

**MINNESOTA INTERNATIONAL
HEALTH VOLUNTEERS -
SSEMBABULE CHILD SURVIVAL
PROJECT, UGANDA**

FINAL EVALUATION REPORT, OCTOBER 1996

Prepared by :

Dr. Anthony K. Mbonye
Dr. Sebastian O. Baine

MIHY Uganda:

Jolene Mullins, MPH, Project Director
Timothy O'Hearn, MPH, Volunteer Administrator
John Kizito, General Services Manager
Mary Ssewamuwe, Program Coordinator
Mary Bukenya, Community Development Coordinator
Elijah Talemwa, Health Educator

MIHV-USA:

Garth Osborn, MPH, Director of Programs
Cecilia Goetz, MA, MPH, Program Officer

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**Prepared by : Dr. A.K. Mbonye*
Dr. S.O. Baine****

**Commissioned by : MIHV Project
P. O. Box 897, Ssembabule, Masaka.**

*** Principal Medical Officer, Maternal Child Health/Family Planning Department,
Ministry of Health, P.O. Box 8, Entebbe - Uganda.**

**** Lecturer, Institute of Public Health, Makerere University
P. O. Box 7072, Kampala - Uganda.**

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Finally the team congratulates MIHV field staff, community health volunteers, the community leadership in the project area and the residents of Ssembabule sub-district for the great achievements in the promotion of health care.

Dr. A.K. Mbonye

Dr. S.O. Baine

October, 1996

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AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BCG	Bacilli-Calmette-Guerin Vaccine
CBD	Community Based Distributor
CBHC	Community Based Health Care
CDD	Control of Diarrhoeal Diseases
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSP	Child Survival Project
DHT	District Health Team
DIP	Detailed Implementation Plan
DISH	Delivery of Improved Services for Health
DMO	District Medical Officer
DNO	District Nursing Officer
DPT	Diphtheria-Pertussis-Tetanus Vaccine
FINCA	Foundation for International Community Assistance
FP	Family Planning
HIS	Health Information System
HIV	Human Immunodeficiency Virus
KPC	Knowledge Practice and Coverage
LC	Local Council
MCH	Maternal Child Health
MIHV	Minnesota International Health Volunteers
MOH	Ministry of Health
NGO	Non-Governmental Organisation
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PNC	Post Natal Care
SOMARC	Social Marketing for Change
STI	Sexually Transmitted Infections
TASO	The AIDS Support Organisation
TBA	Traditional Birth Attendant
TOT	Trainer of Trainers
TT	Tetanus Toxoid
TTBA	Trained Traditional Birth Attendant
UNEPI	Uganda National Expanded Program on Immunization
USAID	United States Agency for International Development
UWESO	Uganda Women's Effort to Save Orphans

EXECUTIVE SUMMARY

The primary goal of the final evaluation of the Minnesota International Health Volunteer (MIHV)-Ssembabule Child Survival Project was to assess the impact, effectiveness and sustainability of the project.

This report reviews MU-IV's revised Detailed Implementation Plan (DIP) presented in the January 1995 Annual Report and proposed activities, and tracks the process of implementation of these activities to the end of the project. It also measures the program output against the set targets. Finally, the report looks at the project support, collaboration with Government departments, other NGOs and community participation in order to analyze the sustainability of the project.

Overall, the project performance has been excellent, largely due to community participation, close collaboration with the district health system and, above all, use of appropriate strategies and interventions requiring minimal resources.

The project has made significant contributions to the community's awareness of health problems. Knowledge of causes, symptoms and simple treatment of common diseases such as malaria, diarrhoea, and acute respiratory infections is high.

Basic knowledge on breastfeeding and nutrition is also high. Health behavioral practices have improved over the life of the project. More women take their children for medical treatment and access immunisation services than prior to implementation of the project.

Knowledge and behavioral practices regarding breastfeeding, family planning, antenatal care, nutrition (particularly Vitamin A), HIV/AIDS, and child care have improved significantly during the project period. The project has contributed to community capacity building by training volunteer health workers, particularly immunisers, TBAs, CBDs, peer educators, and teacher facilitators. MIHV has also trained health unit staff to act as TBA trainers and immunization supervisors, and to perform other activities. Volunteer health workers have been equipped to facilitate their work. However, the project performance has been hampered by lower than projected immunisation coverage rates due to the loss of volunteer immunisers, a direct result of the lack of motivation and monetary incentives.

The project's performance on the management of diarrhoeal diseases has also been below expectation. Prevalence of diarrhoea has increased while, at the same time, knowledge on signs/symptoms, feeding practices and home management of diarrhoea has declined.

Collaboration with the local community also fell below the project's objectives. The steering committees which were proposed to give direction to the project have not been functional since their formation. Although the mid-term evaluation recommended dissolving these committees, the final evaluation team feels that these committees would be a valuable resource to MIHV and provide "ownership" of the project to the community.'

In conclusion, the project has largely achieved its objectives and goals and, over time, the project has learned many important lessons. Working in a remote rural area with minimal facilities and achieving significant health care promotion has been a great public health experience both to MIHV field staff and the benefitting communities.

The evaluation team presents the following recommendations for improving the performance during the next project phase:

- Directors of the project should sign long-term contracts so that there is sufficient time with minimal interruption to sustain the progress of project activities.
- The position of Deputy Director for the project should be re-instated. This and any other positions deemed necessary by the project should be nationally advertised and filled by Ugandan nationals, preferably residents of the project area.
- Steering committees should be re-activated to give clear direction and provide more input into project activities.
- The project should work more closely with Local Councils at all levels to ensure adequate mobilization of the communities and project sustainability.

¹Steering committees originally established were viewed as parallel to already existing Resistance Committees (now known as Local Committees or LCs). Therefore, the decision was made for MIHV to work within the already existing structure rather than imposing a new one. MIHV has a close working relationship and collaboration with the LCs.

- In collaboration with health unit staff, the project should provide intensive support and supervision to volunteer immunizers, TBAs, peer educators and community based distributors (CBDs).
- Family planning services should be strengthened by training more family planning providers and equipping area health units.
- The project should endeavor to collect records on all interventions for inclusion into monthly reports.
- The MIHV project should initiate closer collaboration with the Malaria Control Unit of the Ministry of Health, as well as other government departments, for technical guidance and input.
- The project should also endeavor to strengthen its collaboration with other Non-Governmental Organizations operating in the project area, such as Redd Bama and DISH. Joint strategic planning between all organizations would help to avoid duplication of effort and activities.
- MIHV-Child Survival Project should recruit more volunteer immunizers to bridge the gap created by the drop outs. All volunteers should be given terms of reference after they have been recruited and trained. Volunteers should be given regular refresher courses to update their knowledge and skills. The project should also work closely with the DHT to provide an immunisation allowance to volunteer immunisers.
- The project should provide adequate education materials to peer educators for distribution to homes, community centers, and health units.
- More groups should be involved in community development initiatives and dissemination of health messages. These groups should be consulted before the initiation of development activities to assess their capacity and previous experience in order to maximize benefits from activities.
- The project should work closely with other government departments to provide safe drinking water and improve environmental hygiene.

Introduction:

The Minnesota International Health Volunteers (MIHV)- Ssembabule Child Survival Project began its activities in Ssembabule sub-district in 1993. The project operates in the two counties of Mawogola and Lwemiyaga, located in north-western Masaka district. The project setting is a remote rural area with poor roads, no electricity, no modem communication, and a low level of infrastructure and essential services.

The primary goal of the project is to reduce morbidity and mortality among children and women of childbearing age. The project area was selected in consultation with local and national authorities in an attempt to reduce high disease rates and improve access to health services throughout the sub-district.

The main economic activities in Ssembabule sub-district center around subsistence agriculture and pastoralism. The area has two seasonal variations, a dry season and a wet season, The main crops grown in the area are bananas (matooke), beans, cassava, sweet potatoes and groundnuts. The project serves a potential population of 16 1,000 (Housing and Population Census 199 1) and covers an area of 2,500 square kilometres. Religious affiliations include a mixture of Protestant, Catholic, Islam, and traditional religions. The main ethnic groups in the area are Baganda, Banyankole, Banyarwanda and Bakiga.

The Child Survival initiative includes activities related to the following interventions:

- a Increasing immunisation coverage
- Mitigating the impact of diarrhoeal diseases among children through increased use of ORS and appropriate feeding practices.
- Improving breastfeeding practices; improving children's nutrition and Vitamin A intake.
- Controlling malaria in children and women.
- Providing maternity care by increasing antenatal care coverage, improving delivery care and increasing use of and access to family planning services.
- Increasing awareness and prevention of HIV/AIDS infection and other sexually transmitted diseases.
- Introducing community development activities in the project area geared toward income generation to promote improved health for mothers and children.

The project was designed to build the capacity of local communities through training of community health volunteers such as immunisers, TBAs, and peer educators while strengthening

the skills of existing health unit staff.

MIHV has a long term cooperative agreement with the Government of Uganda through the Ministry of Health. The project carries out its activities in close cooperation with the District Health Team (DHT), Masaka. The project has had overwhelming community support through Local Councils and other community based organisations such as women's groups, drama groups, primary schools, etc.

Although initial funding for the project was received in 1993, a delay in signing country agreements and procuring project equipment and offices space delayed the start of activities to 1994. A baseline survey was carried out in April 1994, and a mid-term evaluation was carried out in November 1995.

The final evaluation of the MIHV project began in September 1996 and had two phases. The first phase focused on conducting a Knowledge Practice and Coverage (KPC) Survey while the second phase involved reviewing documents and holding discussions with community leaders, women of reproductive age, members of DHT (Masaka), Ministry of Health officials (Entebbe), USAID officials and MIHY field staff in Ssembabule, local NGOs such as DISH, AMREF and Rotary International.

This report presents findings of the final evaluation. It includes information from the KPC survey, particularly the section on "output indicator-performance". However, the KPC document should be referred to for further information and specific details.

Objectives:

The primary objective of the final evaluation was to assess the impact, effectiveness and sustainability of the MIHV child survival project.

Methods:

Sources of data for the final evaluation included:

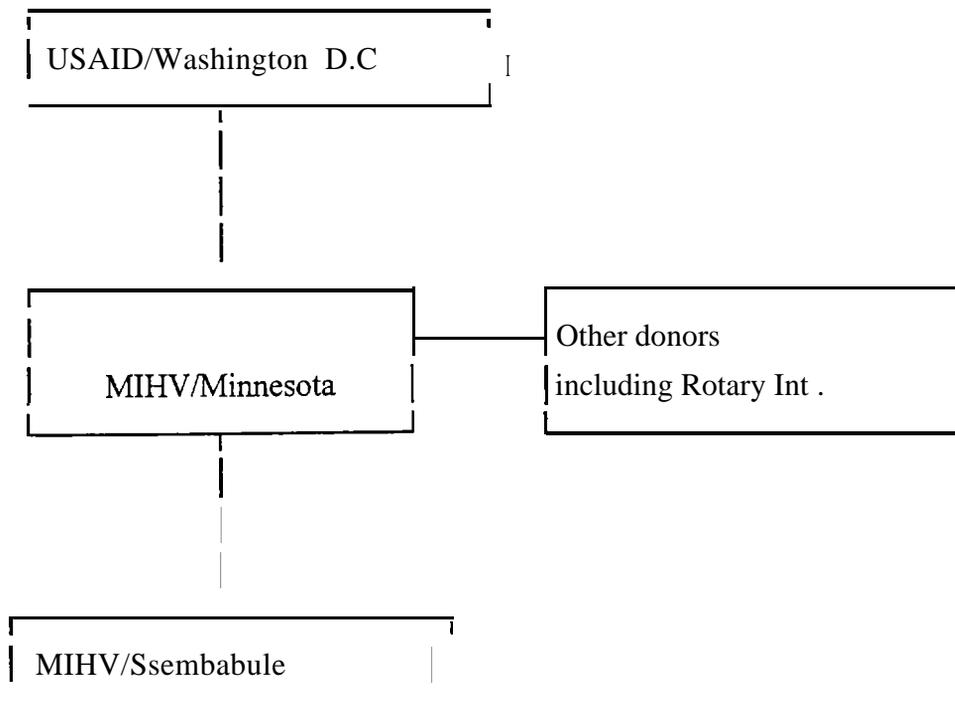
- A. Community meetings and discussions with the following people:
 - Women of child bearing age in each sub-county,
 - Local Councils, TBAs, immunisers, women groups, community health workers, CBDs, peer educators, peer educator facilitators, and other opinion leaders in each sub-county.
 - Discussions with MIHY field staff.
 - Discussions with DHT, Masaka
 - Meeting with Rotary Club President, Masaka.
 - Meeting with DISH personnel
 - Meeting with USAID officials
 - Meeting with Ministry of Health officials in Entebbe and Kampala.
- B. Review of documents:
 - MIHV Revised DIP as presented in the January 1995 Annual Report
 - Annual Reports
 - Monthly Reports
 - Baseline KPC Report, 1994
 - Mid-term Review Reports, 1995
- C. The KPC for final evaluation.
- D. Johns Hopkins University Guidelines for Evaluation of CSP.
- E. USAID Guidelines for the Final Evaluation of CSP.

PROJECT SUPPORT

The project design allows partnership between the Minnesota International Health Volunteers (MIHV), the Ministry of Health through the District Health Team (DHT), health unit staff and beneficiary communities.

RESOURCE SUPPORT FOR THE MIHV PROJECT

Project funding



The project is centrally funded by USAID/Washington D.C. However, the project has also received financial support from other donors such as Rotary International, and Colonial Church of Edina. All the funding received by MIHV/Ssembabule is received through MIHV headquarters.

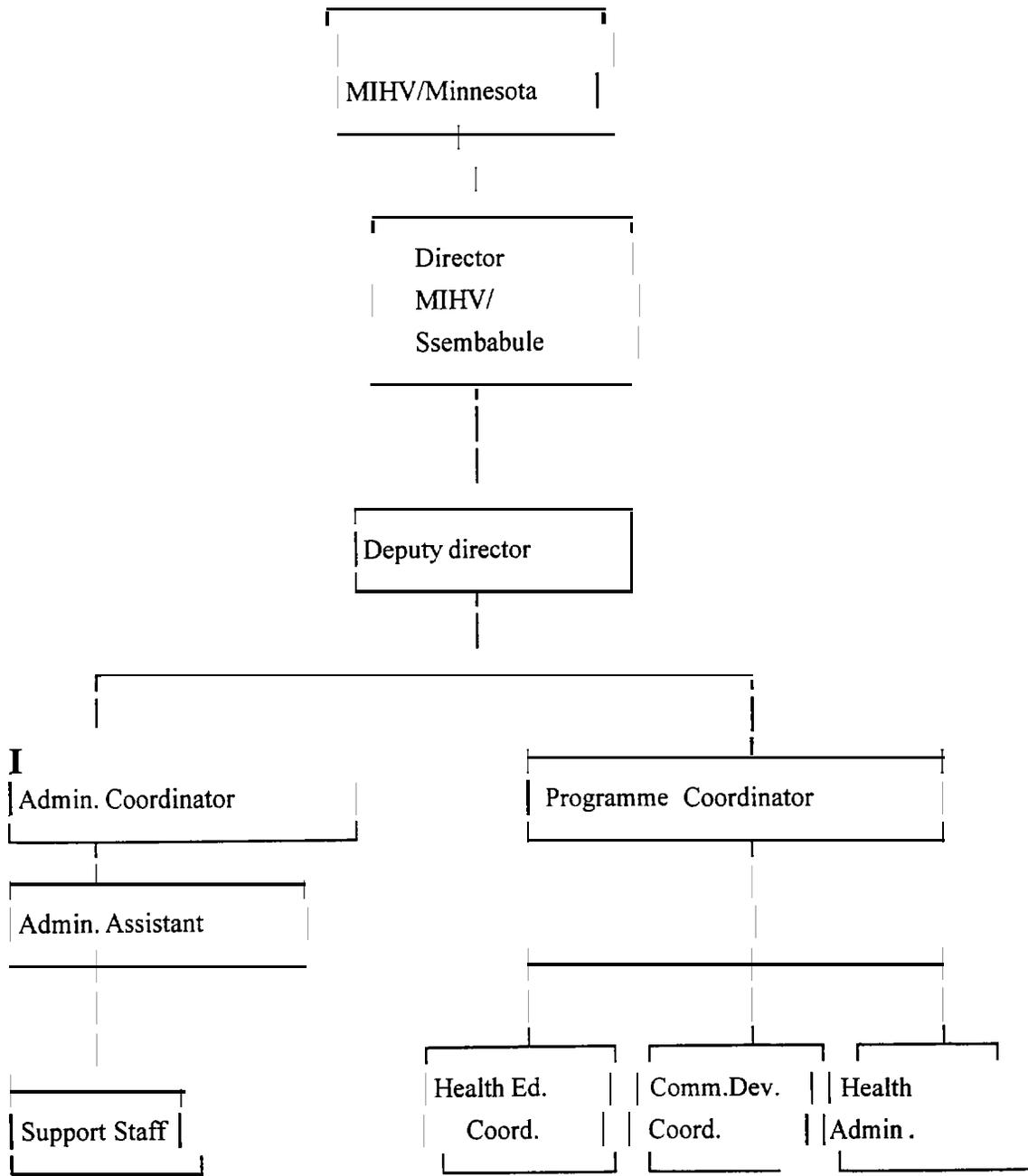
Personnel for the Project

The project staff is composed of international volunteers and Ugandan nationals. The national staff hold positions in project administration, support, and community volunteers.

During the initial phase of the project, volunteer immunisers were selected with the assistance of the Local Councils (LCs), UNEPI and the DHT. The criteria used for selecting these volunteers was very specific, and stated that candidates had to be indigenous to the area served, able to provide time for voluntary services, and have a source of income independent of their volunteer work.

ORGANIZATION STRUCTURE

The evaluation team reviewed the organisational structure as proposed in the revised DIP and noted that this has not been followed. The structure below is proposed by the team to enhance the functioning of the project. Proposed Project Structure:



The evaluation team noted a high turnover rate for the Project Director position. For example, the project has had three Directors since its inception. The evaluation team suggests that this could have a negative effect on the progress of the project as each director has his/her administrative methods and needs time to adjust to the system at the expense of the project. The evaluation team recommends that directors make long-term contracts so as not to impede the project's progress.²

It is also recommended that the Deputy Project Director position be re-established. The Deputy Director should be a Ugandan national **from** the project area willing to work and reside in Ssembabule. This will increase the community's perception of themselves the "owners" of the project. The position of Deputy Director, and other positions deemed necessary by the project, should be advertised nationally.

In the initial phase of the project, steering committees were formed with the assistance of Local Councils. However, as the project continued, a gap developed between the project, Local Council members and the steering committees. The committees had no legal authority to implement decisions. This has resulted in the Local Councils not always taking an active role in achieving the objectives of the project, for example mobilisation of the communities. However, even without Local Council mobilization, the communities actively participate in all project components.

Efforts should be made to increase the involvement of Local Councils. This will make the project be seen as the community's project. Increased mobilisation of the community will help to guarantee sustainability of the project activities even after MIHV has left the project area.

² The first Project Director was a transitional director, hired for six months to replace the Project Director rerouted to MIHV's Kenya project following the debilitation of the Kenya Project Director due to a motor vehicle accident. The second Project Director served in Ssembabule for two and a half years. Our current and third Project Director has been hired on a two year contract. During this time, a Ugandan national will transition in and take over the running of the project for the remaining grant period.

COMMUNITY INVOLVEMENT IN PROJECT ACTIVITIES

The beneficiary communities have contributed to the success of the project in a number of ways:

Immunization

Volunteer immunizers from the project area have been recruited, trained and equipped. These volunteers actively participate in immunization outreach and static sessions. This has increased the number of immunization opportunities for women and children in the project area.

Traditional Birth Attendants

At least one traditional birth attendant has been trained in each parish of the project area with the exception of areas where they do not exist. TBAs have been supplied with safe delivery kits and, in addition to providing better services to women in labour, they have offered to train other traditional birth attendants.

Peer Educators

Nearly ninety school-age children have been trained as peer educators. Peer educators, working with project trained teachers and mentors, have been trained in basic causes of HIV/AIDS and effective measures for prevention. Using an integrated approach, peer educators have also been trained in other areas of prevention and health promotion such as control of diarrheal disease, and malaria, and improved nutrition. The peer educators have produced health education materials (skits, songs, posters) which they use in teaching other children.

Malaria

One hundred sixty-seven (167) drug shopkeepers in the project area have received a one-day training on malaria care. Thirty (30) resource shopkeepers were selected to receive additional intensive training. Following this in-depth training, shopkeepers were provided with calendars imprinted with proper chloroquine dosage for varying age groups. The training has aided the shopkeepers with recognizing basic symptoms of malaria. It has also served as a reminder to shopkeepers that they are not medical professionals, can not prescribe drugs, and have a

responsibility to the community to refer to health professionals as necessary.

The drug shopkeepers were also trained on the proper preparation of oral rehydration solution (ORS) for treatment of diarrhoea. These trained drug shopkeepers have served their communities by providing adequate treatment for malaria with chloroquine and assisted in reducing morbidity and mortality due to diarrhoea-related dehydration.

HEALTH EDUCATION

Health education is an integral part of all the activities in the project.

Educators, school children, health workers, women's groups, TBAs and drug shopkeepers have been trained and participate in the dissemination of health messages in the areas of HIV/AIDS prevention, home management of diarrhoea, nutrition, immunization, etc., to communities within the project area. Ministry of Health, UNICEF, AMREF, DISH and MIHV have provided information, education and communication (IEC) materials used in training and for dissemination of health messages.

COMMUNITY DEVELOPMENT PROJECTS

Community development projects aim to improve nutrition and generate income for families within the project area.

Seven women's groups were provided with local breed steers (three for each group) as an introduction to animal husbandry. As women gain experience in caring for local steers, the mature animals will be sold to obtain funds to buy improved breed dairy cows. The dairy cows will provide milk for family consumption in addition to generating income through the sale of excess milk.

Seeds for demonstration gardens and other small animals projects such as rabbits, chicken and turkeys, are also available. The project has provided two passion fruit seedlings to each woman and to local community health volunteers. The fruits will be utilized by group members as well as sold to obtain money to purchase items needed by the family or group.

These community development projects were noted to be a great support in income generation and promotion of health care. They are sustainable and all geographic areas of the project are involved.

DISTRICT HEALTH TEAM

The District Health Team (DHT) supports the project by providing technical and logistical support. The district health team has been actively involved in the selection and training of volunteers and has conducted workshops in coordination with the project. The DHT is responsible for maintaining the cold-chain system for immunization activities, and participates in support and supervision of the local volunteer health workers and traditional birth attendants.

The District Medical Office is currently considering ways to motivate the local volunteers and hopes to eventually provide sustainable incentives in the form of allowances.

HEALTH INFORMATION SYSTEM

Government health workers at area health units maintain records of their monthly activities. To

date, project staff have only collected immunization records for inclusion into the monthly project reports. These reports are distributed to the District Medical Office, the Ministry of Health, and other interested parties such as Rotary Club/Masaka, Uganda National Expanded Programme of Immunization (UNEPI), and Delivery of Improved Services for Health (DISH), and local authorities.

Health information flow between the MIHV project and the government health system and other organizations is incomplete as not all project interventions are addressed. Records of other interventions should be collected by the project and compiled for inclusion in the monthly report.

PROJECT LINKAGES AND COLLABORATION

Collaboration with District Health Team

MIHV project works in close collaboration with the DHT as earlier indicated. MIHV project activities are incorporated into the District's strategic plan for health. The District Medical Officer serves as the Chairman of the General Steering Committee of the Child Survival Project. The District Nursing Officer is the project liaison for MIHV/Ssembabule.

The DHT has participated in the training of TBAs, CBDs and volunteer immunisers. The DHT supervises the health unit staff and volunteer immunisers. The evaluation team notes this close collaboration and found that in the two months prior to the evaluation exercise, the DMO had visited the project area three times.

The project also works closely with health units in the project area. Health unit staff have received training and been called upon to supervise volunteer immunisers and TBAs. Health unit staff also are facilitators for TBA training. The project has provided funds for the training of Ssembabule health unit staff in Reproductive Health Services (RI-IS).

MII-IV project occasionally provides transport for patients from Ssembabule Health Centre to Masaka Hospital or Villa Maria Hospital. MIHV project also assists with transportation of gas cylinders and vaccines to peripheral health units and immunization outreach sessions. The project support the Cold Chain Technician by providing fuel and per diem for monthly

monitoring of the sub-district's refrigerators.

Collaboration with NGOs

MIHV has collaborated very well with Redd Bar&Norway, an NGO carrying out activities within the district. Project staff has jointly trained TBAs with Redd Barna but the team felt this collaboration was not strong and could be strengthened further in areas of supervision, IEC, strategic planning, etc. There has also been collaboration with the AMREF/DISH project and SOMARC. AMREF/DISH has assisted in the training of TBA trainers, TBAs and two Midwives in reproductive health skills, ST1 diagnosis/management and provision of family planning services. AMREF/DISH has utilized MIHV staff and the project's Ssembabule training site and has used the Ssembabule Health Centre as a practicum site for comprehensive nurse training.

Collaboration with Other Government of Uganda Departments

MB-IV has collaborated with the Ministry of Agriculture, Animal Industry, and Fisheries in its community development activities. They have accessed the experience of the Veterinary/Agricultural staff in establishing passion fruit and livestock projects including cattle, rabbits, chicken, and turkeys.

The collaboration with UNEPI at the Ministry of Health headquarters, Entebbe, has been good. UNEPI participated in the training of volunteer immunisers, and physicians from UNEPI have periodically visited the project area on supervisory visits.

The Director of Health Services (Operations) at the Ministry of Health, UNEPI, and the DHT (Masaka) regularly receive monthly reports of project activities.

The project has not received maximal benefit from the technical expertise of the Ministry of Health's Control of Diarrhoea Diseases (CDD) Division, Malaria Control Unit or Maternal and Child Health Department. The project staff reports that attempts have been made to access the resources of these programs, however, more effort should be made to improve the collaboration with these divisions. It should be noted, however, that the Malaria Control Unit has requested the training materials developed by MIHV for possible implementation by the Unit.

The evaluation team also noted that MIHV has not yet exploited possible collaboration with the

Community Development Assistants of the Ministry of Gender and Community Development.
The Community Development Assistants are stationed at each sub-county and can be utilized to mobilise varying groups of people for community development.

Recommendations

- o MIHV project should work more closely with NGOs resident in the project area at a planning and implementation level to avoid duplication of activities and complement each other's experience in project activities. The DHT should endeavor to coordinate the activities of these NGOs. MIHV should increase its work with DISH to enhance the reproductive health component, IEC and clinical skills for health unit staff.
- o MIHV should endeavor to work with other government departments, particularly community development assistants.
- o MIHV should involve other local groups in community development activities for example: "BIKAOGUZE" (thrift and loan scheme), MUNNO MUKABI, UWESO and FINCA.
- o MIHV should increase its collaboration with the District Education Office in the peer education program.

The Revised DIP provided for the establishment of A Child Survival General Steering Committee chaired by the DMO. The role of the steering committee was to:

- o "Provide input into the design and implementation of all surveys, researches and evaluation tools.
- o Develop concrete program interventions for each component;
- o To mobilise and pledge, human, financial and material resources.
- o To identify opportunities for integrating health and development activities.
- o To share information on activities relating to health in the sub-district,
- o To facilitate proper, accountable, storage, use and distribution of health commodities

available through child survival programs."³

The composition of the General Steering Committee included the DHT, representatives of the sub-county Local Council III, health unit in-charges within the sub-district, representatives of the Sisters of Kitovu Hospital and MIHV field staff.

The Steering Committee had an executive committee and a sub-committee for each component. The revised DIP, presented in the January 1995 Annual Report, provided for creation of sub-county committees, which were supposed to oversee activities in each sub-county.

The evaluation team noted that, at the time of the final evaluation, none of these committees were functional. Information obtained indicates that after the formation of these committees, no clear guidelines were given as to how the committees would operate in relation to the existing Local Council structures.

There was suspicion and competition between the Local Council committees and the project steering committees with the latter being overshadowed by the Local Councils. Decisions of the project steering committees were often ignored by Local Council committees. The project, however, did not endeavor to streamline the functioning of the committees. The steering committee was simply abandoned.

The evaluation team also noted the community leaders recommended that the project have a sub-county coordinator to oversee project activities and to facilitate communication with the community. The team also noted that Local Councils, particularly at LC III (sub-county) level, should be fully involved in project activities since they serve as decision makers and control local finances. The Local Councils can provide support to volunteer health workers and ensure sustainability of the project, as noted in Lwemiyaga where

volunteer vaccinators receive a monthly stipend from the Local Council of USh 1 0,000/= (USD 10.00) for their services.

It is therefore recommended that:

- The Chairman of the sub-county committee should either serve as Coordinator of

³ MIHV Detailed Implementation Plan, P. 27-28.

project activities within each sub-county or appoint a Coordinator.

- The Local Council III members should be members of the sub-county steering committees.
- MIHV should assist both committees to function by providing reasonable support in the way of transportation allowances and meals.

PROCESS INDICATORS: EVALUATION OF PROJECT PERFORMANCE

This section on process indicator-performance compares the proposed input activities for each component, as detailed in the revised DIP, with activities actually carried out by the project. Some indicators and targets were revised and are used in the analysis.

Table 1 .00 below shows the training scheme in the project area.

Table 1 .00: Training Scheme for Ssembabule Sub-District

CADRE TRAINED	TARGET	ACTUAL NO. TRAINED	% ACHIEVE
Volunteer Immunisers	40	40	100%
TBAs	74-96	82	85.4%
Education Session to Women Groups	10	7	70%
Peer Educators	210	280	133%
Teachers Trained	140-210	70	33.3%

Training was carried out for various groups of volunteers such as teachers, traditional birth attendants; immunizers and peer educators as noted in Table 1.00.

Table 2.00 below shows the drop out rate of various cadres of volunteers trained in some parts of the project area.

Table 2.00: Attrition Rates of Community Health Volunteers

CADRE	NO. TRAINED	NO. OF DROP OUTS	% DROPPED OUT
Immunisers: Lwebitakuli	6	1	17%
Mateete	8	3*	38%
Peer Education facilitators for Mij wala sub-county	9	2	22.2%
Peer Education facilitators in Matete	8	1	12.5%

*One immunizer transferred to Ntusi, one enlisted in the military, and one transferred to the DMO's office/Masaka.

The drop out rate in Mateete is not indicative of the entire project area. Overall, the attrition rate of volunteer immunisers was less than 10%. However, reasons cited for leaving the program included the lack of monetary incentives and unmet expectations of volunteer health workers.

Immunisation

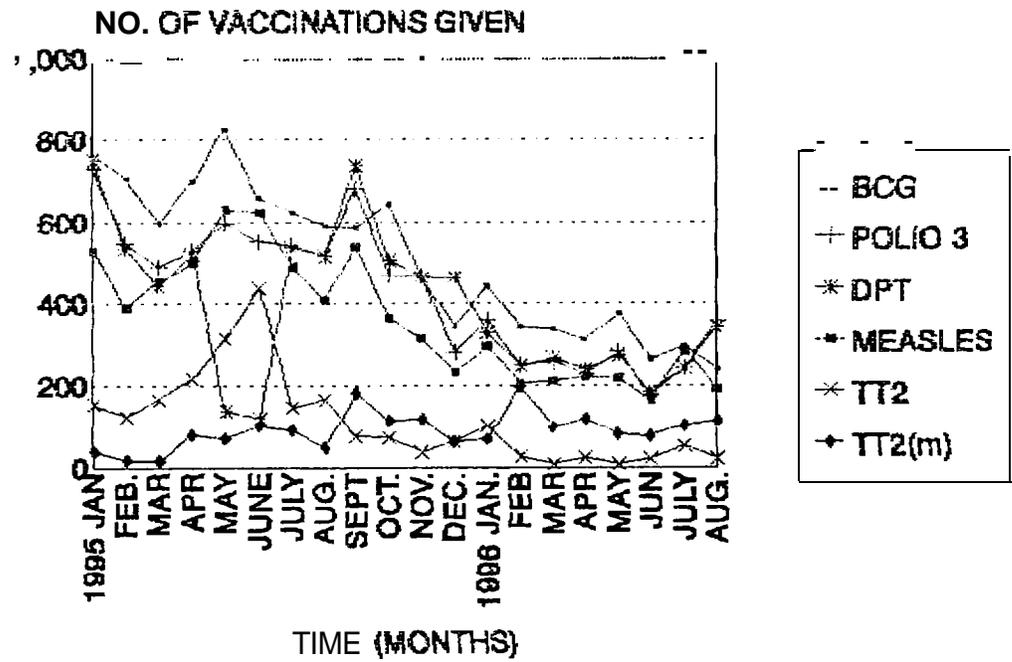
The project has thus far trained 40 Volunteer Immunisers reaching 100% of its target. The trainings were conducted with input from UNEPI and health unit staffs. The National Curriculum for EPI training was used and the recommended duration of training adhered to.

Before, during and after training, the Volunteer Immunisers were told clearly that they would not receive salaries for their services. In fact, selection of these volunteers followed a criteria requiring a volunteer be someone residing in the area with other income generating activities.

The findings of this evaluation indicate that LCs and other community leaders were involved in this exercise. But it seems LCs selected their relatives and/or friends who were unemployed and anticipated future job opportunities. The Evaluation Team learned that the volunteers hoped that at some point they would receive compensation for their services.

MIHV provided each immunisers with a bicycles enabling them to move with ease when traveling to immunisation sessions. They were also provided with rain coats, gum boots and T-shirts. MIHV provided spare parts for the bicycles but no bicycle repair allowance. Due to increased aggrevances by the volunteer immunisers, LCs and other community leaders created a mechanism for motivating immunisers. It was decided that a fee of 100 Ushs (USD .10) be charged for each irnmunisation provided at outreach sessions. The Evaluation Team has learned that because this fee was levied without exhaustive consultation, its management has not been successful. For example with the fee charged at outreach points and not at health units, this has resulted in mothers moving away from outreach centres to avoid being charged. The principle aim of the outreach service is to bring the service nearer to the community. This is now being thwarted. The evaluation team feels that this could be one of the factors related to the observed fall in immunisation rates (see graph below).

IMMUNISATION COVERAGE-SEMBABULE SUB-DISTRICT? (1995-1996)



Source: NHHV (DATA COLLECTED FROM HEALTH UNITS)

A number of volunteer immunisers questioned indicated that they sacrifice a great deal to stop their activities and travel to immunisation sessions. They felt that they should receive an allowance to enable them purchase lunch or a drink. This concern was considered genuine by the evaluation team. The immunisers further identified two sources for this allowance: the MIHV project and/or sub-county funds.

Recommendations

- o MIHV should begin a recruitment drive to secure additional volunteer immunisers to fill the gaps created by non-functional workers.
- o Volunteer immunisers in particular, and all volunteer health workers should receive regular refresher courses to update their knowledge and skills. This would act as a form of motivation and a sign of recognition.
- o MIHV should work closely with the DHT and Local Councils to identify means of providing an immunisation allowance to volunteer immunisers.
- o Although the project has provided two passion fruit seedlings to immunisers as an income generating activity, the scope of this motivation should be increased to include more income generating activities.

Table 3.00 shows the MIHV input activities on immunizations and achievements.

Table 3.00: MIHV Activities and Inputs on Immunisation

Project Proposed Input Activity	Achievement (End of Project)
Select and train 40 community based immunisers	Done
Health unit staff to be trained in collaboration with DMO to supervise immunisation	All Health unit staff were trained before training Volunteer Immunisers
Support through provision of supplies in collaboration with UNEPI	MIHV has provided 5 motorcycles, 40 bicycles and assists in the transport of vaccines to peripheral health units and outreaches.
Home Visits by immunisers	Each immunizer received a bicycle
Involve and train LC members to assist in supervision of immunisation.	Not done

Control of Diarrhoeal Diseases

The baseline study of 1994 showed that diarrhoea and vomiting were prevalent in the project area. The strategy to achieve low morbidity due to diarrhoea proposed to educate mothers on improved hygiene, and proper feeding of children during and after diarrhoea episodes.

The Evaluation Team noted that health messages on diarrhoea management have been passed on to mothers by two categories of health workers: volunteer immunisers and peer group educators.

Peer group educators from Lwebitakuli, Mateete, Mijwala, Lwemiyaga and Ntusi showed a high level of knowledge on causes and control of diarrhoea diseases.

The Evaluation Team noted with satisfaction that the strategy of using “children educators” was most appropriate to bring change of behaviour in their own homes and homes in neighbouring villages. However, supervision of these children should be strengthened.

Table 4.00 shows the MIHV input activities into the control of diarrhoeal diseases intervention.

Table 4.00: MIHV Activities and Inputs on Control of Diarrhoea.

Project Proposed Input Activity	Achievement (End of Project)
Adapt national CDD training curriculum	Done
Training of Immunisers, TBAs on promotion of ORT	All trained
Peer Educators trained on diarrhoea	280 peer educators trained. 70 Teachers trained.
Training shopkeepers in dispensing ORS	167 shopkeepers - 1 day 30 - 1 week + 10 women's group representatives. All CBDs trained.
Provide health education on home management of diarrhoea.	Done
Collaborate with CDD program in training of health unit staff	No close collaboration
Promote CBD distribution of ORS, immunisers, TBAs	Done

Recommendations

- o MIHV should endeavor to develop or procure education materials on diarrhoea diseases, hygiene and home management of diarrhoea using ORS. These education materials should be distributed to homes and health units in the project area.
- o Women's groups should become more involved in dissemination of health messages particularly in the area of diarrhoeal disease and its home management.
- o Information on prevalence of diarrhoea diseases should be collected from either health units or the DMO's office and analysed noting any trends.

Community Development

This component was not a part of the original project proposal. It was included in the Revised DIP after a donation from the Colonial Church of Edina in the United States. The majority of activities for this component began in 1995.

Ten women's groups were selected based on the recommendations of the Local Councils and other community leaders. Thus far seven groups are active and involved in several income generating activities including cattle rearing, passion fruit cultivation and vegetable growing. Two women's groups are also involved in tree planting activities.

The baseline report of 1994 indicated that the project area had ten women groups, twelve school PTA, two CBHC groups, Safe Motherhood, Miteete Dramatic Society, Disabled Children's Association, TASO and Mothers Union. The Evaluation Team did not feel that the majority of these groups have been involved in MIHV community development activities.

Through discussion with members of some women's groups, it was found that MB-IV has not always provided the women with their top priorities in income generation activities. Although women were asked to prepare a "wish list" during the initial phase of their intervention, not all the items requested were provided.

It was also noted by the evaluators that MIHV community development initiatives have not

involved the Community Development Assistants who are active in each project sub-county. Their experience should have been tapped in identifying women's groups having specific skills and experience in income generating activities. The Community Development Assistants should also be used for supervision and monitoring of project activities.

Overall, this is the most impressive component of the project. It promotes health through development initiatives. Collaboration with the Veterinary/Agricultural Officer has brought in a great deal of technical support and innovations which should be carried forward and expanded in the future.

Recommendations

- o More community groups should be involved in community development initiatives and dissemination of messages. More women's groups should be formed to cover the entire project area.
- o There is great potential in tapping existing community capacity through Community Development Assistants. They should be involved in MIHV activities.
- o Women's groups should be surveyed and consulted before initiation of development activities to assess their ability and previous experience in order to maximize management of income generating activities.
- o The project should involve Local Councils in its activities for increased mobilisation of the communities and co-ownership of the project.

Maternal Care

The Revised DIP identified the leading factors in maternal morbidity as anaemia, malaria, limited access to services, and poor nutrition. The strategies to improve maternal morbidity include supply of contraceptives, antenatal care, and identification of high risk pregnancies. As stated earlier, MIHV works closely with health unit staff (midwives), the DHT, Redd Bama and

TBAs in a coordinated effort to improve maternal health.

At least one traditional birth attendant has been trained in each parish in the project area (totalling 83). The three part, three week training covered the areas of nutrition, health education, malaria, management of pregnant women and women in labour, and referral of women with indications of high risk pregnancy to health units for further management.

Maternal record charts and referral forms were supplied to provide guidance to traditional birth attendants on how to assist and determine when to refer mothers to health centres respectively. Traditional birth attendants were also equipped with a simple safe delivery kit with the understanding that the community would replenish it.

Support supervisory visits are conducted bi-monthly during the training period and once every three months after completion of the training. Supervision is provided by the project midwife in cooperation with staff at the area health units (both government and NGO). The trained TBAs have offered to train others. The project has also facilitated the training of two health unit staff members from Ssembabule and one from Lwebitakuli as trainers of trainers (TOT) to participate in support supervision.

Table 5.00 shows MIHV input activities on maternal care.

Table 5.00: MIHV Activities and Inputs on Maternal Care

Project Proposed input Activity	Project Achievement (End of Project)
Adapt MOH TBA training Curriculum	Done
Train Midwives as TOTs for TBAs	Done
Train 76-96 TBAs in three groups through one week session per group	Done
Assess training through 1 month field supervision.	Done but constrained by understaffing and large project area
Provide essential commodities for safe delivery (TBA Kits).	Done
Collaboration with SOMARC in social marketing and cost recovery.	Done
TTBAs to assist LCs and steering committees in identifying pregnant women.	Not done

It is noted that traditional birth attendants have formed associations at sub-county levels (e.g. Mijwala). Each association is to hold monthly meetings. This will help member TBAs to improve their performance by exchanging ideas while increase community awareness through their association.

The evaluation team noted that maternity care initiatives have primarily concentrated on TBA training. The training of TBAs was conducted using the National TBA training curriculum and involved health unit and DHT staff, and AMREF/DISH personnel. The midwives interviewed in health units felt the TBA program had significantly improved referral of mothers at risk with

some TBAs accompanying mothers to health units, a practice that was previously non-existent.

MIHV has also trained eight mid-wives from health units as TBA trainers in order to expand the training program and supervision of TBA activities. There are only four trained family planning providers in the project area, one on the MIHV staff, two at Ssembabule's Health Unit and one at the Mateete Health Unit.

The evaluation team observed that some parishes in the project area do not have trained traditional birth attendants. This was due to the following factors:

- o Traditional birth attendants fearing that they would be stopped from practicing;
- o Traditional birth attendants simply do not exist in some parishes;
- o Local Councils were not cooperative and therefore, did not mobilize the traditional birth attendants in their areas to receive training.

These difficulties could be overcome by:

- o Sensitizing the communities and traditional birth attendants about the importance of training and guarantee security for their practice.
- o Involve the Local Council members, recognized as decision makers and implementers, in adequately mobilizing the communities.
- o The project could, depending on its financial capacity, employ an additional midwife to increase the human resources available in the Mother-Child Health and Family Planning component of the project.

It was also noted that support supervision was not adequate due to understaffing. The initiative of CBDs in social marketing of PILPLAN and condoms was not considered by the evaluation team as an adequate strategy to promote use of family planning. Counselling, examination and selection of a suitable method are basic procedures best provided at a health unit.

Recommendations

- o Health units in the project area should be more involved in maternal care. The midwives, nurses, and medical assistants should be receive basic training and refresher courses in family planning. Staff should be provided with skills to better supervise volunteer health workers.
- o Women's groups should be involved in disseminating health messages on maternal care and mobilising women to access antenatal care.
- o The family planning initiative should be re-invigorated as a strategy to promote maternal health. This should be based on the National Policy Guidelines for Family Planning Provision.

CONTROL OF MALARIA

As stated previously, the malaria component was added into the revised DIP in the first annual report, January 1995. MIHV's revised DIP identified strategies to reduce malaria infection in the project area. Both the baseline study of 1994 and the mid-term review of 1995 indicated that malaria rank number one as the most common health problem in the sub-district. The KPC conducted in September 1996 reports that the community still ranks malaria as the most common health problem.

It should be noted, however, that the percentage of people who perceive malaria as a serious health problem has decreased over the life of the project.

Table 6.00: MIHV Activities and Inputs on Control of Malaria.

PROJECT PROPOSED INPUT ACTIVITY	PROJECT ACHIEVEMENT (End of Project)
Adapt National Malaria control materials for use in local languages.	Attempt by MIHV to collaborate with MCU has not been successful.
Orientation of LCs of steering committees, TBAs, immunisers in appropriate treatment of suspect malaria.	Not done.
Provision of health education regarding prevention and treatment of malaria.	Calendars with treatment regimes provided.
Training of drug shopkeepers and drug vendors in distribution of age appropriate doses.	Done with 167 drug shopkeepers.

The evaluation team notes that the malaria control activities did not receive a great deal of input from either the DHT or the Ministry of Health's Malaria Control Unit.

Recommendations

- Awareness on prevention of malaria should be increased through more seminars involving Local Councils, and health unit staff.
- The MIHV project should initiate closer collaboration with Ministry of Health (Malaria Control Unit), the DHT and engage technical persons on short term consultancies to give technical advice on malaria interventions.
- The strategy to clear bushes around homes, control of breeding sites and encouraging the use of bed nets should be embarked on in the next phase of the project.

HIV/AIDS

This project component had the overall objective of reducing the high HIV prevalence in the project area, by increasing HIV awareness and knowledge of prevention methods. The Revised DIP outlined several objectives and strategies to control HIV infection. The Evaluation Team found the objectives and strategies to be consistent with National Policies on HIV/AIDS prevention.

Table 7.00: MIHV Activities and Inputs on HIV/AIDS

Project Proposed Input Activity	Achievement (End of Project)
Adapt National AIDS Control Program Curriculum materials for use in local languages for the project area.	Adapted three HIV/AIDS educational booklets and the School Health Kit on AIDS.
Adapt UNICEF (child to child) peer health education.	Done
Provide training for AIDS prevention for 2 to 3 school teachers for each of 70 schools, 74-96 TBAs and 40 immunisers.	70 teachers trained. All TBAs and immunisers trained.
Support Master teachers to select peer health educators.	Done
Promotion of AIDS protective behaviour through radio, songs, posters.	Done
Community based distribution of condoms in collaboration with SOMARC	Done. A total of 12 marketbooths and 90 CBDs trained.

The project has trained 280 peer educators from 88 primary schools within the project area. The peer educators have been trained on HIV/AIDS, immunisation, control of diarrhoea diseases and malaria. Peer educators have disseminated messages to educate communities through performances utilizing music, drama and poems.

- o A total of 76 school health clubs were formed. These clubs provide health education to their classmates, students from other schools and within their own communities.
- o A minimum of 632 homes in the project area have been visited by peer educators.
- o A total of 97 community meetings, through which health issues were addressed by teachers, were held in the sub-district.

Through discussions with community leaders, peer educators and teachers, the Evaluation Team noted that the peer education program on HIV/AIDS needs to be customized as necessary to respond to sexual-cultural practices and norms where children do not talk to their elders about sex.

Recommendations

- o Discussions with parents and community leaders should be held to discuss and create appropriate messages to be used in peer education.
- o Peer Educators should be facilitated with teaching aids and materials for demonstration purposes.
- o IEC materials should be developed with the input of Peer Educators and distributed widely within the project area.
- o ST1 counselling, diagnosis, and treatment should be implemented at all health units.
- o Refresher courses should be organized for peer educators, teachers and community leaders.

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OUTPUT INDICATOR-PERFORMANCE

This section presents a summary of the major findings of the KPC carried out as part of the final evaluation. The section provides information measuring project out performance.

Knowledge on health and health seeking behaviour

Overall the project has enhanced the communities' capacity to identify factors affecting their health. Malaria is still considered a major health problem to both children and women. For children, this is followed by diarrhoeal diseases, respiratory illnesses, measles, whooping cough, tetanus and worm infection. Skin diseases are also perceived as a major health problem to children.

The health seeking behaviour has improved over the life of the project. The percentage of mothers who sought treatment when a child had an episode of diarrhoea has increased from 63.0% (baseline) to 79.6% (mid-term) to 81.2% (final evaluation).

The percentage of women seeking care for a child with a respiratory illness is high at 81.4%.

Mothers, on the other hand, perceive malaria, complications of child birth, HIV/AIDS, malnutrition and lower abdominal pain as their most serious health problems. The health seeking behaviour of women has also improved over the life of the project. Ante-natal care, for example, has greatly improved with 74.9% of pregnant women visiting a health unit while pregnant.

60.3% of women knew that a pregnant woman should attend ante-natal care in the first trimester. The percentage of women in labour assisted by a trained health worker has increased to 47.6%.

BREAST FEEDING AND NUTRITION

Knowledge on breastfeeding and breastfeeding practices have improved over the project period.

Table 8.00: Mothers Knowledge on Breastfeeding Practices

BREAST FEEDING PRACTICE	BASELINE n=300	MID-TERM n=300	FINAL KPC n=300
<u>Currently Breastfeeding</u>			
a) All Children	84.0%	83.7%	84.3%
b) 20-23 months of age	35.0%	54.5%	36.4%
<u>Currently not breast feeding</u>	n=47	n=49	n=46
a) Ever been breastfed	94.0%	91.8%	95.7%
b) Never been breastfed	4.0%	8.2%	4.3%
Children aged <4 months exclusively breastfed.	65%	83.6%	100%

The percentage of children below four months exclusively breastfed is 100%, and the percentage all children less than two years currently breastfeeding totalled 84.3%.

Other key indicators of maternal perception of the importance of breastfeeding included:

- o Mothers' knowledge of breastfeeding within eight hours of birth was high at 66.7%.
- o 86.2% of mothers believed that a child should be breastfed longer than one year.
- o 79.4% of mothers were able to identify appropriate foods to give children in addition to breast feeding.

An extremely high percentage of households (98.3%) seem to eat iodized salt i.e. salt brought home in a polythene container with words written on it. This has significantly improved during the project when compared to 86.0% at the mid-term evaluation.

The percentage of women who know that Vitamin A prevents night blindness is low but has also improved during the project from 4.0% (baseline) to 6.3% (mid-term) and 7.4% (final evaluation).

Less than half the mothers surveyed (42.0%) consume foods rich in carbohydrates and only 39.6% eat food rich in protein. Only 17% of mothers report eating fruits and vegetables.

Similarly approximately one-third (34.8%) of children less than 2 years are eating foods rich in carbohydrates, while even fewer, 31.8%, are receiving foods rich in proteins and only 13.4% are eating fruits and vegetables. It must be noted here, as in the introduction, that the limited agricultural diversity of the project area creates serious concerns about nutrition.

However, a good percentage of mothers, (43.0%) give cow's milk as a fluid supplement. Other types of fluids such as water, fruit juice, porridge are rarely given. Worth noting, is that 46.7% of children aged less than two years are given mashed bananas (matooke) as semi-solid foods. Although this food is popular in this area, it has low contents of carbohydrates and proteins.

Diarrhoeal Diseases

The prevalence of reported diarrhoea in the two weeks prior to the survey was 39.1%. This has increased from the mid-term level (34.3%). This prevalence is also above the national figure of 23.5% (UDHS, 1995).

The percentage of mothers who increased frequency of breast feeding and continued giving semi-solid food during an episode of diarrhoea decreased below the mid-term findings. However, the percentage of mothers who give increased amount of drinks during an episode of diarrhoea increased from 32.0% (mid-term) to 45.2% (final evaluation).

The percentage of mothers who sought treatment when a child had diarrhoea increased from 63.0% (baseline) to 79.6% (mid-term) and 81.2% (final evaluation). The percentage of mothers seeking anti-diarrhoeal treatment with drugs has also increased, while the percentage of mothers who utilizing ORS, salt/sugar solution, and/or home made fluids has decreased.

Home management of diarrhoea is low. The percentage of infusions given to children has increased from 2.9% (mid-term) to 3.4% (final evaluation) an indicator that diarrhoeal episodes could have been serious. The mothers' knowledge on how to mix ORS is low (40.7%) for all women interviewed. 48.7% of mothers with children who had an episode of diarrhoea in the last two weeks of the survey did not know how to properly mix ORS.

The knowledge of mothers on signs/symptoms of diarrhoea is also low. For example, 18.7% women knew that a dry mouth, sunken eyes and decreased urine output were serious signs of diarrhoea/dehydration.

Table 9.00: Mothers' Knowledge on Management of Diarrhoea

IMPORTANT ACTIONS A MOTHER SHOULD TAKE IF A CHILD HAD DIARRHOEA	MID-TERM 1995	FINAL-KPC 1996
Initiate fluids soon	16.7%	15.0%
Give a child more drink than usual	11.0%	9.6%
Give ORS	26.0%	19.2%
Give child more frequent feeds	4.7%	6.5%
Take child to hospital/health Centre	37.8%	31.6%
Feed the Child more after diarrhoea episode	3.7%	5.7%
Withhold Fluids	2.0%	1.1%
Withhold Foods	0.3%	0.4%
Others	1.0%	7.8%
Does not Know	10.0%	3.1%
IMPORTANT ACTIONS A MOTHER SHOULD TAKE WHEN A CHILD IS RECOVERING FROM DIARRHOEA.		
Give Child more frequent feeds	42.0%	40.0%
Give food with high calorie content	41.0%	30.2%
Give more foods than usual	20.0%	16.3%
Others	2.7%	8.0%

Table 9.00 continued.

	11.0%	5.5%
	MID-TERM JUN 1995	FINAL-KPC 1996
WHAT CAN A MOTHER DO TO PREVENT A CHILD FROM GETTING DIARRHOEA:		
Breastfeeding exclusively for the first 4-6 months.	4.6%	1.9%
Use of safe drinking water	20.6%	26.4%
Wash hands before touching food.	6.3%	11.4%
Immunize against disease (measles)	7.7%	1.2%
Use Latrines	7.6%	10.5%
Do not Know		24.0%
Others	2.3%	24.7%

The mothers knowledge on the management of diarrhoea is low as shown in the above table.

IMMUNISATION COVERAGE

Through discussion with women, community leaders and health unit staff, the evaluation team noted that immunisation coverage could be improved in all project areas visited. Discussions with immunisers indicated that they were not active primarily due to a lack of motivation. Immunisers and community leaders mentioned that the lack of incentives, for example an immunisation allowance to cater for lunch and drinks, was the most important factor in low immunisation rates. A lack of supervision by health unit staff and MIHV staff was also mentioned as an additional demoralizing factor to volunteer immunisers.

The mid-term review indicated that there was a high attrition rate of volunteer health workers, particularly the immunisers. The results shown in table 11.00 indicate that immunisation coverage on all vaccines has dropped to below 50.0% for children aged 12-23 months and those aged less than 12 months. Despite this decline, the percentage of all children less than two years reported by their mothers to have received immunisation was 59.1% and this percentage has increased over the life of the project as shown by table 10.00.

Table 10.00: Immunization Coverage (children who ever received immunization)

CHILD LESS THAN 2 YEARS WHO EVER RECEIVED IMMUNISATION (N=300)	BASELINE 1994	MID-TERM 1995
YES	39.0%	54.7%
NO	61.0%	44.7%
Does Not Know	-	0.6%
MOTHERS' KNOWLEDGE ON MEASLES VACCINATION		
At what age should a child receive measles vaccine:	-	-
Less than 9 months	78.0%	67.7%
9 Months	28.0%	32.3%
More than 9 months	-	-

The percentage of mothers who know that measles vaccine is given at 9 months is low but has steadily increased since the baseline from 28%, to 32.3% (mid-term), to 41.4% (final evaluation). This is an indicator of maternal knowledge of the immunization schedule.

Knowledge on the number of tetanus toxoid immunisations a mother should have is high at 60.5% (2 + 3 injections). Approximately one-third (32.1%) of mothers knew that they should receive five TT doses. 65.7% of mothers had received at least 2 tetanus immunisations and 23.9% of mothers had TT cards.

Access to immunization in the project area is low at 50.0% indicated by the drop out rate for DPT at 28.3% and polio at 27.9%.

Table 11.00: Immunization Coverage of Children aged 12-23 months.

	BASELINE 1994	MIDTERM 1995	FINAL-KPC 1996
Children aged 12-23 months who received immunisations as recorded on the Card		(n=129)	(n=121)
BCG	-	43.4%	49.6%
Polio 1	-	44.2%	50.4%
Polio 2	-	34.1%	44.6%
Polio 3	-	29.5%	36.4%
DPT 1	-	42.6%	50.0%
DPT 2	-	31.0%	41.3%
DPT 3	-	21.7%	35.5%
Measles	-	27.1%	33.9%

MATERNITY CARE

The percentage of women attending antenatal care clinics is high at 74.9%. It is impressive to note that majority of mothers in the project area are attended during ante-natal care visits by health workers. For example, doctors, midwives and traditional birth attendants provided services to 45.2%, 40.3%, and 10.9% of ante-natal clients respectively.

Mothers' knowledge on when to attend ante-natal care clinic while pregnant has increased. For example, mothers who know that they should attend in the first trimester has increased from 46.7% (mid-term) to 60.3% (final evaluation), while those who do not know when to attend has decreased from 6.0% (mid-term) to 1.7% (final evaluation).

Although a good percentage of mothers attend ante-natal clinics, a relatively high percentage of women in labour are unassisted by health workers. For example, 19.7% and 32.3% of mothers deliver while unattended (self) or receiving assistance from a family member. Only 15.0% and 32.6% are assisted by traditional birth attendants or doctor/midwife/nurse.

Very few women (12.8%) receive post-natal care (PNC).

FERTILITY AND FAMILY PLANNING

The desire to have children is still high with more than half (54.7%) of mothers in the survey indicating that they wanted to have another child in the next two years. Women using a family planning method are few (10.0%) probably due to the desire to have more children. Those using family planning methods chose modern methods over traditional with 30.0% receiving injection (Depo-provera), followed by abstinence (23.3%), breast feeding (20.0%), tubal ligation (13.3%), contraceptive pills (10.0%) and condoms 3.3%.

The demand for family planning services has increased from 15.3% (mid-term) to 24.1% (final evaluation) for women currently using a family planning method who did not want a child in the next two years, and 7.3% (mid-term) to 11.3% (final evaluation) of non-pregnant women.

HIV/AIDS

Knowledge on modes of HIV transmission is fair. The majority (51.6%) of mothers knew that sexual contact with an infected person is a risk for HIV transmission. Knowledge on other routes was low. The perceived risk of acquiring HIV is rather high; 33.8% of mothers thought that they were very likely to get HIV while 41.8% believed they were likely to become infected. Only 3.3% of mothers reported that they were not likely to get HIV infection. However, 37.6% of mothers said they were doing something to specifically protect themselves against HIV with 6.3% condoms and 63.2% having only one sexual partner. It should be noted that 84.3% of mothers reported that they had one only sexual partner in the 4 months prior to the survey.

ENVIRONMENTAL HYGIENE

The main sources of drinking water in the project areas are a well (38.2%) and a pond or a swamp (34.5%). Very few mothers reported using water from protected springs (3.7%) or from bore holes (12.5%). 72.5% of homes in the project area had a pit latrine while 27.5% of homes did not. Of those who had latrines, 61.5% of those latrines were noted not to be in good condition by the surveyor.*

The vast majority of respondents 72.6% did not have a proper pit for garbage disposal. Only 4.5% of households had a garbage disposal pit.

* (Roof, solid floor, depth more than 10 ft., a door and strong walls).

MALARIA

The prevalence of malaria is 38.2% over the mid-term prevalence of 30.7%. Malaria episodes in children over 5 years has slightly increased from 21.7% (mid-term) to 25.0% (final evaluation). (It must be noted that clinical and laboratory diagnosis is extremely rare. Bouts of fever, whether malaria or not, are identified and treated as malaria.)

Treatment was sought primarily from drug shops (47.4%), followed by health units (31.6%), community health workers/traditional birth attendants (10.5%), and doctor/nurses (10.5%). This is a good indication that the community has knowledge of where to seek competent medical care

when they suspect malaria. This can be augmented by intensive community mobilization/sensitization and training, and continued training of drug-shopkeepers and health workers.

ACUTE RESPIRATORY INFECTIONS

Since interventions related to ARI were replaced by the malaria component, mothers' knowledge on acute respiratory illnesses is low. There is a need for increased education on recognition of symptoms of acute respiratory illnesses and training related to appropriate medical care for health care providers. This is especially true since the prevalence of acute respiratory illnesses within the project area is high at 43.9%, well above the national figure of 3 1.2% (UDHS, 1995).

It can be assumed that due to the project interventions related to other health seeking behaviour, a majority of respondents (8 1.4%) indicated that medical care for ARI was sought from a trained health worker. This is a good sign of appropriate and adequate management of respiratory illnesses, and a positive dividend of other project activities.

Project Expenditures

Comparing the budget laid out in the original DIP with the actual project expenditures, there are several areas in which the expenditures differed from the original plan. This is mainly due to the fact that the original DIP was amended in the first annual report, January 1995. Several activity categories, such as training and materials, were increased in the amended DIP. The budget set up in the original DIP was not amended at this time. Discrepancies in expenditures on field salaries occurred because we were able to transition from international to national staff earlier than originally anticipated. A final pipeline analysis is attached.

Project Sustainability

As indicated in the preceding sections, sustainability is enhanced by the community support of the project. The community has provided office facilities to the project and has offered local volunteers to carry out activities in each intervention of the project.

In one sub-county, Lwemiyaga, the community supports volunteer immunisers by paying them a monthly allowance. The community has occasionally provided lunch to immunisers, tables, and materials to facilitate outreach immunisations. The recruitment of national staff into the project, and the close collaboration of the project with the DHT and other government departments are positive signs of sustainability.

The project has trained health volunteers (TBAs, immunisers, CBDs, peer educators and teacher facilitators). The project has also upgraded the skills of health unit midwives as TBA trainers and equipped other health unit staff with the tools to supervise MIHV project activities, even after the project has ended. The training of volunteers and equipping health unit staff with skills was considered key to sustainability by the evaluation team.

The project has involved existing local community groups including women's groups and drama groups into project activities. Since these groups have been in the community and are likely to stay, project activities carried out through them utilizing their talents are also sustainable.

The community development activities initiated by the project, i.e. passion fruit and cattle rearing, are long term and self-sustaining. People involved in the project will develop management skills which may last a lifetime and can be passed on to other community members.

Sustainability Chart

Goal	End-of-Project Objective	Steps to Date	Outcomes
<p>A) Increase community's capacity to provide immunization for all children under 5 on an ongoing basis</p>	<p>1) Create a cadre of trained volunteer community immunizers</p> <p>2) DHT and Health Unit Staff will supervise trained community immunizers</p> <p>3) Community leaders understand the importance of and support community immunization activities</p>	<p>1) Trained 40 volunteers to carry out immunization and educate/mobilize community regarding the importance of immunizing children</p> <p>b) Immunizers provided with bicycles to facilitate transport to outreach sites and home visits</p> <p>c) Motorcycles provided to Health Unit in-charges to facilitate supervision and monitoring; costs covered by District Medical Office</p> <p>2a) Involved DHT in training activities and creation of monitoring system</p> <p>b) Assimilated community immunizers into Health Unit structure</p> <p>3) Sensitized community leaders to the importance of immunization</p>	<p>1) 37 volunteer community immunizers currently working (retention rate of 92.5%)</p> <p>2.) District Health Team (DHT) involved in bi-monthly monitoring; cold chain technician carries out monthly monitoring visits</p> <p>3) Overview of project interventions presented to LCs at sub-county level; further sensitization needed at all levels</p>

<p>B) Upgrade skills of individuals providing antenatal health care</p>	<p>1) Expand the availability of safe maternal health services, including family planning, in the project area</p> <p>2) DHT and Health Unit staff will supervise trained Traditional Birth Attendants</p> <p>3) Community leaders understand importance of, and support, proper Maternal Health Care</p> <p>4) Increase access, through local channels, to methods of family planning</p> <p>5) Establish system whereby Health Unit staff midwives provide training to Traditional Birth Attendants (TBAs)</p>	<p>1a) Trained 83 TBAs in safe birthing practices and Reproductive Health Care</p> <p>b) Created local branches of district-based TBA Associations</p> <p>c) Provide locally-available, inexpensive safe-delivery kits</p> <p>d) Provide Reproductive Health Services training for 2 Health Unit staff members in project area</p> <p>e) Set up referral system between Health Unit and TBAs</p> <p>2a) Initiated monitoring and supervision system incorporating DHT and Health Unit staffs</p> <p>b) Monitoring checklist created for use by DHT</p> <p>3) Sensitized community leaders and mothers to the importance of maternal health and antenatal care</p> <p>4a) Trained 90 Community-Based Distributors (CBDs) to supply and demonstrate condoms to local community, and to resupply birth control pills to women already taking them</p> <p>b) Constructed 12 central locations (market booths) for distribution</p> <p>5) Provided Training of Trainers (TOT) training to midwives and other Health Unit staff</p>	<p>1a) 83 TBAs assisting births in safer manner than previous,</p> <p>b) Local TBA Associations meeting monthly, providing support</p> <p>c) TBAs able to re-stock safe-delivery kits inexpensively and independently</p> <p>d) 2 Health Unit staff members trained</p> <p>e) TBAs referring at-risk pregnancies to health units more consistently</p> <p>2) 1 DHT and Health Unit staffs involved with monitoring and supervision of TBAs</p> <p>3) Insufficient sensitization provided</p> <p>4a) 17 CBDs acting as suppliers of family planning methods</p> <p>b) Condoms and birth control pills available through 12 market booths</p> <p>5) Health Unit midwives able to provide training in proper maternal health care for additional TBAs</p>
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<p>C) Promote health-sustaining behaviors among school-aged children (particularly relating to HIV/AIDS Prevention)</p>	<p>1) Create school-based structure for training and supervision of peer educators providing information on child survival initiatives in 70 schools; train 210 peer educators</p> <p>2) DEO will monitor and supervise peer education activities</p> <p>3) Through peer education program, disseminate information regarding health promotion to community</p>	<p>1a) Trained 70 facilitators and coordinators to administer school program</p> <p>b) Implemented peer education program in 88 schools</p> <p>c) Trained 280 peer educators</p> <p>d) Formed total of 76 health clubs to recruit new peer educators</p> <p>e) Adapted national AIDS curriculums for project area and translated into local languages</p> <p>2a) Involved District Education Officer (DEO) in training</p> <p>b) Requested DEO involvement in monitoring and supervision visits to schools</p> <p>c) Developed and field tested supervision checklist for use by DEO</p> <p>3a) 632 home visits conducted by peer educators</p> <p>b) 97 community meetings conducted by facilitators</p>	<p>1a) 7 peer education coordination centers formed—1 coordinator and 9 facilitators trained per center</p> <p>b) 88 schools running program out of target of 70; 125% of target</p> <p>c) 280 peer educators trained out of target of 210; 133% of target</p> <p>d) 76 out of 88 (86%) schools have health clubs</p> <p>e) Adapted 3 education booklets and national school health kit on AIDS</p> <p>2a) DEO involved in 100% of trainings</p> <p>b) To date DEO has not participated in monitoring and supervision</p> <p>c) Checklist developed and utilized by project</p> <p>3) Information provided regarding health promotion</p>
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<p>D) Promote proper care and treatment during bouts of diarrheal disease</p>	<p>1a) Increase knowledge of proper preparation of Oral Rehydration Solution (ORS)</p> <p>2) Increase knowledge of proper nutrition during bouts of diarrheal disease</p> <p>3) Increase access to ORS</p>	<p>1) Trained volunteer community immunizers, TBAs, peer educators, and drug shopkeepers to educate mothers regarding preparation of CRS</p> <p>2) Pefx educators, facilitators and coordinators and TBAs trained and encouraged to provide community education regarding proper nutrition during bouts of diarrheal disease</p> <p>3a) Trained 90 Community Based Distributors (C B Ds)</p> <p>b) Set up linkages between CBDs, District Medical Office (DMO) and Ministry of Health (MOH), Entebbe</p>	<p>1) Through MHHV-trained community members, education provided to community, particularly women of child-bearing age; 52% of mothers surveyed can properly mix ORS*</p> <p>2) 45,246 of mothers surveyed increase children's food and drink during bouts of diarrheal disease*</p> <p>3) ORS now available through 90 CBDs</p>	<p>1</p>
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<p>E) Promote sustained, age-appropriate treatment for malaria by the community</p>	<p>1) Train community resources in proper, age-appropriate treatment of malaria</p> <p>2) Sensitize community leaders to importance of proper malaria treatment</p>	<p>1a) Provided awareness training to 167 drugshop keepers</p> <p>b) Provided extended training to a cadre of 30 "resource" drugshop keepers</p> <p>c) Trained community volunteers, including peer educators and TBAs, on proper, age-appropriate malaria treatment</p> <p>d) Developed malaria training curriculum, adapted it into local languages</p> <p>e) Creation of wall calendars showing proper, age-appropriate doses of chloroquine for malaria treatment in local languages</p> <p>2) TBAs, peer educators, peer educator coordinators and facilitators meeting with LCs</p>	<p>1a) 167 drugshop keepers have knowledge of proper, age-appropriate treatment for malaria after 1-day workshop</p> <p>b) Since 3-day training, 30 drugshop keepers acting as information resources to other drugshop keepers and distributing malaria treatment</p> <p>c) Community Health Volunteers, peer educators and TBAs providing information on proper, age-appropriate doses of anti-malarial drugs</p> <p>d) Curriculum developed and made available to MOH Entebbe for inclusion in national malaria control curriculum currently in development</p> <p>e) 2000 wall calendars distributed to local leaders, local businesses, CBDs, TBAs, peer educators, drugshop keepers, and other community members</p> <p>2) Need for more sensitization</p>
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<p>F) Increase access to child survival and maternal health services by increasing income and knowledge among women of child bearing age</p>	<p>1) Coordinate income-generating and child survival health promotion activities through 2 women's groups in each sub-county (for a total of 10 groups)</p> <p>2) Monitoring and supervision by Agricultural Extension Officers and Community Development Assistants</p>	<p>1a) Identified 10 women's groups with help of local leaders b) Initial inputs (including livestock and cash crop seedlings) provided to women's groups c) Training in animal husbandry and agriculture provided through Ministry of Agriculture (MOA) Extension Officers d) Community development assistance provided by Community Development Assistants from Ministry of Gender and Community Development e) Initiated process of accessing small business loans through nation-wide savings and credit schemes</p> <p>2) Agricultural Extension Workers and Community Development Assistants participated in monthly monitoring and supervision of women's groups during 10 out of the last 12 months of the project</p>	<p>1) 7 women's groups currently functioning and taking part in all activities (retention rate of 70%)</p> <p>2) Agricultural Extension Workers and Community Development Assistants participated in 83% of monthly monitoring and supervision visits</p>
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<p>3) Promote consistent use of condoms for prevention of HIV/STDs</p>	<p>1) Increase access, through local channels, to condoms for family planning and HIV/STD Prevention</p> <p>2) Sensitize sexually active men and women to the importance of proper and consistent condom use</p> <p>3) DHT to provide bi-monthly monitoring of CBDs and TBAs</p>	<p>1a) Trained 90 Community Based Distributors (CBDs) in social marketing of condoms</p> <p>b) Constructed 12 market booths</p> <p>c) Established linkages between national social marketing program and project area</p> <p>2a) TBAs, peer educator facilitators, community mobilizers providing safer sex awareness education and condom negotiating skills</p> <p>b) CBDs providing individualized education through marketing system</p> <p>3) Developed checklist for market booths</p>	<p>1) 90 CBDs are providing condoms and individual education in the market setting</p> <p>2) TBAs provide HIV awareness and safer sex messages during antenatal/postnatal care; peer educator facilitators provide safer sex information to community groups</p> <p>3) DHT needs to become more integrated into monitoring and supervision activities</p>
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PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

Project Accomplishments

Table 13.00 compares MIHV project targets and achievements on child survival initiatives. Overall the project has achieved over and above its proposed targets.

Table 12.00: Project Targets and Achievements on Child Survival Initiative

OBJECTIVE *	PROJECT TARGET (Revised)	END OF PROJECT ACHIEVEMENT 1996
<u>Immunisation Coverage</u>		
Full Immunisation of Children (12-23 months)	30% - 50%	44.0%
Full Antenatal toxoid coverage (2 doses)	17% - 30%	47.7%
<u>Management of Diarrhoea Diseases</u>		
Treatment of diarrhoea with ORT	48% - 60%	23.4%
Continuation of breast feeding during diarrhoea	68% - 80%	96.4%
Continuation of feeding during diarrhoea	67% - 80%	59.3%
<u>Breast feeding Practices</u>		
Breast feeding within 1 hour of birth	35% - 50%	40.4%
Breast feeding within 8 hrs of birth	16% - 70%	66.7%
Exclusive breast feeding of infants up to 4 months	65% - 75%	100%

Table 12.00 continued.

OBJECTIVE *	PROJECT TARGET (Revised)	END OF PROJECT ACHIEVEMENT 1996
Breast feeding children 20-23 months in addition to complementary foods	35% - 50%	36.4%
Mothers reporting need to add oil/sugar	3.0% - 15%	67.6%
Mothers reporting adding Vitamin A (Leafy green vegetables) or foods rich in oil to complementary foods	3.0% - 15%	25.5%
<u>Maternal Care</u>		
Minimum of one ANC visit	40% - 50%	11.6%
Deliveries assisted by a trained attendant	36% - 50%	32.6%
Contraceptive Prevalence among women who do not want pregnancy in the next 2 years	9% - 15%	24.1%
<u>HIV/AIDS</u>		
Use of Condoms for self protection from HIV	0% - 10%	6.3%
7-16 year olds knowing at least three methods to prevent HIV.**	13% - 30%	72.4%

* Adapted from MIHV Revised DIP revised version, Attachment A.

** 3 methods frequently mentioned by mothers on AIDS prevention i.e. Condoms, stick to one partner and avoid sharp instruments are summed up to measure this objective.

The project has achieved its proposed targets on immunisation. This could not have been achieved without extensive mobilisation of the community and the participation of volunteers in immunisation activities. Outreach immunisation sessions have increased and services have been widely distributed within the project area reaching isolated communities. The increase in service availability has been facilitated by increased personnel and facilitation of transport. The drop in immunisation coverage from mid-term levels is primarily due to the loss of volunteer immunisers and lack of motivation in form of incentives.

The project targets on diarrhoea have not been achieved. Prevalence of diarrhoea has increased over mid-term findings which can be attributed to poor environmental hygiene e.g. solid waste disposal practices, and poor access to safe and palatable drinking water. Many of the bore holes within the project area are not utilized due to the high salinity of the water. Knowledge remains low on home management of diarrhoea (proper mixing of ORS, the importance of breastfeeding, and feeding during episodes of diarrhoea).

The project has improved knowledge and practice on breast feeding and child nutrition. Although the knowledge of mothers that Vitamin A prevents night blindness is low, a high percentage of mothers give foods rich in Vitamin A to children. This can be attributed to the success of vegetable gardening and increased information on nutrition.

The project has attained a high level of family planning use. Social marketing of contraceptives and condoms and training of TBAs can be cited as contributing to this. However, maternity care has gone declined, perhaps due to the lack of midwifery services in the project area. The project area has very few midwives and most health units do not offer delivery care.

The project has achieved significant levels of community awareness on HIV transmission and methods of protection. More people now report having one sexual partner and condom use has increased. These achievements can be attributed to peer education and, once again, the social marketing of condoms making them readily available and easy to obtain. These achievements can be consolidated by intensifying activities, designing a supervisory scheme to monitor volunteer activities, and introduce incentives for motivation.

Lessons Learned

The project has met its objective and made its achievements through community involvement in its activities. Where the community has supported immunisers the attrition rate has been low.

Throughout the life of the project, MIHV has become increasingly aware that for effective grassroots involvement and support, entry into the community through existing local structures is paramount.

The most important lesson for promotion of health care is that health and wealth go hand in hand. Income generating activities are an inexpensive and sustainable strategy that can be replicated in other areas of the district and the nation.

Working in a rural area with no essential services has given tremendous public health experience to MIHV field staff and community volunteers. Improving the health status of a rural and isolated communities using minimal resources has largely been achieved through the use of appropriate strategies including accessing the valuable human resources of the community itself. Volunteerism, though new to Ssembabule, Uganda, and Africa as a whole, is the only sustainable intervention when working in grassroots public health. This has been one of the many lessons learned by the project staff and the benefitting communities.