer educators, engaging faith-based and community leaders, promoting male involvement, and promoting integrated health services in supported clinics.

### Establishing Project Baselines

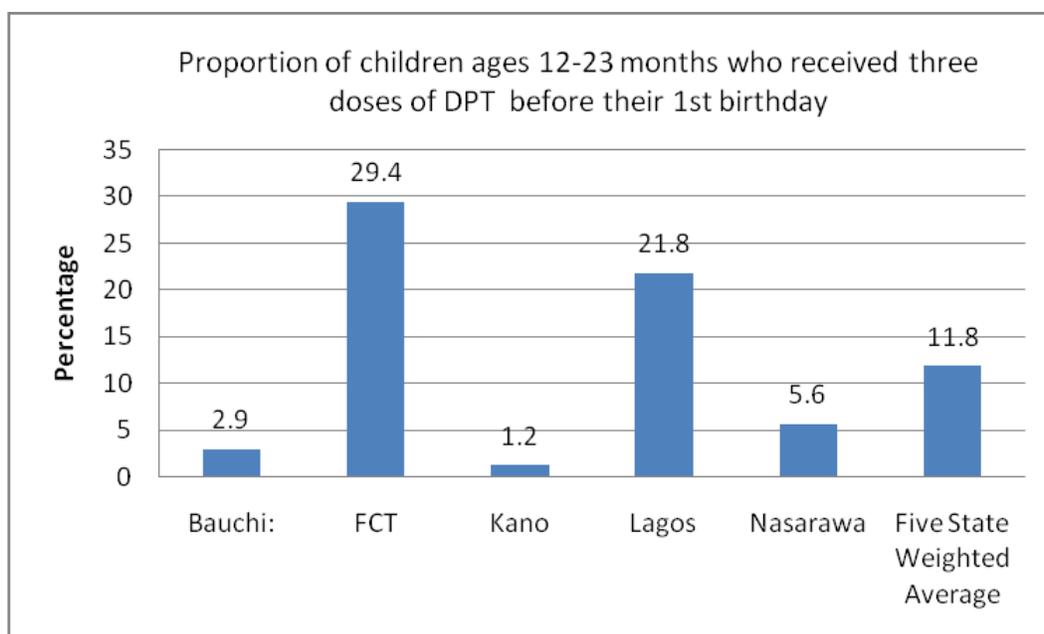
COMPASS contracted a local research agency to conduct a complete inventory of all health facilities, schools, and PMVs in the 51 LGAs. These inventories include information on basic infrastructure and services, as well as geographic coordinates. The inventory data provide several baseline values for the PMP indicators.

In addition, USAID requested that MEASURE Evaluation conduct the baseline assessment for COMPASS. Accordingly, a series of baseline surveys was conducted in the COMPASS LGAs in 2005. Because the data are also useful to COMPASS for its own planning and targeting, COMPASS and MEASURE Evaluation collaborated on the design of the instruments and initial data reporting.

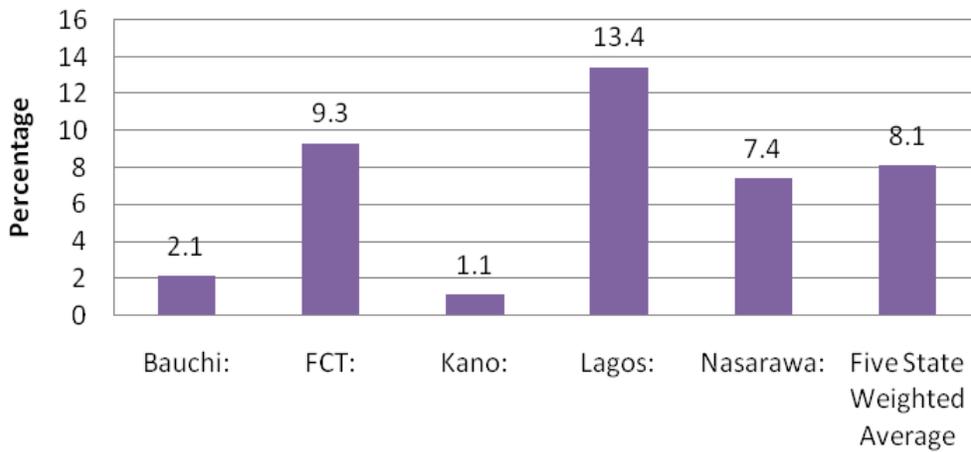
Additionally, the M&E Unit worked with the states to collect a set of service statistics at the health facility level. These were collected for the period January - December 2004 to serve as baseline statistics. Subsequently, monthly service statistics were captured and reported using on-line data entry system developed by COMPASS. The M&E Unit, in collaboration with other project components, developed instruments to support the tracking of project activities and progress at the community level. These include tools for activities related to community mobilization, CCs, child health week and monitoring of radio broadcasts.

### Major Baseline Data

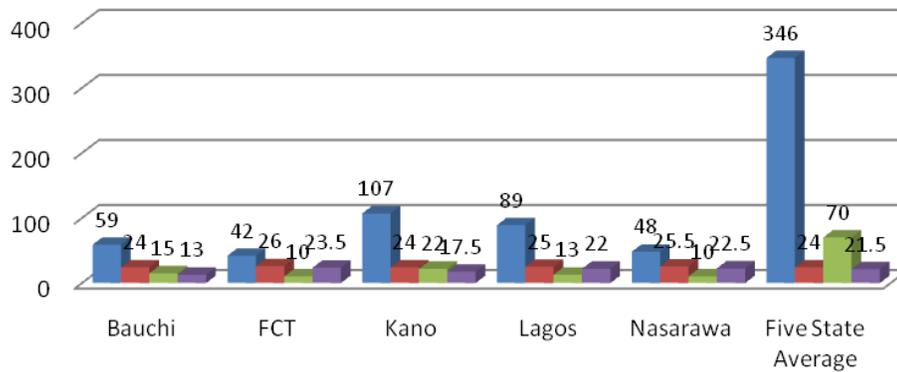
Some of the key baseline data of the Project included:



Proportion of all women 15-49 years who report that they are currently using a modern method of contraception at the time of the survey



Median birth interval in months



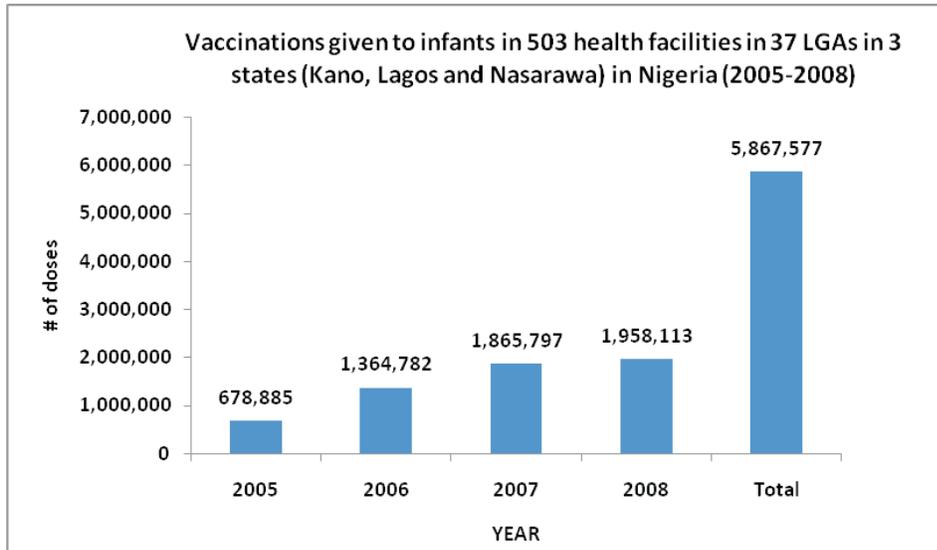
- Between last birth and 2nd-to-last birth N
- Between last birth and 2nd-to-last birth Median
- Between 2nd-to-last birth and 3rd-to-last birth N
- Between 2nd-to-last birth and 3rd-to-last birth Median

## SECTION IV: PROGRAM ACHIEVEMENTS AND RESULTS

A mid-term survey was conducted in 2007. Comparison between baseline and mid-term assessments for key project indicators are made below. In addition, some of the key achievements in the intervention areas of the COMPASS Project from years 1 to 5 are also highlighted:

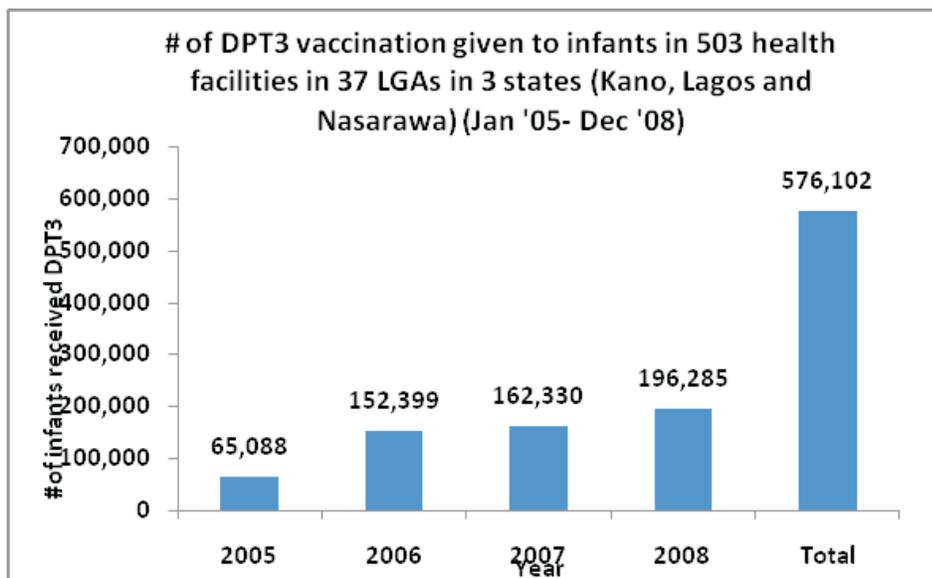
### Immunization

Data collected in each state showed a gradual improvement in the number of vaccinations given in the 503 COMPASS-supported health facilities since 2005. Close to six million vaccines were given between 2005 – 2008.



### Improved DPT 3 coverage

The strategic objective indicator DPT 3 coverage showed gradual improvement over the life of the project. By the end of 2008, the cumulative number of infants who had received DPT 3 was 576,102 which was 71 % of the project target of 810,000.



### COMPASS Cohorts performance in Mathematics and English - 2006 and 2009:

The impact of the various training programs at different levels was visible in the performance of student achievement testing (STA), administered annually in English and Mathematics among COMPASS different cohorts of schools which showed the performance outputs were maintained or improved (please see table below for details).

#### *Student Achievement Testing Administered by the Project over a Four-Year Period*

*Comparative results in English and Mathematics between 2006 and 2009 categorized by school*

		English					Mathematics				
		2006	2007	2008	2009		2006	2007	2008	2009	
Primary 1	Control	68.1	0	0	53.5	↓	70.6	0	0	56.8	↓
	LEAP	65.7	61.9	0	65.8	↑	60.8	69.1	0	68.2	↑
	COMPASS 2006	67.3	64.7	60.3	66.3	↓	68.3	72	69.6	67.9	↓
	COMPASS 2007	0	71.5	65.7	67.6	↓	0	76.5	70.3	70.2	↓
	COMPASS 2008	0	0	56	66.6	↑	0	0	62.8	69.4	↑
Primary 2	Control	0	64	0	58.7	↓	0	63.8	0	56.1	↓
	LEAP	0	58.2	0	62.1	↑	0	61.5	0	61.3	↓
	COMPASS 2006	0	62.7	62.7	65	↑	0	60.3	58.5	61.9	↑
	COMPASS 2007	0	67.4	67.8	65.3	↓	0	66.8	66.1	63.4	↓
	COMPASS 2008	0	0	57.7	66.1	↑	0	0	58.8	63.8	↑
Primary 3	Control	63.2	0	0	60.5	↓	46.8	0	0	45.2	↓
	LEAP	58.7	57.1	0	64	↑	42.1	48	0	52.4	↑
	COMPASS 2006	59.4	60	57.5	65	↑	45.5	48.9	50.6	53.6	↑
	COMPASS 2007	0	70.6	66.9	67.5	↓	0	57.2	56.1	57.3	↑
	COMPASS 2008	0	0	56	66.7	↑	0	0	44.5	54	↑
Primary 4	Control	53.1	0	0	49.6	↓	44.3	0	0	40.3	↓
	LEAP	46.8	49	0	48.5	↑	40.7	45.6	0	48.3	↑
	COMPASS 2006	47.8	49.3	49.2	48.9	↑	35.3	43.5	42.2	44.4	↑
	COMPASS 2007	0	56.4	54.1	54.9	↓	0	54.3	45.7	46.9	↓
	COMPASS 2008	0	0	48.7	57.1	↑	0	0	42.5	47.7	↑
Primary 5	Control	51.7	0	0	48.3	↓	43.7	0	0	35.8	↓
	LEAP	43	47	0	48.2	↑	37.4	39	0	40.9	↑
	COMPASS 2006	48.5	47.1	44.6	48.1	↓	39.6	38.4	39.4	44.1	↑
	COMPASS 2007	0	53	52	54.9	↑	0	49.6	50.6	50.9	↑
	COMPASS 2008	0	0	49	51.3	↑	0	0	45.2	46.3	↑
Primary 6	Control	37.5	0	0	41.9	↑	40.6	0	0	41	↑
	LEAP	35	36.1	0	35.3	↑	41.4	43.1	0	45.4	↑
	COMPASS 2006	36.3	36	32.1	36.7	↑	37.3	40.1	42.4	47.6	↑
	COMPASS 2007	0	40.3	38.3	40.3	ND	0	49.8	45.5	48.4	↓
	COMPASS 2008	0	0	34.3	38.7	↑	0	0	43.5	48.8	↑

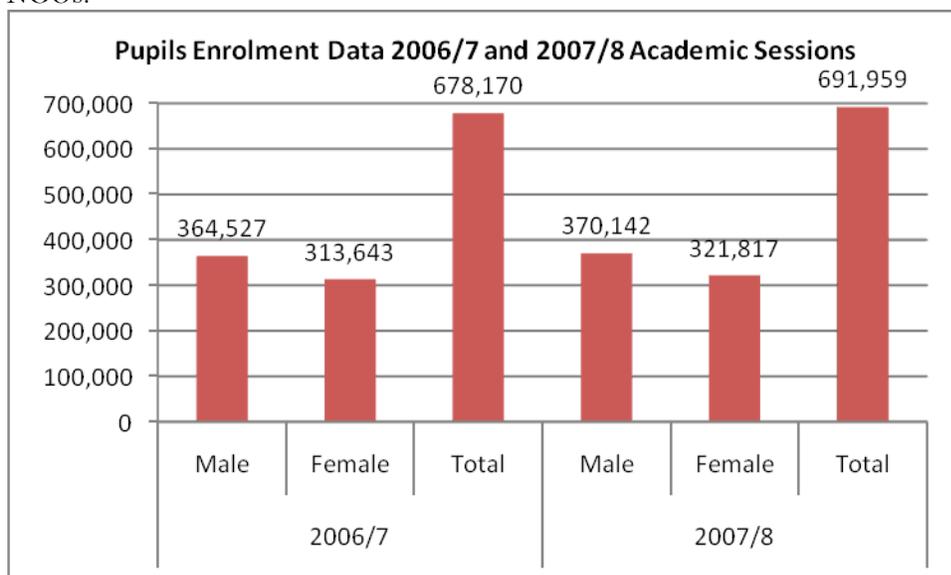
Legend	
↓	Control schools - Performance in Control Schools show <b>downward movement</b>
↑	Performance in the majority of project schools showed <b>upward movement</b>
↓	Performance in a few project schools demonstrated a <b>decline</b>
ND	<b>No difference</b>

### Increased student enrolment in PES department

The COMPASS-supported PES scholarship in the three Colleges of Education increased student enrolment in the PES department from 1,658 to 3,478 (110% increase) and raised the interest of prospective candidates. In Sa'adatu Rimi, there was a significant increase in female student enrolment from 10 to 106. The Colleges of Education also scaled up the number of beneficiaries through various awards. There was also an increase in the employment of lecturers in the PES departments saddled with the responsibility of teaching the PELI program

### Pupil enrolment data 2006/7 and 2007/8

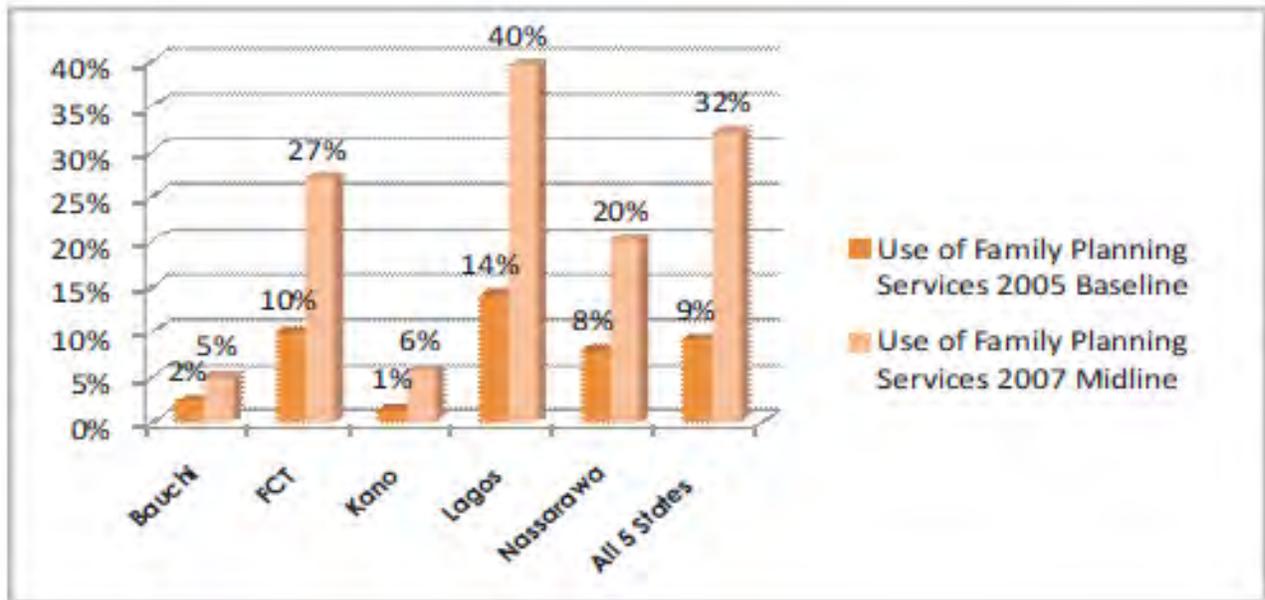
There was a marked increase (2% overall and about 3% girls) in percentage of pupils' enrolment in primary schools as a result of improved learning environments through sub-grants to PTAs and local NGOs.



### Increased CPR

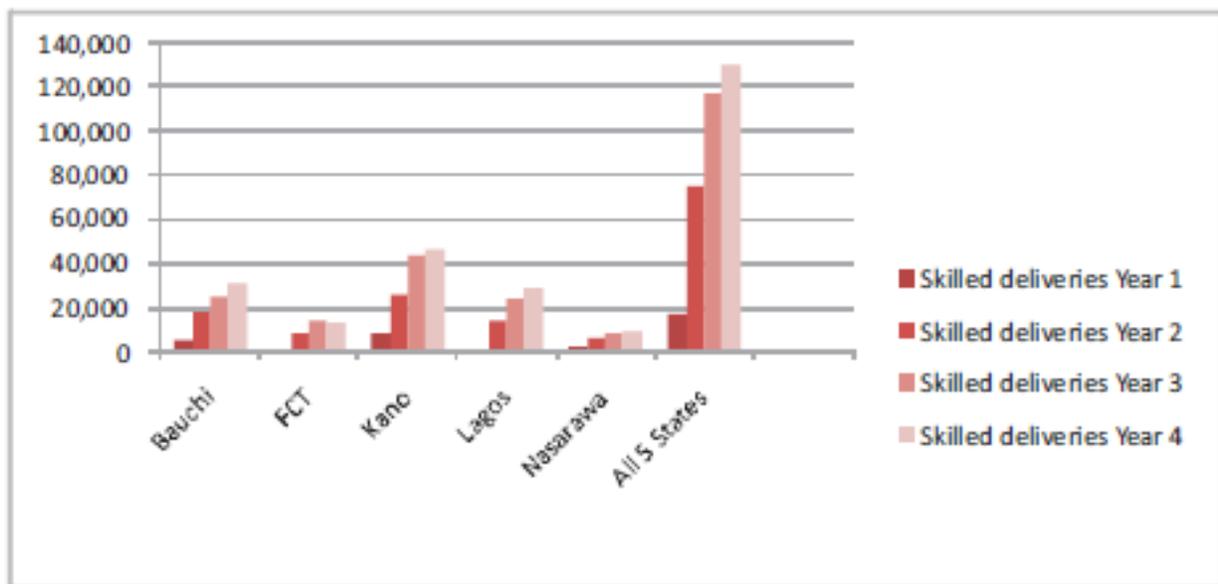
COMPASS interventions contributed significantly to the increase in CPR in the four project states and FCT from 9% in 2005 (baseline) to 32% in 2007 (mid-term)<sup>4</sup>.

<sup>4</sup> Source: Measure Evaluation



### Number of deliveries attended by a skilled provider

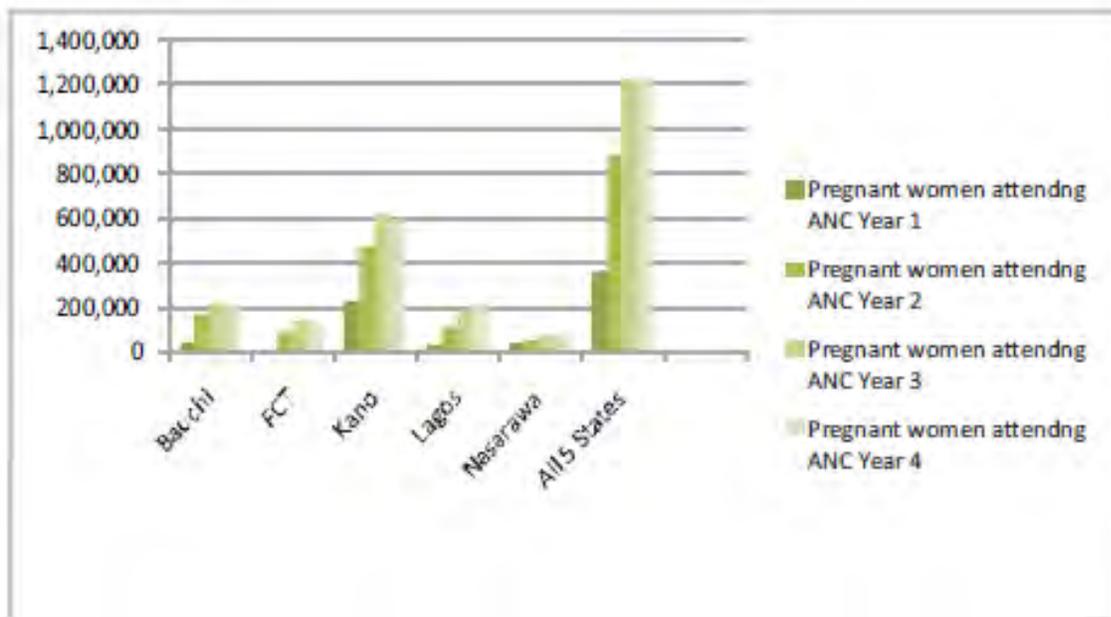
Number of deliveries attended by skilled provider increased over 600%, from 17,200 in 2005 to nearly 130,000 in 2007<sup>5</sup>.



### Number of pregnant women attending ANC

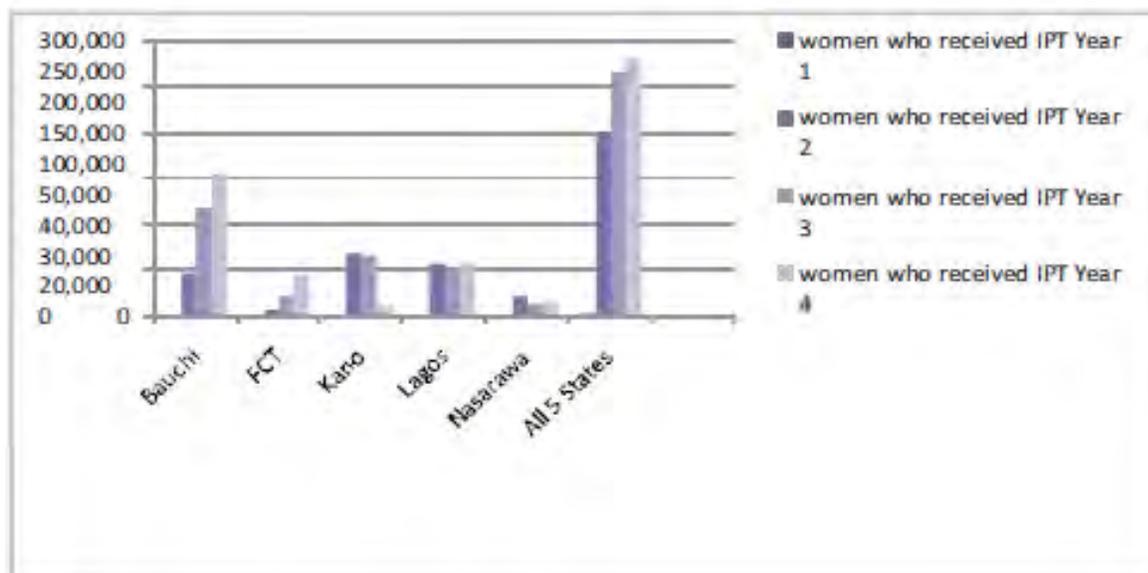
The number of pregnant women attending ANC increased consistently across the five COMPASS-supported states. The number ANC visits increased from 50,883 in 2005 to 210,470 in Bauchi; from 235,940 in 2005 to 590,536 in 2007 in Kano; from 33,962 in 2005 to 212,516 in 2007 in Lagos; from 41,838 in 2005 to 67,766 in 2007 in Nasarawa; and in FCT, the number increased from 6,897 to 137,038. Overall the total number of visits in all five states was between year 1 to year 4 was a cumulative figure of 3,711,062 visits.

<sup>5</sup> COMPASS Monitoring & Evaluation Database



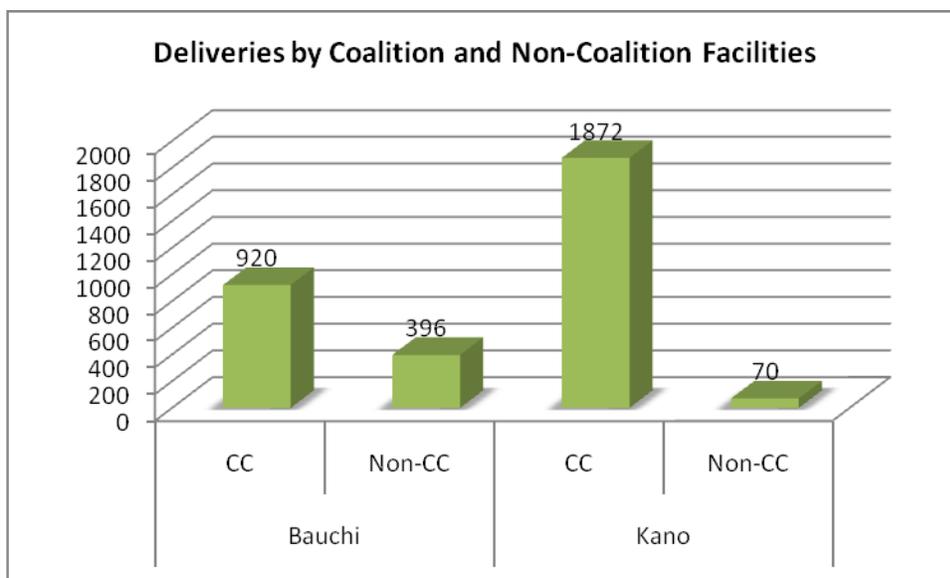
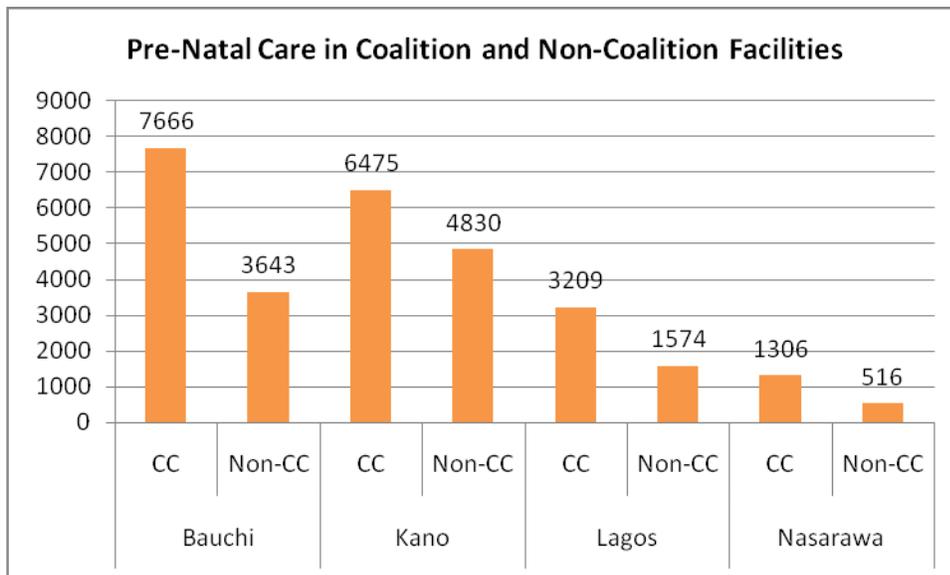
### Women who received IPT during ANC visit

From 2005, the numbers of women receiving IPT in COMPASS-supported health facilities were very low, at only a total of 473 for all five states. However, the numbers increased significantly to a cumulative figure of 299,648 by the end of year 4.



### Increased results in health facilities supported by CCs

In 2007, COMPASS assessed its community mobilization component and found CCs empowered to undertake community mobilization, advocacy, and fundraising activities to improve health and education in their communities. Overall, health service utilization for FP, ANC, facility deliveries, and routine immunization was considerably higher in facilities with CCs and QITs supported by COMPASS than in matched facilities without these community structures. (The graphs below compare utilization data for FP, pre-natal care and facility deliveries between facilities with CCs and QITs and those without.)



In addition to contributing to an increased use of services, in 2008 alone COMPASS-supported communities leveraged about \$3.6 million from individual member contributions, community donations, and funds raised from advocacy efforts with their local government authorities. The funds were used for a wide variety of infrastructure improvement activities, including the construction of new primary health facilities and schools, renovation of existing facilities, toilet construction, electrification, digging boreholes for water, and provision of equipment and supplies such as furniture, blood pressure cuffs, medicine, school first aid kits, radios and batteries for IRI programs, and exercise books and text books. In cases where COMPASS was supporting the renovation of facilities but funding was limited, the CCs/QITs provided matching funds to complete the job.

The sensitization and awareness creation activities targeting men, women and adolescents/youth increased knowledge and changed attitudes and practices of the key behaviors promoted by COMPASS. In 2007 the community mobilization assessment team found *“that people’s attitudes, particularly towards*

*polio immunization and family planning, and people's utilization, particularly for pre-natal care and facility deliveries, had changed*'.

### **Increased participation of community members in social sector development**

The advocacy trainings and mentorship provided to the CCs and Nigerian partners led to an “awakening” among community members with respect to the role they can play in improving health and education governance. Community members began to influence leaders and hold elected representatives accountable for service delivery gaps. For examples, in Lagos, two medical doctors were employed and posted by the Ajeromi Ifelodun LGA. Five nurses were recruited in Alimosho LGA, and the Kosofe LG established a drug revolving fund. In the FCT, Dutsen Alhaji primary healthcare centre (PHC) was renovated, Usafa PHC was fenced, and a borehole was sunk by in the Nuhu PHC.

### **Accountability and dialogues promoted between communities and government officials**

Accountability, dialogue, and trusting relationships between community members and local government authorities improved greatly. Communities and LGAs now perceive themselves as partners in the development process, each bringing valuable contributions to the process. The local governments are now adopting policies and using these as a platform for a sustained community/government interface. There is evidence to suggest that services are becoming more responsive to community needs as a result of this relationship between communities and their LGAs. For example, in Kano, the cold chain stores in Kibiya were renovated, and a medical doctor was recruited to work in Gabasawa. In Bauchi, Kirifi LGA voted to purchase drugs to support the establishment of free ANC and delivery services in the LGA.

### **Alliances built for sustaining action for social sector development**

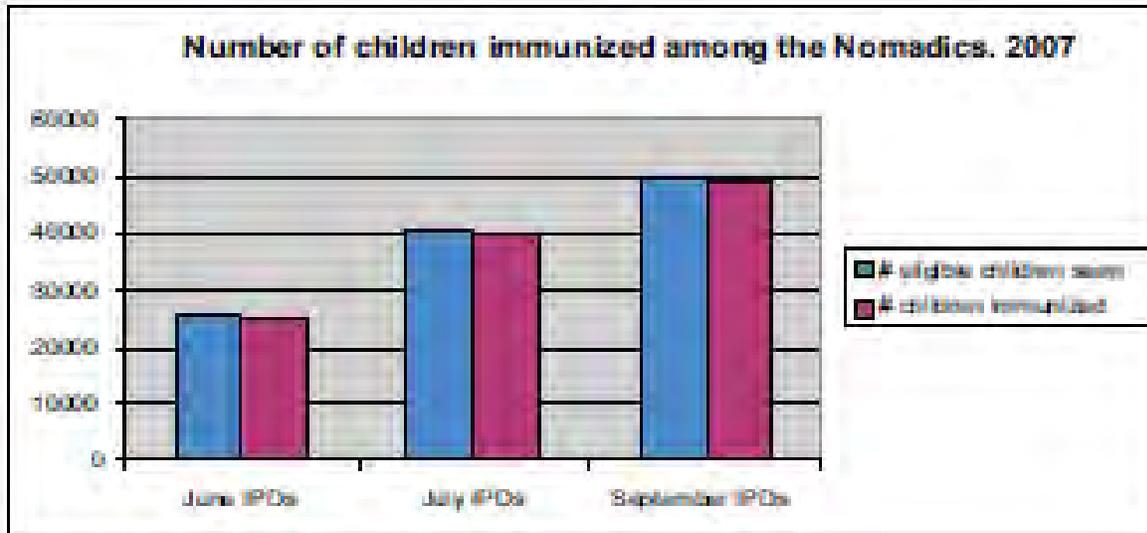
Community members and state-based NGOs now understand the need to build alliances and synergies around issues of common interest. Before now, there was an invisible competition between state and LGA-based FBOs, CBOs, and NGOs. The emphasis placed on “togetherness” paid off. CCs have had exchange visits to learn from established good practices and, most importantly, present a common front in negotiations with government. The Nigerian partners also now see themselves as complimenting each other, each bringing in their specific expertise in the pursuit of common goals. For instance, in Kano, FOMWAN, AHIP, NMA and CSACEFA worked together on the free Integrated Maternal and Child Health Care Bill. These joint projects have helped demonstrate clear linkages between health and education.

### **First ever draft bill on free integrated free MCH care services developed in Kano State**

The Kano State Government draft bill on the free Integrated Maternal and Child Health Care was the first of its kind. The bill was a state-led response and ensured that actors at various levels shared a common vision and had a clear understanding of what their roles and responsibilities were in reducing and ultimately eradicating preventable maternal and child deaths. Kano State presented the draft bill at the National Council on Health meeting and the SMOH directed that other States emulate Kano, in the crafting their state-specific policies that will address system gaps in providing maternal and child health (MCH) services.

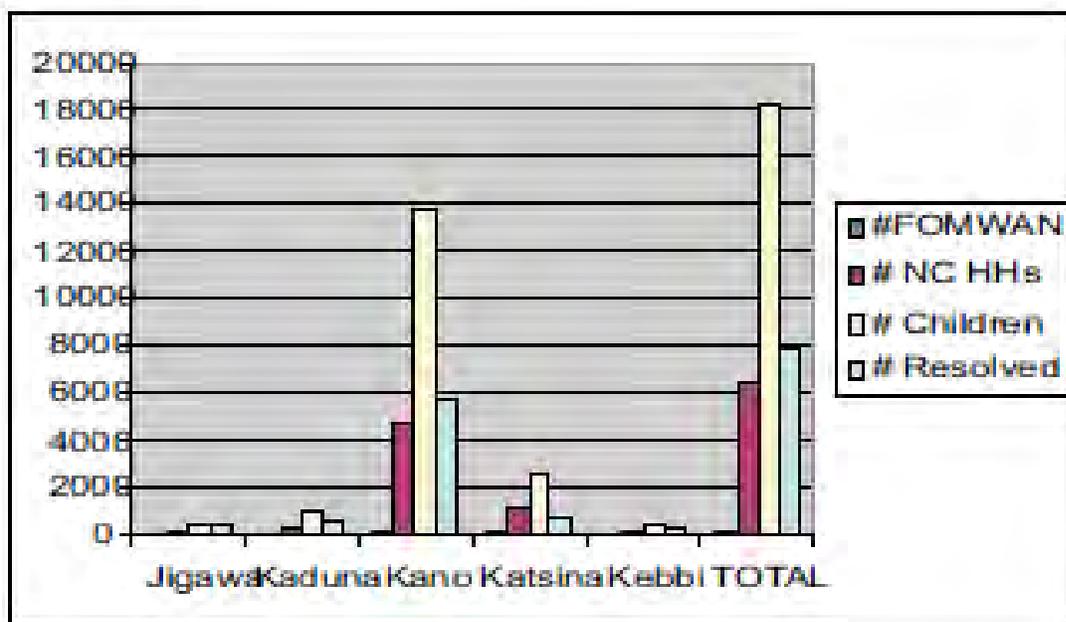
### **Reaching nomadic settlements**

Under the Polio Project, nomadic populations, particularly the Fulani were reached through two associations: Miyetti Allah for Cattle Breeding Nomads and Fulani Development Association of Nigeria (FULDAN). Flag off ceremonies were held in Fulani communities in Takai and Gwarzo LGAs in Kano State by the wife of the governor.



Source: 13th ERC Report

### FOMWAN contributions to identifying children and resolving non-compliance



Among the reported cases of unvaccinated or under-vaccinated children, 52% of cases were resolved following line-listing and follow up to ensure immunization. (source 15<sup>th</sup> ERC report)

### M&E data quality improved

In 2006, only 6% of tally data met the minimum data quality standard. In 2008, 98% of tally data met minimum data quality standards. Similarly, the proportion of monitoring data meeting minimum quality standards remained at least 80%. All (100%) of COMPASS polio-supported LGAs recorded vaccine availability by 2008, following continued pre-implementation assessments of the LGA. Also the number of trainings meeting minimum standard procedure rose from 34% in 2006 to more than 90% in 2008.

The benchmark of non-compliant households was set at 10% or less. The COMPASS Polio Program recorded 2.5% to 3.4% non-compliant households in the communities and between 62% and 86% of these cases were resolved during the period.

## **Final end of project evaluation**

The summative evaluation, as set by COMPASS Project, included: coordinating the end of project evaluation, production of case studies/papers on COMPASS major interventions in the core thematic areas i.e basic education, child survival, RH/FP and community mobilization; updating and printing COMPASS facilities' directories and CC profiles. There was intensified monitoring and supervision of data collection from schools, health facilities and NGOs; monitoring and supervision of data collectors and internal data quality assessment (DQA) to ensure the accuracy of data collected from the various COMPASS sources; monitoring of data collection for specific indicators (such as classrooms equipped with basic instructional materials, clients visits to public and private health providers, etc.); dissemination of COMPASS M&E results via workshops for relevant stakeholders at central, state and LGA levels; and provision of overall response to data needs of USAID and program staff.

Two major summative evaluation exercises were conducted in 2009 (Project year 5) – Classroom Observation and Household/Facility Surveys. The Classroom Observation Survey, which was contracted to an independent contractor, was finalized and a report was made available. The final or summative household/facility evaluation was awarded to MEASURE Evaluation (an independent contractor) by USAID and is expected to measure COMPASS impact following implementation of various health and education strategies in supported communities over a 5-year period. At the time of this report, field activity (data collection) of this contract has been completed and data entered. The result of the evaluation will be available in September 2009.

## **KEY ACHIEVEMENTS**

Some of the key achievements of the Project, under each of the components are recorded herewith:

### ***Child Survival***

COMPASS made a significant contribution to improvements in child health. The child survival component recorded substantial increase in routine immunization coverage, improved access to immunization services, and improved Vitamin A supplementation coverage. Capacity building in child survival interventions was witnessed at all levels, including government, health providers, and community. In its efforts to improve child health, COMPASS collaborated with partners from national, state, and local governments in three states (Lagos, Kano, and Nasarawa) and 37 LGAs and with WHO, UNICEF, private and public health facilities, and other key stakeholders. COMPASS conducted policy dialogues, provided technical guidance on child survival issues, advocated for key interventions and sensitized FMOH/policy makers to ensure their support for child health interventions and institutionalization of child survival strategies and approaches introduced by the project. To increase its reach, COMPASS mobilized communities, raised awareness of the child health issues, guided the communities in making informed decisions and empowered them to take an action aimed at improving the health of the children.

Due to COMPASS efforts, the visits for immunizations provided at 506 COMPASS-supported facilities reached about two million vaccinations (1,958,113) in 2008, compared with 678,885 in 2005. Further increase was reported in Year 2009 (1.34 million visits by July 30, 2009). Overall, 7,205,942 visits for immunizations were made during the life of project. A total of 1,549 outreach sessions were carried out by health facilities and service providers.

A significant increase was reported in the number of DPT-3 vaccinations. 704,618 children received DPT-3 at COMPASS-supported sites during life of the project. While this number constitutes 87 percent of the target, the actual achievement exceeded this result. Due to lack of standards in data reporting across the states/facilities, some of them did not report the data on vaccinations other than OPV during the IPDs, whereas COMPASS data was collected from PHC facilities only. Therefore, the

reported results are below actual achievements level. Low proportion of children receiving DPT3 during first years of project implementation was largely associated with frequent shortages of vaccines at the health facility and LGA levels. Due to vaccine stock-out monitoring, advocacy with key stakeholders and direct support by COMPASS to ensure transportation of vaccines from LGA to facilities, a substantial improvement in vaccines availability was achieved, as demonstrated by data from 14 LGAs in Lagos in 2007-2009. This could, to a certain extent, explain the accelerated increase in DPT3 coverage rate to 196,000 children for 2008 (three-fold increase in DPT3 coverage in 2008, compared with the baseline of 65,088).

COMPASS developed and successfully implemented seven key strategies to promote child survival interventions including PD Hearth, public-private partnerships, IPDs, clinic outreaches, and child health weeks. Use of integrated approaches proved to be effective in extending the reach of the program. Defaulter tracking and integration of immunization with ITN distribution (ITN voucher scheme) were used to address dropouts. The defaulter tracking showed that 40 percent of infants returned for DPT3 after their mothers/caregivers were tracked at the household level and counseled.

Over 9.5 million client visits were made to public and private facilities, exceeding the target of eight million by about 20 percent. From those, about 2.35 million were made for treatment of childhood illnesses. Overall, more than 319,000 cases of child diarrhea were treated, compared with targeted 281,443. In order to appropriately treat cases of diarrhea diseases, the COMPASS child survival team established 113 oral rehydration therapy (ORT) corners and supplied them with 89,600 ORS sachets for the management of childhood diarrhea. The ORT corners provided parents with the demonstrations on the preparations of salt-sugar solutions. Through Vitamin A supplementation activities carried out during IPDs and child health weeks and other campaigns, over 7.7 million children received Vitamin A, exceeding the target of 5 million by 55 percent.

The project distributed approximately two million ITNs (1,954,799 ITNs) in three states: Kano, Lagos and Nasarawa. The target of 280,602 was exceeded seven-fold. In July 2009, a large scale distribution of approximately 1,671,973 ITNs, including 590,000 ITNs provided through USAID funding, was carried out in Kano State. Every household in the 16 COMPASS -supported LGAs was targeted to receive ITNs.

Capacity building efforts included trainings in child health and nutrition for of a total of 5,219 private and public sector providers, exceeding the target of 4,304. In addition, COMPASS trained 3,737 people in malaria, exceeding the target of 3,341. To support the capacity building efforts, the program distributed a number of tools and materials, including Infant and Young Child Feeding protocol (IYCF) and the Micronutrient Deficiency Control (MNDC) guidelines, the Routine Immunization guidelines and Malaria Case Management (MCM) guidelines and IPT. The dissemination was carried out through a strategy of both group orientation for stakeholders in the community and the provision of job aids for the health facilities and the community-based promoters. The program produced and distributed job aids for MCM and IYCF job aids. COMPASS also completed development, printing and distribution of the training manual for PMVs on new MCM.

### ***Basic Education***

Due to the support received from federal, state and community institutions, USAID, other COMPASS components and other development partners, the COMPASS education component is best described as a huge success in the light of the followings:

- The completion of three years course of study by 476 PES students through scholarship award was scaled up by two of COMPASS supported Colleges of Educations by 90 (19 %). This has resulted in PES students' academic performances and responsibilities ranked among the best students in these colleges. These impressive results are attributable to series of training organized by COMPASS for

PES lecturers on pedagogy, the review of PES Literacy and Numeracy curriculum, the establishment of Teacher Resource Centre (TRC), and the introduction of PELI for PES students.

- COMPASS interventions were quite successful in capacity building, which included training over 21,000 teachers in the use of varied pedagogies; development and supply of over 307,000 copies of pedagogical materials; use of technologies (radio, classmates personal computers (CMPC)) for improved learning; training over 4200 PTA executives who implemented 713 PTA schools subgrants; training over 50 lecturers on varied strategies on teaching literacy and numeracy in colleges of education; and training 450 PES students and 53 classroom teachers on the use of information and communication technology (ICT) for lessons.
- COMPASS response to actualize USAID/Intel collaboration yielded a high dividend that attracted the Kano State Government's attention and the state government's decision to expand and sustain ICT-based teacher education program in collaboration with Intel and other major stakeholders especially SchoolNet. Intel supported Sa'adatu Rimi College of Education, Kano with 50 CMPCs, trained 50 lecturers using Intel Teach manual, while the Kano State Government and COMPASS established 4 ICT centers with internet facilities.
- The impact of COMPASS PTA intervention can be seen from the number of facilities that were renovated by COMPASS. This included the training of 4,487 PTA executives who successfully completed 713 projects. The projects provided attractive and conducive learning environments. The training equipped the PTAs with the required advocacy skills to leverage financial support and inculcated the sense of ownership and the consequent spirit for maintaining and protecting the facilities. The embodiment of the success of this intervention is the Gwarzo LGA where COMPASS awarded 13 PTA grants and the LGA set up an education committee that has renovated 21 additional Schools in the LGA using COMPASS mode.

A major challenge in the implementation of the basic education component of the project is the large number of schools selected for intervention. It became obvious that the number of COMPASS-supported schools (1400) were more than manageable size. .

### ***Reproductive Health***

- Various forms of interventions were designed and implemented at the community level to address critical health indicators: maternal and under-5 mortality ratios, low CPR, unmet need of child spacing services, low ANC attendance, and low skilled-assisted delivery.
- Generalized loss of confidence and lack of community ownership of health facilities, lack of RH information and services at the community level, minimal male involvement, and myths and misconceptions about RH were addressed through broad-based, well-planned interventions designed, planned, and executed together with communities. These interventions included: Community involvement in the assessment, planning, implementation and evaluation of RH services and interventions. They were involved through a participatory learning process. The phrase "government hospital", "their health facility" has now been replaced by "our health facility".
- Local NGOs received subgrants to implement community-based activities to get information, education, and services to the grassroots. Initially 18 and later three more such NGOs were involved in training peer health educators (PHEs), community-based promoters including traditional birth attendants (TBAs), volunteer health workers, and community health extension workers to provide information and referral services for women and children including youths.
- The crucial role played by men in FP use and choice of RH services was addressed through targeted training on the Men as Partners (MAP) concept across the 4 states, to promote male involvement in RH and child spacing services. Men were shown to be powerful advocates for RH services in areas where such trainings were conducted.
- The COMPASS team found that exposing religious leaders and FBOs to the health, social, and economic consequences of poor RH was key to overcoming misconceptions about RH services. The women's Muslim association, FOMWAN, trained Islamiyya teachers and monitored the

incorporation of RH messages into their teachings to married women and men, which significantly improved acceptance of this information by these communities.

- Regular outreach campaigns were conducted by health care providers, NGO subgrantees and volunteers, especially in hard-to-reach areas and on market days, to increase demand for RH services and commodities. International days were celebrated by grassroots campaigns aimed at creating awareness and providing services to hard-to-reach groups.
- The COMPASS RH Team supported the FMOH in developing and disseminating the *National Clinical Service Protocol for Obstetric and Newborn Care*, reprinted and disseminated the *National RH/FP Standards of Practice* and *National RH/FP Service Protocols*. A number of job aids on various topics were developed and distributed to the same health facilities.
- Select PHCs in 51 COMPASS-supported LGAs were supported with technical assistance and CC support and were developed into quality or model sites to serve as stimulus for other PHCs to strive to attain similar standards. These quality sites provided integrated health services with trained service providers and extended services hours under a “whole clinic” approach with water, toilet facilities and a reliable supply of electricity. The elements of a model clinic included: quality infrastructure, trained skilled staff and appropriate storage for commodities. Out of the 51 model PHCs, 27 also provided YFS.
- Three teaching hospitals (ABUTH in Zaria, LASUTH in Lagos and JUTH in Jos) were supported in training health care providers (Doctors and Nurse/Midwives) on permanent and long term methods (PLTM) of contraception, specifically, implants and sterilization. Five secondary health care facilities were supported (one in each state and FCT) to function as RH training centers to provide the much needed training of health care providers
- SMOHs were supported with routine monitoring and were provided with supportive supervision and on-the-job training on all aspects of RH. Core teams of trained supervisors have been generated in all COMPASS-supported states. Regular supervision of health facilities and service providers helped in ensuring compliance with quality guidelines and standards.
- YFS were established in 40 health facilities. This included training providers in YFS, renovating facilities to support YFS, and equipping newly-established YFS centers with basic equipment.
- By the end of the project 99 health facilities had been renovated which included new roofs, windows, tiles, verandahs, bathroom facilities, etc. These facilities were also provided with basic supplies and equipment as well as IEC materials, quality guidelines, and service protocols. With these upgrades, clients received improved quality of care.
- Regular monthly and quarterly review meetings helped bring out challenges and lessons learned in service delivery to be addressed on a systematic basis.
- Partnerships and collaborations developed with stakeholders (public and private) at various levels (federal, state, local government and community) have contributed in improving quality of health care services.
- Effective communication between service providers and clients is essential to improving quality of services and increasing demand for services. The preliminary qualitative research findings painted a non-cordial relationship between service providers and their clients. At least 1,500 clinical service providers and 2,000 community-based service providers in all COMPASS project areas were introduced to good interpersonal counseling and communication (IPCC) skills through a module in the training manuals for RH/FP and YFS. The IPCC module improved client-provider interactions, increasing client demand for and satisfaction with RH and ARH services.

### ***Community Mobilization***

- CCs played a prominent role in sharing health and education information throughout their membership and the community. They motivated community members to use health and education services and resolved conflicts and misconceptions. The 2007 Community Mobilization Midline Assessment report summarized the outcome of this function: *“Community coalition and QIT members carried out sensitization activities in their communities ... Health service utilization for family planning,*

*ante-natal care, facility deliveries, and routine immunizations is considerably higher in facilities with CCs and QITs than in matched facilities without these structures”.*

- Members of the coalitions organized themselves to advocate for resources to address problems identified by their QITs. These efforts largely targeted the LGA Chairmen, although local businesses and corporations were also targeted. The LGA forum provided a 'voice' for the members of the community and created a critical mass necessary for effective advocacy interventions. The significant contribution of this activity was captured by *Mitchell Group/Nigeria Monitoring and Evaluation Management Services (MEMS) in its 2008 report on the evaluation of USAID/Nigeria Social Sector Projects: ENHANSE and COMPASS: “While not anticipated in the original design, the project has proven an excellent democracy and governance activity which has given voice, choice and empowered the people at the community level”.*
- An overall theme was chosen for use across the states and FCT with the slogan “*Together, we can make life better!*” This slogan was used as a by-line on all communication materials produced. During the development and testing stage, COMPASS collaborated with ENHANSE to conduct a message harmonization workshop to get all USAID projects, collaborating NGOs, government establishments, and other partners to commit to using consistent messages when presenting and promoting health and education issues. Various mass media materials (posters and radio spots) and tools (provider aids, community-tools, and pamphlets) were developed as outputs.
- To maximize program effectiveness, a multi-media approach using multiple reinforcing communication channels was adopted during the implementation and monitoring stage. These communication channels included mass media (radio drama/magazine serial and radio spots), community mobilization, advocacy, training of service providers, and print materials and job aids.
- Three radio programs were aired throughout the life of the Project. The first two, *Daukar Jinka* (“Partnership and Responsibility”) and *Ku Saurara* (“Listen UP!”), were developed by previous projects and 52 episodes of each program were aired by COMPASS in Bauchi, Kano, and Nasarawa in Year 2 and Year 3 of the Project. These programs reached at least four million people in the three states with information and messages on safe motherhood, child survival, child spacing, client and provider interactions, adolescent physical and mental health, community education and promoting preventive and positive health-seeking behaviours. The third radio program, a 52-episode radio magazine program which included a drama component (*Mu Hada Hannu* in Hausa and *Orita Aje Asese* in Yoruba), was designed, developed, and produced by COMPASS Project. It was aired from January 2007 to January 2008 in all four COMPASS-supported states and FCT. The program targeted parents and caretakers of children aged 0-5 years, children in primary schools aged 6-12 years, and men and women of reproductive age as primary audiences. For secondary audiences, the program targeted religious and traditional rulers, health care providers and teachers. Service providers and community members of CCs, QITs, and PTAs were given air-time during the programs to provide testimonials about their community activities and to inform and mobilize the audience to become involved in enhancing the quality of health and education in their communities. The airing of the third program in Hausa and Yoruba languages helped COMPASS to reach at least 7.3 million people in the four COMPASS-supported states and FCT, Abuja.
- In the first quarter of Year 3, six radio spots in Yoruba language (two each on RH, CS and BE) were produced and aired in Lagos State 3 days per week for 13 weeks. The radio spots promoted desirable behaviors regarding enrolment of children in school; parent participation in PTA activities; attendance and male participation in ANC; use of FP services; exclusive breast feeding; and use of ITNs. In FCT, two radio spots produced and aired in Hausa carried messages about RH/FP, ARH, and safe motherhood. Throughout the life of the project, members of communities in all the COMPASS-supported states participated in several discussions and phone-in programs presenting community-based information and perspectives in health and education.

## Media Advocacy

- A strong partnership with the media was fostered throughout the life of the project at all levels. Central level trainings for media practitioners were conducted, targeting national health and education editors (print and electronic) in Abuja, while each state also conducted similar trainings targeting local media practitioners at the state and community levels. In addition, briefing sessions were held with journalists at central and state levels, keeping journalists abreast of developments in health and education and providing updates on COMPASS activities, challenges, and achievements.
- The journalists were also sponsored to attend field trips to COMPASS-supported communities and health and education facilities, which allowed them to interact with community members and appreciate their efforts and challenges, while at the same time empowering them to report firsthand on COMPASS activities and accomplishments.

### **Production of BCC Materials**

- A wide range of posters, job aids, advocacy kits, cue cards, booklets and leaflets were designed and produced for various audiences to achieve COMPASS goals in health and education. Altogether, more than 1,500,000 copies of assorted IEC materials were distributed into the four states and FCT Abuja, either by community members or by health providers, to increase demand for health and education services. Topics included school enrollment, attendance and completion, girl child education, child labor, pregnancy and childbirth, malaria in pregnancy, routine and supplemental polio immunization, Vitamin A, breastfeeding and nutrition, diarrhea, long-lasting ITN use, child spacing/FP, teenage pregnancy, substance abuse, and sexually transmitted infections and HIV/AIDS.

### **Media Advocacy and Partnership**

- COMPASS empowered a core group of editors and reporters to report on health and education issues. As a result of the media trainings and the relationship built with the media, the coverage of the COMPASS project and events was very high. Reporters and broadcasters were helpful in disseminating information on health and education issues and in reporting success stories emanating from COMPASS supported communities. In addition, work with the media has benefited members of the CCs and QITs who have participated in talk-shows and phone-in programs and are thus now confident in their abilities to engage the media on their own.

### ***Policy & Advocacy***

***Policy Corners:*** One policy corner was established in each of the 51 COMPASS LGAs to encourage public officials to refer to policy documents when crafting programs. These policy corners were furnished with various policy documents including national policies and strategic frameworks, State policies, standards of practice, service protocols, COMPASS manuals and job aids. Registers were opened to track usage of these documents; there was increased usage per quarter. These policy corners were located in the LG Secretariat and community members were able to access these documents. The registers showed that community members consulted the policy documents as their primary source of information when preparing for meetings such as the LG forum and policy dialogues.

***Advocacy Training:*** Community members were empowered through advocacy trainings to effectively engage with government. The 205 CCs, 700 QITs, and 40 Nigerian partner representatives were trained in the advocacy and policy processes. These trainings increased the confidence of community members and provided the foundation for them to systematically articulate and prioritize health and education concerns, then form alliances to seek platforms to address those issues. Seeking channels to resolve these issues formed the bulk of CC and Nigerian partner yearly work plans.

***Local Government Forums and Policy Dialogues:*** Beyond the advocacy trainings, COMPASS facilitated platforms that created opportunities for the communities to dialogue with and advocate to government about their concerns. The LGA forum and policy dialogue proved to be an effective

governance platform for communities and government to begin dialogue and build the trust essential for developing a sustainable partnership. As a result government interventions especially at the local government level began to respond to community priorities in health and education, commodities and instructional materials where supplies, nurses, midwives and teachers were recruited, and health facilities and schools were renovated.

***Creating Partnerships:*** The COMPASS advocacy strategy facilitated stronger linkages and partnerships between the communities (state-based NGOs, FBOs, trade unions) and the government at various levels. Government representatives began to see the advantage of “opening up space” for citizen participation and community members began to see themselves as partners in the development process. State program managers now provide for community representation in meetings and other LGA led initiatives including joint monitoring of projects. New partnerships and alliances were also fostered between state and local government-based NGOs. Rather than seeing themselves as competitors, these organizations began to harness each other’s strengths to present a common front and speak with one voice when negotiating with government. Concerns that were beyond the statutory limits of the local governments are taken up at the state level by the Nigerian partners who are established state-based NGOs and can engage at that level. (The Kano Integrated Maternal and Child Health Care Bill aptly demonstrate this partnership.) This synergy has facilitated a seamless flow of issues/concerns from local governments to the state.

***Public Finance Analysis:*** State budget allocations to health and education are yet to reach the 15 % recommended at the African Heads of State Summit in Abuja or the 25% recommended by UNESCO. However, if available allocations are effectively and efficiently utilized, these can significantly improve service delivery. CCs were supported to access and analyze budget allocations and use data on outcomes to demand accountability. Though there were considerable challenges accessing budget information, community members have begun to see the correlation between budget allocations, implementation of programs, and availability of services and commodities. For example, CC members in Gaya successfully advocated for the costs for the building three additional schools of technology, approved by the State Assembly in the three senatorial districts of the state as a long term strategy for addressing the issue of inadequate nurses and midwives in the clinic and health and facilities, be included in the 2009 budget.

***Policy Environment Score:*** The PES was conducted in three states across the three thematic areas to measure perceptions of the policy environment to guide effective programming. The PES tool was used to measure the overall perceived status of the policy environment in the state, evaluate changes in the policy environment between 2005 and 2009, and identify those areas most in need of improvement in the state. The PES has six broad sections: political support, policy formulation (national, state & local), organizational structure, legal and regulatory environment, program resources, program component, and evaluation and research. Findings were shared with government partners, civil society and other stakeholders to: advocate for increased funding for reproductive health services in the state, inform policy reforms/review at state- or LGA-level, guide managers of public and private sector institutions in choosing program priorities, provide NGOs with information to advocate for increased use of quality services, and to advocate for the use of the tool for subsequent state-led assessments.

***COMPASS Impact Model (CIM):*** The CIM was applied in three states: Nasarawa, Kano and Lagos. The CIM was designed to estimate the health and education benefits of program implementation, assuming that stated objectives in each of the three COMPASS thematic areas were met. The CIMs show the linkages between population factors and broader development issues (health and education), and how state-specific strategies can enable government to respond to development challenges and make measurable progress within a specified period of time. The CIM was designed to: raise awareness about what COMPASS is doing, show how government and communities can work together to find lasting solutions to social sector problems, foster policy dialogues, promote government buy-in to COMPASS strategies for ownership and sustainability, and advocate for improved health and education

services in the state and LGA. Unfortunately this model does not account for challenges in implementation.

### ***Institutional Capacity Building***

#### **Improved organization management capacity for sub grantees**

At baseline, one organization was in the nascent stage, 14 in the emerging stage, and three in the expanding stage of organizational development. At the end of year 2, there were no organizations in the nascent stage, 11 in the emerging stage, and seven in the expanding stage. At the end of year 3, there are no organizations in the nascent stage, 11 in the emerging stage and 10 in the expanding stage of development. By the end of year 4, 14 out of 16 (87.5%) organizations demonstrated an overall increase in OCAT scores compared to the end of year 3 scores; 12 organizations were in the expanding stage and four were in the emerging stage of development.

Compared to the end of year 3 OCAT results, by the end of year 4, 12 out of 16 (75%) organizations showed increases in at least five out of seven elements of organizational effectiveness. Fifteen out of 16 (94%) organizations showed increases in at least three out of seven elements of organizational effectiveness, significantly exceeding the year 4 target of 70% of organizations having an increase in at least three elements of organizational effectiveness. Fourteen out of 16 (87.5%) organizations demonstrated an overall increase in OCAT scores compared to end of year 3 scores. Additional analysis demonstrates that the four organizations in the emerging stage of development are on the cusp of shifting to the expanding stage. While most organizations were very committed to translating the various ICB skills and systems support into improved organizational effectiveness, a few of them did not show the readiness to move to the next level.

#### **Improved scores and funding sources for Nigerian Partners**

All four COMPASS Nigerian Partners had increased overall scores from baseline and three of them (except NMA) were able to access more funds from other agencies and increase their partnership base. By the end of year 4, a considerable amount of technical and financial resources had been spent on further developing the Nigerian partners' capacity. As a result of COMPASS installing Peachtree software for CSACEFA and FOMWAN and providing on-site coaching and mentoring in the use of the software, the organizations are able to generate computerized financial reports on a monthly, quarterly and annual basis, in accordance with USAID and other bilateral donor financial and administrative standards. Unlike before, the CSACEFA accountant can now generate income statements, balance sheets, cash flow statement, and financial analyses. Financial records such as the general ledger, cash account register, and debtors and creditors ledger are now in place.

All Nigerian Partners received tailored support to strengthen various elements of institutional capacity corresponding to the core challenges identified during the OCAT assessment carried out at the beginning of year 4. The assessments revealed that AHIP, FOMWAN and CSACEFA maintained their expanding stage of organizational development, while NMA moved from the emerging to expanding stage.

### ***Public-Private Partnerships***

#### **Resources leveraged exceeded**

Apart from project mechanisms where reports are cross-verified and multiple checks done to ensure data quality and eligibility to meet highest standards of data quality. MEMS, a USAID-supported Project periodically conducts DQAs and their recommendations have further helped the PPP unit in fine-tuning our data quality, validity and precision. MEMS initial assessment of the PPP reports which questioned the validity and precision of some of the reports gave rise to the need for the unit to further systematize its reporting mechanisms and labor rates across the 5 states and this has further made COMPASS' leveraging efforts so successful that by the end of year 4 (September 2008), cumulative PPP contributions have already exceeded the end of project year target of \$5,000,000 by over \$1,000,000.

This achievement is a reflection of the development of tools, systems, systematic training and follow-up support to ensure that all leveraged activities are being recorded, as well as renewed efforts to organize and mobilize CCs, PTAs, and QITs. In Year 4 a total of \$3,566,654 was leveraged against the target of \$1,500,000 (238% of annual target).

### ***Polio Eradication Initiative***

The COMPASS Polio project revived 206 Ward Development Committees (WDCs) and an equal number of Ward Health Sub-committees; trained 618 WDC executives on CAC; supported development of 206 work plans; and linked them up with LGA authorities and, other community structures that the project worked with (TBAs, FOMWAN, Myetti Allah/FULDAN/Imams) to ensure children are in the “Safety Net” of immunization to resolve non compliance households (NCHHs) dialogues were held with men while FOMWAN women engaged women in compound meetings. On yearly basis, an average of 1600 dialogues/compound meetings were held involving 28,000 men/women respectively. On one to one FOMWAN also continued to resolve non compliance. After each round 83% of all non compliance was resolved. In Addition 300 FOMWAN members resolved approximately 2250 NC HH with 68500 children yearly.

The project collaborated with 200 Miyetti Allah/FULDAN to address immunization of children in transit and hard to reach/border communities during which over 120,200 children were immunized per round of IPDs. This was in response to the 13th Expert Review Committee (ERC) recommendations. 1500 TBAs project engaged were oriented on polio disease and the eradication. On the average, each TBA takes a delivery of 6 newborn monthly. Based on this, the TBAs ensured that over 90% new born babies delivered by them were immunized with OPV. The COMPASS Polio team designed and produced 2000 FOMWAN-COMPASS mobilization strategic documents and the Implementation Guidelines

### **Quantitative Scaling-Up**

The COMPASS Polio Program supported the training of TBAs/FOMWAN on the “Reaching Every Ward” approach to community linkages by Immunization Basics in Sokoto State.

- National Primary Health Care Development Agency (NPHCDA) has agreed to fund a 3 million proposal on Training of Trainers of Faith based Organizations on FOMWAN-COMPASS Mobilization Strategies. This was part of commitment to sustain the gains after FOMWAN-dissemination. The FOMWAN dissemination was chaired by the Minister for Women Affairs and Social Welfare, also present were two wives of the Governors of Kaduna and Niger States.
- UNICEF called for a technical meeting on COMPASS Polio strategies in Sokoto State
- The Kebbi State Government has embarked on the adoption of the “COMPASS-FOMWAN TBA Referral Strategy to reduce zero dose in all 27 LGAs
- Disseminations exercise hosted by 17 LGAs chairman in the 17 LGAs paved way for the project to get LGA authority to commit to continue the various community mobilization strategies.

### **Public Recognition**

The COMPASS Project gained wide public acclaims at national and international levels. NPHCDA commended the COMPASS Polio Program at the national debriefings and ERC meetings. The Technical Advisory Group Country Communication review for 2009 in its report praised the mobilization strategies COMPASS developed in collaboration with FOMWAN. Zamfara State coalition of NGOs awarded USAID a certificate as “**Outstanding Development Partner**” on May 16, 2009, in recognition of the contributions of its implementing partners, COMPASS and ACCESS.

The program would have been more successful if COMPASS Polio had worked with WDCs from the onset in 2005 onset, trained them on CAC, and provided grants for their work plan. In addition with limited resources activities should have been in fewer states resulting in visibly greater impact. Moreso,

huge turnover of field workers might have been minimal if the policy for employment was wholesome and not based on consultancy

### ***OVC Wraparound initiative***

COMPASS OVC Wraparound Initiative provided support to 12 USG IPs through capacity building and technical assistance in nutritional care and management of OVC and PLWHA. As a result of COMPASS support, 5 US government IPs (Winrock Aim, Hope World Wide Nigeria, Africare, Christian Aid and AIDSRelief) have implemented nutrition training in their program. Some of the key outcomes of the COMPASS OVC Wraparound Initiative Program are as follow:

- Trained 230 USG IP's Managers, community and facility based service providers on ENA, IYCF, PD Hearth and Nutritional Care and Management of OVC and PLWHA
- Provided TA to 4 USG IPs (Hope World Wide Nigeria, Africare, Winrock AIM and AIDS Relief) on Nutritional Care and Management of OVC and PLWHA. During the TA a total of 127 (HWWN-38, AFRICARE-27, WINROCK-22, AIDSRelief-40) participants were trained on nutritional care and management of OVC and PLWHA.
- Trained 55 community coalitions and caregivers on the CSI tool for conducting assessment of OVC wellbeing.
- Trained 122 community coalitions and caregivers on using the PD Hearth Approach for rehabilitating malnourished OVC.
- Oriented 442 PTAs, Head Teachers, LGEA/SUBEB, CCs and community volunteers on the health and educational needs, psychosocial support and nutritional care of OVC.
- Printed and distributed to partners and relevant government agencies a total of 27,000 (English 10650, Hausa 13850, Yoruba 2500) copies of posters and booklets to create awareness on plight of OVC and encourage behavior change to discourage stigma and discrimination against OVC in the community.
- Aired 1369 (Bauchi- 240, FCT -336, Kano -240, Lagos-288, Nasarawa-265) radio spots on 7 radio stations across 4 states and FCT to create awareness and behavior change among the community on the plight, discrimination and stigmatization against OVC.
- Identified and selected 403 eligible OVC from 6 COMPASS/CSN LGAs in Lagos State for educational support, on a pilot basis.
- Reprinted and distributed to partners 2500 copies of the standard of practice on OVC.

## SECTION VI: COLLABORATION AND PARTNERSHIPS FOR RESULTS

To maximize program outcomes and promote sustainability, the project worked conscientiously with government education partners at the different levels, health facilities, schools, private institutions, other NGOs, and PTAs. Specific areas of collaboration as documented below:

### NATIONAL-LEVEL

**National Commission for Colleges of Education (NCCE):** The COMPASS basic education component received the most cordial and supportive collaboration from the NCCE. At no costs to the Project, the Commission housed the COMPASS IRI studio (and personnel) where all radio programs were produced and reviewed. In the pre-service sub-sector, NCCE led the PES curriculum review as well as training of lecturers as part of its statutory purview. The initial core group for project management and implementation feedback was effectively chaired by NCCE. The Commission also held a series of meetings with COMPASS soliciting for technical support to train its staff on IRI.

**Universal Basic Education Commission (UBEC):** The UBEC was also in the forefront of the core group meetings, providing policy support as well as advice on project implementation. At the last meeting held in August 2008 in Minna, Niger State, UBEC accepted in principle to continue the facilitation of COMPASS core group meetings in 2009. In the words of Aliyu Shaba who represented UBEC during the core group meeting in February 2008, “The COMPASS/USAID PTA sub-grants are a lesson learned and more successful than the implementation of the UBEC-supported self-help projects in the 36 states and FCT simply because of its PTA training methodology and effective monitoring.” The Commission also supported COMPASS in the training of 1000 head teachers with N1.2m.

**Nigeria Educational Research Development Council (NERDC):** NERDC was actively involved in the production of COMPASS-supported English and mathematics curricula distributed to 1400 COMPASS-supported schools. NERDC participated in the core group meetings as well in COMPASS pre-service curriculum review and training workshops.

**Teacher Resource Council of Nigeria (TRCN):** The TRCN was a COMPASS major partner because of its statutory role of maintaining professional standards in the teaching profession. The COMPASS pre-service and in-service teacher trainings were certified by the Council as appropriate for mandatory professional development training and all participants were credited for the number of hours they were trained by the project. The Council was adequately represented and contributed useful inputs during all core group meetings. The Council also supported training of 1,000 head teachers with N500, 000 (\$4170).

**Federal Ministry of Education (FMoE):** Because project interventions were mainly at the state, local government and community levels, limited interaction was established with the FMoE. However, the FMoE endorsed the project for implementation in Kano, Lagos and Nasarawa States. On its part, COMPASS participated in all events organized by the Ministry, particularly Joint Consultative Committee on Education and National Council on Education meetings on policy direction. The project also participated in the formulation, review, and adoption of the teacher education policy.

**National Teachers' Institute (NTI):** Apart from being a major stakeholder in the Core Group Meetings, COMPASS identified NTI as a major stakeholder in teacher education, mandated to provide in-service training opportunities for teachers who are yet to obtain the minimum professional qualification. Therefore, it was regarded consequential to scale up the IRI intervention in view of recent support by the Japan International Cooperation Agency (JICA) and the Commonwealth of Learning, which resulted in government approval of a radio transmission license for NTI. COMPASS provided

initial technical support to the Institute including IRI programs, teachers' guides, and training manuals used during radio broadcasts. The project also provided technical support during a work planning session for the Institute. COMPASS also secured the assurance of the Institute to support the training of head teachers in 1000 COMPASS-supported schools.

**Civil Society Action Coalition on Education for All (CSACEFA):** Following decisions reached at the World Education Summit in Dakar, April 2000, CSACEFA was formed as a coalition of over 450 NGOs working in the area of education. CSACEFA is evenly spread across the 36 states of Nigeria and the FCT with its members working to influence government and other stakeholders to provide an environment that fosters quality education in Nigeria.

As a member of the COMPASS consortium, CSACEFA provided technical support to the basic education component through its dynamic network of members. To maximize results, CSACEFA member organizations, otherwise regarded as community facilitators, conducted periodic trainings for PTA executives and contributed to the development of the PTA training manuals used to train 4,459 PTA members in the three supported states. At the state level, CSACEFA focal persons worked closely with the COMPASS state teams in project implementation and monitoring. The annual work plan session benefited from CSACEFA's input and support, as well as the core group meetings where decisions on the way forward were reached.

**Federation of Muslim Women's Associations in Nigeria (FOMWAN):** As a member of the consortium, FOMWAN supported project implementation and planning. FOMWAN was particularly instrumental in fostering Islamiyya schools' understanding and compliance to project interventions. FOMWAN conducted several strategic advocacy and interactive sessions on girl child education to district heads, Imams, Islamiyya school teachers, and local government chairmen. It monitored the schools and the results of the advocacy visits, interactive sessions, and NGOs that received COMPASS sub-grants. FOMWAN advocated for increases in school furniture, classrooms, and other learning materials, and mobilized various Muslim communities on the importance of education which resulted in increased school enrolment. FOMWAN participated in PTA and in-service teacher trainings, as well as de-worming activities in public and Islamiyya school pupils. FOMWAN was also an active participant of the PES Steering Committee. It organized lectures to sensitize communities on the Universal Basic Education Act and lectured Ulamas in COMPASS supported Islamiyya schools, sensitizing them on immunization issues. The Association led several advocacies to government authorities at different levels on education issues including the employment of PES graduates and timely payment of teachers' salaries. FOMWAN was also involved in regular school monitoring to assess adherence to quality standards and participated in student achievement testing.

**Enabling HIV&AIDS/TB/OVC and Social Sector Environment (ENHANSE) Project:** ENHANSE worked closely with COMPASS in the process of forming policies at the national level. The two projects collaborated on policies regarding teacher education and educational management information systems.

**Global HIV/AIDS Initiative Nigeria (GHAIN) and DELIVER projects:** These two projects offered accommodation on their premises for scoring the 2007 and 2008 student achievement test scripts conducted by COMPASS, thus saving COMPASS hotel expenses.

**United Nations Children's Fund (UNICEF):** COMPASS achieved a major feat in June 2008 when 1,200,000 deworming pills were leveraged from UNICEF. The collaboration brought closure to difficulties in leveraging de-worming drugs in the last four years of project implementation. This symbolic gesture was tactically important for launching the massive de-worming of an additional 311,460 pupils in 16 LGAs in Kano. Some of the drugs were used to de-worm pupils in Lagos and Nasarawa States as well.

**United Nations Educational, Scientific and Cultural Organization (UNESCO):** UNESCO, like other UN bodies working in their focal areas, contributed immensely to building the capacity of education managers. Two COMPASS staff attended such leadership training for school and education managers. Additionally, in January 2009 COMPASS obtained approval for the adaptation of three training manuals for training head teachers in 100 COMPASS-supported schools. These manuals included:

- Human Resource Management Personnel Issues: A training manual for educational management by UNESCO International Institute for Capacity Building in Africa, (2005)
- School Management: A training manual for educational management by UNESCO International Institute for Capacity Building in Africa, (2005)
- School Excellence: A training manual for educational management by UNESCO International Institute for Capacity Building in Africa, (2005)

### **Collaboration with the national program on immunization and other IPs**

The Program established constructive, results-focused collaborative relationships with key partner organizations and stakeholders at the national and local levels. Principal partners included the defunct National Program on Immunization (NPI), (now merged with the NPHCDA), WHO, UNICEF, EU PRIME, Red Cross and Rotary. In Kano, Katsina and Jigawa States, COMPASS Polio Program gave office space to Rotary staff.

Program staff participated in the Core Group and ICC Working Groups, resulting in improved effectiveness of these committees. At the national level, the Polio Project provided technical assistance to the general management of supplemental immunization activities for the entire country, including support to routine immunization through trainings, implementation of IPDs, and strategic guidance to the national working groups on communication, mobilization, and training.

### **Federal Ministry of Health**

FMOH has always been the main coordinating body for many national health programs such as malaria prevention. Partnership with FMOH led to COMPASS participation and membership on the following national committees:

- National Reproductive Health Working Group
- Reproductive Health Commodity Security technical working group Integrated Maternal New born and Child Health core technical committee
- Roll Back Malaria

## **ZONAL LEVEL**

- COMPASS Polio is a key team player at this level with the NPHCDA and participated in the North West Zonal monthly meeting for partners on immunization.
- Voice of America, with input from COMPASS Polio, produced a video clip on religious leaders' support for polio eradication. This video clip has been re-edited by WHO for use in local communities. Also, frequently asked questions in Hausa and Fulfulde were repeatedly aired by VOA.

## **STATE-LEVEL**

### **State Ministries of Education**

Through SUBEB, the Kano SMoE provided first aid boxes to all 605 project-supported Kano schools to promote health care. The Lagos SMoE ensured the smooth running of the inspectorate unit at the local government level; hence inspectors were involved in monitoring 530 public and Islamiyya primary schools. The School Feeding Agency of the Nasarawa SMoE supported COMPASS SHN trainings and school de-worming activities in the state. The three ministries consistently participated in core group

meetings, which gave direction to project implementation and management, and attended five annual work planning meetings.

**State Ministries of Health and States Hospitals Management Board (SHMB)**

These two parastatals of SMOHs; State Primary Health Care Development Agency (SPHCDA) in Bauchi and SHMB in Kano and Nasarawa states played a critical role in the partnership between COMPASS and the states. The SPHCDA and SHMB oversee issues of staff recruitment, management of PHCs and staff and management of secondary health facilities respectively. The two organs of FMOH participated actively in COMPASS's annual work planning sessions, routine monitoring of health facilities and address issues raised relating to the health facilities.

**State governments:** The Lagos State government supported Health and Sustainable Development Association of Nigeria (HESDAN), a COMPASS sub-grantee, by providing an additional N600,000 to Ajao Estate Primary School and N500,000 to upgrade African Bethel Primary School, Ikorodu to a quality site. The state government thereafter upgraded the school and provided modern facilities and infrastructures. It has continued to be a prototype of what an ideal public primary school should be. In Gabasawa LGA, the Kano state government paid a total of N300,000 to the community to purchase the land required for the COMPASS-supported Zakirayamma Primary School.

**Kano, Lagos, and Nasarawa State Universal Basic Education Boards:** SUBEBs in Kano, Lagos and Nasarawa States signed MOUs with COMPASS to support the various strategies pursued by the project. For COMPASS' in-service teacher training, SUBEBs released some of their administrators to be trained as state and cluster trainers and monitors. Throughout the project, SUBEBs provided venues for the teacher trainings and trainings of trainers. They also mandated that all teachers in the selected public schools attend and participate in COMPASS supported in-service trainings. SUBEBs and the State Ministries of Information helped cover the broadcasting expenses for the IRI programs, which became very popular among pupils due to their rich student-centered teaching strategies using stories, songs and games. Between January 2006 and December 2008, the SUBEBs funded 50% of the IRI broadcasts, which cost N12, 080,000 (\$100,600) per session in Lagos, N25, 000,000 (\$208,300) in Kano, and N20, 229,750 (\$168,581) in Nasarawa State

The commitment by SUBEBs to recruit 476 PES graduates who had received COMPASS scholarships was also highly commendable. SUBEBs also offered additional funding for upgrading select project schools in Kano and Lagos States. Throughout the life of the project, COMPASS provided technical support to the State and LGEA Inspectorate/School Services Department to enable them to monitor and mentor teachers in a systematic way. Most of them were also trained as cluster trainers responsible for training teachers. Their role contributed immensely to improving schools and teachers' compliance to basic quality standards in education.

**Other state ministries and agencies:** SMOHs, Local Government Affairs, and Women Affairs and Poverty Alleviation supported the project by participating in work planning sessions as well as core group review meetings. SMOHs in particular supported the SHN intervention through first aid application trainings and facilitated the de-worming program and the training of health service providers and teachers.

**State radio broadcasting houses (State Ministries of Information):** Radio houses in the three foci-states provided air time for IRI broadcasts - Radio Lagos and Radio Kano provided 50% discounts while Nasarawa Broadcasting Station offered a 25% discount. Radio Lagos also offered free air time for other COMPASS information dissemination as required.

**Colleges of Education:** The three Colleges of Education - Sa'adatu Rimi College of Education in Kano State, Adeniran Ogunsanya College of Education in Lagos State, and Akwanga College of Education in

Nasarawa State - participated prominently in the pre-service interventions which included the training of lecturers, the scholarship scheme, the establishment of TRCs, and curriculum review. Sa'adatu Rimi provided 25 additional scholarships to the 43 awarded by COMPASS, provided space for the TRC, opened a budget line for the consumables required in the TRC, motivated the PELI lecturers with an additional allowance, and provided a furnished space in anticipation of donated computers from Intel/USAID collaboration. Adeniran Ogunsanya provided 33 additional scholarships to the 83 awarded by COMPASS, provided space for the TRC, appointed a dean with a fine arts background to manage it, and created a budget line for consumables required in the TRC. It also adopted the PELI scheme for all students in the college, employed more PELI teachers for effective and efficient teaching, motivated PELI lecturers with additional an allowance, and encouraged all the primary schools in Badagry LGA to replicate COMPASS strategies.

Following the provision of scholarships to 350 PES students, the Akwanga College of Education built a block of staff offices and a lecture theatre from the tuition provided by COMPASS. In addition, the College paid N700,000 as differential in the increase of tuition fees to supplement the tuition fees paid to the College. The College also provided space for the TRC.

**Japanese International Cooperation Agency:** JICA collaborated with COMPASS in the implementation of the SHN program in six schools in three LGAs: Ajeromi-Ifelodun, Mushin, and Surulere in Lagos State. It provided equipment and materials to improve cleanliness and sanitation in the schools. JICA trained teachers on environmental sanitation and gardening and supported the production of informational charts on these topics.

## **LOCAL GOVERNMENT –LEVEL**

**Local Government Education Authorities (LGEAs):** The LGEAs supported the in-service training by using their various structures to mobilize teachers and also invested in monitoring schools to ensure quality services in all 37 supported LGAs. This followed the training for inspectors who then mentored teachers using the mentoring instrument developed in collaboration with COMPASS. The LGEAs, through the social mobilization officers, provided technical assistance to PTAs to upgrade their schools to quality sites (schools where comprehensive renovations and essential facilities like toilets, water, furniture etc., were provided).

In May 2007, the COMPASS-supported community coalitions in Gaya LGA of Kano State reinforced their strategies by establishing a community coalition forum representing the interests of all three of the distant communities in the LGA - Gaya Kudu, Gaya Arewa and Kademi. With guidance from COMPASS, the community members mobilized resources and approached two natives of the LGA who occupied seats at the National and State Houses of Assembly to garner their support for two school projects. The National Assembly Representative supplied computers and trained two teachers on computer skills, and the state counterpart provided funds for renovating seven school blocks in the three communities.

Similarly, de-worming interventions and PTA sub-grants received a great boost in Gwarzo LGA, which scaled up a highly successful massive de-worming exercise. It also established a community based committee to develop a short-term plan to address education problems in the 120 primary schools in the area using the COMPASS PTA-subgrants' approach.

In Nasarawa State, the Kokona LGA chairman replicated the in-service training programs in 26 non-project schools with 307 teachers benefiting from the initiative and 35 radio sets procured for the schools. Doma LGA also trained 180 newly-recruited teachers in COMPASS-supported schools.

## COMMUNITY-LEVEL

**Head teachers:** The level to which some schools complied with the basic quality in education interventions was determined to a large extent on the understanding and oversight of the head teacher. In schools where head teachers attended the teacher training sessions, the level of compliance was much higher, especially in IRI facilitation. Head teachers who were also trained along with PTA executives had a better understanding of the projects and were empowered through the trainings to hold regular meetings where issues and ideas for improving school management were discussed, and appropriate action plans were developed and implemented. As a result, teachers trained on pedagogical skills through in-service teacher training and IRI significantly improved their skills to effectively teach literacy and numeracy. In turn, they made learning fun and became agents of change for pupils striving to improve their performance in English and mathematics. The range of project interventions created highly motivated teachers, which improved the school environment and overall quality of education services in COMPASS-supported schools.

**COMPASS NGO subgrantees:** Since the cornerstone of the Project was community participation, the 21 local NGOs who received COMPASS subgrants became pivotal partners in meeting programmatic objectives. Based on a relatively modest budget averaging about \$1,500 per month, the subgrantees maximized their knowledge of and influence in communities to achieve results in health and education.

**Education interventions:** The subgrantee HESDAN intervened in the area of SHN and school infrastructural improvement, transforming four Lagos schools to quality sites - one of which attracted further support from the state government. Nasarawa Centre for Women, Youth and Community (NACWYCA) and Project Agape were involved in PTA training manual development and the training of PTA executive members in 265 supported schools in Nasarawa State. Center for Peace and Rural Development (CENPARD) and Center for Research and Documentation (CRD) each upgraded a primary school to a quality site while CRD also trained 167 SHN master teachers and health providers and 3,453 teachers. It supplied 265 first-aid boxes to 265 schools and provided 780 pairs of pupils' furniture, 39 pairs of teachers' furniture, and 100 blackboards. In Kano, Society for Women and Teenage Children (SWATCH), Yakasai Zumunta, and Youth and Environmental Development Association (YEDA) were instrumental in training PTAs and developing school infrastructure. These NGOs mobilized communities on the importance of girl-child education and mainstreamed 12 street hawking girls in Kano Municipal LGA. With COMPASS subgrant support, 300 hawking girls were supported with writing materials, school uniforms, and shoes. This was in addition to enrolling 200 girls in COMPASS-supported schools during the 2006/2007 school sessions. The School-Based Management Committee, which is a policy shift in the administration of schools, was also trained in the 37 LGAs in the three focus states.

**Health interventions:** The FCT subgrantee, Education as a Vaccine against AIDS (EVA) trained 41 health facility staff on youth-friendly approaches in the delivery RH services and served 10,502 youth at the designated youth-friendly health center. Amukoko Community Partners for Health (AMCPH) improved standards of practice in affiliated hospitals and trained health workers in various aspects of integrated RH, thereby increasing uptake of FP and other RH services. The Grassroots Health Organization of Nigeria (GHON) trained 311 community-based providers and counseled and referred nearly 35,000 community members while Community Health Agency (CHA) trained 140 out-of-school peer health educators/non-traditional condom distributors and referred nearly 28,000 to youth-friendly clinics and other COMPASS-supported facilities. In Bauchi, Rahama Women Development Program educated 48 men on FP and malaria control and how to discuss these topics with other men in the community. Both Women Health Organization of Nigeria (WHON) and Community Health Information Education Forum (CHIEF) conducted advocacy visits and community dialogues to create an enabling environment for improved service delivery and utilization. This included multiple visits to traditional and religious leaders to gain their commitment and support. CHIEF also tracked and accompanied to a health facility over 500 children who had not completed their immunization schedule.

**Resource-leveraging from PTAs, NGOs, and community members:** The COMPASS basic education component developed and implemented a comprehensive support package for PTAs. Building on the former LEAP project, COMPASS integrated the PTAs as a central feature of the CC management structure. In addition, NGOs (especially CSACEFA member organizations) with experienced community facilitators were identified to train PTA executive members in internal management, record keeping, financial management, project planning, implementation and monitoring, and general decision-making and leadership skills. As part of its comprehensive program, COMPASS awarded subgrants to PTAs in supported schools to develop and assess their capacity in governance, and project planning and implementation. Through this initiative, PTAs implemented several school development projects ranging from providing instructional materials, repair/rehabilitation of dilapidated buildings, provision of classroom furniture and instructional materials, the of toilets, and provision of water sources. As a pre-requisite for receiving a subgrant award, the PTAs were required to provide matching contributions like labor, building materials and finance to complement COMPASS efforts and show their commitment. By the end of year 3, PTAs in supported schools leveraged a total of N90,000,000 (\$750,000) for various school improvement projects. In addition, local NGOs receiving COMPASS subgrants provided matching contributions and leveraged additional resources. For instance, SWATCH in Kano, leveraged a generator set, TV and video machines for equipping a girl-friendly center in the Wak primary school in Bebeji LGA. Examples of projects implemented by various community members and individuals include the construction of a clinic in Shehy Abdulwahab Primary School in Gwarzo LGA, and the electrification of school and provision of fittings in Gabasawa LGA by the LGEA.

**Community Coalitions:** Kano State CCs were agents of sustainability for all basic education interventions. They mobilized and sensitized communities and parents to enroll and retain children, especially girls, in schools. In 2004, they influenced policy makers to employ 12 female teachers especially in Ajingi LGA where no female teachers had been employed. In Lagos State, 42 CCs in the 14 COMPASS-supported LGAs were involved in community-level activities such as fundraising, mobilization, advocacy, and monitoring of projects. For instance, in Ojo LGA, the CCs and a traditional ruler donated 24 radios for IRI facilitation in COMPASS-supported schools in the area.

**Gwarzo LGA institutionalizes COMPASS PTA-strategy:** In Gwarzo LGA, they recognized that the COMPASS PTA trainings strengthened the PTAs to increase their capacity to identify, prioritize, and effectively manage sub-grants. As a result, the LGA adopted the PTA strategy and scaled up school development initiatives in all schools in the area. A nine person committee selected from the community coalition was set up to oversee this activity. Each month the LGA set aside N300,000 to renovate and solve priority problems of selected schools.

**Department for International Development (DFID):** Following a PTA sub-grant award to Mujaiheeden Islamiyya Primary School in Kano Municipal LGA and subsequent advocacy efforts of the PTA, the DFID-funded CUBE project provided an additional N5,000,000 for upgrading the school to a quality site. This effort boosted pupils' enrolment from 610 in 2004 to 783 in 2008.

**World Bank:** COMPASS participated in the World Bank stakeholders' workshop in 2007 during which an update on the World Bank-assisted school-based teacher training project was provided. This provoked discussions on appropriate teacher education areas for further support by the World Bank.

**Voluntary Service Overseas (VSO):** COMPASS worked with VSO to build institutional capacity at the College of Education Akwanga and the National Commission with Colleges of Education. The VSO team was supportive of COMPASS pre-service interventions and instructional materials development. The team was also involved in COMPASS basic education trainings and PES curriculum review workshops. Recently, VSO's Nigeria office sought to collaborate more with COMPASS on the strategies employed to improve girls' education.

The successes recorded by the child survival component were a result of involvement of all partners in the planning and implementation of child survival activities at the community, local government, and state levels. Partners were coordinated through the CORE Group at the national level in the NPHCDA and through the state Interagency Coordination Committee (ICC) at the state level. At the LGA level, the primary health care department was the focal point for coordination. At the community level, community coalitions, community health promoters, and volunteers actively participated in social mobilization and communication activities and acted as the linkage between health facilities and communities. The Nigerian Partners FOMWAN, CSACEFA, and NMA played a major role in advocacy and social mobilization of child survival activities. In addition, three NGOs (CHIEF-Lagos, CHRI-Kano and CHF-Nasarawa) that were subgrantees (one in each state) participated in defaulter tracking for immunization.

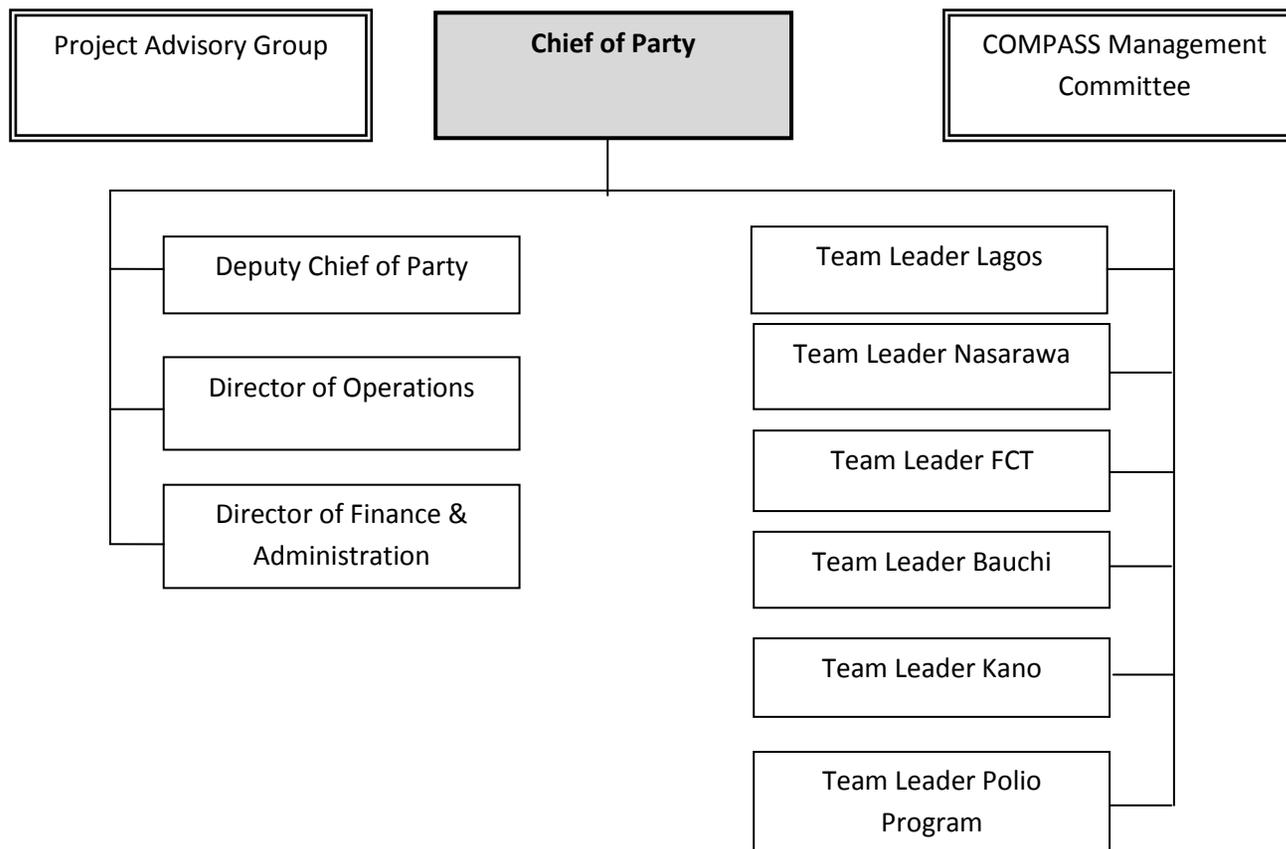
COMPASS also collaborated with two USAID implementing partners, the Society for Family Health and NetMark. COMPASS's malaria program collaborated with national RBM partners including NMCP, WHO, UNICEF, USAID, and private sector representatives. COMPASS staff also provided technical assistance to the NMCP; including support to partners meeting, production of communication materials and job aids, review of training manuals and guidelines, development of a PMV training manual, advocacy to stakeholders, and support to annual commemorations of Africa Malaria Day. COMPASS also actively worked with Society for Family Health (SFH) and AED and USAID's NetMark program in distributing ITNs and making IPT available at the community level.

## SECTION VII: MANAGEMENT AND ADMINISTRATIVE STRUCTURE

### Management and administrative Structure

COMPASS developed an organizational structure that ensured the participation of all stakeholders in the critical process of implementation. The structure was a critical result of year 1 and contributed to establishing the complex coordination and collaboration of local and state government players, key providers of healthcare and education, and community leaders and advocates.

### Project Leadership



**Central and State Management Teams:** The central management team at headquarters in Abuja provided technical and management support to the state teams. The team comprised of senior managers, technical advisors for each core technical area and cross-cutting themes, and financial and administrative personnel. With their support, the state management teams (which mirrored the central level team) guided activities for all COMPASS programs within the state. With direct oversight over the LGA Facilitation Teams, the COMPASS state teams carried the core responsibility of COMPASS Project program implementation.

## SECTION VII: FINANCIAL SUMMARIES

COMPASS received a total obligation of \$81,044,539 from USAID during the lifespan of the project. The breakdown of the expenditure by funding source is as follows:

<b>Funding Source</b>	<b>Life of Project US\$ Amount</b>
Family Planning/ Reproductive Health	\$26,210,000.00
Child Survival /Discretionary Funds	\$9,739,072.00
Polio: Child Survival	\$13,877,000.00
Polio: Economic Support	\$2,000,000.00
Polio: Development Assistance	\$500,000.00
Malaria	\$3,282,865.93
Vitamin A	\$300,000.00
Basic Education / Discretionary Funds	\$16,525,600.99
Africa Education Initiative (in-service)	\$3,660,000.00
Africa Education initiative (pre-service)	\$1,350,000.00
BE for Islamic Communities	\$3,000,000.00
OVC (PEPFAR)	\$600,000.00

As the award recipient, Pathfinder International was responsible for overall project financial management. Pathfinder utilized a fully automated accounting system which was responsive to USAID requirements and performed sub-agreement functions in accordance with the cooperative agreement and applicable USAID regulations.

For grants management, COMPASS implemented a comprehensive grants program at the local and state levels to assist communities in responding to the needs as well as to encourage public-private partnerships for the improvement of social sector services. A detailed grants manual was developed and guided the grants making process. Three levels of grants were proposed – micro grants, community coalition grants and TA and equipment support. However, the community coalition grants level was not implemented based on the methodology adopted for working with community coalitions that ensured that they contributed their own resources (finance, time, skills) and leveraged additional resources from other sources including private philanthropists and government agencies in order to implement specific projects. The decision to exempt community coalitions from receiving grants from the project though challenging demonstrated that true ownership and sustainability can be attained by communities reliance on themselves to address their issues and if needed, leverage funds themselves. This singular strategy, led to the successful formation and utilization of the community coalitions under the Project.

In support of the cost-sharing principle that underlies the USAID-recipient relationship, COMPASS worked with community coalitions, parent-teacher associations, government agencies, and private organizations to leverage a total of \$9,219,589 in order to scale-up program interventions. Also, Pathfinder contributed a total of \$4,052,227 in cost-shared over the life of the project through the utilization of other resources to increase project impact. For example, the Packard Foundation agreed to work with Pathfinder and JHU/CCP to promote synergies between Packard's Private Sector RH Program and COMPASS. In addition to expanding the impact of RH in Kano and FCT, the Packard Program enabled COMPASS to extend essential RH services to hard-to-reach populations and strengthen public-private partnerships in Borno, Katsina, Kaduna, Niger, and Sokoto states. At the same time, COMPASS will benefit from successful private service delivery models already developed under the Packard Program. Pathfinder's Ford Foundation-funded Capacity Building Program for RH NGOs coordinated closely with COMPASS in Kano and was exposed to COMPASS community mobilization techniques and use them for Foundation activities in Mabilla Plateau, Bayelsa Ogoniland in Rivers

State, Ogoni, and Kano. Pathfinder's CIDA-funded project addressed gender issues in HIV/AIDS interventions.

Pathfinder generated \$24,976.45 in program income as a result of proceeds from the sale of ITNs in Lagos State. These proceeds were utilized to support Lagos health facilities through the procurement of minor equipment. Funding sources utilized to implement activities in each COMPASS state is provided in the annex section.

An audit of the project is currently being conducted. A final audit report covering the duration of the project will be submitted to USAID in accordance to the provisions stipulated in 22CFR226.53 "Retention and Access Requirements for Records", and as part of Pathfinder International's A-133 Audit

## SECTION VIII: PROJECT CLOSE-OUT ACTIVITIES

COMPASS was designed as a five-year (2004 – 2009) project with an effective date of May 28, 2004, and an estimated completion date of May 27, 2009. The USAID/Nigeria Mission, however, granted a three-month extension to (August 27, 2009).

The impact of the project’s close-out activities will be witnessed at government, facility, and community levels in the project-supported states. Under its close-out activities plan, teachers and health care providers will no longer benefit from COMPASS trainings for acquiring new skills or refresher trainings to improve quality of services. The 704 project-supported health facilities and 1400 primary schools will not receive support from COMPASS in the form of renovations, supplies and equipment, informational materials, monitoring, and supervision. Agreements with local NGO subgrantees will not be renewed to support improved demand and access to health and education services at the community level. COMPASS will also not be facilitating the creation of CCs and QITs and assisting with their action plans. Local and state-level governments will no longer gain knowledge and insight into relevant issues from COMPASS policy briefs and advocacy visits nor receive support with the development of policy guidelines.

However, given the serious implications on project beneficiaries of terminating a large-scale service delivery program, COMPASS worked closely with its Nigerian Partners to increase their capacity to continue the initiatives, systems, and collaborative relationships established by the project with the hope that the various elements of the project will be sustained at all levels.

### CLOSE-OUT SCHEDULE

COMPASS carefully followed a close-out schedule that fulfilled programmatic, financial and administrative functions in line with both USAID and Pathfinder International’s standard project close-out requirements.

With close consultation with the USAID/Nigeria Mission, the Project collaborated closely with the ENHANSE (at all levels) and Immunisation Basics Project (in Bauchi) to disseminated key results, success stories and project publications in all supported states. The platform was also utilized to document and support key sustainability initiatives proposed or already implemented by community coalitions, schools, parent-teacher associations and government agencies. All dissemination events were completed by the end of July 2009. (See specific dates in table on right).

STATE/EVENT	STATE	COMMUNITY
Kano	April 8	April 9
Lagos	April 15	April 16
FOMWAN	April 20	
Bauchi	April 22	April 23
FCT	April 27	
Nasarawa	April 29	April 20
Polio intervention states	June – July 2009	

As required, copies of all electronic files, publications and other archival products from the Project have been submitted in duplicates and will be retained at both USAID Nigeria and Pathfinder International Offices. Other important aspects of the close-out procedure are included in the attached close-out plan/schedule.

### DISPOSITION OF ASSETS, EQUIPMENT AND FUNDS

Attached is the inventory list of the non-expendable property/equipment with a unit cost exceeding \$5,000. The items were not sold, but donated, with Mission’s approval, to recipients in line with the provisions of 22 CFR 226.34(c).

## SECTION IX: LESSONS LEARNED, CHALLENGES, CHANGES, OPPORTUNITIES, SUSTAINABILITY

### CHALLENGES AND LESSONS LEARNT

As the first major USAID-funded project to integrate education and healthcare on a large scale, COMPASS encountered some challenges but also created some unique opportunities for innovative programming. The wide scope of the project, covering five diverse states of Nigeria, each with its own peculiarities, necessitated constant need for cultural, political, and programmatic sensitivity and flexibility. Some of the key challenges and lessons learned are highlighted below:

### CHALLENGES

- COMPASS was designed as a logical follow-on to three other former USAID-funded projects (LEAP, BASICS II, and VISION). At the onset, COMPASS anticipated absorbing staff who had been involved in the three former projects and adapting many of their tools for rapid initial program implementation. In reality, however, only few of the staff of the preceding projects were readily available while many the tools did not adapt to COMPASS's community-driven focus approach. This slowed down initial implementation and alternative plans had to be put in place. At the end of Year One, however, COMPASS was able to adapt many tools that proved valuable, especially training materials, curricula, Standards of Practice, BCC materials, etc. Establishing offices and hiring local staff in each LGA required important sensitivity to the cultural exigencies. Lagos and FCT, for example, were easier to staff than the other three states.
- Getting some staff who had been used to working in vertical programming to work in COMPASS integrated setting turned out to be a major challenge.
- Hiring at the leadership level also proved challenging in Project Year One. For a variety of reasons, advisors for all three technical areas had to be replaced or had their hiring delayed, a situation which slowed down project implementation because of the absence of consistent leadership at that key level.
- The unanticipated introduction of a massive and comprehensive polio project as an overlay across all COMPASS child survival activities became a demanding diversion of resources. As resources were redirected to polio, other child survival efforts had to be realigned, causing a delay in the full development of this component of the Project.
- The COMPASS' project evaluation methodologies and interpretation of findings as in the midline survey posed its own challenge. The survey included data from facilities and areas that were not supported by COMPASS. The survey reported state level coverage, including LGAs that did not receive support from COMPASS. This methodology issue, therefore, affected the findings that do not demonstrate full impact of COMPASS interventions.(COMPASS was working approximately in one third of the LGAs included in this survey). A corollary issue is the data collection from incomplete information sources, specifically only children with a health card were included to report DPT3 vaccination, while mothers' reports were not included compared to the NDHS survey which used information sources, the health card and mother's report, to report DPT3 rate.
- The multiple agencies established to carry out similar and sometimes same functions, such as the SMoH, Hospital Management Board, SPHCDA, Ministry of Local Government, and State MDG coordinator and all sharing the responsibility of managing primary health care created cumbersome bureaucratic processes that slowed down the development, implementation and sustainability of project policies
- The collapse of the health and education systems in COMPASS states resulted in many competing priorities, pushing COMPASS interventions lower on government policy agenda. The resulting gaps in public service created overwhelming situations in the process of

institutionalizing COMPASS interventions. In addition, obtaining appointments with government audiences to gain government support for the COMPASS project systems, programs, and good practices became more difficult.

- Difficulties faced in accessing budget information at State and LG levels made it impossible to track government allocations to health and education, which are key indicators to determining government's commitments to the sectors.

## LESSONS

- Engagement, empowerment and building capacity of community structures such as CCs, QITs and FOMWAN volunteers provided the critical linkage needed between the health facilities and communities and helped to sensitize and mobilize communities towards reaching the project target groups. Taking ownership of community health improvement process and serving as health action agents, these structures helped communities to identify their needs and contributed to an increased demand for social sector services.
- Coordination/collaboration between government, donors, implementing partners, and other key stakeholders led to increase in impact and cost effectiveness of program implementation. Specific examples include effective ITNs distribution campaign in Kano, where such coordination and contributions from various stakeholders ensured supply and storage of ITNs, distribution, dispensing, community mobilization, training, monitoring and evaluation and monitoring security. Another example includes monitoring and evaluation activities, which were conducted with collaborative efforts of all partners and helped to learn and apply best practices.
- Public-private partnerships played an important role in ensuring sustainability of Project interventions. In order to ensure a continued support for social sector services at the LGA level in particular, advocacy efforts with private sector partners should continued to be ongoing..
- Some of the project targets were set at higher than attainable levels, for instance, it was not feasible to achieve the targeted DPT3 coverage rate and DPT dropout rates. According to the 2003 DHS, only 21.5 percent of children 12-23 months received DPT 3 at any time before the survey, based on either mother's report or child health card. However, the baseline survey had shown that only 13 percent of children had received DPT3. Likewise, the rate of DPT1-DPT3 dropout was set at 2%, based on a baseline study; however, that study covered only a small fraction of 50 children; in the meantime, the 2003 DHS findings showed the dropout rate of 50 percent for DPT1-DPT3 dropouts.
- Shortages of vaccines and medicines at health facilities affected the project's ability to fully meet the targets that were set for appropriate treatment of malaria, diarrhea, and ARI, as well as DPT3 coverage rate. Availability of vaccines improved only during latest years of project implementation, largely due to project interventions aimed at improving pharmaceutical management practices at the PHC facilities. In the meantime, COMPASS was not responsible for provision of medicines and supplies within its scope of services.
- Community empowerment is key to establishing, achieving and sustaining governance system and processes that respond to the needs of communities. The service providers recruited, health facility and schools renovated, commodities purchased, and policies developed are all testimonials to this.
- Capacity building to create a critical mass of States and LGEAs personnel to become skilled trainers, community facilitators and empowered PTAs represent the major sustainable legacy of the basic education component of the Project. Over 90% of COMPASS in-service teacher trainers were drawn from the state and local government personnel while all schools' infrastructures improvement were implemented by PTAs and community-based NGOs. Likewise all trainers in the Pre-Service teacher training were drawn from the three foci colleges COMPASS worked with.

- The Project underestimated the level of infrastructural and personnel decay in schools. The impact of the basic education component of the Project would have been more if the Project had worked or targeted less number of schools, LGAs, teachers and pupils instead of 1400 schools, 37 LGAs involving over 21,000 teachers and 700,000 pupils.
- Demonstrating linkages between policy, program and budget and translating them to service delivery at the health facility and school levels was difficult to achieve within the project timeframe. Though senior level public officers have begun to make these linkages, there are still gaps in understanding the need to pay attention to building systems that will enable complementarily and coherence between the different planning and implementation agencies at the State and LG levels.
- The decay in the selected Colleges of Education (CoEs) and primary schools at the inception of the project was more serious than anticipated. There existed a wide gap between teacher education curriculum and the school environment. For instance, none of the Primary Education Studies (PES) lecturers in the selected CoEs had any requisite teaching background nor had received any training in the peculiar pedagogical skills before the commencement of the Project. Most of the students admitted to study PES were not academically and psychologically ready for the teaching career as they were largely students that could not be placed in any other departments. School facilities were in an abysmal state of disrepair. Apart from being poorly motivated, most of the teachers were unqualified (78.36% in Kano, 69.4% in Nasarawa and 36.31% in Lagos {*Source: Ed Data Bank, FMOE, 2006*}).
- The Project witnessed an initial resistance by teachers to the use of IRI as a training tool and apathy by Islamiyya schools to fully participate in all USAID/COMPASS in-service teachers training program. Likewise, schools inspectors' were initially reluctant to adopt Student Centered Teaching Approach (3 Ps Lesson plan format, seating arrangement, Cooperative Learning, use of Instructional Materials, Gender sensitivity among others) practiced by teachers trained by COMPASS. The Kano State government's inability to secure and pay for air time on state radio for IRI broadcast to schools at the beginning of the project delayed the take-off of the IRI radio program and subsequently resulted in inability to meet the targeted outcomes in Year One.

## KEY PROJECT CHANGES

- In order to further decentralize the project management and administrative system, the Project invested in establishing LGA field offices and recruited LGA facilitation teams in all 51 LGAs in Year One of program implementation. This structure was not in the original concept proposal and was unsustainable due to the huge costs associated with its implementation. However, the project retained some LGA field officers who facilitated program interventions at the grassroots throughout the lifespan of COMPASS.
- COMPASS project planned to renovate all selected 1400 schools through level 1a sub-grants which had little or no impact in a typical school within the community. The level of sub-grants was subsequently substantially raised to the next level to make schools become quality sites and serve as models that meet the Basic Quality Standards of Education (BQSE) expected of a school in Nigeria.
- The initial areas of intervention in COMPASS pre-service program did not include the training of lecturers and establishment of TRC. Changes were made to accommodate these important thematic areas to address the gaps identified in lecturers' pedagogical skills as well as paucity of instructional materials in the preparation of teachers for the primary schools in Nigeria.
- The frequency of in-service teacher training changed from bi-monthly to quarterly largely due to inadequate funding and the size of school teachers involved. The quarterly trainings which were of 8 hours duration later increased to 24 hours in later years of the project in response to recommendation by USAID COMPASS evaluation team.

- Monitoring of initial 700 schools in 37 LGAs was limited to COMPASS BE staff but later expanded to involve 143 COMPASS trained inspectors to monitor schools and mentor teachers in the 1400 schools whose reports were analyzed on quarterly basis.
- The COMPASS BE Core Group Meeting was targeted at pre-service stakeholders initially. After two years on the project, the Core Group Meeting had to be expanded to include all basic education stakeholders (PTA, CCs, Radio Houses, MoE, MoH, LGEAs, SUBEBs, Nigerian partners etc) which serve as platform for sharing challenges, achievement, proffering solutions to issues and making commitments to effect positive change(s) on the project.
- At inception, it was planned that OVC from other USG IPs would be enrolled in COMPASS supported schools in Lagos State and retained to complete their basic education through resource leveraging. Due to the inability of some OVC USG IPs in Lagos State to submit their list of eligible OVC and the absence of COMPASS supported schools in most communities where the US government IPs were working, COMPASS had to work for the continuation of this critical component of the OVC program (through MOU) with the CSN. COMPASS employed the services of COMPASS Community Coalitions to identify OVC for educational support. The process of identification, verification and selection of OVC was time consuming. The identified OVCs were handed over to CSN for continued provision of services to the selected children after COMPASS project closeout.
- The targeted quantity of ITNs that were purchased or subsidized by the project was 280,602. Upon request from USAID, COMPASS distributed additional quantities of ITNs. Specifically, this included a large scale distribution effort in Kano (overall, more than 1.9 million ITNs, including about 590,000 purchased through USAID funds and the rest that were donated by the World Bank) that required appropriate shifts in human and financial resources.
- The establishment of ORT Corners and food demonstration centers in selected health facilities was not in the original plan. However, this was needed to meet the demand created through campaigns that raised awareness of the community, using seven key CS interventions. This effort also included the procurement of cooking utensils and 89,600 ORS sachets that were distributed to the centers.
- The child survival program was expanded to include the Polio Special Project to the COMPASS Portfolio in 2005.

## OPPORTUNITIES

- The establishment of ORT Corners in 113 COMPASS-supported health facilities led to improved treatment and care for children with diarrhea through ensuring availability and accessibility of quality treatment services for children with diarrhea. COMPASS trained the providers of these services in national protocols and monitored their compliance. In addition, health facilities, where ORT corners were established, trained mothers in salt-sugar solutions preparation.
- PMVs frequently served as first-line care providers/first point of contact for communities with regard to their health needs, in both urban and rural settings. However, most PMVs were not informed about new malaria treatment guidelines and did not have this knowledge, which contributed to prescription of ineffective drugs or regimens. COMPASS collaborated with PMVs, developed and provided guidelines for PMVs and trained them, thus extending the reach of child survival interventions to cover more community members and improve the quality of treatment. Collaboration with PMVs also helped to improve referrals to the PHC facilities for additional care and management.
- Use of integrated approaches, such as seven key child survival interventions strategy, during sensitization and community meetings enhanced community awareness of child survival issues, improved acceptability of child health services provided by health facilities, and led to better coverage and improvement in efficiency of interventions due to leveraging of resources.

- Innovative strategies, such as PD Hearth, integration of an ITN voucher scheme with infant routine immunization, generated increase in demand, improved the reach and increased utilization of services. For instance, through providing incentives, ITN voucher scheme increased DPT3 coverage and reduced drop-outs from DPT1-DPT3, increased awareness of ITNs utilization and improved their availability. Through the ITN voucher scheme, eligible mothers, whose infants completed a required set of DPT vaccinations, received a voucher for buying an ITN at the discounted rate at the distribution point created in close proximity by the participating ITN distributors. Seventeen thousand vouchers were given to the mothers who came for immunization and 97 percent of recipients redeemed vouchers for nets. COMPASS developed the voucher scheme in collaboration with NetMark, Nasarawa SMOH, and private ITN distributors and implemented it at 35 participating facilities in seven LGAs in the state. Another strategy, called PD Hearth, allowed mothers to share best practices in child care and nutrition, to address child malnutrition; provided mothers with an opportunity to learn about child survival interventions and improve their health seeking behavior.
- Campaigns such as Child Health Weeks, Immunization Plus Days and Local Immunization Days generated an immediate impact by reaching a large proportion of children, who were earlier missed or dropped out, providing access for and improving coverage of hard-to-reach communities and carrying out various child survival interventions, including Vitamin A supplementation.
- COMPASS's holistic approach of combining policy and advocacy facilitated a bottom up policy approach to address the needs and concerns of the communities. As a result, government programs and policies began to reflect community priorities. Community advocacy results included the development strategic plan for SPHCDA to operationalize its goals and objectives in Bauchi, and the drafting of the IMCHC Bill to address gaps in maternal and child health care delivery in Kano.
- Facilitating joint meetings between community representatives and government demonstrated to governments that communities are a valuable resource in developing responsive policies and programs. Government themselves adopted the LGA forum and policy dialogue as a platform for dialogue and feedback on program impact and relevance. Technical meetings between project staff and government partners were leveraged as additional opportunities to build capacity and transfer skills for sustained results.
- Collaboration between the NPs and CCs, Religious leaders, FBOs, and policy champions in pursuing advocacy objectives helped build a network of organizations that regularly hold governments accountable for the provision of quality services at the State level.
- COMPASS Education Core Group meeting was held twice a year to disseminate information, review work progress and challenges; share best practices and recommend solutions to problems. Stakeholders made voluntary commitments to enhance the project objectives. This largely accounted for the sense of ownership and high level of participation required to sustain the project long after its close out.
- COMPASS succeeded in establishing strong working relationship with development partners, the private sector and other federal and state institutions and in leveraging financial and technical support. In addition to airing the IRI program for free, institutions such as UBEC, TRCN and NTI, and Lagos State Government contributed to the tune of **N4.675m (\$39,932)** to support the training of 1,000 head teachers and the hosting of a Core Group Meeting.
- Intel provided 50 Classmate PCs to Sa'adatu Rimi CoE, Kano, donated 700 copies of training manuals and trained 51 lecturers and 53 primary school teachers on ICT. UNICEF donated **1,200,000** de-worming drugs; UNESCO's approved the use of training manuals on School Management; ENHANSE collaborated with COMPASS on teacher education and NEMIS policies and VSO's contributed in reviewing PES English and Mathematics curriculum and in designing the pre-service training manuals.

- FOMWAN was instrumental to making Islamiyya school's proprietors in Lagos State allow their teachers to participate fully in in-service teacher training sessions, an issue that could have been a major constraint to BE project delivery. Similarly, CSACEFA a major COMPASS partner was responsible for training about 4500 PTA executives in 1400 schools through its affiliate members who were trained as Community Facilitators.

## **SUSTAINABILITY**

Nigeria has witnessed a surge of funding for social sector services, much of which is increasingly channeled through NGOs. While disbursements increase, adequate management and organizational systems are not always in place to put the increased funding to use in a timely and effective manner. The ICB unit's role was to strengthen the capacities of these organizations to sustain their activities and support local communities in improving and sustaining the quality of education and health care services. To this end, selected Nigerian Partner members participated in trainer of trainer's workshops in financial management, proposal writing, and strategic planning to enable them to provide step-down training on the information to community coalition members spread across the five states. The ICB component worked with Nigerian Partners to build sustainable and effective financial systems, supported by strategic planning and laying the foundation for financial sustainability. The unit supported the NGOs as needed to write fundable proposals as initiated by these organizations to increase their funding base and sustain COMPASS activities in the long term.

COMPASS created a critical mass of people in schools, health facilities, communities, civil society organizations and government agencies who are key players in sustaining project initiatives. The Project invested resources to build their capacities in a targeted way, offered more support, mentoring and skills where needed and encouraged use of acquired skills to address community needs and issues. By December 2008, 130 of the COMPASS' 215 community coalitions had formally registered with various levels of government (LGA, state and national), which gives them opportunities to be recognized and able to seek donor support. In addition, COMPASS supported and encouraged the CCs to market themselves and their accomplishments within and outside their own communities. To demonstrate their usefulness and sustainability, some other projects have used selected CCs as platforms for implementing specific interventions. Additionally, the Project recorded successes of some CCs which developed local alternative sources (communal farms, boreholes, etc) for funding change initiatives. (Please see "Our Change Story: a compilation of COMPASS success stories" for examples)

Throughout project intervention, there were documented evidences of communities, private organizations and government agencies that replicated specific project strategies. Some examples are included in the attached strategy documents by program area. Additionally, during the different levels of dissemination events in all supported communities and states, participants developed specific action plans to assure sustainability of specific project initiatives.

The management in the Colleges of Education evolved a tradition of instructional development in COMPASS-supported TRCs by regularly supplying basic education consumable materials. Each of the three Colleges of Education has provided additional scholarships beyond the scholarships provided by the project. The adoption of core group meetings as a forum for discussion of basic education issues is a lasting legacy that COMPASS is bequeathing. Also, the SUBEBs and radio stations have expressed commitment to the broadcast of IRI programs in their states, and the Teachers Registration Council signaled its interest in adopting the COMPASS modules for training of teachers to facilitate accreditation and registration of teachers. The essence of any education project is to bring about positive change in schools and their host communities for an assured future. These changes cannot be fully realized without the full involvement and participation of all stakeholders. This is the approach that COMPASS has adopted in order to realize its set goals and objectives as indicated by the series of achievements mentioned in this report.

A number of COMPASS interventions (listed below) have proved quite successful and worthy of replication. The concept of “Model Sites” which showcases a whole clinic approach to improving quality of health care is one of such. At least 1 model site has been established in each of the 51 COMPASS LGAs for this purpose.

- YFS centers established to cater for the ever growing needs of the adolescent population.
- Three reproductive health related standards of practice and service protocols and a number of job aids developed and reproduced for the FMOH as lasting legacies that need to be replicated in the 36 states of the federation not only in COMPASS-supported states.
- QITs will remain an invaluable structure in sustainable quality improvement at the HFs. They serve as watch dogs in the HFs and ensure prompt and timely resolution of challenges in the HFs. The QITs mechanism is a key legacy of the Project that can be strengthened and replicated by the communities and governments.
- Some key areas of the Project that require specific attention include:
  - Standard of Practice and service protocols need to be scaled up to all HFs in the country.
  - YFS centers (40) need to be supported and replicated by FMOH and SMOHs.
  - QITs need to be institutionalized for them to be sustainable. They may require incorporation into the membership of the WDCs.
- Kebbi State government embarked on a plan to scale up the COMPASS-TBA Referrals Strategy for newborns that led to improved defaulters tracing in all 21 LGAs and 224 wards of the state. Jigawa State is also committed to scaling up TBAs referral of newborns and defaulter tracking in each of the eight Tunduma councils. In Sokoto State, discussions with UNICEF addressed replication of parts of the COMPASS strategy. In Kaduna State, the only commitment received was from the LGA chairmen of Markafi and Giwa which are COMPASS LGAs. The chairman showed intent to continue the FOMWAN and TBA activities and to empower WDCs through the following steps:
  - Meeting with health educators monthly to improve their capacity through trainings and discussions
  - FOMWAN activities to mobilize 40 households in their neighborhoods after COMPASS pulls out, as well as adding on other health activities;
  - TBAs will refer and trace newborn defaulters.

## SECTION X: RECOMMENDATIONS FOR FUTURE PROGRAMS

### RECOMMENDATIONS

- Improvements in health systems, specifically the PHC center, can considerably increase effectiveness of interventions especially those aimed at improving child health. While improvements are needed at all levels of PHC system, specific areas of improvement at health facility level include planning, management (financial/budget management and human resources management), access to and availability of high quality services and medicines/vaccines.
- Pharmaceutical management practices at the health facility level require serious attention. Shortages of essential medicines and vaccines at the health facility level pose a serious challenge to effective implementation of child health programs. For instance, shortage of anti-malarials, may lead to treatment failure and development of drug resistance. Uninterrupted availability of ACTs is a prerequisite to effective treatment of malaria. Lack of medicines and vaccines for treatment and prevention of childhood illnesses can compromise the efforts of child health programs. While COMPASS worked at the LGA and PHC facility levels and achieved improvements in availability of vaccines at the PHC facility level, there is still a need for capacity building in pharmaceutical management at the national, state, LGA, and health facility levels, to ensure understanding of the scope and impact of the problem and obtain support and commitment to ensuring uninterrupted supply of essential medicines, as well as build expertise in procurement. This is especially important at the national and state government levels, as the government procures ITNs, vaccines, and anti-malarial medicines. Therefore, the PHC facilities and services will benefit from training in logistics, quantification, and general aspects of pharmaceutical management. Monitoring and supervision efforts should be continued at the state, LGA and IPs levels, to ensure availability and to build capacity in drug/vaccine quantification.
- COMPASS built local capacity in developing and implementing child health interventions. Due to COMPASS efforts, thousands of providers were trained. The capacity building efforts also included communities that are now more empowered to make informed decisions regarding the children's health. The scale of capacity building efforts ensured supply of quality services to address child health issues and meet the increased demand. Future programs can build on these resources. Various tools, IEC materials and best practices developed by the program continue to be replicated and scaled up by the state, LGA and development partners. The technical materials developed by the program will continue to serve as reference guides for the government and development partners. Partners and programs can continue building on COMPASS' experience, lessons learned and strategies that proved to be effective in improving child health. Integrated approaches, innovative strategies, private-public partnerships enhanced the impact of COMPASS CS program, and can be applied at a larger scale.
- Continued collaboration among government, donors, implementing partners and other stakeholders can further improve the impact of the program through the use of harmonized approaches, leveraging resources and achieving synergies in child health interventions across the country.
- Mobilizing communities will continue to be a powerful tool to increase utilization of basic education, reproductive health/family planning, and child health services and enhancing an impact on child health; therefore, the future programs should continue the efforts to build capacity at the community level, involve community structures and leaders, and empower the communities to ensure ownership of child health programs.
- Provision should be made for a full complement of an M&E unit by employing adequate number of staff for the unit instead of relying on non-project staff to embark on the duty of data collection.

Projects should not rely on outsiders to collect data instead project staff should be engaged in monitoring especially if they will be held accountable for non-performance. If for any reason, data collectors were to be used, they should be tested hands, teachable, and made to go through a rigorous training and practice to demonstrate their honesty and integrity. In some instances, data falsification by data collectors was an issue under the project.

- Each project should sign an MOU with the Local Government Service Commission to leave trained staff at the service delivery points or alternatively transfer them only to facilities with trained personnel to ensure continuity in service delivery and practice.
- Prior to selection of project sites in any particular LGA accessibility should be considered as a key criteria for selection.
- Quarterly data collection-related meetings should be held with MCH Coordinators and PHC Directors. Registers should be brought to the project office for quarterly validation exercise by project staff and a feedback meeting should be organized for the project LGAs in future.
- Project funders and donors should try to work collectively with the management information systems (MIS) of the states and LGAs to develop and use common/standardized data collection registers as well as solving some of the systemic issues highlighted and currently affecting the quality of the data from health service delivery points. The current practice of having multiplicity of registers in a single health facility should be discouraged.

## CONCLUSION

The COMPASS Project achieved significant results in improving the use of social sector services in the supported communities and local government areas in all supported States. The COMPASS midline evaluation results indicated that the COMPASS Project impacted lives positively: At the LGA and community levels, more mothers delivered babies safely, the survival rates of babies increased, more men were involved in education and health promotion for their families and more girls and boys were provided with equal platforms to acquire literacy and numeracy skills to lead Nigeria's communities into the future.

In 2007, a team of program managers from Engenderhealth visited COMPASS-supported communities to assess community involvement in reproductive health/family planning. At the end of their mission, they noted that “most providers indicated an increase in the number of men attending family planning clinics with their female partners, as well as an increase in the number of clients requesting IUDs”.

In June 2008, a team of USAID consultants evaluated the COMPASS Project and noted among others that “there appeared to be significant benefits from active community participation, especially in the health sector”. According to the evaluators, active participation led to increased support from the community to improve health service (e.g. donations of equipment, land, and cash from community benefactors and in-kind contributions, including materials, time, and labor). In addition, greater involvement and commitment at the community, LGA, and state levels attracted additional funding from other donors. The evaluation team also noted that coalition members expressed enormous enthusiasm, dedication, and commitment to continuing relevant activities, even after COMPASS support.

The community mobilization activities of the COMPASS Project (especially the CCs and QITs) in supported communities have awakened the inertia abilities of community members to become change agents and advocates in their communities. The CC members utilized the platforms created by the Project to pioneer and implement change initiatives that will remain as legacies of the Project in their local communities for years to come.

## **ANNEX**

**Annex 1:** Recommendations and Conclusions on ICB support to the four Nigerian Partner Organizations

**Annex 2:** Project Monitoring Plan

**Annex 3:** Year 1 – 5 Results Chart

**Annex 4:** Contact sheet of sub-grantees

**Annex 5:** Approval to conduct endline evaluation surveys

**Annex 6:** Informed consent form\_IRB\_Healthfacility\_Endline

**Annex 7:** Informed consent form\_IRB\_HH\_Endline

**Annex 8:** Informed consent form\_IRB\_School\_Endline

**Annex 9:** Funding sources utilized to implement programs by state

## **Annex 1: Recommendations and Conclusions on ICB support to the four Nigerian Partner Organizations**

To strengthen the four Nigerian Partners' organizational effectiveness and based on assessments carried out, the ICB unit over the years have provided training, targeted technical support and equipment assistance to the organization.

### **AHIP**

End of project results compared to the OCAT end of Year 4 results show that AHIP has increased overall scores, and also had increases in all 7 elements of organizational development. AHIP moved from expanding to mature stage of development.

In previous years, the internal governance systems of the organization was rather weak; the board was not effective; did not have clear roles and responsibilities and the ED was solely providing the leadership in terms of policy guidance, financial oversight and fundraising, while she could rely on the board to only advocate and lobby on AHIP's behalf. Based on past assessments done by the ICB unit and other donor agencies on the organization; Ford Foundation resolved to support AHIP in strengthening its board and members including the management staff to position it as an organization that can survive the founder. The technical support has commenced with board restructuring and appropriate mentoring of the ED and management staff and this will culminate in the appointment of an ED by 2012 with the present ED and founder retiring to the board by the said year. Key persons with appropriate skills will be part of the new board to provide strategic guidance and leadership to the organization.

### **Institutional Sustainability Recommendations**

Though AHIP has pushed into the cusp of mature organization, it needs to do the following to achieve institutional sustainability:

- The Leadership and management restructuring which is on going needs to be sustained;
- Commitment of the ED and management to implement the governance systems put in place
- Increased adherence to its Personal policy, transport policy, financial, HIV/AIDS in the workplace policy, pension scheme, vehicle running, office policies which are being presently reviewed by the consultant.
- Implementation of staff development plan need to be sustained to create the enabling environment for staff to work effectively and be self motivated.
- Separation of duties needs to be strengthened under its financial control systems and the Auditor needs to be changed having been auditing AHIP's financial affairs for over 6 years.
- Systematically implement and use procurement procedures

To a large extent, its projects are sustainable especially the vocational skills centre, the clinics, some of its activities being sustained by the Traditional and Religious leaders, CBOs, PEs and the HFs renovated by AHIP have CD groups made up of LG officials, emirate and community members ensuring that quality services are being maintained.

### **Program sustainability Recommendation**

- Though ICB unit supported in developing an MIS, this has not been in use as the staff trained on the use have left the organization. Thus AHIP needs to start using computerized software that will store, collate, analyze and generate better quality reports.
- Need to systematically undertake periodic surveys of its community to determine satisfaction with its activities or services

- It needs to ensure that all its clinics have SOPs in place and define quality standards for its Institute of Human Development
- Play a key role within the Kano network of NGOs to provide necessary guidance and mentoring to smaller NGOs within the state
- It needs to develop an annual media plan
- Annual systematic review of its strategic plan
- Institute annual work planning and budgeting

The organization has a strong funding base with funding from Macarthur, Ford Foundation, Packard and more recent, EU, Population Council, Oxfam Novib and the Global Fund. It also has a strong income generation base through its Human Development Institute and to a large extent can financially sustain its own and COMPASS initiated activities.

### **Financial sustainability Recommendation**

- AHIP needs to make the operations of its IGAs more systematic and organized to run as separate subsidiaries
- Needs to review and finalize its documented Financial Sustainability plan to complement its already established diversified sources of income.

### **CSACEFA**

End of project results compared to the OCAT end of Year 4 results show that CSACEFA had increased overall scores, and also had increases in all 7 elements of organizational development though CSACEFA is still at the expanding stage of organizational development.

In terms of institutional sustainability, CSACEFA as a coalition has been able to comply with its constitution to a large extent especially on transparent elections of its Facilitating Council which is made up of zonal coordinators who provide policy guidance and leadership for the organization. There is also a 3-man board which has been dormant and not been involved in leadership, this board was put in place by their first and major funder (CEF).

### **Institutional Sustainability Recommendations**

- CSACEFA needs to reconstitute its BOT to provide necessary leadership
- Needs to develop selection criteria for its Facilitating Council members to ensure effectiveness and ability to respond to policy issues in a timely manner
- Training of Board and FC on their roles and responsibilities
- Increased adherence of secretariat staff to HR, Financial and operational procedures
- The MIS officer which COMPASS helped to recruit needs to continue to ensure that the CSACEFA MIS and improved reporting system is maintained.
- It needs to implement staff appraisal system for HR development
- It needs to strengthen its inventory audit and code all assets
- Systematically implement and use procurement procedures

The coalition is made up of independent NGOs nationwide who have their specific mission and objects. These member organizations are responsible for implementing the activities of the coalition while the secretariat monitors and coordinates. CSACEFA has contributed to and led policy activities nationwide; a few of these policies have been adopted. For the secretariat to ensure the implementation of quality service by members, it recently put in place a mechanism of signing MOUs with such members. The coalition has as part of its membership, AHIP, EVA, NACWYCA and FOMWAN just to mention a few who have expertise in community mobilization, negotiation, conflict resolution etc. The coalition has become more strategic for government actors and IDPs, thus should institute the following to ensure increased sustainability and technical skills on education issues, policy and advocacy at the state and zonal levels:

### **Program sustainability Recommendation**

- Secretariat needs to provide and train all states on defined quality standards and code of conduct for the coalition
- Need to systematically undertake periodic surveys of its community to determine satisfaction with its activities or services
- Orient key state members on CSACEFA program areas
- Hold members NGOs accountable for providing timely and accurate reports to the secretariat on a monthly basis.
- Annual systematic review of strategic plan
- It needs to harness the technical skills from all its strong member organizations to mentor the weak ones.

Since its engagement with COMPASS, it has gotten major funding from OSIWA, and more recently from Oxfam Novib and is recently partnering on the ESSPIN (DFID) project. It also does consultancies for UN agencies; OSAP MDG; UBE and FMOE. Its funding portfolio has grown from one major funder in the last 2 years. It has ability to some extent to financially sustain its own and COMPASS initiated activities.

### **Financial sustainability Recommendation**

- Develop private sector collaboration and alliances to leverage more resources
- Develop more fundable proposals for its program areas
- Institutionalize consultancy remittances from staff and member organizations that implement activities for the coalition
- Need to implement its financial sustainability plan

### **FOMWAN**

End of project results compared to the OCAT end of Year 4 results show that FOMWAN had increased overall scores, and also had increases in all 7 elements of organizational development though CSACEFA is still at the expanding stage of organizational development.

In terms of institutional sustainability, FOMWAN as a religious network organization uses the Islamic system is used in electing officers who make up the National Executive Committee, it also has a board made up of founders who have life tenure. FOMWAN has a relatively strong board and leadership, its staffing base was also recently upgraded by COMPASS to address programmatic and management gaps.

### **Institutional Sustainability Recommendations**

- Expand board to include younger women to infuse vibrancy
- Criteria on the election of Amirahs should be reviewed and strengthened
- Increased adherence of secretariat staff to HR, Financial and operational procedures
- Review of the organogram to reflect current staffing and integrate project team
- Continued mentoring of all state officers by HQ staff
- It needs to implement staff development and appraisal systems for HR development to adequately motivate staff
- Systematically implement and use its procurement procedures as necessary
- Strengthening internal communication within the headquarters and between the national office and the zones, states and LGAs
- Systematically implement and use procurement procedures

FOMWAN was established as a Faith Based network volunteer organization and over the years, the network has been working through its members in an ad hoc manner to implement activities according to its state objects. To ensure program sustainability and effectiveness it became imperative that FOMWAN moved into

recruiting core professional technical staff to carry its program forward and to position it as a NGO to be reckoned with, to this end, COMPASS supported in recruiting and training an accountant, Project Coordinator and M&E staff to drive FOMWAN operations in view of the inability of FOMWAN members to commit more the required time to FOMWAN activities as expected. Based on its track record it can, to a large extent, sustain its own and its COMPASS activities. The staff members, enabled by the NEC, are expected to address the following programmatic issues:

#### **Program sustainability Recommendation**

- A move from ad-hoc arrangement to a more organized and systematic approach to M&E
- Develop an organization wide database
- Need to systematically undertake periodic surveys of its community to determine satisfaction with its activities or services
- Generating, proper storage and dissemination of progress reports and assessments
- Revise its volunteer policy
- Conform to standard tax regulations for its staff
- Annual systematic review of strategic plan
- Institute annual work planning and budgeting
- Ensure all its schools, facilities have required SOPs in place

In the last 2 years, FOMWAN has expanded its funding base to include funding from Population Council; it is also a partner on the NECAIN and SUNMAB projects, it has expanded its strategic alliance to include NPHCDA and other government actors who have come to recognize its strength in community mobilization and advocacy. Though its funding base has grown, more work needs to be done in the following areas:

#### **Financial sustainability Recommendation**

- Pro-active approach to proposal development : so far FOMWAN has been approached by funders to respond to proposals
- Need to implement its financial sustainability plan
- The HQ needs to institute a systematic approach to collect states' dues, levies and contributions and its rental sources of income

#### **NMA**

End of project results compared to the OCAT end of Year 4 results show that NMA had increased overall scores, and also had increases in all 7 elements of organizational development though NMA is still at the expanding stage of organizational development.

The Nigerian Medical Association (NMA) was founded in 1960 to promote the interest of its members, as well as to help shape national policies and legislations to improve healthcare delivery. Policy decisions are made by the Association's National Executive Council (NEC) which is the governing body. The National Executive Council has full powers to act on its behalf in the period between the Annual Delegates' Meetings (Highest level of governance). Though the process of election into this body is transparent, the change of leadership every 2 years does not ensure continuity within the body. All members trained at the state and national levels were not able to translate the skills acquired into the association because of their loose structure.

#### **Institutional Sustainability Recommendations**

- The need for a constitutional amendment to put a process in place where there can be an overlap to enable ex-officio impart knowledge and skills on the new
- Increased adherence of secretariat staff to HR, Financial and operational procedures
- It needs to implement staff development and appraisal systems for HR development to adequately motivate staff

- Systematically implement and use procurement procedures
- Organization need to conform to standard tax regulations
- Need to procure and use appropriate computerized software accounting system
- Need to re-brand NMA and orientate its members on the need to volunteer some of their time for social development

Having been focusing on members' welfare and interest for the past 4 decades, the need for NMA to enter into the foray of programme development and implementation became imperative when COMPASS engaged it as a partner. Though the association has partaken in programmes funded by UNFPA, UNICEF, WHO, USAID, The Ford Foundation, and the John D and Catherine T MacArthur Foundation and others, but is yet to implement or successfully run a grant of its own. It has responded to occasional RFPs with limited success because of institutional challenges. NMA has solid financial base but has not been able to prove that it can sustain COMPASS activities as only its members feel a sense of ownership of its activities.

#### **Program sustainability Recommendation**

- There is need for NMA to sustain its programs Unit that COMPASS assisted it to establish
- The need to have its PMT institutionalized and not tied to NEC tenure.
- Systematic review of its strategic plan and annual planning meetings.
- Need to systematically undertake periodic surveys of its community to determine satisfaction with its activities or services
- Institute and M&E system
- Need to document and collate all medical researched by its members to inform programme development
- Harness their good relations with private sector for community development

NMA has always had a good financial base as it Collects 70% from MDCN as practicing fees paid by doctors, endorsement payments by companies that produce health products, sales from medical exhibition of brochures and lapel pins and adverts in magazines. It however has not yet succeeded in running a grant. The association has enough resources to financially sustain COMPASS activities if it is willing and committed to doing this.

#### **Financial sustainability Recommendation**

- Pro-active approach to proposal development and responding to funders enquiries in a timely manner
- Need to implement its financial sustainability plan
- Association needs to implement fully its new strategy of collecting members fees and dues
- Improve on its collaboration with other CSOs to leverage resources for social sector development.

## Annex 5: Approval to conduct endline evaluation surveys



April 15, 2009

Anastasia J. Gage  
Associate Professor,  
Department of International Health and Development,  
Tulane School of Public Health and Tropical Medicine, 1440, Canal Street,  
Suite 2200 TB - 46,  
New Orleans, LA 70112,  
United States of America.

Dear Dr. Gage,

### **APPROVAL TO CONDUCT END-LINE EVALUATION SURVEYS FOR THE COMPASS PROJECT**

The COMPASS Institutional Review Committee (IRC) has reviewed the survey instruments and consent forms for the proposed end-line survey in Nigeria. Members of the committee provided comments and observations that may be useful to your survey; however, no content harmful to human subjects was identified.

Consequently, you have been given approval to proceed with the end-line survey, while taking into consideration the various comments and observations from the different components of the COMPASS project, as sent to you via email. Please send us versions of all reviewed documents for verification and record purposes.

We wish you success with your surveys in Nigeria.

Oluwadaisi Isaac Feyisetan  
Char: COMPASS IRC

## **Annex 6: Informed consent form\_IRB\_Healthfacility\_Endline**

### **Tulane University Health Sciences Center Consent to Participate in Research (Health Facility Survey)**

#### **Study Title:**

End-line Study of the COMPASS Health and Education Project in Nigeria

#### **Performance Sites**

Bauchi, Kano, Nasawara, Lagos States and the FCT

#### **Investigators:**

Dr. Anastasia Gage (Tulane)  
Professor Alfred Adewuyi (CRERD)

#### **Sponsor:**

United States Agency for International Development

#### **Disclosure of Potential Conflict of Interest:**

The investigator(s) in this study are also health researchers. They are interested in the knowledge to be gained from this study. You are under no obligation to participate in this survey.

#### **Purpose:**

The purpose of this research is to obtain information on health services and products that are available to the community through hospitals, clinics and patent medical vendors. You will be asked questions about drug stock, immunizations and family planning services, ANC products and services, and training.

#### **Procedures:**

This facility was chosen because it is within a randomly chosen census enumeration area. If you agree to be in this study you will be asked a series of questions. It will take about 30 to 45 minutes to answer the questions in this survey. Everything you say will be kept private. Participation in this study is voluntary. You can choose to participate or not to participate, and you may choose not to answer any question that you do not want to answer or end the interview at any time. However, your honest answers to these questions will help us to advise on possible improvements in the delivery and quality of health services and primary education in this area.

#### **Potential Risks:**

Your answers are completely confidential. Although we will ask your name and the name of the facility, this information will be strictly confidential and no one will see it except the project staff. Your name, or the name of the facility, will never be used in connection with any of the information you tell me.

#### **Potential Benefits:**

The immediate benefits to you will be minimal, but the information obtained from the study participants will be used to improve the quality and delivery of reproductive and child health care services and primary school interventions in Nigerian communities.

**Voluntary Participation:**

Participation in research is voluntary. You may choose to participate or not. If you choose to participate but later change your mind, you may stop the interview at any time. Refusal to participate or withdrawal from the study will not result in penalty or any loss of benefits to which you are otherwise entitled.

**Confidentiality:**

Your information will be kept private to the extent allowed by law. We will separate your name from the questionnaire so that such information cannot be linked back to you or the facility. If results are published, all will be unlinked in any way to you.

**Costs/Payment:**

You will not be offered any cash payment to take part in this study. There is no cost to you for participating in this study.

**Study Outcome**

If you have any questions about the study please feel free to ask the interviewer. If later you have any questions regarding the study or results from this study, please contact Mr. Feyisetan Daisi at 234-9-672-0021 (COMPASS Nigeria, Plot 1456 Justice Sovernimo Street, Asokoro Abuja) or Dr. Anastasia J. Gage at 001-504-988-3655 (Department of International Health and Development, Tulane University School of Public Health and Tropical Medicine, 1440 Canal Street, Suite 2200, New Orleans, LA, 70112, USA).

**Questions**

If you have other questions about this research or the COMPASS Project you may contact the United States Agency for International Development, who are sponsoring this research (USAID/Nigeria, Plot 9-11, Mambila Crescent, Aso Drive, Maitama Abuja, Tel: 234-9-461-9300). If you have questions about your rights as a study participant contact the Tulane University IRB Compliance Officer at 001-504-988-3229.

I have read this consent` form and volunteer to participate in this research; or, I am unable to read but this consent document has been read and explained to me by \_\_\_\_\_ (Name of reader).

\_\_\_\_\_  
Subject Date

\_\_\_\_\_  
Parent/Legally Authorized Representative (if applicable) Date

\_\_\_\_\_  
Person Obtaining Consent Date

## **Tulane University Health Sciences Center Consent to Participate in Research (Household Survey)**

**Study Title:**

End-line Study of the COMPASS Health and Education Project in Nigeria

**Performance Sites**

Bauchi, Kano, Nasawara, Lagos States and the FCT

**Investigators:**

Dr. Anastasia Gage (Tulane)

Professor Alfred Adewuyi (CRERD)

**Sponsor:**

United States Agency for International Development

**Disclosure of Potential Conflict of Interest:**

The investigator(s) in this study are also health researchers. They are interested in the knowledge to be gained from this study and in your well-being. You are under no obligation to participate in this survey.

**Purpose:**

The purpose of this research is to obtain information on health issues that are important, such as knowledge, attitudes, and behaviors with regards to immunizations, FP, ANC, child survival and STI/HIV/AIDS. We would also like to ask you about primary school education and schools in this area.

**Procedures:**

You have been randomly chosen to be asked to be in this study. If you agree to be in this study you will be asked a series of questions. It will take about 30 to 45 minutes to answer the questions in this survey. Everything you say will be kept private. Participation in this study is voluntary. You can choose to participate or not to participate, and you may choose not to answer any question that you do not want to answer or end the interview at any time. If you decide not to participate, it will not affect your rights in any way. You will not receive any money for your participation in the study. However, your honest answers to these questions will help us to advise on possible improvements in the delivery and quality of health services and primary education in this area.

**Potential Risks:**

Some of the questions may be embarrassing or upsetting. Your answers are completely confidential. Although we will ask your name, this information will be strictly confidential and no one will see it except the project staff. Your name will never be used in connection with any of the information you tell me.

**Potential Benefits:**

The immediate benefits to you will be minimal, but the information obtained from the study participants will be used to improve the quality and delivery of reproductive and child health care services and primary school interventions in Nigerian communities.

**Voluntary Participation:**

Participation in research is voluntary. You may choose to participate or not. If you choose to participate but later change your mind, you may stop the interview at any time. Refusal to participate or withdrawal from the study will not result in penalty or any loss of benefits to which you are otherwise entitled.

**Confidentiality:**

Your information will be kept private to the extent allowed by law. We will separate your name on the questionnaire so that such information cannot be linked back to you. If results are published, all will be unlinked in any way to you.

**Costs/Payment:**

You will not be offered any cash payment to take part in this study. There is no cost to you for participating in this study.

**Study Outcome**

If you have any questions about the study please feel free to ask the interviewer. If later you have any questions regarding the study or results from this study, please contact Mr. Temple Jagha at 234-9-672-0021 (COMPASS Nigeria, Plot 1456 Justice Sowerimo Street, Asokoro Abuja) or Dr. Anastasia Gage at 001-504-988-3655 (Department of International Health and Development, Tulane University School of Public Health and Tropical Medicine, 1440 Canal Street, Suite 2200, New Orleans, LA, 70112, USA).

**Questions**

If you have other questions about this research or the COMPASS Project you may contact the United States Agency for International Development, who are sponsoring this research (USAID/Nigeria, Plot 9-11, Mambila Crescent, Aso Drive, Maitama Abuja, Tel: 234-9-461-9300). If you have questions about your rights as a study participant contact the Tulane University IRB Compliance Officer at 001-504-988-3229.

I have read this consent form and volunteer to participate in this research; or, I am unable to read but this consent document has been read and explained to me by \_\_\_\_\_  
(Name of reader).

\_\_\_\_\_  
Subject

\_\_\_\_\_  
Date

\_\_\_\_\_  
Assent of minor aged 15 – 17 years old (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person Obtaining Consent

\_\_\_\_\_  
Date

## **Annex 8: Informed consent form\_IRB\_School\_Endline**

### **Tulane University Health Sciences Center Consent to Participate in Research (School Survey)**

#### **Study Title:**

End-line Study of the COMPASS Health and Education Project in Nigeria

#### **Performance Sites**

Bauchi, Kano, Nasawara, Lagos States and the FCT

#### **Investigators:**

Dr. Anastasia Gage (Tulane)  
Professor Alfred Adewuyi (CRERD)

#### **Sponsor:**

United States Agency for International Development

#### **Disclosure of Potential Conflict of Interest:**

The investigator(s) in this study are also health researchers. They are interested in the knowledge to be gained from this study. You are under no obligation to participate in this survey.

#### **Purpose:**

The purpose of this research is to obtain information on education services and primary schools available to the community. You will be asked questions about enrollment, attendance, curriculum, infrastructure, and teacher training.

#### **Procedures:**

This primary school was chosen because it is within a randomly chosen census enumeration area. We have randomly chosen one teacher from each grade here at your school. If you agree to be in this study you will be asked a series of questions. It will take about 30 to 45 minutes to answer the questions in this survey. Everything you say will be kept private. Participation in this study is voluntary. You can choose to participate or not to participate, and you may choose not to answer any question that you do not want to answer or end the interview at any time. However, your honest answers to these questions will help us to advise on possible improvements in the delivery and quality of health services and primary education in this area.

#### **Potential Risks:**

Your answers are completely confidential. Although we will ask your name and the name of the school, this information will be strictly confidential and no one will see it except the project staff. Your name, or the name of the facility, will never be used in connection with any of the information you tell me.

#### **Potential Benefits:**

The immediate benefits to you will be minimal, but the information obtained from the study participants will be used to improve the quality and delivery of primary school programs in Nigerian communities.

**Voluntary Participation:**

Participation in research is voluntary. You may choose to participate or not. If you choose to participate but later change your mind, you may stop the interview at any time. Refusal to participate or withdrawal from the study will not result in penalty or any loss of benefits to which you are otherwise entitled.

**Confidentiality:**

Your information will be kept private to the extent allowed by law. We will separate your name on the questionnaire so that such information cannot be linked back to you or this school. If results are published, all will be unlinked in any way to you or this school.

**Costs/Payment:**

You will not be offered any cash payment to take part in this study. There is no cost to you for participating in this study.

**Study Outcome**

If you have any questions about the study please feel free to ask the interviewer. If later you have any questions regarding the study or results from this study, please contact Mr. Feyisetan Daisi at 234-9-672-0021 (COMPASS Nigeria, Plot 1456 Justice Sowermimo Stret, Asokoro Abuja) or Dr. Anastasia Gage at 001-504-988-3655 (Department of International Health and Development, Tulane University School of Public Health and Tropical Medicine, 1440 Canal Street, Suite 2200, New Orleans, LA, 70112, USA).

**Questions**

If you have other questions about this research or the COMPASS Project you may contact the United States Agency for International Development, who are sponsoring this research (USAID/Nigeria, Plot 9-11, Mambila Crescent, Aso Drive, Maitama Abuja, Tel: 234-9-461-9300).If you have questions about your rights as a study participant contact the Tulane University IRB Compliance Officer at 001-504-988-3229.

I have read this consent form and volunteer to participate in this research; or, I am unable to read but this consent document has been read and explained to me by \_\_\_\_\_  
(Name of reader).

\_\_\_\_\_  
Subject Date

\_\_\_\_\_  
Parent/Legally Authorized Representative (if applicable) Date

\_\_\_\_\_  
Person Obtaining Consent Date

**ANNEX 9: FUNDING SOURCES UTILIZED TO IMPLEMENT PROGRAMS BY STATE**

State	Family Planning/ Reproductive Health	Child Survival /Discretionary Funds	Polio: Child Survival	Polio: Economic Support	Polio: Development Assistance	Malaria	Vit am in A	Basic Education / Discretionary Funds	Africa Education Initiative (in-service)	Africa Education initiative (pre-service)	BE for Islamic Communities	OVC (PEPFAR)
Bauchi	X	x										x
FCT	X											
Kano	X	x	x	x	x	x	x	x	x	x	x	x
Lagos	X	x				x	x	x	x	x	x	x
Nasarawa	X	x				x	x	x	x	x	x	x
Jigawa			x	x								
Sokoto			x	x								
Zamfara			x	x								
Kaduna			x	x								
Katsina			x	x								
Kebbi			x	x								

## ABBREVIATIONS AND ACRONYMS

<b>ABUTH</b>	Ahmadu Bello University Teaching Hospital	<b>IPT</b>	Intermittent Preventive Treatment
<b>AHIP</b>	Adolescent Health Information Project	<b>IRI</b>	Interactive Radio Instruction
<b>AMCPH</b>	Amukoko Community Partners for Health (NGO)	<b>IRS</b>	Indoor Residual Spraying
<b>ARH</b>	Adolescent Reproductive Health	<b>ITN</b>	Insecticide Treated Nets
<b>BCC</b>	Behavior Change Communication	<b>IUD</b>	Intra-Uterine Device
<b>BQSoE</b>	Basic Quality Standards of Education	<b>IYCF</b>	Infant and Young Child Feeding
<b>CAC</b>	Community Action Cycle	<b>JHU/CCP</b>	Johns Hopkins University/Center for Communications Programs
<b>CAII</b>	Creative Associates International, Inc.	<b>JICA</b>	Japanese International Cooperation Agency
<b>CBO</b>	Community-Based Organization	<b>JUTH</b>	Jos University Teaching Hospital
<b>CC</b>	Community Coalition	<b>KPVTA</b>	Kano Polio Victims Trust Association
<b>CENPERD</b>	Center for Peace and Rural Development (NGO)	<b>LASUTH</b>	Lagos State University Teaching Hospital
<b>CHA</b>	Community Health Agency (NGO)	<b>LEAP</b>	Literacy Enhancement Assistance Project
<b>CHIEF</b>	Community Health Information Education Forum (NGO)	<b>LGA</b>	Local Government Area
<b>CIM</b>	COMPASS Impact Model	<b>LGEA</b>	Local Government Education Authority
<b>CMPC</b>	Classmates' Personal Computers	<b>M&amp;E</b>	Monitoring and Evaluation
<b>COMPASS</b>	Community Participation for Action in the Social Sector	<b>MAP</b>	Men as Partners
<b>COE</b>	College of Education	<b>MCH</b>	Maternal and Child Health
<b>CPR</b>	Contraceptive Prevalence Rate	<b>MCM</b>	Malaria Case Management
<b>CRD</b>	Centre for Research and Documentation (NGO)	<b>MDG</b>	Millennium Development Goal
<b>CRF</b>	Child Rights Foundation (NGO)	<b>MMR</b>	Maternal Mortality Rate
<b>CSACEFA</b>	Civil Society Action Coalition on Education for All	<b>MNDC</b>	Micronutrient Deficiency Control
<b>CSI</b>	Child Status Index	<b>MOST</b>	Management and Organizational Sustainability Tool
<b>CSN</b>	Catholic Secretariat of Nigeria	<b>MOU</b>	Memorandum of Understanding
<b>CSO</b>	Civil Society Organization	<b>MSH</b>	Management Sciences for Health
<b>CSP</b>	Country Strategic Plan	<b>NACWYCA</b>	Nasarawa Centre for Women, Youth and Community Action (NGO)
<b>DFID</b>	Department for International Development	<b>NCCE</b>	National Commission of Colleges of Education
<b>DPT</b>	Diphtheria, Pertussis and Tetanus	<b>NDHS</b>	Nigerian Demographic and Health Surveys
<b>DQA</b>	Data and Quality Assessment	<b>NEPAD</b>	New Partnership for Africa's Development
<b>ENHANSE</b>	Enabling HIV&AIDS/TB/OVC and Social Sector Environment	<b>NERDC</b>	National Education Resource Development Council
<b>ERC</b>	Expert Review Committee	<b>NGO</b>	Non-Governmental Organization
<b>EVA</b>	Education as a Vaccine against AIDS	<b>NCHH</b>	Non-compliance Household
<b>FBO</b>	Faith-Based Organization	<b>NIDs</b>	National Immunization Days
<b>FCT</b>	Federal Capital Territory	<b>NMA</b>	Nigerian Medical Association
<b>FG</b>	Futures Group	<b>NMCP</b>	National Malaria Control Program
<b>FGoN</b>	Federal Government of Nigeria	<b>NPHCDA</b>	National Primary Healthcare Development Agency
<b>FMoE</b>	Federal Ministry of Education	<b>NPI</b>	National Program on Immunization
<b>FOMWAN</b>	Federation of Muslim Women's Associations in Nigeria	<b>NTI</b>	National Teachers' Institute
<b>FP</b>	Family Planning	<b>OCAT</b>	Organizational Capacity Assessment Tool
<b>FULDAN</b>	Fulani Development Association of Nigeria	<b>ORT</b>	Oral Rehydration Therapy
<b>GHAIN</b>	Global HIV/AIDS Initiative Nigeria	<b>OVC</b>	Orphans and Vulnerable Children
<b>GHON</b>	Grassroots Health Organization of Nigeria (NGO)	<b>PATH</b>	Program for Appropriate Technologies in Health
<b>HESDAN</b>	Health and Sustainable Development Assoc. of Nigeria (NGO)	<b>PD</b>	Positive Deviance
<b>HDI</b>	Human Development Initiative (NGO)	<b>PDQ</b>	Partnership-Defined Quality
<b>ICB</b>	Institutional Capacity Building	<b>PELI</b>	Proficiency English Language Intervention
<b>ICC</b>	Inter-Agency Coordinating Committee	<b>PES</b>	Primary Education Studies
<b>ICT</b>	Information and Communication Technology	<b>PHC</b>	Primary Healthcare Center
<b>IEC</b>	Information, Education, and Communication	<b>PHE</b>	Peer Health Educator
<b>IPCC</b>	Interpersonal Communication and Counseling	<b>PLTM</b>	Permanent and Long-term Methods
<b>IPD</b>	Immunization Plus Days	<b>PMP</b>	Performance Monitoring Plan
<b>PMTCT</b>	Prevention of Mother-to-Child Transmission	<b>SWATCH</b>	Society for Women and Teenage Children
<b>PMV</b>	Patent Medicine Vendors	<b>SWODEN</b>	Society for Women Empowerment and Development of Nigeria (NGO)

<b>PPP</b>	Public-Private Partnerships	<b>TBA</b>	Traditional Birth Attendant
<b>PTA</b>	Parent-Teacher Association	<b>TRC</b>	Teacher Resource Center
<b>QIT</b>	Quality Improvement Team	<b>TRCN</b>	Teacher Resource Council of Nigeria
<b>RAHAMA</b>	RAHAMA Women's Development Program (NGO)	<b>UBEC</b>	Universal Basic Education Committee
<b>RH</b>	Reproductive Health	<b>UNESCO</b>	United Nations Children's Fund
<b>RHISA</b>	Reproductive Health Initiative Support Association (NGO)	<b>UNICEF</b>	United Nations Children's Fund
<b>SCT</b>	Student-Centered Teaching	<b>USAID</b>	United States Agency for International Development
<b>SFH</b>	Society for Family Health	<b>VSO</b>	Voluntary Service Overseas
<b>SHN</b>	School Health and Nutrition	<b>WB</b>	World Bank
<b>SMoE</b>	State Ministry of Education	<b>WDC</b>	Ward Development Committee
<b>SMoH</b>	State Ministry of Health	<b>WHED</b>	Women's Health Education and Development (NGO)
<b>SO</b>	Strategic Objective	<b>WHON</b>	Women's Health Organization of Nigeria (NGO)
<b>SPHCDA</b>	State Primary Healthcare Development Agency	<b>WHO</b>	World Health Organization
<b>STA</b>	Student Achievement Testing	<b>YEDA</b>	Youth and Environmental Development Association (NGO)
<b>STTA</b>	Short-Term Technical Assistance	<b>YFS</b>	Youth-Friendly Services
<b>SUBEB</b>	State Universal Basic Education Board		

**Pathfinder International**  
**Adolescent Health Information Project**  
**Civil Society Action Coalition on Education for All**  
**Creative Associates International Inc.**  
**Federation of Muslim Women's Associations of Nigeria**  
**Futures Group International**  
**Johns Hopkins University/Center for Communication Program**  
**Management Sciences for Health**