

MID-TERM EVALUATION

CHILD SURVIVAL PROJECT IN SEMUTO AND BUTUNTUMULA

AMREF UGANDA

PROJECT N°; 9384500

AN EVALUATION REPORT PREPARED BY

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1. INTRODUCTION

1.1 Background Information - Child Survival Project

General Information

A child survival Project funded by USAID was implemented by AMREF -Uganda in two sub-counties of Semuto and Butuntumula in the Luwero district of Uganda from October 1992. The project is now in its 20th month running, of the **expected** 36 months left period. Luwero district in central Uganda was the centre of **intensified** fighting during the civil war between 1981 - 1986 that resulted in its being massively devastated. Semuto as the sub-county was the most affected area in the district. Butuntumula on the other hand was also at the centre of the conflict. The results of these conflict has been the enormous number of orphans as well as destruction of the community infrastructure. Butuntumula is also the largest sub-county in the district and with a scattered and nomadic population. Since 1986 many attempts have been made to resettle and rehabilitate the populations in this areas. Programs in these areas started as emergency rehabilitation projects, and turned developmental after substantial resettlement had been achieved.

As a means of reaching the majority of the populations most affected AMREF implemented a community based child survival project in the two sub-counties. The goal was to help improve the health status of the people in the two project areas through strengthening capacities and capabilities of the communities so that they, in turn intervene to reduce their disease burden, especially among children and pregnant women the most vulnerable and remote.

Baseline Survey

As a means of understanding more the health problems and how communities are coping with them, a baseline survey focussing on proposed intervention areas in the project proposal, was carried out in February 1993. This comprehensive survey produced extremely important statistics which has formed a large part of the basis for this evaluation.

1.2 Target Population:

The project proposal targeted the population of Semuto and Butuntumula sub-counties of Luwero district. According to 1991 census, the breakdown of the population in the two areas was according to ~~the~~ intentions of the Child Survival Project was:

1. Children ~~4~~ = 1,830
2. Children ~~5~~ = 7,553
3. Child Bearing Women = 8,956
4. Malaria Total Population = 38,935

I , The number of communities in the Semuto Sub-county target area is 34 with a population of 14,427 and another 42 communities populated by 24,508 persons in the Butuntumula

Sub-county yielding a total impact population of 38,935 in 76 villages

1.3. **Key Interventions:**

The project proposed to intervene in the following areas, as the most crucial in the child survival and development concept:

1. Community organization through:
 - Sub-county, Parish, and Village Health Committees
 - Community Health Workers
 - Traditional Birth Attendants
 - Health Visit Management Committee
Unit
2. Strengthening EPI
 - Community mobilisation for immunisation
 - O u t r e a c h e s
 - Training.
3. Strengthening CDD/ORT activities
 - Community mobilisation for diarrhoea control
 - Training
 - Provision of ORS
 - Home environment and Sanitation.
4. Malaria Control through:
 - Community education
 - Rapid access to treatment
 - Provision of bed nets (impregnated)
 - Training.
5. Maternal Health through:
 - Training TBAs
 - Nutrition edudation
 - Family planning
 - Malaria control
 - Ante Natal Care
 - Delivery care.
6. Nutrition
 - Introduction of growth monitoring
 - Nutrition education

7. **A I D S C o n t r o l**
 Health education
 Condom advocacy
 Training
 Counselling

8. **ARI Control**
 Training VHWS on early recognition of ALRI
 and referral.

1.4. Main Goal of Project

The main goal of the project is to improve the health of the Ugandan people, particularly those under age 5 years and pregnant women, of Semuto and Butuntumula sub-counties through sustainable community based strategies in health and Child welfare.

1.5. Project Duration: 36 MONTHS

Start date: 1 O/01/92 End date: 09/30/95

D. Cost of Project:

CASH FROM AID	=	\$400,191
TOTAL ANNUAL	=	136,794/FY1
	=	142,225/FY2
	=	121,172/FY3

A.I.D. funding per beneficiary for Project = US\$ 18.41

A.I.D. funding per beneficiary per year = US\$ 6.14

1.6. Specific Activities and Level of Effort per Intervention:

1. **Diarrhoeal Diseases**
 Distribute packets of ORS through a community network
 Promote use of ORS packets
 Promote use of home-fluids
 Dietary management of diarrhea
 Home environment and sanitation
 Training - diarrhoea management and control

2. **Immunization**
 Promote immunization

Training in immunization
Strengthen the district EPI programme

3. Nutrition
 - Provide scales and growth charts
 - Counsel mothers on breast feeding/weaning
 - Training in maternal nutrition
 - Training in growth monitoring
4. ALRI
 - Health education
 - Improve referral system
 - Training
5. Maternal Care and Family Planning
 - Distribute contraceptives
 - Promote exclusive breast-feeding
 - Promote child spacing or family planning
 - Antenatal care
 - Delivery Care
 - Train TBAs in improved birth practices
6. Malaria Control
 - Provision of bed nets
 - Treatment of clinical malaria
 - Health education

1.7. **Project Objectives**

1. ORT Treatment rate increased by 30%
2. Increase fully immunized rate by 30% at age one year or up to 80% by EOP
3. Increase utilization of ANC services by 30%
4. Assess the potential for sustainable impregnated bed net project - self supporting

1.8. **Project Outputs**

- | | | |
|----|----------------------------------|-------|
| 1. | Cluster Surveys | 3 |
| 2. | Village Health Committees formed | 20 |
| 3. | TBAs Trained | 40 |
| 4. | Community Health Workers trained | 40 |
| 5. | Children <1 year fully immunized | 80% |
| 6. | Impregnated nets distributed | 2,700 |

7.	Malaria consultations for control	3
8.	New contraceptive users increased (10%)	900

1.9	Project Emphasis	Percent of Effort
1.	EPI	15%
2.	Control of diarrhoeal diseases	15%
3.	Malaria	20%
4.	Nutrition	15%
5.	ALRI	5%
6.	FP/Maternal Health	20%
7.	Others	10%
	- A I D S I S T D	
	- Water and sanitation	
	- Income generating activities	

2.0 **TERMS OF REFERENCE FOR THE MID-TERM EVALUATION**

1. To prepare a report that meets the requirements for a mid-term evaluation as specified by FHA/PVC.
2. To assess whether project indicators are being met, whether they are still relevant, and to recommend whether any changes should be made in these indicators.
3. To review implementation plans and strategies for relevance and suggestions about any changes.
4. To comment as to whether the reporting requirements have been met and make suggestions about any changes.
5. To assess staffing levels and comment as to whether any changes are suggested.
6. To assess and comment upon whether the project is truly community based, and to comment upon future sustainability.
7. To assess expenditure levels and comment as to whether changes in the budget are appropriate.
8. To assess and comment upon the impact of the project on gender issues.
9. To make recommendations as to whether a project extension would be desirable and suggest any major changes in design for an extension proposal.

3.0 METHODOLOGY

3.1 **Overview:**

From the terms of reference for this evaluation stated above, we have defined the scope and specific data needed to come to a judged evaluation. We have therefore selected the most efficient methodologies to collect and analyze information that is reliable, timely and relevant to the exercise. The best approach we selected for the evaluation is by use of rapid assessment techniques (methods) together with review of available reports, documents and discussions with a number of people involved with the project. The information we needed according to the terms of reference was; institutional capabilities and capacities; processes of interventions, constraints and successes.

The following methodologies have therefore been used:

3.2. **Cluster sampling approach:**

Areas of the evaluation were grouped up in village clusters, and a number of villages selected for the survey. Within each village women in the child-bearing age (15 - 49) and women with children aged 1 - 2 were interviewed. I ”

Below are the villages selected.

Villages visited in Butuntumula:

Wanonda	Kasiiso
Mbale	Genda
Yandwe	
Kibikke	
Ndibulungi	

Villages visited in Semuto:

Kikondo	Bbambaga
Kitoto	Kalembedde
Kalege	Wabikokoma
Kaloke	Kikyusa
Kitekanya	Semuto
Nkuzongere	

3.3. Lot quality assurance sampling

We have employed this method on the assumptions that a small sample from a lot (batch) of workers is going to be representative of the whole lot of workers. This is because the training and supervision involving these groups had been standardized and yet the information sought was in small amounts and most was a Yes/No answers required.

Below is the list of groups selected for the survey:

- i) Village Health Workers (VHWs - 10)
- ii) Traditional Birth Attendants (TBAs - 10)
- iii) Community Leaders (10).

3.4. Limited discussion groups

As a means of getting more information on the Project, discussions were held with different people directly or indirectly associated with the project. These included District Officials, County Leaders and AMREF staff.

Below is the list of people with whom discussion were held:

DMO	-	Dr. Lukoda
DHI		A. Sebi
DHE	-	F. Senkima Mbalu
M/A Ag. i/c	-	Sekiyiva
N/O		Kajuta

Midwife/FP Provider/TOT TBA M. Serunjoji Nalongo

TOT/in-charge Butuntumula Health Unit - Mrs M. Kasule Nalongo

RC 1		Mr. Wamala
RC 1	-	Ms. Nabakoza
RC3	-	Secretary Semuto - Mr. Charles. Semuwunda
Sub-county Chief Butuntumula - Mr. J. Kinogi		

AMREF staff

Mr. Kasule Basil - Facilitator/Trainer
Mrs. Regina Nabukeera
Mr. Henry Bagarukayo - Project Leader

3.5. **Review of records and reports**

As part of the implementation of the project many reports have been produced. These were reviewed and form a large part of the evaluation.

Below is the list of documents reviewed:

- (a) Detailed implementation plan Child Survival Programme Luwero District. I
- (b) A baseline survey in two sub-counties in Uganda (Feb-March 1993)
- (c) Project quarterly reports of programs being implemented.
- (d) Minutes of village health committees , Trainers, TBAs, CHWs, Health management committees, Sub-country working committees, District Steering Committee meetings.
- (e) Work plans

4.0 **FINDINGS**

4.1 **Project Outputs**

A summary of project accomplishments is shown in table 1. Besides the bed net distribution, most other areas of output have **gone** beyond the targets. The training **component has been** particularly very successful. New contraceptive users have increased to 21% in project area, this is quite high compared to the national average of (5-7%).

TABLE 1: Table one shows Project- outputs according to target and accomplishments so far at the review period.

output		Target Y3	Real Output Y2				Total
			Butuntumula		Semuto		
1.	Cluster Surveys	3					1
			<u>Comu. U/T</u>		<u>Comp. U/T</u>		<u>Comp. U/T</u>
			-		-		64 0
2.	TBAse Health Committees formed	40	34	26	30	-	51 26
4.	Community Health Workers trained	40	20	24	36	62	56 86
5.	Children <1 year fully immunized	80%	62%		60%		43%
6.	Impregnated nets distributed	2,700	4		168		172
7.	Sensitization session on impregnation bed nets	100	31		51.		82
8.	Malaria consultations for control (from Nairobi)	3	0 -		2		2
9.	New contraceptive users	900	27		165		192 (21%) ²
10.	TOTs						
	TOT/TBA	6	1		0		
	TOT/CHW		0		0		
	TOT/AIDS	6	0		2		
	CHW/STD AIDS		0		0		

Key: Comp.= completed
 U/T = under training
 TOTs = Training of trainers

SEMUTO

Immunisation:

TABLE 2 : Shows children reached by immunisation program in Semuto project area.

July - December 1993				Semuto January - June 1994			
	Target	Immunised	Coverage rate	Vaccine	Target	Immunised	Coverage rate
BCG	500	344	68.8%	BCG	600	371	61.8%
OPVO	500	60	8.3%	OPVO	600	73	12.2%
OPV1	500	348	69.6%	OPV1	600	382	63.6%
OPV2	500	340	68%	OPV2	600	422	70.3%
OPV3	500	317	63.4%	OPV3	600	375	62.5%
DPT1	500	346	69.2%	DPT1	"	386	64.3%
DPT2	500	347	69.4%	DPT2	"	415	69.1%
DPT3	500	326	65.2%	DPT3	"	379	63.2%
Measles	500	321	64.2%	Measles	"	379	63.2%

Figures accurately available are for the half year 1993, and half of 1994. If the whole year 1994 is considered Semuto's coverage rate is well above the 90% mark if effort continues for the same pace for the rest of 1994.

BUTUNTUMULA

Immunisation:

TABLE 3: Shows the children reached by Immunisation program in Butuntumula project area.

1992				1993				* 1994 Jan - June			
Vacc	Targ.	Immuni	cov.ra te	Vacc	Targ	Immuni sed	Cov.rate	Vacc	Targ.	Immunis ed	Cov.rate
BCG	1879	167	8.8%	BCG	1930	1097	56.8%	BCG	1982	375	18.9%
OPV'	1879	I -	I -	OPVO		83	4.3%	OPVO		23	1.1%
OPV1	1879	92	4.8%	OPV1		1005	52%	OPV1		308	15.5%
OPV2	1879	89	4.7%	OPV2		769	39.8%	OPV2		215	10.8%
OPV3		76	4%	OPV3		750	38.8%	OPV3		275	13.8%
DPT1		92	4.8%	DPT1		1007	52.1%	DPT1		308	15.5%
DPT2		89	4.7%	DPT2		769	39.8%	DPT2		246	12.4%
DPT3		86	4.5%	DPT3		750	38.8%	DPT3		286	14.4%
Measles	1879	125	6.6%	Measles		1031	53.4%	Measles		301	15.1%

* Figure for half of 1994 - this is likely to double by end of 1994

4.2 Gender Balance

We reviewed the composition of/membership to a number of committees in the project area. The intention was to find out the male/female mix. At all committees nearly 75% of membership was male, except for the district steering committee where 50% were female. The committee reviewed were: Health units management committee of Semuto; sub-county committee of Semuto and Butuntumula; and the district steering committee. See compositions below:

1 HUMCS (Semuto)

Members 9 - (2 Females 7 Males)
Secretary = Medical assistant in charge of Health Units,

2. Sub-county - Semuto

Members 9 : (2 Females 7 Males) - picked from communities
Secretary is the Health Assistant

3. Sub-county Committee (Butuntumula)

2 AMREF staff
2 Executive RC 3
5 specially elected members
1 Health Assistant
1 Community Development Assistant
1 Veterinary assistant
1 Agricultural assistant

1 Representative for Head Teachers

Composition: 3 Female , rest are males

District Steering Committee of C/S

It combines both projects - Orphans and C/S.
Commissioner Labour & Social Welfare representative for children
D.M.O. Luwero
D.E.S. Luwero
D.E.O. Luwero
RC 5 Women representative (Secretary for women affairs)
RC 5 Chairman
D.H.E
D.H.V

AMREF staff

Female = 4 Males = 4

4.3 **Interview**

4.3.1. Facilitators of the Project

(a) Successes

Training has been fine.

IGA Animal feeds program has not been well - rest quite well.

Paraffin selling

Farming - pigs - poultry

Carpentry shop

Drug kits to 50 CHWs

TBA kits 34 TBAs

Mosquito nets

Supplies to CHWs, TBAs e.g. kits

CHWs in Semuto have started treating minor ailments and are doing well. Their records are well kept.

(b) Difficulties:

There is too much work for **each** facilitator making it difficult to cope and be effective.

IGA funds so far generated are very low and this might make it difficult for sustainability.

Recommendation:

Project need to be extended for another three (3) year period to enable more country mobilisation.

Project should be extended to the neighboring sub-counties who are in need.

Each CHW should be responsible for up to 25 households and not the project recommended 50 - 100 households. This will make CHWs more effective as their services are free.

4.3.2. District Health Team (DHT):

- (a) DMO, DHI,DHE,DHV,Nursing Officer

The program is highly appreciated by the district health delivery services to the extent that the two project areas are now acting as “demonstration gardens” to the rest of the district. The project area especially Butuntumula, because of the success of the project is now used as a field training site by the district .

Their contribution on the success of the project so far on:

- (1) The multi-disiplinary nature of the project that allows appropriate and guided involvement in training, supervision and through the district steering committee where policy changes and strategies of the project are discussed on a regular basis.
- (2) The enormous experience of AMREF in dealing with Child Survival Programs with a multi-sectoral approach.
- (3) The community mobilisation that has been carried out in the project areas, that has made people aware of general issues such as: Home environment and sanitation, need for immunisation and support to CHWs and TBAs.

Recommendation:

Extension of the project areas to county levels

Extension of the project period for another three years to consolidate what is already being achieved.

4.3.3. Sub-county level leaders:

All those interviewed were aware of the project and easily mentioned areas in which the project has assisted their people i.e. Immunisation, Family Planning, Home improvement, training of country health workers and TBAs, and general health education. Because of the importance of the project to the communities, leaders hold meeting at sub-county levels to review progress and areas where communities should be mobilized to act.

- That there has been very good collaboration between the facilitators of the project and the community leaders.

4.4 Survey

I '

4.4.1 Major health problems in project areas:

The major health problems identified shown in table 1 were mainly:

Lack of safe water for home use, malaria, food insecurity. It appears that the project may need to actively be more involved in supporting water supply strategies in both areas and intensify its malaria control work. The different groups indicated the plight of people towards securing food. There is a need to address this situation, and probably educate people to adopt to cereal foods and improve their storage facilities. Many other problems were mentioned in isolation but have been left out of this table as it includes only the summary of major issues mentioned.

4.4.2 TBAs Knowledge and Practice:

TBAs will continue to play a leading role 'in Child Survival and development within these communities. In general TBAs were aware of the need for immunisation of children, child spacing and risks that can occur during pregnancy. Most importantly they were practicing appropriate referral of pregnant women at risk without delay. The responses were better in Semuto in comparison with Butuntumula and probably this is a reflection of the long nature of the community based activities in Semuto (Table 4).

, P'

4.4.3 VHWs Knowledge and Practice:

Among the major problems identified for interventions in project areas are Immunisable diseases, Diarrhoeal diseases, Family Planning, Malaria, AIDS and Acute lower respiratory infections. Table 6 a, b show the results of survey among VHWs whom the project identified as the main implementor. In general these VHWs were adequately equipped with knowledge to practice interventions proposed. There is a need to conduct refresher courses for AIDS and immunisation where doubts still exist.

4.4.4 Community Leaders Involvement:

It was impressive to observe that the leadership at the levels within the project area and the district at large were aware of the project and had been actively involved in project management. However, many indicated that there is a need to change the direction 'of project focus. The areas they wanted the project to focus on were water supply, income generating activities and drugs. (Table 7). These are issues which appear to be raised by the entire cross-sections of people we have discussed with. It must be pointed out that these activities are not priority areas of child survival concept.

TABLE 4: Major Health Problems in the Project areas as perceived by different Project Target Groups.

SEMUTO					BUTUNTUMULA				
PROBLEM	Leaders 10	CHWs 10	TBAs 10	Women 50 (%)	PROBLEM	Leaders 10	CHWs 10	TBAs 10	Women 50 (%)
Water	8	5	3	15 (30)	Water	7	9	7	25 (50)
Malaria	9	5	3	11 (22)	Malaria	3	1	5	2 (4)
Food insecurity	4	3	5	11 (22)	Food insecurity	6	8	6	10 (20)
ALRTI Sanitation Diarrhoea	2	4	2	3 (6)	ALRTI Sanitation Diarrhoea	1	1	-	10 (20)
AIDS	1	-	1	-	AIDS	1	-	-	1 (2)
AIDS	-	-	1	-					

TABLE 5: Knowledge about Family Planning, Mother C-are, Child Care and Immunisation by TBAs in the two Project Areas.

FACTORS	SEMUTO TBAs (10)	BUTUNTUMULA TBA TBAs (10)	TOTAL n = 20
Identify correctly 3 FP methods:			
Yes	8	8	16 (80)
No	2	2	4
Aware of schedule for measles vaccine:			
Yes	6	7	13 (65)
No	4	3	7
Could explain reasons for immunizations:			
Yes	5	6	11 (55)
No	5	4	9
Could identify pregnant women at risk:			
Yes	10	7	17 (81)
No	0	3	3
Describe how to care for cord			
Yes	10	10	20 (100)
No	0	0	0
Knew the danger of blood for AIDS transmission during childbirth			
Yes	10	10	20 (100)
No	0	0	0
Had adequate knowledge of presenting AIDS transmission during childbirth:			
Yes	10	10	20 (100)
No	0	0	0

TABLE 6 (a). Knowledge about Family Planning, Diarrhoea Diseases, and Immunisation by Village Health Workers (VHWs) in the two Project Areas.

FACTORS	SEMUTO CHWs (10)	BUTUNTUMULA CHWS (10)	TOTAL, (2 Project Area n = 20)
Name 3 FP methods:			
Yes	7	6	13 (65)
No	3	4	7
Describe signs for severe diarrhoea in a child			
Yes	9	7	16 (SO)
No	1	3	4
Mention signs of severe dehydration:			
Yes	9	8	17 (81)
No	1	2	3
Describe correctly how to mix ORS			
Yes	8	9	17 (81)
No	2	1	3
Give reasons why child should be immunized:			
Yes.	9	7	16 (80)
No	1	3	4
Correctly describe Uganda's under-one year immunisation schedule:			
Yes	4	8	12 (60)
No	6	2	8

TABLE 6 (b). Knowledge about Malaria, ALRTI, and AIDS by Village Health Workers (VHWs) in the two Project Areas.

FACTORS	SEM-UTO CHWs (10)	BUTUNTUMULA CHWS (10)	TOTAL (2 Project Area n = 20)
Identified correctly that AIDS cannot be transmitted by sharing food with AIDS sufferer:			
Yes	10	2	12 (60)
No	0	8	8
Correctly told how AIDS can be prevented in Uganda			
Yes	8	7	15 (75)
No	2	3	5
Correctly list signs of clinical malaria			
Yes	9	8	17 (81)
No	1	2	3
Correctly described treatment of malaria			
Yes	10	10	20 (100)
No	0	0	0
Correctly described how child with ALRTI presents:			
Yes	10	7	17 (81)
No	0	3	3
Correctly indicated what a CHW should do for a child with ALRTI			
Yes	9	6	15 (75)
No	1	4	5

TABLE 7. Community Leaders' Knowledge and Participation in the Child Survival Project in the Project Areas.

FACTORS	SEMUTO (10)	BUTUNTUMULA (10)	TOTAL 20 (%)
Whether Leader has heard of the project:			
Yes	10	9	19 (95)
No	0	1	1
Whether project has addressed area problems according to Leader			17 (81)
Yes	10	7	3
No	0	3	
Whether leader would like change in direction of project focus:	9	7	16 (80)
Yes	1	3	4
No			
Whether Leader has been involved in major decisions of the project:			
Yes	10	8	18 (90)
No	0	2	2
What they want project to focus on in future:			
- Water (bore-holes)	6	5	11
- Improve income generating activities	2		2
- TBA assistance			
- Drugs	0	2	2
	1		1

4.4.5 Women of Child-bearing age in the project

Family Planning:

Women of the child bearing age who form an important part for the Child Survival were questioned on a number of issues regarding the project to assess their knowledge and practice.

On issues regarding family planning, although most women had heard about family planning, more so from community health workers, few had used or were using family planning methods. However, the number currently using family planning (10% and have used family planning before 24%) far exceed the national average of 5 - 7%. This is one area where the project has made great gains (Table 8).

Immunisation/Malaria

I ' --- ---

It was pleasing to note that most women interviewed had clear and positive answers to why they should take their children for immunisation. This is in one way an indication of the success of the community mobilisation exercise by the project.

There was also evidence to indicate that these women culturally had a symptom complex they refer to as malaria. This is a base from which more sensitization about malaria could be launched especially in regard to acceptance of use of bed nets which appears to be very low at the moment.

Women Health

A substantial number of women interviewed had attended antenatal clinics for their most recent pregnancy and most of them had delivered either in health units or helped by TBAs (Table 10).

Their knowledge about AIDS was quite adequate, however deficiencies were noticed as far as caring for AIDS sufferers were concerned. Most women particularly in Butuntumula thought one could get AIDS by sharing food with someone with AIDS. This is not so and there is therefore the need to sensitize communities so that they get a positive approach to community based care for the AIDS victims (Table II).

Furthermore, although these women had known about condoms, very few had used them and in Semuto all those interviewed had no idea of where to get condoms from in case of need (Table 11).

4.4.6 Children Profile in Project Areas

In Semuto all but one child screened had immunisation cards. In Butuntumula (48%) had cards; and fully immunised were 62% in Semuto and 40% in Butuntumula. These figures show progress from those observed in the baseline survey. There is need to intensify immunisation program in Butuntumula and consolidate in Semuto. Because of large distances between clusters' of populations in the project areas, there is a need to invest more in outreach services (Table 12).

Growth monitoring is still poorly carried out especially in Butuntumula. For the remaining period of the project this area should be given special attention. About 18% of children surveyed in the two project areas had an episode of diarrhoea in the last 7 days, Furthermore, most of these, episodes were managed by giving oral fluids. This is very important finding and indicates how the program through the CHWs had reached the people. Home fluids appear to be 'the most used, and there is a need to increase capacities of utilization of ORS (Table 3).

TABLE 8. KNOWLEDGE ABOUT FAMILY PLANNING BY MOTHERS OF CHILD BEARING AGE IN THE TWO PROJECT AREAS.

Factor	Semuto Women (50)	Butuntumula Women (50)	Total N=100
<u>Heard of FP:</u>			
Yes	46	43	89
No	4	7	11
<u>If Yes, from Who:</u>			
Radio	3	19	22
CHW/Fp	29	13	42
Health worker	12	10	22
TBA	6	8	14
<u>Ever used FP:</u>			
Yes	17	7	24
No	33	43	76
<u>If Yes, what method:</u>			
Pill	6	6	12
Breast-feeding	2	1	3
Injection	9		9
<u>Are YOU on FP now:</u>			
Yes	9	1	10
No	41	49	90
<u>Which method:</u>			
Pill	1	1	2
Breast-feeding	2		2
Injktion	6		6

TABLE 9. KNOWLEDGE ABOUT IMMUNISATION AND MALARIA BY MOTHERS OF CHILD BEARING AGE.

Factors	Semuto Women (50)	Butuntumula Women (50)	Total N=100
<u>Reasons for immunisation;</u>			
Correct	46	44	90
Wrong	4	6	8
<u>Identification of malaria illness;</u>			
High fever & chills			
Loss of appetite & fever	35	31	66
General weakness	7	3	10
Don't know	2	1	3
	6	15	21
<u>Heard about bed net programme;</u>			
Yes	45	37	
No	5	13	
<u>If yes, do you use bed net;</u>			
Yes	2	2	4
No	48	48	96

TABLE 10. ANC AND DELIVERY PREFERENCE OF WOMEN OF CHILD BEARING AGE IN THE TWO, PROJECT AREAS.

Factors	Semuto Women (50)	Butuntumulg Women (50)	Total N=100
<u>Where did you deliver your last baby;</u>			
Health unit			
At TBA's	38	33	71
At home	7	12	19
	5	5	10
<u>Did you attend ANC;</u>			
Yes	45	31	76
No	5	19	24

TABLE II. KNOWLEDGE ABOUT AIDS AND CONDOM USE AMONG WOMEN OF CHILD BEARING AGE IN THE TWO PROJECT AREAS

Factors	Semuto Women (50)	Butuntumula Women (50)	Total N=100
<u>Heard about condoms:</u>			
Yes	47	46	93
No	3	4	7
<u>Have you seen a condom:</u>			
Yes			
No	34	31	65
	16	19	35
<u>Have you used a condom:</u>			
Yes			
No	7	1	8
	43	49	92
<u>If yes where did you get it from:</u>			
FP clinic	5	1	6
Shops	2		2
<u>Do you know where you can buy a condom:</u>			
FP clinic		14	14
Shop		27	27
CHW		7	7
Don't know	50	2	52
<u>Have you heard about AIDS:</u>			
Yes			
No	50	50	50
<u>How would you prevent yourself from getting AIDS:</u>			
Correct answer			
Wrong answer	47	47	94
	3	3	6
<u>Can you get AIDS by sharing food with AIDS sufferer:</u>			
Yes			
No	4	15	19
	46	35	81

TABLE 12. IMMUNISATION AND DELIVERY PROFILE OF CHILDREN IN PROJECT AREA.

Factors	Semuto Under fives (50)	Butuntumula Under fives (50)	Total N=100
<u>Does child have an immunisation card:</u>			
Yes	49	24	73
No	1	26	27
<u>Where child was delivered</u>			
Health unit	38	28	66
TBA's/home	18	22	33
<u>Who delivered the child</u>			
Midwife	39	28	67
TBA	10	9	19
Other	1	13	14
<u>Growth & Monitor card</u>			
Yes	46	22	68
No	4	28	32
<u>Immunisation Status of Child</u>			
Fully immunized	31 (62%)	20 (40%)	51
Not fully immunized	19	30	49
<u>Weight Last Four Months</u>			
Weighed	27 (54%)	6 (12%)	33 (33%)
Not Weighed	23	44	67

TABLE 13. OCCURRENCE AND MANAGEMENT OF DIARRHOEA IN CHILDREN IN THE STUDY AREA

Factors	Semuto Under fives (50)	Butuntumula Under fives (50)	Total N=100
<u>Did child get diarrhoea in last one week</u>			
Yes			
No	7	18	18
	43	32	75
<u>What did you do</u>			
Took to clinic	5	9	14
Managed at home		9	1
Gave fluids	45	32	77
<u>Treated with what</u>			
Home fluids	17	11	78
ORS	30	26	10
Tablet	3	13	4
<u>If ORS. where did you get it from</u>			
Health unit			
CHW	19	26	3
	11		3

5.0 FRAME WORK OF EVALUATION

5.1; **General comments**

There is no doubt that the communities in project area have been mobilized for Child Survival and development. The level of community participation goes beyond mere provision of labour to active involvement in decision making, planning and activity implementation. This is commendable because it provides the basis for sustainability. The general set up of the project which is a multi-sectorial in approach has meant a continuous consultation with other partners working in the project areas and the district as a whole. This should continue, as it strengthens not only the project areas but also the district as a whole.

5.2. **Specific Areas of Evaluation**

5.2.1 Accomplishments:

The project at mid-term has accomplished a lot according to its objectives. In most cases the project has performed beyond the set targets and this has been because of their careful rationalization processes enabling most courses previously planned for residential to be run as non-residential course. This has resulted in many more communities trained without losing quality. Most obvious accomplishments are in areas of

(i) Training

A lot of CHWs and TBAs have been trained and already are practicing (Table' 1). Most of them interviewed had adequate knowledge about key, factors that are crucial for child survival and development. Besides, there has been so far no drop out indicating the high degree of sensitization by project (Tables 5, & 6).

(ii) Community capacity empowerment:

This is in most cases the most difficult to achieve and maintain as most communities tend to "burn" out. However, the tremendous involvement of communities through their village health committees etc. 'evidenced by their regular meetings with minutes indicate a positive success of the project.

(iii) Intervention activities:

(a) Immunisation:

Through the project support, many children have been reached and immunised. In Semuto it is very likely that by the end of 1994 over 80% of children aged 1 - 2 years will be fully immunized,

In Butuntumula, a lot of effort has been put into the immunisation program. The coverage has gone from less than 22% baseline data to about 40% in a period of one year and with no previous community mobilisation activities experienced in Semuto (Table 15). A lot of effort still needs to be put in the area. One major problem identified in Butuntumula that may contribute to the level immunisation coverage is the nature of population in this area. Scatter and sparse - because of this drawback, static immunization centers may not reach the target population. There is therefore a need to investigate more in mobile clinics in order to reach the remote populations.

(b) Mother care

The training of TBAs and therefore change in their practices has by no doubt saved women from dying in childbirth. Most TBAs now refer high risk mothers and encourage pregnant women to attend ante-natal clinic. The results of the survey clearly support this achievement with nearly 90% of target pregnant women attending ante-natal clinic in Semuto and 62% in Butuntumula. (see table 10)

5.2.2 Relevance to Child Survival Problem:

The major causes of morbidity and mortality for children in the project 'area are malaria,' acute respiratory infections, diarrhoea and malnutrition. The project has attempted to address these issues through a Primary Health Care approach. Sensitization of communities about these major diseases has been carried out and knowledge about these diseases by care-givers is now adequate (Table 8,9,10 & 11). Besides active interventions such as availability of anti-malarial, ORS and bed-nets easily accessible to communities are now in place at almost village level. Evidence from survey indicate that ORT and home made solution use in treatment of-episodes of diarrhoea, has increased substantially. (Table 14)

The important aspect and uniqueness of this project is the targeting of communities themselves through intensified CHW and TBA, VHWS training to implement the intervention. This in itself means the interventions in place and their mix are simple, easily applicable at community level with affordable resources and rationalization of finances. This appears to be the major theme of this project which is commendable.

5.2.3 Effectiveness of Project:

The accomplishments so far have been in line with stated objectives. Many times projects tend to, divert away from set objective, but this does not appear to be the case in this project. In fact the progress has been so much especially in area of training that set targets for the project period (3 years) has been surpassed (table 1). Drawbacks have been in supervision, growth and monitoring and availability of simple diagnostic facilities for malaria at health unit levels, These constraints have somehow prevented the project reaching some high risk groups in these specific interventions.

5.2.4 Relevance to development:

The communities targeted for in the project areas suffered massively during the civil war that lasted for more than five years. This resulted in displacement of people, high mortality, infrastructure damage and loss of personal belonging including gardens. Therefore poverty is a strong barrier to their development and to addressing children's needs, Besides the area has many orphans whose needs pose a special problem. Food security and safe water have been' major resulting problems. The project has rightly addressed the issues by initiating income generating activities. Although these activities have not substantially taken off, that environment created is in itself a stimulant for individual families. The empowerment of women through encouraging their participation in leadership role, income generating activities and food security issues has been part of the project and needs further emphasis.

5.2.5 Design and Implementation:

(i) Design

The project was designed, to address health problems of a defined areas, with a targeted population residing the project area. This has been the implementation strategy. However, spill-over services have been given to neighbouring areas which is logical (i.e. community education, immunisation, family planning and malaria control.) A number of changes have been made appropriately 'by management e.g. training more TBAs and CHWs. The explanation given for change in directions are adequate and clearly show that the monitoring process in place is good. Project has been now running for 20 months (started 1.10.1992).

(ii) Management and Use of Data

The project has an effective HIS from MoH, as well as a community-based information systems through CHWs, TBAs and village health committees. These records collected have been simple yet sufficient to address project objectives and monitoring progress of the project . However, the data collected by CHWs which

is vital particularly for malaria has not been well utilized and there is a need to address the situation. Besides most CHWs and TBAs appear not to understand the value of data collected, and we suggest strongly that this be addressed. Most data collected is quantitative in nature although from now and then information originating from discussion groups is collected. The baseline survey data appears to be the reference point for a number of activities, however there is no indication of any other survey so far done for monitoring. What is important is that the project through use of its information system has made many decisions i.e. in change of strategy for training CHW, TBAs; change of strategy in EPI activities, and in supervision. The indicators particularly for malaria, and EPI need refinement. The indicators need to be modified particularly so that they are more action-oriented rather than present training sessions-based indicators.

(a) EPI:

- Reporting on morbidity and mortality from measles, or other six immunisable diseases
- estimation of coverage for EPI antigens in % of target population and not only report number of children covered.

(b) Malaria

- Reports of cases of clinical malaria attended to by VHWs.

(c) Mother care:

I

- Number of pregnant women consulting TBA during pregnancy
- number of pregnant women at risk referred by TBA
- number of deliveries conducted by TBAs

(d) General environmental issues:

- Number of pit-latrines constructed
- number of water supplies constructed, rehabilitated etc.

(iii) Community Education and Social Promotion

This aspect of the project has had the maximum input and has probably had the maximum impact, According to the results most communities are not only aware of the project but also have gained much knowledge from it and changed a lot of their practices in the areas of project interventions.

5.2.6 Human Resources for Child Survival:

The project has a staff of 10 people listed below. The field co-ordinators have local counterparts but it is important to point out that all the staff except one are local Ugandans which in a way is a factor for local capacity building. Their mix has a range of experiences as indicated in their CVs, that meet the expectation of the project even beyond. This seems to be an important factor for the successes of the project so far.

Being a community-based project, multi-sectoral horizontal implementation of the activities is a pre-requisite. This has been met by the much-purpose nature of the workers and their particular experience in such settings from elsewhere. Besides this, project has many community volunteers ensuring sustainability and community ownership.

1	County Director
1	Project Manager
2	Field Co-ordinator
2	Drivers
2	Clerks
2	Typists

Community Volunteers:

10	Trainers TOTs
40	CHWS
40	TBAs
140	VHW

5.2.7 Supplies and Materials for Local Staff

Various materials have been supplied by project to the staff and are being utilized. These include: Educational posters on nutrition, malaria, food, manuals, handouts on various subjects, 'and diarrhoea. Also supplies of ORS, condoms are regular. Each trained CHW receive a drug kit, and TBA a delivery kit in Semuto. This practice needs, to be adopted as a matter of urgency in Butuntumula. The sell of bed-nets has had a slow start. Although contributed to late arrival of bed-nets to project area, there is also a likely load of lack of purchasing power by communities. Although bed-nets are now sold at 50% subsidiary, most people still take the cost to be high. There is the need to sensitize communities about the value of bed-nets and explore ways' of having nets made by community groups to reduce costs and move on sustainability. The TOTs receive subsidized bicycles and field co-ordinators have access to vehicles.

5.2.8 Quality

The quality exhibited by the local staff including the CHW and TBAs is very good. Their knowledge about Child Survival concept is re-assuring, and the practice of counselling women is commendable.

5.2.9 Supervision and Monitoring

The approach used for supervision and monitoring is adequate and is not based on fault finding, but rather educational need finding which, is in itself commendable. However, there is a need, to have more adequate supervisory visits to CHW and TBAs to ensure quality of their work.

5.2.10 Use of Central Funding

There seems to be regular mechanisms of support and monitoring of field activities from the central office. There has also been constant consultations between the field staff and the project coordinator and project director. Such interactions have resulted in the smooth running of the project. Besides the project coordinator spends one week, every month residing in the project areas supporting the activities of the field staff. AID. gave USA \$ 102,444 for administrative monitoring and technical support of the project. These functions supported by A.1.D funds have been very vital for the implementation of the project. So far funds have been utilized for the following items:

- Malariologist - Nairobi AMREF office
- Project Coordinator
- CBHC Facilitator/Trainer - Semuto
- CBHC Facilitator/Trainer - Butuntumula
- Project Drivers

Up to date the project has spent USA \$ 60,834 of the \$ 102,444. At this rate of spending the funding is just about right and there appear to be neither underspending nor overspending.

5.2.11 PVO's Use of Technical Support

The project needed to have a baseline information that would enable it to assess its impact. Besides a number of interventions needed external technical support i.e. malaria control using impregnated bed nets, developing manuals for TBAs and CHWs. So far support has been given in the following areas:

- (a) External technical assistance in malaria control strategies including training
- (b) Baseline survey.
 - It appears that this assistance helped in training local capacities and was valuable. There will be a need for external support in carrying out the final survey towards the end of the project to assess impact.

5.2.12 Assessment of Counterpart Relationships

The chief counterpart organization of the project are: MoH, Mo particularly the district medical office and district executive secretary. Technical implementation of the project, it is the DMO that is involved. The collaborative activities have been in areas of: EPI, FP, training of TBAs, and supervising activities. Exchanges take place in areas of EPI program - AMREF provides transport for outreach activities whereas DMO - office provides the rest. Exchange of education materials take place as well as human resources

5.2.13 Referral Relationships

The project area has a number of referral sites, that are within the district health delivery systems. These are Butuntumula dispensary, Luwero Health centre, Kasaala Mission Hospital, Semuto Health centre and Nakaseke district hospital. From available records, the project appears to have made good use of these facilities and in some instances supported the strengthening of these facilities. There appear also to be good dialogue between the referral sites and the community project. For example, Kasaala hospital stores the vaccines for the project EPI activities; the staff of Luwero Health centre are involved in training of CHWs, TBAs, - AMREF avails their vehicle and Semuto health centre for emergency transportation of sick patients.

5.2.14 PVO/NGO Networking

There has been some network between the project and NGOs operating in the areas. These NGOs are World Vision, Plan International (for Child sponsorship) and Kasaala Mission Hospital. The only noticeable situation is in EPI activities where network with area mission hospital is taking place.

5.2.15 Budget Management

Our overall impression of budget management is that they have been on target and the project although flexible in its budgetary use, the flexibility has been done in instances where project objectives would be enhanced and beneficiaries particularly the children would benefit more. Examining the 1994 Country Project Pipeline Analysis for Luwero Child Survival Project the project has so far spent nearly 2/3 of the total agreement budget for the project period. The project is 2/3 away of the project life. The remaining funds if used according to the work plan will be just sufficient to complete the project. There could be a short fall in funds due to the changing dollar/shilling value. And at this stage there is no indication that the budget will be underspent by the end of the project.

5.2.16 Sustainability

The project has built into the program three main factors that may lead to sustainability. These are emphasis of community capacity building; empowerment of communities for project ownership; and creation of income generating activities for alternative sources of funding for sustainability. However, it is very unlikely that these activities will be mature by end of project and we strongly recommend the extensions of the project for at least three more years to enable the community initiative to grow.

So far the project has created an atmosphere whereby CHW and TBAs are rewarded through sale of drugs (for CHW), fee for service (for TBAs) which has resulted in little or no drop out. Couple with incentives in training, subsidized purchase of bicycles etc., the morale of staff whereby in project is quite high. What is however likely to sustain is the fees for service. Community improvement, MoH involvement take place not only at planning but also at implementation, management and monitoring of project activities. This is almost total county participation. The mechanisms for this to continue appear to be still fragile at this stage.

5.2.17 Recurrent Costs and Cost Recovery Mechanisms

There is no doubt that the Country Director and Project Coordinator have a good understand@ of the resources required as inputs to sustain effective child survival activities. Their emphasis on building community capacities such as CHWs and TBAs underscores their preoccupation of.. sustainability of the activities beyond the project life.

Costs that appear to be unlikely to be sustainable in these communities are those related b purchase of bed-nets by individual families.